NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

AGENDA

Meeting Title	Inaugural Governing Body Part 1 Meeting	**Date**	Wednesday 12 May 2021
Chair	Dr John Pepper	**Time**	1.00pm
Minute Taker	Corporate PA	**Venue/ Location**	Via Microsoft Teams

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

Reference	Agenda Item	Presenter	Purpose	Paper	Time
GB-21-05.007	Introduction and Apologies	John Pepper	I	Verbal	1.00
GB-21-05.008	Members' Declarations of Interests	John Pepper	I	Enclosure	
GB-21-05.009	Introductory Comments by the Chair	John Pepper	I	Verbal	1.05
GB-21-05.010	Accountable Officer's Report	Claire Skidmore	I	Verbal	1.10
GB-21-05.011	Minutes from previous meetings: • Shropshire CCG and Telford and Wrekin CCG Committees in Common - 10 March 2021 • Shropshire CCG and Telford and Wrekin CCG Extraordinary Committees in Common – 24 March 2021 • Shropshire, Telford and Wrekin CCG - 14 April 2021		A A A	Enclosure Enclosure Enclosure	1.15
GB-21-05.012	Matters Arising from previous meetings: • Shropshire CCG and Telford and Wrekin CCG Committees in Common - 10 March 2021 • Shropshire CCG and Telford and Wrekin CCG Extraordinary Committees in Common - 24 March 2021 – *No further actions noted* • Shropshire, Telford and Wrekin CCG - 14 April 2021		A A	Enclosure Enclosure	1.20

GB-21-05.013	Questions from Members of the Public Guidelines on submitting questions can be found at: https://www.shropshiretelfordandwrekinccg.nhs.uk/about-us/governing-body/governing-body-meetings/		I	Verbal	1.30
Assurance and Committee Reports					
	<u>Quality and Performance</u>				
GB-21-05.014	a) Performance Report	Julie Davies	S	Enclosure	1.30
	b) Quality Report	Zena Young	S	Enclosure	1.40
GB-21-05.015	Findings from Niche consultancy report into the SI processes at SaTH and the system deaths analysis	Zena Young	S	Enclosure	1.45
	<u>Finance</u>				
GB-21-05.016	Finance Report Month 12	Laura Clare	S	Enclosure	1.55
GB-21-05.017	Update on progress against our ICS pledges	Claire Skidmore	I	Enclosure	2.05
GB-21-05.018	IT Strategy Update	Laura Clare Stephen James	S	Enclosure	2.15
GB-21-05.019	Assuring Involvement Committee	Meredith Vivian	S, I	Enclosure	2.20
Decision Making					
GB-21-05.020	CCG Corporate Mission Statement and Strategic Priorities	Claire Skidmore	A	Enclosure	2.25
GB-21-05.021	Operational Plan	Sam Tilley	A	Verbal	2.30
GB-21-05.022	2021/22 Finance Plan	Laura Clare	A	Enclosure	2.35
GB-21-05.023	Governing Body Annual Cycle of Business April 2021-March 2022	Alison Smith	A	Enclosure	2.40
GB-21-05.024	Transition to new CCG – adoption of key strategies and policies: • Commissioning Strategy (App 1) • Communications and Engagement Strategy (App 2) • OD Strategy and Plan (App 3) • Risk Management Strategy (App 4) • Conflicts of Interest Policy (App 5) • Health and Safety Policy (App 6) Adoption of NHS Shropshire CCG and NHS Telford and Wrekin CCG Policies:	Alison Smith	A	Enclosures	2.45

	• CCG Policies for Adoption by STWCCG (App 7) • Medicines Management Policies for Adoption by STWCCG (App 8)				
OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY (Issues or key points to be raised by exception with the Chairs of the Committees outside of the Governing Body meetings)					
	For both NHS Shropshire CCG and NHS Telford and Wrekin CCG Committees in Common meetings:				2.45
GB-21-05.025	Audit Committee – 17 March 2021		S	Enclosure	
GB-21-05.026	Strategic Commissioning Committee – 17 March 2021		S	Enclosure	
GB-21-05.027	Finance Committee – 24 March 2021		S	Enclosure	
GB-21-05.028	Quality & Performance Committee – 24 March 2021		S	Enclosure	
GB-21-05.029	Primary Care Commissioning Committee – 3 February 2021		S	Enclosure	
	Previous NHS Shropshire CCG Reports Only:				
GB-21-05.030	South Shropshire Locality Forum – 4 February 2021, 3 March 2021		S	Enclosure	
GB-21-05.031	Shrewsbury and Atcham Locality Forum – 18 February 2021, 18 March 2021		S	Enclosure	
GB-21-05.032	North Shropshire Locality Forum – 25 February 2021, 22 April 2021		S	Enclosure	
	Previous NHS Telford and Wrekin CCG Reports Only:				
GB-21-05.033	TWCCG Practice Forum – 16 February 2021		S	Enclosure	
GB-21-05.034	Any Other Business	John Pepper		Verbal	2.50
	Date and Time of Next Meeting – Wednesday 14 July 2021 time to be confirmed				
***RESOLVE**:*	*To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)*				

Dr John Pepper
Chair

Mrs Claire Skidmore
Interim Accountable Officer

Members of NHS Shropshire, Telford and Wrekin CCG Governing Body
Register of Interests - 6 May 2021

Surname	Forename	Position/Job Title	Committee Attendance	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			SCC = Strategic Commissioning Committee FC = Finance & Performance Committee Q&PC = Quality & Performance Committee PCCC = Primary Care Commissioning Committee AC = Audit Committee RC = Remuneration Committee	**Financial Interest**	**Non-Financial Professional Interest**	**Non-Financial Personal Interest**	**Direct or Indirect?**		**From (ie review date form completed)**	**To**	
Ahmed	Astakhar	Joint Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion **Attendee**	SCC, F&PC, RC					None declared	1.2.21		
Allen	Martin	Joint Independent Secondary Care Doctor Governing Body Member	Q&PC, F&PC	X			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust, which is a contractor of the CCG	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Member of CRG (Respiratory Specialist Commissioning)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	22.1.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Board Executive member of the British Thoracic Society	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	NHSD. Member of CAB (Casemix Advisory Board)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	National Clinical Respiratory Lead for GIRFT NHS Innovation (NHSI)	22.1.21	ongoing	Level 1 - Note on Register

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					X		Direct	Member of the Long Term Plan Delivery Board (respiratory) with responsibility for the pneumonia workstream	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of National (regional reporting and program) and Regional Long Covid Boards	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Advisory Board Member (at request of RCP) for assessing mechanisms for innovation payment under the aligned incentive scheme (NHSE/I)	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the RCP and HQIP NACAP Board, including the coding and QI improvement agendas	01.04.21	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member for Governance & Audit - **Attendee**	F&PC, RC, AC,				Direct	None declared	20.1.21		Left post on 31.1.21 as a Director in Royal Mail Group, which is not a contractor of Shropshire and Telford CCGs
Bryceland	Rachael	Joint GP/Healthcare Professional Governing Body Member	Q&PC	X			Direct	Employee of Stirchley and Sutton Hill Medical Practice	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Dream Medical in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a provider of executive coaching and consultancy	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is CEO of Tipping Point Training, provider of Mental Health First Aid	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Cawley	Lynn	Representative of Healthwatch Shropshire - **Attendee**	Q&PC					None declared	1.2.21	ongoing	Level 1 - Note on Register
Clare	Laura	Interim Executive Director of Finance	F&PC			X	Indirect	Sister is a physiotherapist at Midlands Partnership	27.1.21		Level 2 - Restrict involvement in any relevant commissioning
Davies	Julie	Director of Performance - **Attendee**	PCCC					None declared	1.2.21		
Ilesanmi	Mary	GP/Healthcare Professional Governing Body Member	SCC	X			Direct	GP Partner of Church Stretton Medical Practice	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Practice is a Member of the South West Shropshire PCN	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a Locum Consultant in Obstetrics and Gynaecology at SaTH	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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James	Stephen	Chief Clinical Information Officer (CCIO)	SCC					None declared	20.1.21		
Kelly	Marion	Representative of Healthwatch Telford and Wrekin - **Attendee**	To be confirmed					To be confirmed			
MacArthur	Donna	Lay Member for Primary Care	PCCC, RC, AC, SCC			X	Indirect	Son's partner is the daughter of a Director working at Wolverhampton CCG	20.1.21	ongoing	Level 1 - Note on Register
Matthee	Michael	GP/Healthcare Professional Governing Body Member	North Localty Forum, F&PC	X			Direct	GP Partner at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	GP Member of North Shropshire PCN	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Wife is Practice Manager at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Noakes	Liz	Director of Public Health for Telford and Wrekin - **Attendee**		X			Direct	Assistant Director, Telford and Wrekin Council	29.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Honorary Senior Lecturer, Chester University	29.1.21	ongoing	Level 1 - Note on Register
Parker	Claire	Joint Director of Partnerships - **Attendee**	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum			X	Indirect	Daughter is working as admin staff for CHC Team and is line managed by the CHC Team.	27.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Pepper	John	Chair	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X			Direct	Salaried General Practitioner at Belvidere Medical Practice (part of Darwin Group)	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Belvidere Medical Practice is involved in the Cavell Centre Project	01.04.21	ongoing	Level 2 - Restsrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	19.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Family member provided evidence to Ockenden Review	01.04.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions or discussions on historical issues raised within the scope of the Ockenden Review. This does not exclude from commissioning decisions or discussions on current maternity and neonatal services or any service provided by SaTH more generally.
Pringle	Adam	Vice Clinical Chair and GP/ Healthcare Professional Governing Body Member	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X			Direct	GP Partner, Teldoc General Practice	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Teldoc is a Member of Teldoc Primary Care Network	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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				X			Direct	Work on a sessional basis for Shropshire Doctors Co-Operative Ltd (Shropdoc) an out of hours primary care services provider, which is a contractor of the CCG.	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Work on a sessional basis for Churchmere Medical Practice	22.3.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Property owner of Lawley Medical Practice site	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - **Attendee**		X			Direct	Director of Public Health for Shropshire	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Interim Medical Director - **Attendee**	PCCC					None declared	19.1.21		
Skidmore	Claire	Executive Director of Finance	F&PC, ACiC, PCCC					None declared	15.1.21		
Smith	Alison	Director of Corporate Affairs - **Attendee**	AC			X	Indirect	Related to a member of staff in my portfolio structure who is married to my cousin. The individual is not directly line managed by me.	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Smith	Fiona	Joint GP/Healthcare Professional Governing Body Member	SCC	X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	20.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Shawbirch Medical Practice is a Member of Newport/Central PCN	20.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Indirect	Son-in-Law works as a technician for the Audiology Team at SaTH	17.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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Tilley	Samantha	Joint Director of Planning - **Attendee**	SCC			X	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	27.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Trenchard	Steve	Joint Interim Executive Director of Transformation	SCC, PCCC					None declared	22.1.21		
Vivian	Meredith	Deputy Chair and Joint Lay Member for Patient & Public Involvement (PPI)	Q&PC, RC, AC, PCCC		X		Direct	Trustee of the Strettons Mayfair Trust (voluntary sector organisation that provides a range of health and care services to the population of Church Stretton and surrounding villages)	26.1.21	ongoing	Level 1 - Note on Register

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				X			Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Warren	Audrey	Chief Nurse	SCC, Q&PCiC					None declared	1.4.21		
Young	Zena	Executive Director of Quality	SCC, F&PC, Q&PC, PCCC					None declared	22.1.21		
MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE NHS SHROPSHIRE AND TELFORD AND WREKIN CCGs WITHIN THE LAST 6 MONTHS											
Evans	David	Joint Accountable Officer	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum, JSCC		X		Direct	Shared post - Joint Accountable Officer of Shropshire and Telford and Wrekin CCGs	2.2.21		Left SCCG and TWCCG on secondment on 31.3.21
					X		Direct	Member of the Telford and Wrekin Health and Wellbeing Board	2.2.21		
						X	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	2.2.21		
Povey	Julian	Joint Chair	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum		X		Direct	Shared post - Joint Chair of Shropshire and Telford and Wrekin CCGs	1.2.21		Left SCCG and TWCCG on 31.3.21
				X			Direct	GP Member at Pontesbury Medical Practice	1.2.21		
				X			Direct	Practice Member of Shrewsbury & Atcham Primary Care Network	1.2.21		

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						X	Indirect	Wife is Member of University College Shrewsbury - Advisory Board	1.2.21		
				X			Indirect	Wife is Medical Director at Shropshire Community Health NHS Trust	1.2.21		
Timmis	Keith	Lay Member for Governance for NHS Shropshire CCG	F&PC, AC, Q&PC, RC								Left SCCG and TWCCG on 31.3.21
McCabe	Julie	Joint Independent Registered Nurse Clinical Governing Body Member	SCC, Q&PC		X			Shared post across Shropshire and Telford and Wrekin CCGs	1.8.20		Left SCCG and TWCCG on 31.1.21

NHS Shropshire CCG
NHS Telford and Wrekin CCG

MINUTES

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

Wednesday 10 March 2021 at 9.00am

Using Microsoft Teams

Present from NHS Shropshire CCG:

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

Present from NHS Telford and Wrekin CCG:

Dr Julian Povey	Joint CCG Chair for Shropshire and Telford and Wrekin CCGs
Mr David Evans	Joint Accountable Officer for Shropshire and Telford and Wrekin CCGs
Mrs Claire Skidmore	Joint Executive Director of Finance for Shropshire and Telford and Wrekin CCGs
Dr Adam Pringle	Joint Vice Clinical Chair, GP/Healthcare Professional Governing Body Member
Dr John Pepper	Joint GP/Healthcare Professional Governing Body Member
Dr Michael Matthee	Joint GP/Healthcare Professional Governing Body Member
Mr Steve Trenchard	Joint Interim Executive Director of Transformation for Shropshire and Telford and Wrekin CCGs
Mrs Zena Young	Joint Executive Director of Quality for Shropshire and Telford and Wrekin CCGs
Mr Meredith Vivian	Joint Lay Member for Patient and Public Involvement
Mrs Donna MacArthur	Joint Lay Member for Primary Care

Attendees for both meetings:

Dr Julie Davies	Joint Director of Performance for Shropshire and Telford and Wrekin CCGs
Ms Alison Smith	Joint Director of Corporate Affairs for Shropshire and Telford and Wrekin CCGs
Mrs Sam Tilley	Joint Director of Planning for Shropshire and Telford and Wrekin CCGs
Ms Claire Parker	Joint Director of Partnerships for Shropshire and Telford and Wrekin CCGs
Dr Deborah Shepherd	Joint Interim Medical Director for Shropshire and Telford and Wrekin CCGs
Dr Stephen James	Joint Chief Clinical Information Officer for Shropshire and Telford and Wrekin CCGs
Mr Ash Ahmed	Joint Associate Lay Member for Patient and Public Involvement - Equality, Diversity and Inclusion
Mrs Liz Noakes	Director of Public Health for Telford and Wrekin
Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Mrs Sarah Smith	Personal Assistant – Transcription of minutes (not in attendance)

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

Minute No. GB-21-03.031 - Apologies

2.1 Apologies were noted from:

Dr Martin Allen Joint Secondary Care Doctor Governing Body Member

Minute No. GB-21-03.032 - Declarations of Interests

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

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

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

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

Minute No. GB-21-03.033 - Introductory Comments from the Chair

4.1 Dr Povey confirmed the last time the Governing Bodies had met in public was in March 2020 at the University Centre in Shrewsbury and things had changed considerably since then. We were still an ongoing pandemic and we were now seeing decreasing numbers of covid-19 cases in phase 3, however, there were still a large number of people in hospital with currently 78 people in hospital and 15 people in ITU.

4.2 Further impacts of the pandemic had been seen on further services with waiting times rising for the 26 and 52 week waits. The latest figures highlights there are over 11,000, 26 week waits and 3,752, 52 week waits within the system. It was reported there was also increasing demand on mental health services within practices.

4.3 Dr Povey noted the CCGs had faced a lot of challenges and advised today was also the last meeting of both NHS Shropshire CCG and NHS Telford and Wrekin CCG as the last CCGs meeting in common. Both CCGs were created in 2013 and since August 2020 both CCGs had come together with a new structure and have been meeting as Governing Bodies in common. Dr Povey reported from 1 April 2021 there would only be around 106 CCGs which will have been reduced from over 200 CCGs in 2013 and with 15 systems now having one CCG. The new CCG will be formed as NHS Shropshire, Telford and Wrekin CCG and will work towards the white paper ambition of integration, innovation, and working together to improve health and social care for all. Whilst the way forward was around development towards an ICS, working as a system and moving commissioning functions into the ICS, it was important to acknowledge the gains of the CCGs which had been made from 2012 onwards.

4.4 Dr Povey highlighted the work around the provider sector regime which looked at collaboration and avoiding the need to procure and going out to tender. It showed potential increase with the use of AQP and Dr Povey suggested looking at this as a system, as it could potentially destabilise services provided.

4.5 Dr Povey advised that as well as being the last Governing Board meeting for both CCGs it was also the last Governing Board meeting for Mr Timmis who was Shropshire CCGs Audit Chair and Lay member for Governance. Dr Povey thanked Mr Timmis for all his input and wished him well for the future adding that Mr Timmis would be greatly missed. Mr Geoff Braden would now be the single Lay Member for Audit in the new CCG.

4.6 Mr Evans, Accountable Officer was also moving on and this Board meeting would also be Mr Evans's last Governing Board meeting. Dr Povey confirmed that Mr Evans had been the Accountable Officer for over 8 years starting off at NHS Telford & Wrekin CCG. Mr Evans had done tremendous work over the last year especially in working towards a single CCG and Dr Povey thanked Mr Evans, wishing him well, adding that Mr Evans would be hugely missed by staff and the whole system.

4.7 Dr Povey confirmed that Dr Pepper would be taking up his new role as Chair from 1 April 2021 and wished him well in his new role. The new Accountable Officer would be put in place as soon as possible with details of the new Accountable Officer being announced shortly.

Minute No. GB-21-03.034 – Accountable Officer's Report

5.1 COVID-19 Vaccination Programme – Mr Evans reported that well over 200,000 people across Shropshire, Telford and Wrekin had now been vaccinated and in putting this into context, added that on 9 January 2021 around 11,000 people had been vaccinated which was a massive achievement. Mr Evans expressed his personal thanks and also relayed thanks on behalf of the CCG Board to all staff involved, both within the CCG and across system partners, the voluntary sector, and other statutory organisations for example the fire service who had contributed along with the Local Authority and NHS partners. Mr Evans noted the data from the last league table showed that NHS Telford & Wrekin CCG was rated 1st in

country with Shropshire CCG being 5th for vaccinating the over 65s. This was an amazing achievement whilst recognising that the vaccination programme had got off to a slow start.

5.2 Transforming Care and Learning Disabilities – Mr Evans reported transforming care and learning disabilities had been escalated for some time and this work was being led by Ms Parker. An escalation meeting had taken place approximately 3 weeks ago and it was anticipated the CCG would come out of escalation possibly by the first quarter of the new financial year, or failing that by the second quarter of the financial year. Mr Evans thanked Ms Parker and the team for their input.

5.3 Independent Enquiry for Child Exploitation for Telford - Mr Evans and Mrs Young would be meeting with the Chair of the Independent Enquiry for Child Exploitation for Telford. This was a routine meeting and no further concern relating to this for the CCG was expected, however, an update would be given to the Governing Board in due course.

5.3 Staff departures – Mr Evans thanked Dr Povey for his kind words earlier and advised it was also the last meeting for Dr Povey. Mr Evans relayed his thanks to Dr Povey both on a personal level and also on behalf of the CCG Board for his huge contribution to Shropshire CCG and latterly Telford & Wrekin CCG, adding that Dr Povey's contribution had been much valued. Mr Evans also thanked Mr Timmis for his hard work during his time at the CCGs.

5.4 In a further response to Dr Povey's kind words Mr Evans expressed that it had been a huge privilege to lead the CCGs noting the CCG Boards and staff had been supportive both as a collective and as individuals. Mr Evans highlighted he would miss the people in the organisation and noted the significant improvements that had been made, for example with transforming care and the vaccination programme. Mr Evans confirmed that an enormous difference had been made for our population and thanked all members of staff along with Governing Board members. Mr Evans added it had been a privilege to work alongside all staff over the years. Dr Povey also thanked Mr Evans for his kind words regarding his departure.

Minute No. GB-21-03.035 – Minutes of the Previous Meetings – 13 January 2021

6.1 The minutes of the previous NHS Shropshire CCG and NHS Telford and Wrekin Governing Body meetings in common held on 13 January 2021 were presented and approved as a true and accurate record of the meeting subject to the following amendments:

Page 10, paragraph 11.60, line 1 notes a paper would be taken to the Gold Command Meeting in relation to establishing a Children's and Young People's Partnership Board. It was agreed an action point be added under this section with the detail that feedback would be given to Governing Body members after the paper had been taken to the Gold Command Meeting. Ms Parker reported the Partnership Board meeting had been approved and there would be 4 meetings held annually commencing in April 2021. Further feedback would be given at a future meeting from the Partnership Board meetings and the terms of reference for this group would be circulated. Mrs Cawley, Healthwatch Shropshire also requested feedback from the Partnership Board meetings for Healthwatch.

Page 21, paragraph 19.3, line 4: change 'was in the with' to 'was in line with'.

RESOLVE: Governing Body Members of NHS Shropshire CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire CCG held on 13 January 2021.

RESOLVE: Governing Body Members of NHS Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Telford and Wrekin CCG held on 13 January 2021.

ACTION: Ms Parker to circulate the Partnership Board terms of reference and feedback to the Governing Body and Healthwatch following the Partnership Board meetings.

ACTION: The agreed amendments would be made to the minutes as noted in paragraph 6.1 above.

Minute No. GB-21-03.036 – Matters Arising from the Minutes of the Previous Meetings held on 13 January 2021

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

GB-21-01.004 – Draft ICS Application – Mr Evans confirmed the draft ICS application had been circulated to Governing Body Members and asked for confirmation that members had received this. Mr Evans reported the draft ICS application could not yet be published due to it being a draft application. In relation to feedback from regional and national panel meetings Mr Evans noted feedback had not been received from the national panel, however some feedback had been received from the regional meeting and actions were being taken forward advising there was nothing of significant concern.

GB-21-01.006 – Matters Arising *[b/f from GB-20-01-010 – Shropshire CCG Strategic Priorities]* - Dr Davies reported data had now been received and initial analysis shows that there appears to be some variation in the on-scene timings in relation to the rural and urban areas. Further analysis was ongoing in order to take out site to site transfers of patients done by ambulance to confirm the data and advised a paper would be brought back to the next Governing Board meeting in May to formally close this action.

GB-21-01.006 – Matters Arising b/f GB-20-11.123 – [Quality and Performance Report] - Dr Povey advised it was disappointing that the Niche consultancy report into the SI processes at SaTH and the system deaths analysis was not being presented at this meeting. Mrs Young confirmed she had a meeting scheduled with Niche this week and advised the delay to this report was due to Covid-19 impacts on staff capacity to undertake the work. It was noted the report would be taken to the May Governing Board meeting.

GB-21-01.010 – Performance and Quality Report – Quality – As noted in the matters arising above (GB-21-01.006 – Matters Arising b/f GB-20-11.123) it was anticipated the Niche report would be presented at the May Governing Board meeting.

GB-21-01.010 – Performance and Quality Report – Quality - Ms Cawley noted a meeting was still due to take place with the quality team members in relation to the hot topic on urology. It was agreed Ms Cawley and Mrs Young liaise in relation to the current position with the system quality oversight arrangements which are under review from an ICS perspective.

GB-21-01.016 – Digital Update Report - Dr James gave his apologies that the information on the digitised ReSPECT form had not yet been circulated. Dr James would arrange to have the form re-circulated to Practices immediately.

GB-21-01.017 – Update on System Improvement Plan - Ms Parker agreed to check whether information had been included in the Primary Care Newsletter with a link to further information on psychological health and well-being support for staff.

GB-21-01.019 – Integrated Urgent Care - Implementation Review Final report - Ms Parker reported that a response was awaited in relation to whether the palliative care service was commissioned by SaTH or the CCGs and advised this may be a mixed picture, in that, some elements are commissioned by SaTH and some elements are commissioned by the CCG. Ms Parker confirmed she had asked Mrs Tracey Jones who was the lead for the end of life work to clarify this information and to do a breakdown of the service. Ms Parker would feedback to the Governing Board once the detail was available.

ACTIONS:

- **Dr Davies to bring a paper back to the May Governing Board meeting in relation to data around on-scene timings and the connection with rural and urban areas once further analysis had been completed on the data.**
- **Mrs Young confirmed the Niche consultancy report into the SI processes at SaTH and the system deaths analysis would be presented at the May Governing Board meeting.**
- **Ms Cawley and Mrs Young to liaise in relation to the current position with the System Quality Oversight arrangements which are under review from an ICS perspective.**
- **Dr James would arrange to have the digitised ReSPECT form re-circulated to Practices immediately.**

- **Ms Parker agreed to check whether information had been included in the Primary Care Newsletter with the link to further information on psychological health and well-being support for staff.**

- **Ms Parker had asked Mrs Tracey Jones who was the lead for the end of life work to clarify the information around commissioning of the palliative care service and produce a breakdown of the service. Ms Parker would feedback to the Governing Board once the detail was available.**

Minute No. GB-21-03.037 – Public Questions

8.1 Dr Povey advised the CCGs had received no questions from the public for this meeting.

ASSURANCE

Minute No. GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report

9.1 Performance – Dr Davies presented the Performance section of the joint Quality and Performance Report, which was taken as read. Dr Davies updated Governing Body members on the A&E performance and the requirement for the system to produce an improvement plan in order to demonstrate 85% could be achieved during 2021 and 2022 with working with system colleagues. It was noted that potential urgent care metrics were likely to follow in shadow form and therefore some changes with reporting were expected in the next year.

9.2 In relation to treatment waiting times, Dr Davies advised the pandemic continued to affect this but confirmed that key triggers had been met within the acute sector and the Covid-19 demand had reduced. SATH were now in a position to start to reopen theatres and recovery areas on the Shrewsbury site and were rescheduling P2s. The Telford site and restoration would take slightly longer and weekly meetings were now taking place to get feedback on their recovery. Dr Davies advised further detail on their recovery position would be brought back to the next meeting; however, it was important to note the backlog was considerable, and would therefore take time to recover. Clarification was also being sought from the national centre regarding funding.

9.3 Dr Davies advised progress had been made with the combined list with orthopaedics and this had worked well with confirmation being received this morning that the P2s for orthopaedics will all be scheduled and likely to be treated by mid-April. Dr Davies confirmed the Nuffield Hospital was continuing to be used for cancer treatment and P2s, albeit with some limitations with some patients being unable to attend the Nuffield. However patients that were able to attend were going to the Nuffield and capacity was being fully used until the end of March.

9.4 Dr Davies confirmed that since writing the report there had been further improvements with the cancer booking times and advised the booking times was now down to 17 days locally and it was hoped by the end of March this would be 14 days. Further detail and a paper on this would be reported in the next agenda item.

9.5 Dr Davies advised in relation to mental health, a member of staff would be commencing their trial role next week as the performance assurance manager and Dr Davies confirmed she had requested that as part of their trial period, the work and focus be around mental health actions and improvement as this was an area that needed more focus now that capacity was in place.

9.6 Dr Matthee asked about 14 day rules for paediatrics and children with malignancies. It was noted that pre Covid-19, work had commenced with Dr Matthee, Mrs Gail Fortes-Mayer and a paediatrician to look at the 14 day rule. Dr Matthee confirmed he was happy to be involved in this work going forward and asked for an update. Dr Davies agreed to contact Dr Matthee direct to discuss how to take this work forward and would also raise this at the cancer group meeting.

ACTION: Dr Davies to raise 14 day rule for paediatrics and children at the Cancer Group meeting and liaise with Dr Matthee on how to take this work forward.

9.7 Quality – Mrs Young presented the Quality section of the Quality and Performance Report and assumed the paper as read. Mrs Young drew Members' attention to the points as listed below:

9.8 Mrs Young advised SaTH remained the most challenged provider and a cause for concern but there were a number of governance measures in place so that the CCG could understand the issues being faced by

the Trust and how they were dealt with. Assurance continued to be requested around incident management and a selective review was being done of the incidents predating early 2020 to check how actions have been embedded into practice. All issues were raised at an internal meeting at the Trust yesterday, particularly around maternity.

9.9 Mrs Young reported there were a number of Covid-19 outbreaks, noting there was high assurance received to the System Oversight Assurance Group (SOAG) meeting regarding the management of the cases. Of particular note, were the definitions for attribution in which patients need to be inpatients for 8 days or more in order to get a Covid-19 positive position, to be attributed to a hospital acquired in either possible of definite categories. The CCG continued to support SaTH's incident management approach to outbreaks.

9.10 Mrs Young confirmed feedback had been given to providers for the quality accounts for 2019-20 however; the quality assurance visits had been paused across most providers advising they were only being done where necessary, on a need basis or in exceptional circumstances where there were concerns. The CCG would continue to triangulate information and have line of sight of the quality of care in the absence of going into clinical settings. Clinical visits were still being carried out in care homes and in domiciliary settings as part of the health protection role to Covid-19. Mrs Young reported that additional staffing had been secured on a temporary basis for the IPC team and to help with the Covid-19 work.

9.11 Dr Matthee asked whether any progress had been made with the referrals for patients and the access to referrals for early years. Dr Pringle also highlighted concerns over the testing backlog with endoscopy surveillance. Dr Davies confirmed that work was ongoing with this and Dr Pringle's point would be noted and factored into this work.

9.12 Mr Vivian asked Mrs Young for her view on the quality accounts and if she felt they were in alignment with her view. Mrs Young advised that generally the quality accounts were in line but they were lightweight due to Covid-19. Mrs Young reported all objectives for this year had been covered however; many organisations had put down fewer objectives for this year noting that further areas of improvement had been noted.

9.13 Ms Parker raised serious incidents and asked about the progress with this and SaTH with their theming, trending and learning. It was noted that serious incidents had been raised at the Quality Review meeting and at the Trust's internal meeting yesterday, where they were asked about their learning. Mrs Young advised SaTH were not able to give assurance at the moment, however in relation to maternity the Trust were currently working on this to ensure that lessons are learned and embedded. SaTH had also invested further in their central governance processes and were fully committed to the process.

9.14 Dr Povey commented that SaTH would need to demonstrate to the system how the learning was being embedded and Mrs Young advised in relation to serious incidents SaTH were following the NHS framework. Mrs Young noted that the CCG attended SaTH's weekly serious incidents meeting where the CCG also contributed to these meetings. SaTH's internal process has strengthened in the last 6 months and through the Commissioning Quality Review meetings and other governance meetings, SaTH were bringing themed reviews and had made changes. Mrs Young advised issues around workforce consistency and workforce organisational memory were major factors in embedding learning and there had been a significant focus on SaTH, however, SaTH were now more engaged with the CCGs. The same process of assurance was also applied to other providers in relation to serious incidents and when looking at themes and trends with the serious incident information coming through.

9.15 Mr Trenchard advised Midlands Partnership NHS Foundation Trust (MPFT) do an annual lookback in terms of suicide reports focussing on local and national benchmarking along with themes arising with serious incidents in terms of clusters. Mr Trenchard reported that with the pathway work the CCGs were carrying out, this was supporting work in relation to the safety planning aspect and themed reviews were being done in relation to young people who have ended up in SaTH alongside quality of services work. Mrs Young confirmed that this information and other feedback went to the CCGs Quality and Performance Committee. Dr Povey raised the definition of HARMS noting the definition of HARMS should be uniform across the system.

9.16 Dr Matthee asked about processes that had been put in place to prevent people attempting suicide and Mr Trenchard confirmed discussions had taken place with MPFT regarding near misses of suicide and Mrs Young advised continual discussions were held through a variety of avenues including through the Commissioning Quality Review meetings which were held with the Trust and issues in relation to crisis response times and the CCG were discussed. The CCG were continuously gaining assurance around access times and how the Trust risk assessed on a continued basis.

9.17 Mr Trenchard advised there was a wider suicide prevention group chaired by public health which included other partners. There had been investment for this from national teams in terms of intervention with families. Mr Trenchard would pick this point up with MPFT regarding Dr Matthee getting feedback and responses from MPFT to ensure a response was given. Mr Trenchard advised the GP mental health survey around mental health services and the quality of services had been taken to the Quality and Performance Committee previously and noted risk assessments were a key area of this work with feedback awaited on the survey. Mr Trenchard confirmed that as part of the investment for re-designing community services, the MPFT had redesigned the pathways in recognition that realignment of the nationally mandated models was needed in order to include greater visibility of the mental health workforce with GPs and Primary Care Networks (PCNs).

9.18 Mrs MacArthur asked about the current position with A&E and HARMS. Dr Davies advised the activity was not as high in comparison to last year; however, there was variability of cases. The Trust was focussing on earlier discharges and now had an internal discharge dashboard in order to remove the 12 hour breaches. Managing discharges along with other key issues such as managing three pathways with Covid-19 (positive, negative and queries) was a challenge and the IPC oversight may evolve to help with this in time noting it was not a volume issue overall, but it was about variability of activity. SaTH were also looking at the physical infrastructure and challenges with ambulances being able to offload patients successfully. It was anticipated the draft improvement plan would be received by the end of this month and this would be reported through the Urgent Emergency Care (UEC) Delivery Board and due to workforce challenges the target of 95% would not be achieved however, the aim was to get to 85% and this has been acknowledged by NHSE/I.

9.19 Dr Matthee raised concerns about serious incidents and the learning being fed back to staff and teams on the ground. Mrs Young advised information was fed back to staff but learning was not always embedded due to human factors and workforce changes and variables. Internal audits did pick these issues up.

9.20 Dr Matthee asked about maternity services and antenatal care and Mrs Young confirmed there had been discussions recently around pharmacology and maternity care with a separate group taking this work forward with the Medicines Management Team and others alongside Dr Priya George.

9.21 Mrs Young noted there was an error on page 52 of the quality report advising that item 2.1, second bullet point down in relation the never event. This bullet point should read there was a never event identified and there was an immediate learning point. Mrs Young gave her apologies for not correcting this before publication. Dr Povey also raised a potential error in section 2.3 of the quality report and it was noted that this information should be moved to section 2.9 relating to MPFT. It was agreed that this error be captured in the minutes and amended for future reports.

9.22 Dr Povey asked Dr Davies for any advice that could be given to the public in relation to long waiting times and any advice on what to do following a referral to hospital. Dr Davies advised if patients were awaiting a referral or appointment from when they were seen as an out-patient or were waiting for follow on treatment then it was advisable to contact the hospital direct. Dr Davies confirmed the hospital were working through outpatient referrals as quickly as possible and noted this would be raised at the Gold Command meeting on how to take this forward.

RESOLVE: NHS Shropshire CCG NOTED the content of the Quality and Performance report and the actions being taken to address the issues identified.

RESOLVE: NHS Telford and Wrekin CCG NOTED the content of the Quality and Performance report and the actions being taken to address the issues identified.

ACTIONS:

- **Mr Trenchard would liaise with MPFT regarding Dr Matthee receiving feedback and responses.**
- **Agreed the error on page 52 of the quality report relating to the never event be amended to read 'the never event identified there was an immediate learning point'. Also agreed the error in section 2.3 of the quality report be amended so that the information was moved from section 2.3 to 2.9 of the report relating to MPFT. It was agreed these errors be captured and the amendments made for future reports.**

Minute No. GB-21-03.039 – Breast Cancer Services

10.1 Dr Davies presented this item and taking the paper as read, the following points were highlighted:

10.2 Dr Davies said that the situation with bookings continued to improve with bookings currently at day 17 for both systematic and cancer referrals and there was a confidence that the bookings could get to day 14 by the end of the month as advised by the Trust. In relation to demand and capacity this was very light and a paper would be taken to the Joint Strategic Commissioning Committee (JSCC) around further actions that could help improve demand and capacity in order to get to a more sustainable position taking into account the considerable recovery from for example the breast screening programme.

10.3 Dr Pringle expressed concern about the 2 week waits for both systematic and cancer referrals and for prioritising patients for cancer referrals. Dr Davies confirmed the focus would be on lessons learned and why locally the same process used by other systems was not being followed. Dr Davies advised the capacity was now there and back as it was previously with estates work completed. It was about making it sustainable and looking at the breast systematic pathways and breast cancer pathways as demand would be increasing. Dr Davies confirmed extra lists were being put in place but it had to be sustainable with the capacity in place due to the continued pressures around earlier diagnosis.

RESOLVE: NHS Shropshire CCG NOTED the contents of the report and received assurance in relation to Breast Cancer Services.

RESOLVE: NHS Telford and Wrekin CCG NOTED the contents of the report and received assurance in relation to Breast Cancer Services.

Minute No. GB-21-03.040 – Maternity Update

11.1 Mrs Young took Members through the Executive Summary of the Maternity Update report and assumed the paper as read. The following points were noted:

11.2 Mrs Young advised that following on from the last Board meeting and the first Ockenden report into the care at SaTH along with the national recommendations made. The Trust had submitted the required information to NHSE/I and LMNS (Local Maternity & Neonatal System) had been cited on this information and included in both returns. Mrs Young advised it was anticipated that further returns would be required to be sent to NHSE/I and LMNS would take account of receiving these reports when due.

11.3 Mrs Young confirmed a request had been made to provide a return on the responsibilities of LMNS and to look at compliance against principle 2 in order to provide information on quality oversight in light of the Ockenden report and the ICS requirements and work. This submission had been made and a further meeting was awaited with NHSE/I to discuss the submissions and receive feedback. A review was being undertaken on the quality governance arrangements with a view to putting arrangements in place which would dovetail with the ICS arrangements. The overall governance was awaited for the ICS and the work was ongoing with the terms of reference and how these can be rolled out.

11.4 Mrs Young updated Members regarding the maternity records at SaTH and noted the CCGs received information regarding exceptions and escalations noting that where there were exceptions the CCG further investigated these cases and sought further assurance and investigation. It was noted the Trust's current method of audit was based on a manual mode of accounts and record keeping which limited their ability to provide good evidence and assurance due to time constraints and processes. SaTH were currently looking to use the Badgernet Maternity Notes System which was an electronic maternity record system due to be implemented by May or June 2021. However, the implementation of the internal IT programme had been delayed somewhat due to the impact of Covid-19.

11.5 Mrs Young also reported the CSNT submission data period has been extended by 3 months and this posed a challenge for SaTH as 3 more months of manual audit would result in a possible risk that not all data would be completed and submitted. SaTH were continuing to do what they could and the CCGs would be undertaking a quality assurance process on a fair proportion of this information.

11.6 Mrs Young confirmed the Trust were making progress with their Saving Babies Lives Care Bundle and there was an external review being done by the Maternity Neonatal Network which confirmed that progress was being made. The Trust had submitted a self-assessment return and this appeared to be an accurate reflection of the situation at the Trust. The network was confident the Trust would make further progress in the latter period and sign off the policies which were sent to the network and which were outside of The National Institute for Health and Care Excellence (NICE) guidance. These policies had been adopted with CCGs approval and at a meeting yesterday the University Hospitals Birmingham NHS Foundation Trust (UHB) obstetrician clinical lead was in attendance and confirmed this was the correct interpretation of that requirement.

11.7 Mrs Young reported the continuity of carer teams were a key part of improving perinatal mortality and safety over time and this was also a national ambition through the transformation programme. The Trust had two teams in place and they were seeking to have seven teams. This would require recruitment to vacancies and to the new staffing plan around birth rate plus which is the maternity workforce assessment tool; however, there were issues with recruiting staff in order for progress to be made. This was a regional and national issue but the Trust were fully committed to rolling this out and SaTH were in an average position with progress and was following the national mandate to target certain groups first.

11.8 It was reported the MBRRACE report was also attached and detailed Shropshire, Telford & Wrekin as a system, were rated red for still births, neonatal deaths and extended perinatal mortality which pertained to the calendar year 2018 data. The organisational level for SaTH was rated amber. Mrs Young confirmed that University Hospitals North Midlands (UHNM) were also included in the data and they were on the neonatal pathway and rated red for the same metric after moderated adjusted data. There was some improvement work needed for both Trusts in relation to still births, neonatal deaths and extended perinatal mortality along with saving babies lives, the continuity of care and of the maternity transformation work. Also included in the report was patient experience information which gives positive assurance around services and Mrs Young highlighted the transforming midwifery care proposal noting approval was still awaited at a national level. NHSE had asked the CCG to look at the proposals again in light of the Ockenden report to confirm they are the right proposals and Mrs Young confirmed this would be done alongside the inequalities agenda which has taken more prominence over last 12 months. It was noted the report would be going to the LMNS Programme Board meeting at the end of April to indicate where the proposals meet the needs or need to be varied from the work already done. Once approval had been given, changes could be implemented.

11.9 In summary, there were no particular areas of escalation, and the areas mentioned were being pursued and progressed. As noted, the data quality was still not fully reliable due to the nature of the manual accounts and records, however with a new electronic dashboard system (the Badgernet Maternity Notes System) due to be put in place, this would significantly help the audit reliance.

11.10 Mr Timmis understood the points made regarding SaTH's slow response and with the concerns previously made about need for pace with continuity of care, however noted this was long-standing issue with the Trust accepting change adding that this would need to be a priority of LMNS going forward in looking for quicker responses from SaTH. Mr Timmis raised concerns of staff recruitment for band 6 midwifery positions advising SaTH were aware of continuity of care but this was very much reliant on a stable workforce.

11.11 Mrs Noakes commented that it was disappointing about the progress with continuity of care as this work was trying to tackle the inequalities agenda. It was noted that new transformation community services were ready to be progressed, however, this work was unable to go out to consultation plus the figures did not seem to be at the level aimed for at this stage. Mrs Noakes suggested asking people who are offered continuity of care to see how many people accepted it. Further discussion was held in relation to the promotion of this service and where SaTH were locating the two teams. Mrs Young confirmed the continuity of carer teams noting they were operating in the areas of priority around the county and there was detail provided to the LMNS Board about this. The CCGs would continue to seek information and assurance through the LMNS Board and give feedback to the Governing Board meeting. It was acknowledged the service was a huge challenge and Dr Pepper proposed that a piece of work be done on the continuity of care service to look at this in more detail. It was noted this work would be done at LMNS Board and then feedback would come back to this Board meeting.

11.12 Dr Pepper enquired about the Badgernet Maternity Notes system and of the quality of the data. Mrs Young confirmed that the improvements were anticipated as there would be a standardisation around the information inputted noting that at present the audit information was down to a lot of interpretation rather than metrics.

11.13 Mrs Young confirmed in section 6 of the report with regard to the Quality Operational Committee and the information relating to one neonatal death and a unit being put in place, this should be seen as a positive position. In section 7 relating to service user feedback, it was recognised it was vital to have a system that responds to individual patients when things do not go right, highlighting the Maternity Voices Partnership (MVP) was also a forum where people could raise concerns. Discussion took place about how active the MVP was as the newsletter on their website was from summer 2018. Mrs Young advised they were an active group and they were fully embedded as co-producers of the maternity hand held documents. Mrs Young reported MVP was embedded in groups and discussions alongside Healthwatch regarding the Ockenden review alongside reviewing the quality strategy. It was noted that MVP was funded through the LMNS and Mrs Young agreed to look at the MVP website to see what material they had on there.

11.14 Dr Pringle expressed his sadness and concern that the outcome data from 2018 was still in the red category adding that although figures were improving it would be difficult to gain assurance until the red category for poor performance for quality was significantly improved. Delays in implementing the maternity changes were acknowledged and that this was adding to the problem however, it was also acknowledged that the consultation was ready to progress.

11.15 Concern was expressed in relation to the caesarean section rates being below the expected elective rates and that it was suggested that high emergency rates could indicate women were having inappropriate trials of labour or delivering dangerously which had resulted in having a caesarean section. Discussion took place as to if these rates were contributing to our poor outcomes and it was suggested that there had been a step backwards. Dr Pringle proposed the Trust be asked about changes and perhaps be asked to conduct a retrospective audit of emergency caesarean sections to see if there were groups of patients who were going in for a caesarean section delivery, who should not be going in for caesarean section delivery. It also suggested that current standards of care were not being delivered in an area where there were poor outcomes.

11.16 In response to the discussion on caesarean section rates, Mrs Young reported caesarean section was made up of a number of components including maternal choice. It was noted that the CCGs commissioned in accordance with NICE guidance and that the CCGs were not at variance with that. Mrs Young advised information was triangulated with the birth outcomes and more positive indicators for birth trauma for both mother and baby along with brain injuries were being seen. The indicators were monitored and the Trust had been asked to look at the data around caesarean sections. This information would come back to the Quality & Performance Committee meeting and then to a future Governing Board meeting.

11.17 Dr Povey raised the figures relating to the target for caesarean sections and asked for clarification about the figures. Mrs Young agreed to look at these figures and clarify the data.

11.18 Dr Pringle agreed patient choice mattered however; patient choice was made on basis of the information given to the patient. Dr Pringle confirmed SaTH had a history of aiming for a low caesarean section rate coupled with poor outcomes over many years and having a below predicted elective caesarean rate was concerning. The changes that were needed to be made have not come to fruition over time and Dr Pringle commented the figures looked quite large. Mrs Young thanked Dr Pringle for raising awareness and for a helpful discussion, advising elective caesarean sections had been discussed with SaTH alongside the limited clinical value and with reviewing the policy in order to ensure that the policy reflected commissioning was in line with NICE guidance.

RESOLVE: NHS Shropshire CCG NOTED the contents of the report and progress being made along with actions taken to address any concerns.

RESOLVE: NHS Shropshire CCG NOTED the contents of the report and progress being made along with actions taken to address any concerns.

ACTIONS:

- **Mrs Young agreed to look at the MVP website to see what material was detailed there.**
- **Following discussion regarding the target for caesarean sections, clarification was requested in relation to the figures. Mrs Young agreed to look at these figures and clarify the data.**

FINANCE

Minute No. GB-21-03.041 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report including Quality, Innovation, Productivity and Prevention (QIPP) schemes

12.1 Mrs Skidmore presented the combined Finance and Contracting report for the period up to the end of the Month 10 position, which was taken as read. The following key headlines were focussed upon:

12.2 Mrs Skidmore reported the finance regime this year had been very different and particularly challenging with the months 1-6 position forced to a break even position through a non-recurrent allocation from NHSE/I. Planning was ongoing with month 7 onwards to the end of financial year and Mrs Skidmore confirmed that as part of the planning requirements when setting the plans in late summer/autumn the CCGs were unable to break-even and were issued with budget allocation that represented the £15 million

deficit between both CCGs. This was not an agreed position, but the CCGs had been working hard to come closer to the break-even position.

12.3 Mrs Skidmore highlighted that when the plans were set the CCGs took a very prudent view and noted that it had been extremely hard for all organisations this year to set forecasts due to the fluidity of the situation. Caution had been applied to all plans over the last few months and Mrs Skidmore confirmed that in month 10 the forecast deficit position for both CCGs had been reduced further and notwithstanding the additional budget allocation of £15 million, the forecast deficit position was now £5 million above the breakeven point which when breaking these figures down showed that it was a deficit of £3 million for Shropshire CCG and £2 million for Telford & Wrekin CCG. Mrs Skidmore confirmed the month 10 position was a strong reflection of the current situation and the CCGs were not anticipating any worsening of the positon adding that within the position the CCGs had been able to bring down the risk assessment of the figures due to the confidence gained about the position as the year end was nearing.

12.4 The QIPP plans had not continued as originally planned and Mrs Skidmore praised the hard work of the prescribing and CHC teams advising that savings had still been made in year of just under £7 million for the individual commissioning and prescribing position. Mrs Skidmore highlighted some interim support had been in place in order to help with CHC in particular due to this also being the biggest area of concern which had been impacted considerably by covid-19. Work was ongoing with the forward plans and there was progress with the deep dive work which was currently informing our month 11 position at present.

12.5 Mr Timmis raised concerns that had been made previously at the Finance Committee regarding the underlying position and noted that given the issues outlined today, in that the underlying position had not been addressed in the same way this year due to the pandemic. Mr Timmis noted the position had deteriorated further and was now in a very poor position and currently running at over £71 million. Mr Timmis advised the Governing Body would need to be aware of this situation and of the extremely difficult underlying positon.

12.6 Mr Vivian asked for clarification about the figures for individual commissioning and the £1.7 million and whether this related to deferring costs. Mrs Skidmore confirmed a piece of work had been undertaken by an independent accountant in order to look at the CHC forecasting methodology and assessments along with reviewing the activity and how this may change, along with the average prices that are used for forecasting. Mrs Skidmore confirmed that based on this review and subsequent information held by the CCGs along with work done with CHC and Broadcare, it showed that assessments were able to be changed confidently noting this was the detail behind those figures.

12.7 Mr Vivian raised the detail in the report relating to the £0.5 million financial improvement as a result of neurology services going. Mr Vivian reported the use of the word “improvement” was perhaps not appropriate as services were currently not being provided to patients. In reply to Mr Vivan’s comment, Mrs Skidmore confirmed this wording could be refined. Mrs Skidmore agreed to look at the point regarding savings in neurology and the interpretation of the narrative.

12.8 Dr Povey commented on and asked for an update on the primary care allocation and how NHSE/I had changed the allocation from £2.5 million to £1.4 million. Mrs Skidmore confirmed discussions were still ongoing with colleagues at NHSE/I concerning any additional funding. At present the CCGs were still carrying the full extent of the expenditure and this was included in the CCGs positon.

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

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

ACTION: Mrs Skidmore agreed to look at the point regarding savings in neurology and the interpretation of the narrative.

Minute No. GB-21-03.042 – 2021/22 Plan Update

13.1 Mrs Skidmore presented this item and the following points were noted:

13.2 Mrs Skidmore noted it had been a strange year for financial planning and alongside not being able to produce a financial plan, the national planning guidance had been delayed. From a practical aspect teams would need to have a mandate to work from in order to continue to operate so that expenditure is not paused on 1 April 2021. Mrs Skidmore reiterated that it continued to be a challenging situation and there continued to be deterioration in the underlying position moving forward. Conversations were being held at a system level to come up with a plan on how to work and do things differently and the new

financial framework and principles will be worked with and noting that as a system it would operate under conditions which would only allocate monies received. Mrs Skidmore confirmed as part of this work with the cost base, CCGs had been working on refining and developing the model to help support the system work and also help sustain the underlying position during the first year, whilst the work starts to look at a longer term financial plan in order to address the deficit position in future.

13.3 In relation to planning guidance Mrs Skidmore advised she had taken a paper to the Finance Committee to discuss planning guidance further and some figures had been drafted based on what the CCGs were aware of regarding the cost base along with some assumptions made around the income the CCGs may receive. Mrs Skidmore confirmed approval was being sought for these plans and stated plans had been put in place for the quarter 1 operating budget whilst the planning guidance was awaited. Work on this basis would allow the management team to spend within limits whilst giving a mandate they could work against. It was noted that no new investments were anticipated.

13.4 Mr Timmis confirmed the Finance Committee supported the approach that has been taken, however the Finance Committee remained extremely concerned over this item and of the savings that have got to be achieved over the next financial year. Mr Timmis noted that he had met with Mr Braden as the new Chair of the Finance Committee and Mrs Skidmore last week regarding these issues and it was highlighted that approximately £13 million of savings would need to be found in year, but the level of plans that were in place to support these savings were only around £4 or £5 million, adding these plans were not as robust as they would normally be at this time of year. Mr Timmis added the CCGs would need to focus on where the savings were going to be made from as this was a key area, if significant savings were needed in order to share the burden as part of the system. Mr Timmis commented it was important the CCGs looked at the list of schemes to ensure savings were met whilst also raising concerns about time constraints and serving notice for some schemes.

13.5 In response, Mrs Skidmore advised that with the quarter 1 position it was anticipated QIPP would be fully operational and things would be increased. For the annual period Mrs Skidmore confirmed a paper would be taken to the Finance Committee which would describe how the CCGs were planning to address these issues and this would also be reported on at the next Governing Board meeting. It was suggested that session on QIPP planning be added to agenda for the next Board Development Session due to be held at the end of March 2021. Mrs Skidmore agreed to keep Board Members briefed through informal channels as well as the formal routes.

RESOLVE: NHS Shropshire CCG NOTED the information contained in the report and supported the 2021/22 Q1 operational budget for use within the CCG until guidance is received based on Q1 figures contained within the report.

RESOLVE: NHS Telford and Wrekin CCG NOTED the information contained in the report and supported the 2021/22 Q1 operational budget for use within the CCG until guidance is received based on Q1 figures contained within the report.

ACTION: Mrs Skidmore agreed to keep Board Members briefed on QIPP Planning progress through informal channels as well as the formal routes.

Minute No. GB-21-03.043 – COVID-19 Update

14.1 Mrs Tilley, Dr Davies and Mr Trenchard presented a verbal update on the current position of the response to the COVID-19 pandemic and the following key points were raised:

14.2 Dr Povey noted that a written update would be useful for the Governing Board meeting but appreciated things were fast moving and constantly changing.

14.3 Mrs Tilley advised the situation remained dynamic and fluid but the picture was improving. The prevalence rates were improving with Telford and Wrekin having a rate of 51 per 100,000 of the population and for Shropshire it was 49.8 per 100,000 of the population. Work was proceeding with note of caution and with the awareness that as lockdown eases this may impact on a downward trajectory. Mrs Tilley confirmed that all planning work was with this caveat in mind.

14.4 Mrs Tilley reported the position at SaTH was improving and cases tracking through from the community were improving in terms of rates with improvements being seen within the Trust, particularly in ITU. The de-escalation plans and triggers around restoring services and repatriating staff back to their usual positions were in place and this was being initiated in line with the CCGs plans. Mrs Tilley confirmed the community capacity position was currently good and Covid-19 figures within community hospital settings were now into low single figures.

14.5 Mrs Tilley updated members regarding the vaccination programme and noted there was a significant amount of activity as the programme moved forward. The current vaccination figures as of midnight last night were that just over 208,000 people had been vaccinated and the figure was nearing the 50% of the population mark having been vaccinated. In relation to the vaccination cohorts and percentages of people vaccinated, as set out in the JCVI guidance, all people in the cohort aged 65 years and above, data showed that the uptake was above 90% with some cohorts reaching 100%. For the 60-64 age group cohort, the percentage was now above 80% vaccinated and for the 55-59 age group cohort, which commenced this week the uptake was above 45%. The 50-54 age group cohort was expected to open up next week with the ambition that all of the 50s would be vaccinated by the end of March 2021. Mrs Tilley confirmed vaccination supplies were expected to increase by next week and at that point there would be a further ramp up with the activity going through the programme which would include the commencement of second doses, which was also now fully part of the vaccination programme. Further planning was also being done in relation to rolling out the vaccination programme to the under 50s group and it was envisaged that as autumn and winter approached the vaccination programme would be aligned with the flu vaccination programme alongside looking at the best longer term model with looking at how to deliver the vaccinations into the future.

14.6 Mrs Noakes confirmed that in Telford & Wrekin there was good news in terms of infection rates declining and there had been a 64% reduction in cases over the last week, however, it was noted that caution needed to be applied. Mrs Noakes advised in Telford there had been a long slow decline of rates and there had been significant outbreaks in workplaces over the last few weeks and months, and these would likely to be continued going forward. The importance of following the rules was noted and Mrs Noakes commented that the all public sector organisations needed to work closely with workplaces to ensure workplaces are Covid-19 secure and that any cases get reported and contacts isolated as appropriate. Dr Povey agreed it was important for everyone to stick to the advice and guidelines even if they have had their immunisations.

14.7 Dr Davies raised demand and capacity work and commented the de-escalation plan was on schedule with the Acute Demand and Capacity Meeting continuing to meet once a week until the end of April 2021, at which point it would be reviewed. Underlying trends would continue to be monitored as there was still some anxiety around potential Covid-19 cases increasing, particularly within the workplace and with schools going back and lockdown easing. Rates would continue to be monitored alongside the effects of the impact of the vaccination programme.

14.8 Dr Davies confirmed that in relation to the restore and recovery work, providers had now restarted their restore and recovery weekly meetings and at the end of the month there would be a System Elective and Cancer Recovery Meeting to consolidate provider positions and to look at responsible population with patients going out of area for treatment. This work would be reporting formally through the committee structure from April 2021 onwards in terms of the restore and recovery programme.

14.9 Dr Pepper commented this was very good news about the covid-19 prevalence rates and vaccinations advising communication had been received from Amanda Pritchard recently asking to look at the staff uptake for vaccinations due to some areas being low with uptake. Dr Pepper enquired as to whether any work had been done to look into staff vaccination uptake figures to ensure a clear message was going out about vaccinations and also focussing on IPC. Mrs Tilley confirmed the staff vaccination uptake was good and a human resources group were continuously working on this to ensure these messages were getting out to staff to ensure they had taken up the vaccine. The same was being done with all groups of the population and continuing to revisit and look at the figures and members of population who had not had their vaccination. New guidance had been issued from NHSE as to how certain groups of staff could be managed in terms of people that have so far declined to take the vaccine and how supportive conversations could be put in place for staff. Risk assessments were being looked at to help staff work in an appropriate way if they had not been vaccinated.

14.10 Mrs Noakes raised inequalities and noted that a system wide group had been set up to look at vaccine hesitancy within the population, advising she would be chairing this group. Mrs Noakes advised this meeting would be supported by a range of partners and there was some innovation in that area highlighting the CCGs also had health inequalities funding to support the uptake of the vaccinations for the most hesitant groups of our population. Helen Onions, Bernie Lee and Claire Parker were currently working on this and looking at producing a plan together which looked at ways of using that funding.

14.11 Dr Shepherd asked about the delivery of the second vaccination as part of the vaccination programme and Mrs Tilley confirmed that as part of the modelling work being done there was currently sufficient workforce to deliver this, however this would continue to be monitored closely with this being an ongoing piece of work.

14.12 Mr Vivian raised the supply of vaccines and asked if there were any issues with supply. Mrs Tilley advised the supply had been slightly less over the last couple of weeks, however, this was made known to the CCGs as nationally it was identified that the supply may reduce for 2-4 weeks, but then increase again and this was a national position. Supplies would increase back to prior levels and supplemented with additional supplies given that second doses would need to be factored in, plus the expansion into the under 50 cohort, which is a large group of the population. Mr Vivian expressed his thanks to Mrs Tilley, Mrs Noakes and Ms Robinson for the fantastic work with the vaccination programme. Dr Povey seconded this and gave his thanks to all staff, volunteers and anyone involved in the vaccination programme with all the venues being set up and the logistics of this programme. Dr Povey also confirmed the weekly numbers from 2.6 million to 4 million nationally of vaccines was an increase to take account of the second doses and the next cohort of the population.

14.13 Mrs MacArthur agreed it was great news regarding the uptake of figures for the vaccine and asked if there was any further breakdown data for the uptake of the vaccine for some of the BAME community and the most deprived population. Mrs Tilley confirmed an update regarding vaccination figures were sent to the Governing Body every Tuesday evening and figures relating to this were in this update periodically. The uptake in BAME communities was now looking good and as mentioned previously by Mrs Noakes there was now a group looking at some of these inequalities and how these issues would be addressed going forward. Mrs Tilley reported the last set of figures she had seen, it was reported that the uptake figures was above 75% in BAME communities showing that significant progress had been made with approximately a few hundred people left to vaccinate in that group. Mrs Tilley confirmed that work with the inequalities elements and would be ongoing and data would continue to be supplied.

14.14 Dr Matthee confirmed for information purposes that Practices were still getting lots of phone calls regarding the vaccinations and second dose queries which centred around venues. Dr Matthee raised the virtual ward and asked if this was still being utilised. Mrs Tilley confirmed the virtual ward was still running and there was a review currently taking pace which would be reported on next week to look at how we may expand the use of this. Work was ongoing with regional colleagues, NHSE and also locally with clinicians and managers in order to progress this review and to understand how we increase the usage of the virtual ward to the level of what we expected when we put it in place. Dr Pringle asked for clarification of the age limit and if it was for the over 65s or vulnerable people only and why this was limited to a certain subsection of the population. Mrs Tilley advised the referral criteria was currently being looked at as it was felt this had been too restrictive and this was part of the review.

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

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

DECISION-MAKING

Minute No. GB-21-03.044 – Bridging arrangements for GP IT Futures

15.1 Dr Povey reported there was a potential conflict of interest with GP Partners for this item and on reflection and following discussions with Mr Evans and Mr Timmis, it had been agreed with the assumption Mr Braden was happy with these arrangements from a Telford perspective that GP Partners would be able to contribute to the discussion but they would not be able to vote on this item.

15.2 Mrs Skidmore presented this item and updated members about the GP system of choice framework advising the national NHS digital team had decided to rename and revamp this system and it was now named the GP IT Futures framework. The planning work for the transition to the new framework had been progressing over the last 2 years with some arrangements being put in place in January 2020 and some time-limited agreements put in place so that CCGs had time to progress and put procurement arrangements in place and for NHS digital to put things in place too. Mrs Skidmore advised that due to the impact of COVID-19 there had been insufficient time to enable a full national procurement process as originally envisaged in the Framework and therefore NHS Digital had been working to secure an interim arrangement to allow time for a full process to occur. The digital team were working closely with our IT team and the bridging plan was not suggesting any changes to our current arrangements for the interim period, however Governing Body sign off and support was required for this work so that contractual bridging arrangements could be put in place ahead of a 2021/22 full procurement process.

15.3 Mrs Skidmore highlighted the cost pressures associated with this work noting that previously the budget was held centrally but now the budgets had been passed to the CCGs for funding for the existing service. Mrs Skidmore confirmed there was a large scale review taking place with IT budgets.

15.4 Mr Timmis gave his support for the contractual bridging arrangements and asked for clarification about the wording in the paper in relation to paragraph one stating "no legally compliant route to extend". Mrs Skidmore clarified the position noting there was no legal arrangement for us to extend the current arrangements but the production of the new arrangements is the lawful way to do it.

15.5 Mrs MacArthur also supported this way forward and timings for any procurement and whether this could be noted within the timeframe. Mrs Skidmore confirmed the CCG were working very closely with NHSD to secure a start date and this work was in the plans.

RESOLVE: NHS Shropshire CCG APPROVED the sign off of call off order forms for the suppliers listed in Table 1 in order that contractual bridging arrangements can be put in place ahead of a 2021/22 full procurement process.

RESOLVE: NHS Telford and Wrekin CCG APPROVED the sign off of call off order forms for the suppliers listed in Table 1 in order that contractual bridging arrangements can be put in place ahead of a 2021/22 full procurement process.

Minute No. GB-21-03.045 – Update on the System Improvement Plan

16.1 Mr Evans presented the verbal update on the System Improvement Plan (SIP) previously and noted this was linked to SaTH's Care Quality Commission (CQC) requirements and to SaTH's Improvement Plan. Work was ongoing and progress was being made and this was being overseen by SOAG.

16.2 Mr Trenchard reported on the decision that had been made with the Integrated Care Systems (ICS) to align the SIP with the ICS submission and key pieces of work which feed into the SIP. A single plan overseen by SOAG which would incorporate a number of elements and alignment with the first 6 months along with the winter schemes were currently being evaluated and would come to the UEC Delivery Group. David Stout would be leading on the alignment of the key programmes for system transformation on behalf of all the Chief Executives and there were also a number of pieces of work where schemes were being developed rapidly. Mr Trenchard advised in future, a paper would come to the Governing Board meeting updating members on future schemes and a report regarding aligning the schemes into one plan would come to the May Governing Board meeting.

16.3 Dr Matthee asked where Futurefit sat within the SIP. In response, Mr Evans confirmed that in terms of long term plans, the Hospital Transformation Programme (previously named Futurefit) had now moved into the Trust so that the clinical model could be developed and implemented. It was noted the Trust had been given £6 million to develop the outline business case and there had been several meetings over the last couple of weeks with SaTH, NHSE/I and the system regarding how this work could be progressed. Mr Evans confirmed this work would include schedules of accommodation to a certain degree and implementing the clinical model which addresses some concerns in relation to CQC and sustainability of clinical services in the longer term, however, some issues would need to be addressed in the shorter term too. Progress was being made and the Trust would be looking at the outline business case shortly.

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

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

ACTION: Mr Trenchard to bring a report back to the May Governing Board meeting detailing the alignment of schemes with the SIP.

Minute No. GB-21-03.046 – Single Strategic Commissioner – Vision and Strategic Objectives

17.1 Mr Evans presented this item and took the paper as read. The following points were noted:

17.2 Mr Evans advised the report set out the current position and sought ratification and Governing Board approval for the next stage in becoming a single strategic commissioner organisation from 1 April 2021. Mr Evans reported that workshops had been held jointly with the two CCG Boards since August last year and had been facilitated by Deloitte. Governing Board approval was required for the purpose statement and strategic priorities such as ensuring we understand the health needs of our population, addressing health and inequalities in moving forward as a single strategic commissioner. To ensure the CCG participates, supports and facilitates joint system working with a shared vision, purpose and narrative for the system financial balance both as a single strategic commissioner and for the system overall and that the CCG commissions improvements in health outcomes in terms of quality and safety.

17.3 Dr Shepherd commented on the purpose statement and proposed to amend the narrative to qualify or describe health outcomes the CCG were aiming for. Dr Shepherd suggested adding some narrative to describe the CCG would be identifying health outcomes and looking for improved health outcomes. Members agreed this narrative should be added to the purpose statement to ensure clarity. Mrs Noakes agreed with the comments suggesting that all the words were there but not quite in the right order. Mrs Noakes advised it was not just about commissioning of services but also about partnership working, the role as an anchor institution adding there were various ways the CCGs could reduce health inequalities. Partnership working was not truly reflected in the outcomes.

17.4 Mr Vivian commented about the language used in the statement and suggested using present tense rather than past tense. Mr Vivian proposed replacing the term 'ensuring' with 'we strive to' and also suggested taking out the word 'will' all the way through the document. Mr Vivian commented that the strategic priorities felt a bit mixed and suggested there should also be some narrative in their regarding holding healthcare providers to account.

17.5 Mr Evans confirmed presently the two CCGs were operating as two CCG Governing Boards meeting jointly in trying to shape the vision and purpose of the new organisation. The challenge is getting the balance right for the new organisation and recommended the strategic priorities be reviewed fairly quickly in the first couple of Governing Board meetings so that the new organisation can review them and establish whether they are still appropriate for the new organisation.

17.6 Dr Povey noted the comments and highlighted that time constraints was a major factor agreeing the strategic principles were not perfect but they were the initial strategic outcomes which could be developed and changed. Dr Povey confirmed that CCGs Board workshops had focussed on this previously and had given input towards the strategic outcomes. It was now for the new CCG to look at and adapt them. Dr Povey therefore suggested approving the purpose statement and strategic priorities with the recommendation that the new CCG review them as soon as possible. It was therefore agreed to add in the narrative regarding improving healthcare outcomes and support the recommendation for the new CCG to review the strategic priorities to ensure they were still appropriate.

17.7 Dr Pepper commented that he supported this approach and of the recommendation that the statement and priorities should be actively looked at within a further Board development workshop in April so that they could be ready to be represented in May. Mr Vivian also gave his support for this approach and proposed that a small group of members be set up to look at the strategic priorities further. Mr Trenchard added this was an opportunity to co-produce the strategic priorities with staff and gave his support for health improvement and partnership working which was critical for the new ICS.

RESOLVE: NHS Shropshire CCG NOTED the recent development work the Governing Body members have undertaken and the outputs of these discussions

RESOLVE: NHS Telford and Wrekin CCG NOTED the recent development work the Governing Body members have undertaken and the outputs of these discussions.

ACTION: It was agreed to add in the narrative regarding improving healthcare outcomes and support the recommendation for the new CCG to review the strategic priorities as soon as possible to ensure they are still appropriate.

Minute No. GB-21-03.047 - Update on NHS Patient Safety Specialist

18.1 Mrs Young presented this item and the following points were noted:

18.2 Mrs Young advised this was an update further to a paper which was brought to Governing Board meeting in November 2020. The CCGs had recruited to the post of patient safety specialist and since November 2020 there had been a national review, which was published in February (appended in papers) which shifted the scope of the role to recognise the wider determinants around health inequalities and diversities and inclusion of references to certain groups. Mrs Young commented the national update was there for information purposes and noted that some of the ambition had been amended to take account of this. It was envisaged there would be a module which all staff would need to undertake with further modules for the patient safety specialist specifically.

18.3 Mrs Young reported in terms of a local update, the CCGs had secured funding for this post substantively; however recruitment had been delayed due to management of change. It was noted that as a system the local system meeting had been maintained which would deliver the strategy and report to the ICS Quality and Safety Committee in due course.

18.4 The CCG Governing Body were asked to note the content of the report and acknowledge the delay in recruitment to the role of patient safety specialist due to CCG Management of Change and approve the recommendation of an update being presented to the Governing Board meeting on a bi-annual basis. Members noted all the information and approved the recommendation.

RESOLVE: NHS Shropshire CCG NOTED the content of the report and acknowledged the delay in recruitment to the role of patient safety specialist and APPROVED the recommendation of an updated being presented at the Governing Board meeting on a bi-annual basis.

RESOLVE: NHS Telford and Wrekin CCG NOTED the content of the report and acknowledged the delay in recruitment to the role of patient safety specialist and APPROVED the recommendation of an updated being presented at the Governing Board meeting on a bi-annual basis.

GOVERNANCE

Minute No. GB-21-03.048 - Joint Board Assurance Framework (BAF)

19.1 Ms Smith presented this item and reported there had been several discussions at the Audit Committee meetings in common regarding how risks are allocated on the joint interim BAF to Committees where it is pertinent or whether to retain them at Governing Body meetings and the new Governing Body going forward. Ms Smith commented that the Audit Committee would take a view for the whole BAF but each Committee would look at their own individual risks and look at their own BAF risks.

19.2 The Governing Body were asked to accept and note the content of this report; to support appendix A for assurance purposes; review the updated strategic risk position and confirm that the current level of risk was acceptable in line with actions outlined and discuss and approve the suggested allocation of BAF risks to Committees as outlined in section 1.4.

19.3 Mrs Young highlighted that on page 131 (risk number 2, column 7) under section 2 had not quite made it to print and there was text missing from the document. Mrs Young apologised and agreed to send the rest of the narrative to Ms Smith so that the document could be amended. Ms Smith advised that when Committee meeting papers were PDF'd the format of the reports changed. Ms Smith suggested that the BAF be sent out in word version in future so that the Governing Body could view the whole document.

19.4 The Governing Body noted the context of the report and approved the suggestion of allocating BAF risks to Committees as outlined in section 1.4.

RESOLVE: NHS Shropshire CCG NOTED the content of the report and APPROVED the recommendation of allocating BAF risks to Committees as outlined in section 1.4.

RESOLVE: NHS Telford and Wrekin CCG NOTED the content of the report and APPROVED the recommendation of allocating BAF risks to Committees as outlined in section 1.4.

Minute No. GB-21-03.049 - CCG Wellbeing Guardian

20.1 Ms Smith presented this item for other NHS approval and noted there was a requirement for a Wellbeing champion to be appointed in NHS Trust and organisations and this had been outlined in the NHS Peoples Plan 2020-21. Mr Vivian had volunteered to undertake this role for the two CCGs and the report proposed Mr Vivian was formally appointed to it.

20.2 Discussion was held around the role of the Wellbeing Guardian and Ms Smith confirmed she had attended a webinar regarding the role of a Well-being Guardian and it was a developing picture with no prescribed definition of the role. The Well-being Guardian role could be developed by organisations so that it can be aimed at their staff and related to the organisational risks. The role would be the voice on the Governing Body relating to the wellbeing of CCG staff.

20.3 Mr Vivian commented that as well as continuing his role as lay member for Patient and Public Involvement (PPI) and being Deputy Chair, he confirmed he had also volunteered for this role of Well-being champion, advising the role would look at what or if any changes were impacting on the CCG staff. Mr Vivian proposed it would be useful to see a report being presented to the Governing Board meeting, twice a year reporting on the well-being of the CCG staff and discussions were ongoing about this. Dr Povey acknowledged it was about how well-being was measured and much of this work would be linked to the staff surveys.

20.4 The Governing Body approved the appointment of Mr Meredith Vivian, Lay Member PPI and Deputy Chair, as the existing CCGs and new CCG Well-being Guardian until the end of his tenure as a Governing Body member.

RESOLVE: NHS Shropshire CCG APPROVED the appointment of Mr Meredith Vivian, Lay Member PPI and Deputy Chair, as the existing CCGs and new CCG Well-being Guardian until the end of his tenure as a Governing Body member.

RESOLVE: NHS Telford and Wrekin CCG APPROVED the appointment of Mr Meredith Vivian, Lay Member PPI and Deputy Chair, as the existing CCGs and new CCG Well-being Guardian until the end of his tenure as a Governing Body member.

OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY

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

NHS Shropshire CCG and NHS Telford and Wrekin CCG Joint reports:
Minute Nos. GB-21-03.050 to GB-21-03.053

Audit Committees in Common – 20 January 2021
Joint Strategic Commissioning Committee – 20 January 2021
Finance & Performance Committees in Common – 27 January 2021
Quality & Performance Committees in Common – 27 January 2021

For: NHS Shropshire CCG Only:
Minute Nos. GB-2020-03.054 to GB-2020-03.056

South Shropshire Locality Forum – 6 January 2021
Shrewsbury and Atcham Locality Forum – 21 January 2021
North Shropshire Locality Forum – 28 January 2021

For: NHS Telford and Wrekin CCG Only:
Minute No. GB-21-03.057

Telford and Wrekin CCG Practice Forum – 19 January 2021

21.2 Mr Vivian referred to the Joint Strategic Commissioning Committee (JSCC) notes from the meeting held on 20 January 2021 and asked for an update on the Shropshire care closer to home service which in the notes referred to this being under the Shropshire Integrated Place Partnership (ShIPP). Dr Shepherd confirmed the ShIPP Board had not met since the first meeting in January 2021 and the next meeting was scheduled for April 2021. Dr Shepherd advised care closer to home would be overseen and delivered by the ShIPP Board, however, there had been a slight delay due to an awaited decision from the JSCC as to whether a procurement process was needed or this service could be commissioned from providers. It was noted the new chairs would meet in April and look at what actions would need to be taken forward. Work had been done on the terms of reference and actions would now be progressed. Mr Trenchard commented that one of the big areas of work for the system was the out of hospital community model which aligns with the Futurefit work and in terms of investment; this was being looked at through the System Sustainability Committee.

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

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

Minute No. GB-21-03.058 – Any Other Business

22.1 Ms Smith raised an item of any other business and updated the members in relation to the registered nurse position for the CCG. Ms Smith reported that Mrs Julie McCabe had resigned from her post as registered nurse from the two CCG Governing Bodies in January 2021 which left the CCG with a vacancy. Ms Smith confirmed that Ms Audrey Warren has been offered the post as registered nurse and asked for members' approval and support of this appointment advising all appointments would be ratified at the new CCG Board meeting in April. The Governing Board noted the information and approved the appointment of Ms Audrey Warren as registered nurse.

RESOLVE: ***NHS Shropshire CCG Governing Body RECEIVED and NOTED the information and approved the appointment of Ms Audrey Warren as the new registered nurse.***

RESOLVE: ***NHS Telford and Wrekin CCG Governing Body RECEIVED the NOTED and approved the appointment of Ms Audrey Warren as the new registered nurse.***

22.2 Dr Pepper took the opportunity to highlight the departure of Dr Povey noting this was Dr Povey's last CCG Board meeting. Dr Pepper gave thanks to Dr Povey for all his hard work and took members through Dr Povey's achievements since first joining the PCT in 2009, with the shadow CCG work in 2012 and then promotion to the Chair position of the CCG in 2015. Dr Pepper advised that over the last 12 years Dr Povey had made many notable achievements and more recently with bringing the two CCGs together. Dr Povey had been involved in work which included Futurefit from pre consultation stage and onwards, taking part in the development of the STP with it moving into an ICS including being part of the process of appointing an independent chair and in primary care settings encouraging premises development. Dr Pepper confirmed there had been multiple procurement and commissioning achievements such as the community pain clinic service, community ophthalmology, orthopaedic pathways, end of life care, and overseeing change in mental health services from a hospital to a community based model and the procurement of 0-25 mental health services provision.

22.3 Dr Pepper advised the Chair position was much more complex noting that Dr Povey had also been co-chair of the Shropshire Health and Well-being Board and a member of the West Midlands Clinical Senate. Dr Pepper highlighted Dr Povey's commitment and support to the development of leadership and encouragement of people, commenting the leadership that had been promoted within the CCG membership team with two cohorts of GPs having been through the leadership programmes and producing 12 individuals who had gone on to do leadership roles within the health economy including Dr Pepper.

22.4 Dr Pepper went on to say that Dr Povey had made a huge contribution, with clinical leadership locally and the relationships with the membership, with CCG staff and the organisation as a whole. Dr Povey has been a CCG chair alongside five Accountable Officers and has provided continuity and knowledge alongside being a practising GP. Dr Povey is very highly respected in our healthcare community and has demonstrated ability and effectiveness across clinical and organisational domains, remaining articulate and providing challenge when needed, being a true leader. Dr Pepper advised the bar had been set high and Dr Povey had consistently put healthcare of the population at the forefront. Dr Pepper said as a friend, fellow board member, and as a GP he wanted to thank Dr Povey for all his hard work. The Governing Board joined Dr Pepper in thanking Dr Povey for all his contributions and showed appreciation for all his hard work giving Dr Povey best wishes for his return to full time General Practice.

22.5 Dr Povey thanked Dr Pepper and the Governing Board for their kind words and said it had been a joy and a great pleasure working with everyone, thanking everyone for all their help over his time whilst being at the CCG.

DATE OF NEXT MEETING

It was confirmed that the date of the next scheduled Governing Body Part 1 meeting is: Wednesday 12 May 2021 – time, venue and modality of the meeting to be confirmed nearer the time.

Dr Povey officially closed the meeting at 12.45 pm.

SIGNED …….. DATE ……

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

Wednesday 24th March 2021 at 10am
Via Microsoft Teams

Present from Shropshire CCG

Mr Meredith Vivian	Deputy Chair and Joint Member for Patient and Public Involvement
Mrs Claire Skidmore	Joint Executive Director of Finance for Shropshire and Telford and Wrekin CCGs
Mrs Rachael Bryceland	Joint GP/Healthcare Professional Governing Body Member
Ms Fiona Smith	Joint GP/Healthcare Professional Governing Body Member
Dr Pepper	Joint GP/Healthcare Professional Governing Body Member
Dr Pringle	Joint Vice Clinical Chair and GP/Healthcare Professional Governing Body Member
Mr Steve Trenchard	Joint Interim Executive Director of Transformation for Shropshire and Telford Wrekin CCGs
Mrs Donna MacArthur	Joint Lay Member, Primary Care
Mr Ash Ahmed	Joint Lay Member, Patient and Public Involvement - Equality, Diversity and Inclusion
Mr Keith Timmis	Lay Member, Governance, Shropshire CCG

Present from Telford and Wrekin CCG

Mr Meredith Vivian	Deputy Chair and Joint Member for Patient and Public Involvement
Mrs Claire Skidmore	Joint Executive Director of Finance for Shropshire and Telford and Wrekin CCGs
Mrs Rachael Bryceland	Joint GP/Healthcare Professional Governing Body Member
Ms Fiona Smith	Joint GP/Healthcare Professional Governing Body Member
Dr Pepper	Joint GP/Healthcare Professional Governing Body Member
Dr Pringle	Joint Vice Clinical Chair and GP/Healthcare Professional Governing Body Member
Mr Steve Trenchard	Joint Interim Executive Director of Transformation for Shropshire and Telford Wrekin CCGs
Mrs Donna MacArthur	Joint Lay Member, Primary Care
Mr Ash Ahmed	Joint Lay Member, Patient and Public Involvement - Equality, Diversity and Inclusion
Mr Geoff Braden	Lay Member, Governance, Telford and Wrekin CCG

Attendees for both CCGs:

Dr Julie Davies	Joint Director of Performance for Shropshire and Telford and Wrekin CCGs
Miss Alison Smith	Joint Director of Corporate Affairs for Shropshire and Telford and Wrekin CCG
Mrs Sam Tilley	Joint Director of Planning for Shropshire and Telford and Wrekin CCGs

Ms Claire Parker	Joint Director of Partnerships for Shropshire and Telford and Wrekin CCGs
Dr Deborah Shepherd	Joint Interim Medical Director for Shropshire and Telford and Wrekin CCGs
Mrs Sonja Corfield	Minute Taker

Mr Vivian welcomed members to the NHS Shropshire CCG and NHS Telford and Wrekin CCG Governing Body meetings in common.

Minute No. EGB-21-03.058 – Apologies

1.1 Apologies noted from:

Mrs Zena Young, Joint Executive Director of Nursing and Quality for Shropshire and Telford and Wrekin CCGs.
Dr Martin Allen, Joint Secondary Care Doctor for Shropshire and Telford and Wrekin CCGs.

Minute No. EGB-21-03.059 - Declarations of Interests

2.1 Mr Vivian requested any declarations of interests for today's meeting and Dr Pringle advised that he had completed a few days of locum working which has been submitted via email. Mr Vivian thanked Dr Pringle for his input.

2.2 Mr Vivian checked with Miss Smith and confirmed that this declaration did not conflict with any item on the agenda.

Minute No. EGB-21-03.060 – Single Strategic Commissioner – Close Down and Transition Plan

3.1 Mr Vivian requested Miss Smith to set the scene and assist in any queries or questions and first outlined that the transition process had been an enormous exercise to get two organisations in to the position where a wholly new organisation could emerge. Miss Smith has led the line on this project and Mr Vivian went on to congratulate Miss Smith on driving the project forward. Mr Vivian sent his many thanks to all the directors and staff involved for all their hard in their own areas of expertise.

3.2 Mr Vivian went on to hand over to Miss Smith to discuss the papers and any areas which may need particular attention.

3.3 Miss Smith advised that she assumed everyone has read the report but wished to highlight the following points:

- In December 2020 both Governing Bodies delegated to their respective Audit Committees the oversight of the due diligence and transition process. There has been a robust process of giving progress updates to Audit Committee which was documented in the report. Audit committees have been fully cited on all of the issues that arose and actions taken for addressing these.

- In section 2 - Governing Body Membership the AO position will be filled on a short term basis by Mrs Skidmore. This has now been issued to NHS England together with Mrs Clare as the interim Executive Director for Finance deputising for Mrs Skidmore whilst she is fulfilling the Interim AO role.
- NHSE/I are due to imminently issue the Grant of Merger documents within the next few days.

3.4 In terms of the staff due-diligence process this has been a huge piece of work which MLCSU HR team had been working on. Most of the staff records are kept on the ESR which makes the process of creating staff transfer documents more straightforward. However there have been additional lines of work that has been undertaken around things that are not captured on the ESR system such as secondment arrangements, excess mileage etc. but this has all been captured manually as part of the due-diligence process. The TUPE consultation has been completed with staff on Monday 22nd March 2021; this process ensured that staff transfer across to a new organisation with the same terms and conditions. Two issues have been identified from the consultation feedback; a difference in how annual leave is calculated in the annual leave policies between the two CCGs and that Shropshire CCG has a long service policy which Telford and Wrekin CCG does not. To address these issues the new Annual leave policy for the new CCG will use the Shropshire CCG calculation of rounding up to the nearest hour and the Shropshire CCG Long Service Policy will be adopted for the new CCG.

3.5 Miss Smith highlighted that some Audit Committee members had sat on a panel meeting with the Head Internal Audit to scrutinise the due diligence process to ensure that workstreams were progressing eh work required and any issues were identified early in the process. A number of issues where identified which are have been or are being addressed. Audit Committee have also provided oversight to the due diligence tracker over the course of three meetings to look at the detail of progress which was attached for the Governing Bodies information. Miss Smith advised that some of the lines are showing ‘still in progress’ some of these are ongoing pieces of work with will not end until the 31st March 2021, for instance any disciplinary which might arise in this short period would need to be captured. Some items are ongoing due to the nature of the pieces of work for example the construction of a new ledger and ESR structure.

3.6 Miss Smith went onto note that the NHS England Mergers Due-Diligence check point happened over the course of two days the 18th and the 25th February 2021 the outputs of which were very positive. The finding was the Due-Diligence process was very robust and no further detail was required. Mrs Sullivan, Regional Mergers Lead NHSEI response to Miss Smith and Mr Evans via email advised that this was the best Due-Diligence process that Mrs Sullivan had experienced in overseeing seven mergers that she had supported previously. Miss Smith went on to congratulate the teams involved across the two CCGs as they had done tremendous job in a very short space of time.

3.7 A further report to Audit Committees in the March meetings had included further information on the progress of reviewing and preparing new policies. There were a lot of policies still being reviewed and all policies had been captured on a policy tracker. Clearly Covid has meant that capacity within the teams to undertake these reviews was being focussed instead upon supporting the Covid 19 Vaccinations centres as a priority. This meant that there will be policies that will need aligning after the creation of the new CCG, but a plan is in place which has been shared with the Audit Committee and there has been a risk analysis done on those in terms of finance, risk to patients, quality etc. The risk ratings have been documented within the report. It was agreed with the Audit Committees that post 1st April 2021 that progress against the policy tracker would be presented to the new Audit Committee on a regular basis to highlight any areas of concern that require intervention or escalating for further action or focus.

3.8 Finally, Miss Smith highlighted that the commissioned report from Mills and Reeve who are legal advisers to both CCGs on the due-diligence process, had not yet been received but was expected by close of business on 24th March 2021. However, the feedback received verbally has been that all information has been received apart from a handful of minor issues of checking accuracy of information provided which has now been completed. Mills and Reeve have also advised that what they have seen is robust, meeting all the due-diligence questions in the due-diligence tracker and do not foresee any issues of concern.

3.9 Miss Smith added that the next steps are for NHSEI to issue the grant of merger, formal property transfer agreement and staff transfer agreement which is imminent this week so are prepared for transfer 1st April 2021 and also have a comprehensive programme of communication that is planned for the 1st April to all stakeholders, Governing Body members, practice membership and staff members of the CCGs.

Questions and Queries

3.10 Mr Vivian thanked Miss Smith and opened up to questions.

3.11 Dr Pepper mentioned the due diligence process and particularly about data abstraction, systems migration, IT, security. Our IT infrastructure was completed in terms of listing but the part about how all the data held on the systems would migrate was stating “in progress” and 50% complete. Did Miss Alison Smith advise that is now much more progressed. Are the IT records going to transfer smoothly in the process?

3.12 Miss Smith answered with this was on track and the issue was stated in the report to the Governing Body as a live issues at that point but by the 31st March.21 these issues will have been resolved. Mrs Skidmore added the assurance that all of the actions are in place to happen or have happened by now. It is where the information sits in the very background of the systems and making sure the data is assigned to the new organisation code and stored appropriately.

3.13 Miss Smith added that this is one area which NHSEI had focussed upon in the check point meetings as this was an area which has been acknowledged as not going smoothly in other CCG transition arrangements and they had asked specific questions around this area of planning to seek a greater level of assurance. Dr Pepper thanked Miss Smith for the information provided.

3.14 Mrs Bryceland asked if there was going to be a joint website for the pathways and all the clinical information available from the 1st April 2021?

3.15 Miss Smith advised the new website with look similar to Shropshire and Telford & Wrekin existing websites in terms of content. Design wise the content set out on the website will have a separate section for clinical policies so it would be readily available and easy accessible for clinical colleagues to access.

3.16 Mr Vivian asks for any further comments or queries on the Due-Diligence process but there were no further comments made.

3.17 Mr Vivian asked members of the Audit Committees specifically if there were any comments they wished to add.

3.18 There were no comments from the Audit Committee members.

Communications

3.19 Mr Vivian asked that the communication out to stakeholders and the membership included both a vote of thanks to those that had enabled the CCGs to complete this transition and also a clear message as to the benefits of creating a single CCG for patients and the wider health system. Miss Smith agreed to ensure that the communication included these points.

Policy Alignment

3.20 Mr Vivian talked about some policies will require significant amount of work and possibly engagement with the population effected, which could not be done overnight and some policies, such as the IVF may be highly controversial. These would need to be managed very carefully and asked the Governing Bodies to note that policy alignment would need to continue to have regular oversight by the new Audit Committee.

3.21 Dr Shepherd added that clinical policies are being reviewed; the fertility policy specifically is sitting with Dr Shepherd at the moment. And she was planning to take it to the Strategic Commissioning Committee for discussion next month and will be subject to discussion and if appropriate patient engagement and consultation.

3.22 Dr Davies wanted to discuss in terms of the correspondence to staff about the new employment arrangements, when are the letters going to be circulated to staff?

3.23 Miss Smith responded to Dr Davies that there are two letters that go out, one letter will go out in the next few days from the current employer to the member of staff to confirm that they will be transferred. The member of staff will then receive a second letter from the new organisation to confirm they have been received into the new organisation as an employee.

3.24 Miss Smith thanked all staff across the two CCGs for their efforts in completing a significant piece of work in a short amount of time which had been recognised as an exemplar.

3.25 Mr Vivian then proceeded to take the recommendation for each Governing Body in turn:

NHS Shropshire CCG Governing Body noted the content of the report and agreed that sufficient action and planning had taken place to provide assurance that the CCG will by the deadlines set, have completed a robust due diligence process to support the transition to a single CCG in April 2021.

NHS Telford and Wrekin CCG Governing Body noted the content of the report and agreed that sufficient action and planning had taken place to provide assurance that the CCG will by the deadlines set, have completed a robust due diligence process to support the transition to a single CCG in April 2021.

Minute No. EGB-21-03.061 – Any Other Business

4.1 There were no further items raised for discussion.

4.2 Mr Vivian thanked everyone for their time and trouble and attending the meeting. Mr Vivian thanked Miss Smith for getting the CCG's to the point of transition.

Mr Vivian closed the meeting at 10:33am

NHS Shropshire, Telford and Wrekin CCG
Governing Body's Extraordinary Part 1 Meeting

Wednesday 14th April 2021 at 11:00am
Via Microsoft Teams

Present from Shropshire, Telford and Wrekin CCG

Dr John Pepper	Chair
Mr Meredith Vivian	Deputy Chair and Lay Member for Patient and Public Involvement
Mr Geoff Braden	Lay Member for Governance
Miss Alison Smith	Director of Corporate Affairs
Mrs Donna MacArthur	Lay Member, Primary Care
Mrs Claire Skidmore	Interim Accountable Officer
Dr Julie Davies	Director of Performance
Mr Steve Trenchard	Interim Executive Director of Transformation
Ms Claire Parker	Director of Partnership
Dr Martin Allen	Secondary Care Doctor Governing Body Member
Dr Deborah Shepherd	Interim Medical Director
Dr Stephen James	Interim Chief Clinical Information Officer
Dr Adam Pringle	Vice Clinical Chair and GP/Healthcare Professional Governing Body Member
Dr Michael Matthee	GP/Healthcare professional Governing Body Member
Dr Mary Ilesanmi	GP/Healthcare professional Governing Body Member
Mrs Rachael Bryceland	GP/Healthcare Professional Governing Body Member
Ms Fiona Smith	GP/Healthcare Professional Governing Body Member
Mrs Laura Clare	Interim Executive Director of Finance
Mrs Audrey Warren	Registered Nurse Governing Body Member
Ms Vanessa Barrett	Chair, Healthwatch Shropshire
Mrs Sonja Corfield	Minute Taker

Minute No. GB-21-04.01 – Apologies

Apologies noted from:

Mrs Zena Young	Executive Director of Nursing and Quality
Mrs Sam Tilley	Director of Planning
Mr Ash Ahmed	Lay Member for Patient and Public Involvement - Equality, Diversity and Inclusion

Minute No. GB-21-04.02 – Members Declarations of Interests

Dr Martin Allen has been invited to attend the NHSEI Working Group looking at the use of the new blended payments and incentive of payments of innovation. Dr Allen will update his Declaration of Interests accordingly

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Minute No. GB-21-04.03 – Adoption of Key Transition Documentation:

Miss Alison Smith advised that the purpose of this item was to present the documentation which has been issued to NHS Shropshire, Telford and Wrekin CCG, by NHS England and NHS improvement following the completion of the due diligence process and the discharge of the conditions that were imposed following the successful application process. The documentation is for the new Governing Body of the new CCG to receive and note, and Miss Smith asked the Governing Body to note particularly the grant of merger and legal transfer of all staff and property assets and liabilities from the two pre-existing CCGs, NHS Shropshire CCG and NHS Telford & Wrekin CCG to the new CCG. This also included the new delegation agreement between the new CCG and NHS England for the delegated responsibility to commission primary care services across the whole geographical foot print of Shropshire, Telford & Wrekin.

Miss Smith drew Governing Body Members' attention to the Constitution and Governance Handbook which was also attached to the report and reminded the Governing Body that there had been a lengthy process of a consultation with the two then memberships of the two existing CCGs on the content of both of these documents culminating in a vote to approve, which resulted in the Constitution and Governance Handbook being submitted to NHS England and NHS Improvement.

During the consultation period, one area of disparity between the Governance Handbook and the Constitution was highlighted. The Governance Handbook, which included the scheme of reservation and delegation, had included a delegation from the Governing Body to the Audit Committee to approve the final accounts and annual report on behalf of the Governing Body. However, the terms of reference of the Audit Committee outlined in the Constitution that the Governing Body still retained the approval process for final accounts and annual reports. Given the current way of working at the time of the two CCGs, which was to have delegation to the Audit Committees to approve the annual accounts and annual reports, the Constitution was changed in line with the scheme of reservation and delegation in the Governance Handbook and following membership approval submitted to NHSE/I. On receipt of the documents NHSE/I have asked in the letter to the Accountable Officer accompanying the Grant of Merger document that the CCG reconsiders this delegation which they believe is contrary to best practice and amend both documents so that the Governing Body approves final accounts and annual report.

Miss Smith went onto explain that, in light of the request form NHSE/I to reconsider this issue the report proposes to change the Governance Handbook on page 9 to reflect that the Governing Body still retains the approval for final accounts and final report. Miss Smith confirmed that under the Constitution the Governing Body has the ability to amend the content of the Governance Handbook without further ratification from the Membership.

The report also proposes to amend the Constitution as shown on pages 43-44 as track changes. Miss Smith confirmed that under section 1.4.2 of the Constitution the Governing Body could approve, on the recommendation of the Accountable Officer, non-material changes to the Constitution where these will not be changing the reserved powers of the membership. Miss Smith confirmed that the report recommended that the proposed change was made under this clause in the Constitution as it was neither a material change not amending the reserved powers of the membership and would align with the Governing Body retaining the approval of annual accounts and the annual report in the Governance Handbook.

Mr John Pepper confirmed there were no questions on the content of the paper and the Governing Body:

- Received the grant of merger
- Received and adopted the property transfer scheme
- Received and adopted the staff transfer scheme
- Received and adopted the Constitution and Governance Handbook with highlighted amendments as outlined in the report; and
- Received and adopted the primary care delegation agreement

Minute No. GB-21-04.04 – Confirmation of Key Roles

Miss Alison Smith highlighted that appointment to the Governing Body roles outlined in the paper had been reported to the Governing Body meetings in Common of NHS Shropshire CCG and NHS Telford and Wrekin CCG in the last financial year and the purpose of the paper was for the Governing Body of the new CCG to ratify these appointments.

Miss Smith highlighted two amendments; one in section 3 where the title 'Health and Wellbeing Guardian' should read 'Wellbeing Guardian' which Mr Meredith Vivian had been appointed to and the second was a miss-spelling of Dr Deborah Shepherd's name which Miss Smith apologised for.

Mr Meredith Vivian raised a query regarding the Primary Care Commissioning Committee as a statutory body delegated from NHSE/I and asked if the Lay Member for Primary Care was required to be a statutory role.

Miss Alison Smith explained that the statutory roles on the Governing Body were the Lay Members for Governance and the Lay Member for Patient and Public Involvement as these are set out in the legislation. The Lay Member linked to Primary Care is described as a mandated role by NHSE, because it had delegated the Commissioning of Primary Care to the CCG and the requirements in the delegation agreement was to create a standalone Primary Care Commissioning Committee that had a Lay member chairing it.

The majority of CCGs at the time of taking the delegation for primary care, only had two Lay Members under the legislation which resulted in the CCG recruiting an additional Lay Member to be solely focused on the primary care agenda.

There were no further questions and the Governing Body approved the appointments outlined in the report.

Minute No. GB-21-04.05 – Due Diligence Assurance Report

Miss Alison Smith introduced the report and reminded the Governing Body that this information had been presented to the previous Governing Body meetings in common of the two previous existing CCGs.

Miss Smith drew the Governing Body Members' attention to the reference to the legal advisors; Mills and Reeve report which had not been available for presentation at the Governing Body meetings in common in March. Mills and Reeve had been commissioned by the two previous CCGs to have oversight of the due-diligence process and were provided with all the due diligence information so they were fully conversant with the full details. The conclusion from Mills and Reeve report was there has been a very comprehensive robust due diligence exercise undertaken. However, the report outlined three areas which were also included in the risk and issue section of the Governing Body report. These issues were as follows:

- Harmonisation of policies was presented and discussed at the Governing Body meetings in common in March. Work had already taken place prior to the Mills and Reeve recommendation in their report around prioritisation and rag rating. This action was still on-gong. The Corporate Affairs Manager was taking an oversight of the policies and liaising with each of the policy owners for those who still had yet to be aligned and ratified. They will keep a close watch on this and it had been agreed to bring a regular report to the Audit Committee to show progress against the policy tracker to provide assurance through that mechanism.
- There were some contracts that the two CCGs had with the same suppliers but on different terms which would need to be aligned. However, the Deputy Director for Contracting had compiled two registers of both health care contracts and goods and services contracts and will be working with each of the contract owners to look at the contracts and find out which can be aligned and how this could be achieved. The approach will need to be pragmatic as the CCG is unlikely to exist beyond April 2022, so they will need to be prioritised in line with available staff capacity.
- Conditions, recommendations and due diligence tracker all needed to be completed. Miss Alison Smith and Ms Kate Owen were following up on all of the outstanding actions and outstanding areas of work that were forecast to go beyond the 31st March 2021, such as setting up the new ESR staffing structure, creating the new ledger etc. which. Miss Smith agreed to monitor this process and produce a report to the Audit Committee to give a full update on any outstanding actions.

Dr Adam Pringle raised a concern on the risk matrix, particularly the policy disinvestment item which was categorised as a high risk and asked for clarification on the type of risk identified.

Mrs Claire Skidmore confirmed that the risk related to the absence of policy describing how disinvestment is calculated. Mrs Claire Skidmore added that there is mitigation in place as the work to harmonise and re-draft that policy is already underway. The plan for that policy is to be presented to the Strategic Commissioning Committee at the end of April 2021. Mrs Skidmore acknowledged there was a short timeframe for mitigating that risk and ensuring that policy was in place.

Dr John Pepper noted that NHS England/Improvement now has to be sighted on all investments and disinvestments. Mrs Skidmore responded that the system process is in place now, but that this policy is internal to the CCG and is still needs to be followed in parallel with the system process.

Dr John Pepper thanked Mr Adam Pringle and Mrs Claire Skidmore for their contributions.

Dr John Pepper thanked Miss Alison Smith for her hard work, and noted the positive comments in the Mills and Reeve report. He went onto note that this had been a huge piece of work. Miss Smith responded by thanking all those members of staff in both CCGs who had contributed to the transition process.

The Governing Body noted the report.

Minute No. GB-21-04.06 – Next Meeting

Wednesday 12th May 2021 at to be confirmed via MS TEAMS.

Meeting closed at: 11:23am.

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

ACTIONS FROM THE GOVERNING BODY PART 1 MEETINGS IN COMMON – 10 MARCH 2021

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-21-03.055 – Minutes of the Previous Meeting – 13 January 2021	Ms Parker to circulate the Partnership Board terms of reference and feedback to the Governing Body and Healthwatch following the Partnership Board meetings.	Ms Claire Parker	Next meeting	
GB-21-03.055 – Minutes of the Previous Meeting – 13 January 2021	The agreed amendments to be made to the draft minutes as noted in paragraph 6.1.	Mrs Sandra Stackhouse		Completed
GB-21-03.036 – Matters Arising b/f GB-21-01.004 – Draft ICS Application	Mr Evans to arrange for a copy of the draft ICS application to be circulated to Members for information.	Mr David Evans		Completed
	Mr Evans to double-check whether the draft ICS application can be published in the public domain.	Mr David Evans		The draft ICS application could not yet be published due to it being a draft application.
	Mr Evans to update Governing Body Members on the ICS application and the outcome following the regional and national panel meetings.	Mr David Evans		Feedback not yet received from the national panel. Some feedback had been received from the regional meeting and actions were being taken forward. There was nothing of significant concern.

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-21-03.036 – Matters Arising *[b/f GB-20-01-010 – Shropshire CCG Strategic Priorities]*	Dr Davies to share the data on the ambulance crew on-scene timings with Members when received. [Updates provided by Dr Davies: 09.09.20 Information has been requested to include data from April, which was expected to be received for presentation at the next meeting. 11.11.20 WMAS have still not provided the data requested – this has been escalated to the Regional Commissioner] 13.1.21 - Data has now been received and the CCG BI team are currently analysing it. Verbal update on findings to be given at the meeting.	Dr Julie Davies / Mr Steve Trenchard	Next meeting	Further analysis was ongoing in order to take out site to site transfers of patients done by ambulance. A paper would be brought back to the next Governing Board meeting in May to formally close this action.
GB-21-03.036 – Matters Arising *b/f GB-20-07.084 –* [Update on SEND Inspection Report]	The Executive Team to agree a process for providing the Governing Body with assurance around SEND.	Ms Claire Parker	May meeting	
GB-21-03.036 – Matters Arising *b/f GB-20-11.123 –* [Quality and Performance Report]	Mrs Young to bring back findings from the Niche consultancy report into the SI processes at SaTH and the system deaths analysis.	Mrs Zena Young	May meeting	The Niche report is delayed due to COVID-19 activity impacting on staff availability. Report on the May Board Meeting. Action closed
GB-21-03.036 – Matters Arising *b/f GB-20-11.123 –* [Quality and Performance Report	Mrs Young confirmed that the work on the case reviews had just taken place and a report would be presented to the next meeting.	Mrs Zena Young	May meeting	The Niche report is delayed due to COVID-19 activity impacting on staff availability. Report on the May

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
				Board Meeting. Action closed.
GB-21-03.036 – Matters Arising *b/f GB-21-01.010* – [Quality and Performance Report]	Mrs Young and Ms Cawley to meet to further discuss Healthwatch running a 'Hot Topic' on Neurology. 13.1.21 - A meeting has been arranged with a Quality Team member.	Mrs Zena Young / Ms Lynn Cawley	May meeting	Ms Cawley was still due to meeting with a quality team member. Ms Cawley and Mrs Young to liaise in relation to the current position with the system quality oversight arrangements which are under review from an ICS perspective. Action closed.
GB-21-03.036 – Matters Arising *b/f GB-21-01.016* – *[*Digital Update Report]	Dr James to arrange to have the information on the digitised ReSPECT form re-circulated to practices, for information. 13.1.21 - Dr James confirmed that the Integrated Care Record, CareCentric, contains a module called Care Flow Connect which supports case management and multidisciplinary team (MDT) working. It is accessible to MDT members via the web or an app.	Dr Stephen James	As soon as possible	Dr James gave his apologies noting that the information on the digitised ReSPECT form would be re-circulated to Practices immediately.
	Dr James to present a Digital Update Report to the Governing Body meetings on a quarterly basis.	Dr Stephen James	May meeting	Included on May agenda
	Digital Update Report to be included on the Governing Body May agenda.	Mrs Sandra Stackhouse	May meeting	Complete

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-21-03.036 – Matters Arising *b/f GB-21-01.017 – [*Update on System Improvement Plan]	Mr Trenchard to arrange to include in the Primary Care Newsletter the link to further information on psychological health and well-being support for staff.	Mr Steve Trenchard/ Ms Claire Parker	As soon as possible	Ms Parker to check whether information had been included in the Primary Care Newsletter with a link to further information on psychological health and well-being support for staff.
GB-21-03.036 – Matters Arising *b/f GB-21-01.018 –* **[**SEND Inspection Report and Written Statement of Action (WSOA)]	Ms Parker to present an update on SEND to the Governing Body's meeting in May. An item on SEND to be included on the May agenda.	Ms Claire Parker Mrs Sandra Stackhouse	May meeting May meeting	
GB-21-03.036 – Matters Arising *b/f GB-21-01.019* **–** **[**Integrated Urgent Care Implementation Review Final report]	Ms Parker to confirm whether the palliative care service is commissioned by SaTH or the CCGs.	Ms Claire Parker	As soon as possible	Ms Parker confirmed she had asked Mrs Tracey Jones who was the lead for the end of life work to clarify this information and to do a breakdown of the service. Ms Parker would feedback to the Governing Board once the detail was available.
GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report	Dr Davies to raise 14 day rule for paediatrics and children at the Cancer Group meeting and liaise with Dr Matthee on how to take this work forward.	Dr Julie Davies	May meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
Performance				
GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report Quality	Mr Trenchard to liaise with MPFT regarding Dr Matthee receiving feedback and responses. Agreed the error on page 52 of the quality report relating to the never event be amended to read 'the never event identified there was an immediate learning point'. Also agreed the error in section 2.3 of the quality report be amended so that the information was moved from section 2.3 to 2.9 of the report relating to MPFT. It was agreed these errors be captured and the amendments made for future reports.	Mr Steve Trenchard Mrs Sandra Stackhouse	May meeting May meeting	 Action closed
GB-21-03.040 – Maternity Update	Mrs Young agreed to look at the MVP website to see what material was detailed there. Following discussion regarding the target for caesarean sections, clarification was requested in relation to the figures. Mrs Young agreed to look at these figures and clarify the data.	Mrs Zena Young Mrs Zena Young	May meeting May meeting	
GB-21-03.041 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Finance and Contracting Report including Quality, Innovation, Productivity and Prevention (QIPP) schemes	Mrs Skidmore agreed to look at the point regarding savings in neurology and the interpretation of the narrative.	Mrs Claire Skidmore	May meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-21-03.042 – 2021/22 Plan Update	Mrs Skidmore agreed to keep Board Members briefed on QIPP Planning progress through informal channels as well as the formal routes.	Mrs Claire Skidmore	Ongoing	
GB-21-03.045 – Update on the System Improvement Plan	Mr Trenchard to bring a report back to the May Governing Board meeting detailing the alignment of schemes with the SIP.	Mr Steve Trenchard	May meeting	
GB-21-03.046 – Single Strategic Commissioner – Vision and Strategic Objectives	It was agreed to add in the narrative regarding improving healthcare outcomes and support the recommendation for the new CCG to review the strategic priorities as soon as possible to ensure they are still appropriate.	Dr John Pepper	May meeting	

NHS Shropshire, Telford and Wrekin CCG
Governing Body Part 1 Meeting

Wednesday 14th April 2021 at 11:00am

	Agenda Item	Action	Actioned By	Date
1.	**GB-21-04.02 Members Declaration of Interests**	Dr Allen to update his declaration of interest form to include his new conflict of interest.	Dr Martin Allen	Complete
2.	**GB2-21-04.04 Confirmation of Key Roles**	Miss Smith to arrange the amendment in Section 3 of the report from 'Health and Wellbeing Guardian' to 'Wellbeing Guardian'. Also to amend the spelling of Dr Shepherd's surname.	Miss Alison Smith	Complete

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	**Agenda Item:**
GB-21-05.014a	Performance Report

Executive Lead (s):	**Author(s):**
Julie Davies Director of Performance julie.davies47@nhs.net	

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

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Quality & Performance Committee	28th April 2021	S, D, I

Executive Summary (key points in the report):
Due to exceptional circumstances for this month only the performance report being presented to Governing Body is the same one that went to the last Quality & Performance Committee in April.

As a result of the ongoing pandemic situation, the scope and detail of this report are limited due to suspension of many of the data flows. Performance against certain indicators is expected to continue to deteriorate in this period (for example, RTT waiting lists). Recovery planning is now underway as Covid demand has reduced to very low levels. The draft recovery plans for the first half of 21/22 (referred to as H1) will available in early May and final plans are due to be submitted to NHSEI in early June. It is not clear yet how and when the performance reporting will recover and how the elective recovery will be routinely monitored by NHSEI. The CCG will of course adapt its reporting to meet the regulator requirements.

The CCG Governing Body, at a recent board development workshop, agreed to adopt the 'Making Data Count' Methodology for its data reporting. This will take a few months to implement as staff require training, new reports will need to be constructed and it will also require enough data points of any new metrics to be collected for the statistical process control (SPC) methodology to be applied.

Performance measures related to the Urgent and Emergency Care environment locally remain challenging in particular in relation to the 4 hour treatment standard for A&E though there has been an improvement through March as a result of some of the process changes being enacted. Ambulance handover delays in excess of 1 hour have also improved notably at PRH.

The NHS111 First Initiative continues to show positive indications of achieving objectives even though true measurement of impact is difficult in the current circumstances.

Elective activity at local providers has continued to recover gradually following the January Covid wave. Redeployment of staff to the Covid vaccination programme and staff taking of deferred leave will continue to limit capacity for the next few months. Consequently, waiting times for Elective care and Diagnostics continue to show high numbers of long waiters. Planning is underway for the first half of the 2021/22 financial year aiming to restore as much elective capacity as possible, deal with the most urgent cases first whilst still providing capacity for any future Covid upsurge.

In general, cancer performance has held up reasonably. Staffing and capacity shortages have impacted since Christmas but recovery plans are in place to achieve performance standards in the summer months.

IAPT activity remains well below targeted levels due to lower levels of presentation and the CCGs recovery in this will be dependent on the mental health priorities for investment to be agreed for the 2021/22 year.

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

Recommendations/Actions Required:

The Governing Body is asked to note:-

- the content of the report,
- that the Quality & Performance Committee agreed as it will take several months to develop the new Making Data Count Report, during that time, the interim reports will be a combination of the old and new methodologies at programme level until all staff have been trained and the all data flows are in place
- the current actions being taken to address the issues identified.

1 Key Performance Challenges

At month 11 of 2020/21, unless otherwise indicated

Area	Indicator	Target *or National rate*	Latest Position		Change from last period		Headline issues/actions
			SCCG	TWCCG	SCCG	TWCCG	
A&E	**4-hour A&E** (SaTH, M12)	**95%**	**71.3%**		↑		Walk-in attendance to ED at both sites increased markedly during March. This seems particularly to have been associated with resumption of schools at the beginning of the month as a substantial part of the increase is in the under 16 age bands. The increase is more noticeable at the PRH site. Ambulance attendances have, by contrast, remained relatively stable with comparatively little variation. This would add support to a view that suggests there is a core level of 'serious' need which are delivered by ambulance and which has remained quite stable before and during the Covid pandemic, albeit with significant day to day variances. The variable factor in A&E activity would therefore appear to be the Walk In activity at the less serious end of the severity spectrum. It is this section of demand which has shown most volatility and responsiveness to external events. Performance against the 4 hour standard has improved at both sites during March particularly at PRH. This follows from some of the work being done with ECIST to improve operational processes including MADE (Multi Agency Discharge Event) reviews at both sites In March, the SaTH reported 23 over-12-hour breaches which were mainly linked to volumes of arrivals, overall flow and the complexity of managing varying numbers of COVID +ve and –ve within the emergency departments. Despite much lower levels of Covid generally, the trust clearly needs to continue to operate these IPC processes to ensure risk is minimised. The initiatives identified under the Winter Plan umbrella have been reviewed and recommendations made as to which should be incorporated into business as usual. Planning for next winter has commenced and a workshop is being scheduled for early May to identify potential initiatives to deal with demand for the winter of 21/22. The NHS111 First project continues to operate and will be migrated into business as usual as the work has now settled into a standardised set of processes and arrangements. Numbers continue to be encouraging and

						there remains no evidence that the process has increased propensity for the local population to call NHS111, nor that more callers are being directed toward the ED.
	Over 1 Hour Ambulance handover delays (SaTH, M11)	**0**	**177**			In March, SaTH reported 177 ambulance handover delays of over 1 hour with 72% (127) of these occurring at RSH. This represents an improvement in performance which is most noticeable at PRH. Preliminary data indicates this improving position has been continued into April. Delays do still tend to occur but these are more likely to be concentrated into a smaller number of individual days when concentration of ambulance arrivals is particularly problematic.
RTT	**Referral to Treatment** within 18 weeks	**92%**	**59.3%**	**60.7%**		As the impact of emergency demand from the Covid pandemic has reduced since the January peak, elective services are beginning to be restored across both main providers. Elective capacity is still limited in terms of Theatre capacity primarily due to staffing availability and capacity is further reduced by the need for staff to take some well-earned and deferred annual leave. The CCG and providers are currently planning the level of activity that is realistically achievable for the first 6 months of the 2021/22 financial year. This will focus on ensuring there is adequate coverage for any further Covid wave but will concentrate more on the restoration of elective capacity. Plans will include making some use of Independent Sector providers. In this planning process priority will still be given to provision of cancer care and other urgent elective care arrangements including diagnostic capacity. Between 75% and 80% of the CCGs total of over 52 week waiters are at SaTH or RJAH, the remainder being at out of county providers. Given the scale of the backlog, it must be anticipated that recovery in the waiting times and reduction in waiting numbers will take some time to make any significant headway. Although routine referrals from Primary Care remain around 30% lower than pre-Covid levels, the planning assumption is that this will gradually return to normal levels over the summer months. This will add numbers to the waiting list at an increasing rate and as capacity is likely to be below normal levels for some time, the expectation unfortunately has to be for an increase in numbers waiting for a period before any reduction is observed.
	Referral to Treatment waits > 52 weeks	**0**	**2594**	**1396**		

	Diagnostic waits of more than 6 weeks	**1%**	**32..6%**	**33.6%**			Imaging capacity enhancements remain in place and activity levels have been maintained at an encouraging level over the past few weeks. Endoscopy capacity, however, is still challenged due to the aerosol generating nature of many of the procedures. Good progress is being made in reducing waits over 6 weeks for diagnostic tests. Continued progress with this is dependent on retaining existing levels of capacity which is being supplemented by additional external and in house provision. Plans for the first half of the 21/22 financial year are being constructed on the assumption that the additional facilities are retained. Current expectations are for replacement scanning facilities to come on line at PRH in May and for a new Imaging Pod to be operational from August. A business case is being progressed through SaTH to extend the external contract for a mobile CT scanner, although this may now be at risk due to the mobile capacity being managed at a national contract level. Staffing resources for Imaging remain a risk for this and other health economies.

Cancer waits	**2 week wait** from urgent referral	**93%**	**84.5%**	**80.6%**	⇔	↓	2ww cancer (and 2 week symptomatic breast) performance deteriorated due to the capacity issues in the breast cancer service due to IPC requirements now addressed by the completion of estates work. An improvement trajectory to address the metrics for both the suspected cancer and symptomatic pathways has been put forward that shows the performance being recovered by the beginning of July. The breast team have reported that they believe this will be met. The team are putting on extra WLI capacity wherever possible and have been discussing with the CCG how the referral pathway can be best used by general practice, especially regarding women presenting with breast pain only as a symptom. 62 day cancer performance is coming under increasing pressure due to the impact of the Covid surge. The CCG requested an impact assessment from SaTH to understand the potential consequences of this. SaTH continue to have weekly calls with West Midlands Cancer Alliance (WMCA) to explore if there is any additional capacity Out of County. SaTH was responsible for 3.5 waits of at least 104 days for English patients at M11. A number of 62 day and 104+ day breaches are due to complex cases which the various teams are working proactively to address. Referrals decreased substantially during the Covid 19 peak but now recovering to just slightly below normal levels. An issue that affects most pathways is the pressure on radiology access, with the team putting in place streamlined pathways to make sure that the most urgent patients are seen first. Significant capacity issues in diagnostics are impacting performance but cancer and other urgent cases are being given priority. Cancer Assurance Meetings continue, with Commissioner attendance as required.
	2 week wait from breast referral	**93%**	**11.9%**	**16.4%**	↓	↑	
	31 days to cancer treatment (surgery)	**94%**	**86.4%**	**81.8%**	↑	↓	
	62 days from referral to cancer treatment	**85%**	**69.8%**	**69.6%**	↓	↓	
	62 days, referral from screening to treatment	**90%**	**83.3%**	**66.7%**	↓	↓	
Dementia	**Dementia Diagnosis** Rate	**66.7%**	**62.3%**	**59.8%**	⇔	⇔	Both sides of the county remain below target level for this measure. The expectation is that performance will improve as Covid related issue decrease.
Mental Health	IAPT Access	**25%** at year End	**10.98%** (YTD, M11)	**11.66%** (YTD, M11)	↑	↑	Access levels for IAPT have been slowly recovering month on month since the Covid Wave 1 period but numbers presenting are still significantly below normal levels despite efforts to encourage more presentation. Planning for the first half of the 21/22 will be focussed on improving the performance on this metric

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

1.2 Appendix 1 shows further detail on the indicators reported here. Future reporting to the Governing Body will be structured around the key metrics within the Oversight Framework identifying metrics where performance is Good, Average and Poor. Focus will be on those metrics where the rating is Poor and those where performance has deteriorated over a number of successive periods. This will be developed when the Performance Team is in place after the Management of Change Process is concluded.

Appendix 1 Exception Reporting: Priority Areas at end of February 2021

1. A&E Waits at Shrewsbury and Telford Hospitals (month 12, 2020/21)

Local Lead	Key Performance Indicator	Target	Latest Position		Change from last period	Last achieved
			Official	Un-validated		
SC/EP	A&E attendances admitted/ treated/ discharged in 4 hours	**95%**	**71.3%**		↑	n/a
	Ambulance handover delays > 1 hour	**0**	**177**		↓	
	A&E patients waiting more than 12 hours for admission	**0**	**23**		↓	

2. RTT and Diagnostic Waits

Local Lead	Key Performance Indicator	Target	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
AP	Referral to Treatment within 18 weeks	**92%**	**59.3%**		↓	Nov '18	**60.7%**		↓	Dec '18
AP	Referral to Treatment > 52 weeks	**0**	**2594**		↑	Feb '20	**1396**		↑	Mar '20
AP	Diagnostic test waits > 6 weeks	**1%**	**32.6%**		↓	Jun '19	**33.6%**		↓	Feb '19

3. Cancer Waits

Local Lead	Key Performance Indicator	Target	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
HR	2WW Urgent referral	**93%**	**84.5%**		↓	Aug '20	**80.6%**		↓	Sep '20
HR	2WW Breast (cancer not suspected)	**93%**	**11.9%**		↓	Aug '20	**16.4%**		↑	Jul '20
HR	31-day wait for cancer treatment	**96%**	**94.3%**		↓	Jan '21	**95.7%**		↑	Dec '20
HR	31-day wait for subsequent treatment (surgery)	**94%**	**86.4%**		↑	May '20	**91.7%**		↑	Oct '20
HR	62-day wait from GP referral to cancer treatment	**85%**	**69.8%**		↓	July '20	**69.6%**		↓	Dec '18
HR	62-day wait for treatment after referral from cancer screening	**90%**	**83.3%**		↓	Nov '20	**0%**		↓	Nov '20

4. Dementia Diagnosis Rate

Local Lead	Key Performance Indicator	Target	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
FS	Dementia Diagnosed, as a proportion of estimated prevalence in over-65s	**66.7%**	**62.3%**		↓	Apr '20	**59.8%**		↓	Mar '20

5. IAPT Access Rate (YTD, month 11)

Local Lead	Key Performance Indicator	Target	Latest Position: SCCG				Latest Position: TWCCG			
			Official	Un-validated	Change from previous	Last achieved	Official	Un-validated	Change from previous	Last achieved
CD	Access to IAPT services for the section of the at-risk population	**25% by year end**	**10.98% YTD**		↑	New target level for 20/21	**11.66% YTD**		↑	Dec '19

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **Shropshire, Telford and Wrekin CCG Governing Body Meetings in Common held in Public on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.014b	Quality Exception Report (summary QPC March and April 2021)

Executive Lead (s):	Author(s):
Zena Young Executive Director of Nursing & Quality Zena.young@nhs.net	Tracey Slater Associate Director of Quality Tracey.slater4@nhs.net

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

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

Executive Summary (key points in the report):

Quality

- An update on quality impacts of commissioned services is provided. SaTH remain the most challenged provider and cause for concern within the health system.
- The CCG continue to request assurances that learning from all incidents is embedded in practice over time and is working with the trust to undertake selective review of historical incidents at SaTH that pre-date the current Director of Nursing & Quality.
- The CCG have reviewed staff survey results for all of our four major providers.
- Quality Assurance visits across most providers are being reinstated from April. Assurance from internal QA processes is being sought via CQRM's.

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

Recommendations/Actions Required:
That CCG Governing Body note the content of this report

1.0 Quality

Areas of concern, current position and actions

1.1 Shrewsbury and Telford Hospitals NHS Trust:

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

- CQC visit February 2021 (unannounced): Mental health services for Children and Young People were inspected; the trust has been served with a further Section 31 relating to CYP. There is on-going system work to address the remaining elements of the improvement notice.
- CQC has published a report following a focused inspection of critical care services at PRH relating to the provision of out of hour's anaesthetic cover. The shortage of anaesthetists is a recognised national issue and the trust is mitigating this. SaTH remain rated 'Inadequate' overall.
- There are some challenges within the trust to achieve the expected 95% target for sepsis screening. Performance in relation to patients screened as 'high risk' having had the appropriate action taken as per Sepsis 6 remains below target, this is being monitored monthly via CQRM
- Paediatric triage time has decreased at RSH average of 78% at RSH and 80% at PRH. Reasons for lower compliance are discussed and monitored via CQRM
- Stroke Sentinel National Audit Programme – February 2021 reported best level results since August-November 2016 with a SSNAP rating of 'B'.
- The CCG have been made aware a number of senior midwifery leadership staff are not currently at work, coupled with senior vacancy at departmental level and has asked for assurances on the thresholds for safe staffing and mitigating actions.
- SaTH continue to report 12 hour breaches. The CCG continues to work with the Trust on reviewing assurance of care received by patients waiting extended periods for admission to include cross reference with a Sis reported.
- A number of concurrent Covid-19 outbreaks have been reported across the trust site and these have been managed in accordance with the Incident Management process. An outbreak of pseudomonas reported previously involving PRH ITU has been downgraded.
- SaTH staff survey results are better and above the mid-point peer group for safe environment. They are predominantly lower than the benchmarked peers and towards the level of the worst benchmarked peers for health and wellbeing; immediate managers; morale; quality of care; safety culture; staff engagement and team work.
- The provision of neurology services commenced on at RWT on 1st May 2021. The transfer of care will be monitored by CCG Quality Team

1.2 Robert Jones and Agnes Hunt Orthopaedic Hospital

- There are no significant quality concerns to report by exception
- RJAH staff survey results show the trust has generally performed marginally better than benchmarked peer groups across the parameters for equality and diversity; health and wellbeing and morale, 'safety culture', was very slightly below the benchmarked peer group.

1.3 Midlands Partnership FT

- MPFT have been supporting with the recent SaTH S31 notice, there has been extra support provided to SaTH by MPFT and work is under way across the systems to find solutions and potential options.
- MPFT have continued to request extensions for their SI's, the CCG are working with the trust in line with the NHSE/I SI framework.

- Staff survey results show there has been a slight improvement in morale and safe environment. The Shropshire Group results are slightly lower than the average within the trust but morale and team working are comparable.

1.4 Shropshire Community Healthcare NHS Trust

- There are no significant quality concerns to report by exception.
- SCHT staff survey identified that they achieved the highest score for Community Trusts for Equality, Diversity and Inclusion ,close to average percentage rates in all the domains either above or below compared to other Trusts

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

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

1.6 Primary Care

- The CCG and partners are continuing work to improve the uptake and quality of Annual Health Checks for people with Learning Disabilities. There is significant variation in uptake of AHCs across the system. A multi-agency approach is being developed to ensure system buy-in to improve this area with a focus on the 14-18 year age group.

1.7 West Midlands Ambulance Service (WMAS)

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

1.8 Care Homes

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

1.9 Independent Providers

- Nothing to report by exception.

2.0 Safeguarding

- The section 31 notice has created system challenges to ensure adherence to the notice in relation to children presenting in ED without a physical health need. The notice has created a number of system wide review meetings to ensure Executive oversight and scrutiny of processes in relation to children attending ED who require mental health support. The CCG Safeguarding / LAC Team is engaged in seeking assurance in terms of any identified areas of risk. The numbers of children that are coming into care continues to rise. There are currently 921 looked after children (LAC) pan Shropshire, in addition our hosted LAC population is 778. Recent data for Quarter 3 submitted to CQRM demonstrated that the completion of review health assessments is above trajectory which is positive.

2.1 Infection prevention and control

- The CCG IPC service continue to support the local health & social care response to the Covid-19 pandemic with a number of specific work streams including facilitating the IPC work stream and the provision of advice & support to primary care and the care sector. As the prevalence level of COVID-19 continues to fall within the community and the impact and pressures on providers continues to reduce, the IPC service is offering IPC assurance audits, training and support for care homes. This IPC restoration plan will support care home providers with contingence planning ahead of winter

2021/22 for outbreak management, recognition and impact from possible Influenza, Norovirus and COVID-19.

2.2 Serious Incident Review

- A report on serious incidents was presented to QPC March meeting. There are a number of thematic reviews underway to include deteriorating patient, a delayed diagnosis.

2.3 Niche Review of Mortality

- To be presented as a separate report

2.4 Patient Experience

- The CCG continue to work closely with patient experience leads from our provider organisations.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT AND MONITORING

Agenda item	GB-21-05.015
Committee:	Governing Body
Date:	12 May 2021

Title of report:	Niche Independent Review of Deaths and Serious Incidents
Responsible Director:	Zena Young, Executive Director of Nursing & Quality
Author of report:	Charlotte Dunn, Quality & Performance Monitoring Officer Zena Young, Executive Director of Nursing & Quality
Presenter:	Zena Young, Executive Director of Nursing & Quality Deborah Shepherd, Interim Medical Director

Purpose of the report:

The purpose of this report is to summarise the key findings of a recent independent review into serious incidents and deaths which was commissioned by Shropshire and Telford and Wrekin CCGs in 2019. The review was undertaken by an external organisation; Niche Health and Care Consulting and focussed on a system wide case note review of a cohort of patients who had been admitted through and discharged from Shrewsbury and Telford Hospital NHS Trust during the last episode of their care.

Key issues or points to note:

The review looked at a cohort of 167 randomly selected patients receiving care as an in-patient at SaTH or had been provided with services pre-or post-admission from other health care organisations in Shropshire between the dates of January - June 2020, and had either died whilst an inpatient or died within 30 days following discharge.

The overall quality of care judgements across the health system (based on 124 ratings) showed: excellent, good or adequate care in 77 cases (62%). Good or excellent ratings were given in 52 cases (42%) and poor or very poor ratings were given in 47 cases (38%).

The report identified the following high level findings:

There is evidence that the very elderly experience delays in the admission pathway. The older the age bands, the more patients being admitted between 22:00 and 06:00.

Initial management and admission saw excellent care in 87% of cases with rapid initial assessment, good sepsis management and good documentation. ICU and timely emergency care also featured in the excellent ratings.

There was a marked difference in the quality of care of patients with a severe mental illness and some evidence of poorer quality of care for those patient with or showing signs of dementia.

23 patients were identified with Type 2 Diabetes. 39% of cases were rated as poor or very poor care overall. The breakdown of care ratings by age shows the poorest quality of care among the very elderly.

Additional findings are identified, categorised at the various phases of care level.

The system reflected on the study approach in order to inform our maturing system approach to quality governance.

Next steps:

- The Steering Group met to consider the findings and next steps and agreed to distribute the report within their own organisations' Learning from Death's governance groups.

- The report will be presented to the system End of Life Care Group to consider relevant findings in the development of an overarching End of Life Care strategy.

- The steering group agreed to form a new system-level Learning from Deaths group to bring together best practice and agree improvement areas, some of which arise from the findings of this report.

Actions required by Governing Body:

The Governing Body are asked to note the contents of the report and the next steps for STW system approach to Learning from Deaths.

Shropshire, Telford and Wrekin Clinical Commissioning Group

Does this report and its recommendations have implications and impact with regards to the following:

1	Additional staffing or financial resources implications	No
2	Health inequalities	No
3	Human Rights, equality and diversity requirements	No
4	Clinical engagement The project steering group had participation from system NHS provider clinical representatives.	Yes
5	Patient and public engagement	No
6	Risk to financial and clinical sustainability	No

1. Background

In October 2019 Shropshire and Telford and Wrekin CCGs jointly commissioned Niche Health and Social Care Consulting (Niche) to undertake an independent review into deaths and serious incidents. They recognised that their residents received care from a range of services including primary care, ambulance services, acute hospitals and community hospitals and wanted to gain a system wide view of the quality of that care.

The review involved two phases; Phase 1 to look at the process or reporting deaths and serious incidents at Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Phase 2 to carry out a system wide patient case note review for those patients who had been through SaTH during their last episode of care.

Due to several serious incident reviews taking place at SaTH in 2020, the decision was made to remove this aspect of Phase 1 and re-define the approach so that there was more focus on the Learning from Deaths (LfD) process both within SaTH and at the other 3 main providers across the system (Midlands Partnership Foundation Trust (MPFT), Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) and Shropshire Community Health NHS Trust (SCHT)). Phase 2 was to remain the same.

Phase 1 findings have been reported back to SaTH's Learning from Deaths group and assurances sought by the CCG on improvements required as part of the Phase 1 report recommendations. The CCG remain sighted on that improvement work which has largely been completed.

This report will focus on Phase 2 of the review only.

2. Methodology and Patient Cohort

Niche used an adapted structured judgment review (SJR) methodology with input from the providers at the Steering Group. Software was provided by Clarity Informatics (widely known for use in Mortality Reviews).

In addition to the conventional Royal College of Physicians case note review, additions included a preadmission phase and an end of life phase of care. There were therefore a total of 8 phases of care that were considered as part of the review:

- Preadmission
- Initial Management and Admission
- Ongoing care
- Procedure care
- Perioperative care
- Readmission
- Discharge
- End of life care

The review looked at deaths from January to June 2020 for those who had been an inpatient at SaTH hospitals, those who had died as an inpatient or those who had died within 30 days after discharge, who had been provided with services pre-or post-admission from other health care organisations in Shropshire.

1061 patients were identified as having died as an inpatient at SaTH between January and June 2020; 578 via Royal Shrewsbury Hospital (RSH) and 483 via Princess Royal Hospital (PRH). A further 603 patients were identified as having died within 30 days of discharge; 391 discharged from RSH and 212 from PRH.

From the above, a cohort of 200 patients was randomly selected and from a process of elimination of those under 18 years of age (x1), registered with an out of area GP (x33) or duplicates (x1) there were 165 patients remaining. 56 patients were known to SCHT, 33 to MPFT and 6 to RJAH.

The patients were registered with 42 different GP practices across Shropshire, Telford and Wrekin and were aged 18 years and over (50% under 65, 35% aged 66-84 and 15% aged over 85).

Records were accessed either electronically or in hard copy from the 4 main providers, the patients' GP practices, Out of Hours providers and West Midlands Ambulance Service, where available within the records.

It was agreed from the outset that any cases identifying immediate concerns would be raised directly to the lead for each provider or practice.

3. Findings

The review found that care varied from excellent, when the system provided timely and coordinated care, and very poor, with delay and lack of escalation and where patient wishes were not respected.

The overall quality of care judgements across the health system (based on 124 ratings) showed: excellent, good or adequate care in 77 cases (62%). Good or excellent ratings were given in 52 cases (42%). Poor or very poor care ratings were given in 47 cases (38%).

Summary of care ratings by phase (numbers)

Rating	Preadmission *	Initial Management and Admission *	Ongoing Care *	Procedure Care	Perioperative Care	Readmission	Discharge *	End of Life *	Overall
Excellent	11	19	16	4	1	1	12	14	11
Good	34	65	34	10	3	8	9	27	41
Adequate	27	22	33	15	0	3	12	25	25
Poor	18	10	24	4	0	3	17	25	37
Very Poor	4	6	6	3	0	2	8	10	10
Total	94	122	113	36	4	17	58	101	124

Summary of care ratings by phase (%)

Rating	Preadmission	Initial Management and Admission	Ongoing Care	Procedure Care	Perioperative Care	Readmission	Discharge	End of Life	Overall
Excellent	11.7%	15.6%	14.2%	11.1%	25.0%	5.9%	20.7%	13.9%	8.9%
Good	36.2%	53.3%	30.1%	27.8%	75.0%	47.1%	15.5%	26.7%	33.1%
Adequate	28.7%	18.0%	29.2%	41.7%	0.0%	17.6%	20.7%	24.8%	20.2%
Poor	19.1%	8.2%	21.2%	11.1%	0.0%	17.6%	29.3%	24.8%	29.8%
Very Poor	4.3%	4.9%	5.3%	8.3%	0.0%	11.8%	13.8%	9.9%	8.1%

There were a number of themes identified within the 8 phases of care, each will be discussed in turn.

3.1 Preadmission

- There was a lack of coordination of care, even where patients were known to the system.
- There was a lack of ongoing planning for patients with known chronic diseases, especially for oncology patients where there was ineffective access to care noted.
- There was a limited use of admission avoidance processes and these are not streamlined across the county.
- The structure for specialist nurses was not clear and the use of the specialist nurse appeared to be haphazard.

The percentage of cases with adequate, good or excellent care for Preadmission was 77%.

3.2 Initial Management and Admission

- Initial Management and Admission was the highest rated phase of care with 87% of cases rated as adequate, good or excellent. These cases included rapid initial assessment, good sepsis management and good documentation. However, caring for patients with a variety of mental health needs raised a number of issues for this patient group including capacity assessment.

- ICU care and timely emergency care also feature in the excellent ratings. These cases include pre-alerts, immediate emergency preparation and emergency operations all promptly and efficiently delivered. Involvement of critical care outreach and multidisciplinary team input were characteristics of these cases and fast access to diagnostic scanning was also apparent.

- There is evidence that the very elderly (and those more likely to be suffering from dementia) are experiencing delays in the admission pathway. The older the age band, the greater the proportion of patients who are admitted between 22:00 and 06:00. This is suggestive of delays in preadmission pathways.

- More admissions of patients who died occurred on Tuesdays. There is no clear reason for this evident from the review. However, it may be an impact of weekend care requiring Monday review before patients are admitted.

The percentage of cases with adequate, good or excellent care for Initial Management and Admission was 87%.

3.3 Ongoing Care

- Of the 23 patients who were identified as having Type 2 Diabetes, 48% of those cases were rated as good or excellent, 13% rated as adequate and 39% rated as poor or very poor in relation to diabetes management care across the system. The poorest quality of care was seen among the older patients.

- There was some evidence of a poorer quality of care delivered to people with or showing signs of dementia.

- There was also a marked difference in the quality of care of patients with a severe mental illness.

The percentage of cases with adequate, good or excellent care for Ongoing care was 73%

3.4 Procedure Care

- There were 36 patients reviewed as part of care during a procedure (21% of the 165 total).

- 39% of the patients were rated as good or excellent care, 42% were rated as adequate and 19% were rated as poor or very poor.

3.5 Perioperative Care

- There were 4 cases relating to the perioperative care phase (2% of the 165 total). 75% were rated as good and 25% rated as excellent.

3.6 Readmission

- There were 17 cases relating to the readmission care phase (10% of the 165 total). 53% were rated as good or excellent, 18% were rated adequate and 29 were rated as poor or very poor.

- Readmission, in some cases, was because of poor planning, medical optimisation or lack of consideration of the ongoing end of life care or Advanced Care Plan wishes of the patient.

- Where care was rated as excellent, there was coordinated care between all parties involved.

3.7 Discharge

- Of the 58 cases relating to discharges, 36% of those were rated as good or excellent, 21% were rated as adequate and 43% were rated as poor or very poor.

- The areas of concern around discharge planning related to poor documentation, lack of engagement with primary care and apparent lack of documented engagement with community services. It is important to note here that this may be due to Covid-19 and the restrictions around access to patients and wards.

The percentage of cases with adequate, good or excellent care for Discharge was 57%.

3.8 End of life care

- 101 cases involved end of life care which is 61% of the total cohort of patient notes reviewed. 41% of the care was rated as good or excellent, 24% was rated as adequate and 35% was rated as poor or very poor.

- Where the care was excellent, it was felt that the staff could not have done more.
- However, for those falling into the poor or very poor rating there was poor recognition that the patient was end of life, thus delaying end of life care plans and implementation of the end of life pathway.
- There was poor documentation in relation to decision making and family/patient involvement.
- There was a lack of mental capacity assessments for those patients who were dying.
- There was inconsistency in the involvement of palliative care team.
- In relation to ReSPECT forms, they were of poor quality, poorly completed and focussed on ceilings of care, not patient wishes.

The percentage of cases with adequate, good or excellent care for Preadmission was 65%.

4. Recommendations

The following recommendations were made:

- Record management reviews and assessments in relation to accessing information from a ward and provider perspective through to the availability of inpatient deaths and those within 30 days of discharge across all providers.
- Pathway reviews and audits both in relation to speciality areas such as oncology and advance respiratory disease and wider community pathways such as fast track discharges and admission avoidance. With the inclusion of Shropdoc, the out of area provider, to see where they have had to provide immediate intervention.
- Safeguarding and the need for re-emphasis around the implementation and application of the Mental Capacity Act 2005, particularly in relation to vulnerable adults.
- Mental health care review across the system to understand the needs of people presenting with difficulties, particularly for patients who are end of life, alcohol dependent or have been seen through emergency admission.
- Care of the very elderly so that admissions can be avoided where possible, or expedited, to reduce the number of admissions after 22:00.
- Timelier implementation of end of life care plans and palliative care team involvement, along with the early use of ReSPECT forms to allow advance planning with consideration of the patient's wishes and preferences.

- Urgent diabetic care review for community patients and those being transferred between providers, with particular emphasis around monitoring and administration in the community.

- Clinical monitoring in relation to sepsis management to ensure early implementation of the pathway, and the use of fluid balance charts to allow early identification of acute kidney injury for those patients who are end of life.

The above recommendations will be considered from both an independent provider and system wide perspective, and whilst there is a reasonable amount of work still to be done, it should be acknowledged that many changes have already been made.

For example, SaTH are currently working in collaboration with MPFT to ensure there is more support for mental health patients within the acute setting and in terms of discharges, SaTH are currently leading on a system wide piece of work looking at how discharges can be improved.

5. Reflections on process and system learning

The Steering Group were keen to reflect on the approach and process of this review, in order to inform our maturing system approach to quality governance.

- Delays due to Covid-19 pandemic influenced and impacted the study design and completion within expected timeframe.

- Changes in key personnel - This caused delays at times and made it difficult to know who information needed to be sought from. It also allowed for confusion with the original scope, roles and responsibilities.

- Learning - Clear documentation and points of contact within organisations (rather than relying on the steering group representatives) are key in ensuring projects like this run as smoothly as possible in the future.

- Information Governance (IG) processes – IG processes were inconsistent across the system which meant a lot of time was spent trying to get access to records and systems before the review could take place.

- Learning – Ensuring IG processes are clarified from the outset of a project will prevent delays later on. There needs to be early input from those relevant people so that expectations and requirements are clear. It is positive to note that progress has already been made in relation to this and the IG teams now have more communication.

6. **Next steps**

- The Steering Group met to consider the findings and next steps and agreed to distribute the report within their own organisations' Learning from Death's governance groups.

- The report will be presented to the system End of Life Care Group to consider relevant findings in the development of an overarching End of Life Care strategy.

- The steering group agreed to form a new system-level Learning from Deaths group to bring together best practice and agree improvement areas, some of which arise from the findings of this report.

The full report is attached for information.

Independent Review of Deaths and Serious Incidents – Phase 2

Shropshire Clinical Commissioning Group

Final Report

Highly confidential

29 March 2021

niche HEALTH & SOCIAL CARE CONSULTING

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29 March 2021

Dear Zena,

Draft Report – Phase 2 – Independent Review of Deaths and Serious Incidents

Please find below our Final Report following the completion of Phase 2 (Structured Judgement Review of Clinical Quality across the health system) of our work to undertake an Independent Review of Deaths and Serious Incidents.

Our Final Report has been written in line with the Terms of Reference as agreed with Shropshire Commissioning Group and Telford and Wrekin Clinical Commissioning Group on 9 October 2019. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. The scope of our work has been confined only to the areas set out in the Terms of Reference and a wider review may uncover other areas of concern.

Events which may occur outside of the timescale of this review will render our report out of date. Our report has not been written in line with any UK or other (overseas) auditing standards, and we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This is a confidential Final Report and is for the sole attention of Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group must seek our prior written approval before this Draft Report can be shared or released. Different versions of this Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report should be regarded as definitive.

Yours sincerely,

Mary-Ann Bruce
Partner, Investigations and Governance
Niche Health and Social Care Consulting

insight integrity impact

Contents and contacts

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Scope, methodology and patient cohort

Scope and methodology

Scope

Background to System Review (Phase 2)

Shropshire and Telford and Wrekin Clinical Commissioning Groups ('the CCGs') recognise that care provided to their residents involves a range of organisations that include primary care services, ambulance services and community services, as well as acute and emergency care in hospital.

The CCGs commissioned a patient case note review of the health care system using a Structured Judgement Review (SJR) approach. This would enable the CCGs to secure a wider system view of care of patients admitted through and discharged from Shrewsbury and Telford NHS Trust (SaTH) hospitals.

Methodology

We used an adapted SJR methodology for the case review, with the adaptions being agreed in advance with the review Steering Group. Clarity Informatics provided standard software used widely for Mortality Reviews.

The main additions to the conventional Royal College of Physicians (RCP) case note review method was to include a preadmission phase and an end of life phase of care. This meant that the overall care rating was made up of assessments across all phases throughout a patient's care. The phases were:

- Preadmission
- Initial Management and Admission
- Ongoing Care
- Procedure Care
- Perioperative care
- Readmission
- Discharge
- End of life care

We agreed at the outset that should any case cause immediate concern, this would be raised directly to the lead for each provider or practice; this included specific cases that highlighted a possible need for further, local review outside of this system review.

The review involved accessing notes for those who had been an inpatient at SaTH hospitals, those who had died as an inpatient or those who had died within 30 days after discharge, who had been provided with services pre- or post-admission from other health care organisations in Shropshire.

This included accessing notes from:

- the patient's general practice;
- Shropshire Doctors On Call (ShropDoc);
- West Midlands Ambulance Service (where available in other records);
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH);
- Shropshire Community Health Care NHS Foundation Trust (SCHCT);
- Midlands Partnership NHS Foundation Trust (MPFT), the mental health care provider.

Form of records

- SaTH – medical records were all in hard copy.
- GP records – we had direct access to EMIS or VisionHealth system (one practice) for primary care (GP) records.
- SCHCT provided on-site direct access to aspects of RiO, the electronic patient record being rolled out in the Trust.
- RJAH provided pre-downloaded records for patients identified in the cohort.
- MPFT provided pre-downloaded records for patients identified in the cohort.
- West Midlands Ambulance Service (WMAS) records – where available in the SaTH, hard copy medical records were reviewed.
- Shropdoc letters were almost exclusively available in the GP electronic system (EMIS). Where necessary, we spoke with the Medical Director of Shropdoc to gain the necessary information for out-of-hours primary care.

Profile of the patient cohort

The patient cohort

1061 patients were identified as having died as an inpatient in SaTH between January and June 2020: 578 via Royal Shrewsbury Hospital (RSH) and 483 via Princess Royal Hospital in Telford (PRH). 603 patients were identified as dying within 30 days following discharge between January and June 2020: 391 discharged from RSH and 212 from PRH. We were informed that the identification of patients who had died within 30 days was not a complete picture as SaTH were unable to extract a full and complete data set. However, we identified 200 patients from the combined lists provided which were randomly selected using the following criteria:

- Age – all deaths under 65 years, representing 50% of the cohort; the balance of the cohort was 35% aged 66–84 and 15% aged 85 and over. This was to enable the review to take a wider view of types of cases. A purely age-based cohort would result in a focus largely on the death of frail elderly patients. The sample needed to be sufficient to identify care in the older age groups and enable a review of other age bands.
- Specialty – to include 40% of cases in the sample from general medicine and 10% from general surgery, which was representative of the total deaths.

From past experience of this type of work, a random selection on age alone results in a representative age selection that can be overly focussed on the very elderly for learning purposes. We therefore restricted the numbers of over-65 deaths in order to provide some protection from focussing solely on the frail or elderly care pathway.

Of the 200 patients randomly selected from the list of total deaths, 33 were under the care of Welsh GPs and were therefore excluded from the review, one was duplicated and one was under 18 years.

The list of patients was shared by the Trust with other provider organisations to cross-reference and identify patients known to the other providers.

Of the 165 remaining patients aged 18 and over, the number identified as being known to other providers' Trusts was as follows:

- Shropshire Community Health Care – 56
- Midlands Partnership – 33
- Robert Jones and Agnes Hunt Orthopaedic Hospital – 6

Key characteristics of the final cohort of 165 patients

- The 165 patient cases reviewed were registered with 42 different GP practices across Telford and Wrekin and Shropshire. See Appendix 1.
- 98 patients were recorded as admitted via RSH and 63 were recorded as admitted via PRH. The remaining cases were unknown, or in some cases found to have been discharged in 2019.
- 6 patients (4%) had a learning disability recorded.
- 11 patients (6%) had a diagnosed severe mental health illness.
- 36 patients (22%) had a confirmed or unconfirmed diagnosis of memory problems or confusion.
- 4 patients (2%) were referred to the Coroner.
- 26 patients (16%) had a known cancer diagnosis; five patients (2%) had a documented direct admission plan to an Oncology ward.
- 6 patients (4%) were on home oxygen for advance respiratory disease.
- There were 78 (47%) patients with evidence of ReSPECT forms in the patient medical records. Of these, were 48 (62%) related to RSH and 30 (48%) related to PRH patients.
- None of the patients from RJAH had records from other providers to support an overall care rating.

Executive summary

Executive summary

Summary

Our review demonstrated a tale of two halves: care varied between excellent, when the system provided timely and coordinated care, and very poor, with delay and lack of escalation and where patient wishes were not respected.

Our summary of the detailed findings is given below.

The overall quality of care judgements across the health system (based on 124 ratings) showed:

- excellent, good or adequate care in 77 cases (62%). Good or excellent ratings were given in 52 cases (42%).
- Initial Management and Admission was the most highly rated phase of care, with 87% of cases rated as adequate or above.
- Poor or very poor care ratings were given in 47 cases (38%).

Of the main (*) care phases, the percentage of cases with adequate or better care is as below:

- Preadmission – 77%
- Initial Management and Assessment – 87%
- Ongoing Care – 73%
- Discharge – 57%
- End of Life – 65%

Summary of care ratings by phase (numbers)

Rating	Preadmission *	Initial Management and Admission *	Ongoing Care *	Procedure Care	Perioperative Care	Readmission	Discharge *	End of Life *	Overall
Excellent	11	19	16	4	1	1	12	14	11
Good	34	65	34	10	3	8	9	27	41
Adequate	27	22	33	15	0	3	12	25	25
Poor	18	10	24	4	0	3	17	25	37
Very Poor	4	6	6	3	0	2	8	10	10
Total	**94**	**122**	**113**	**36**	**4**	**17**	**58**	**101**	**124**

Executive summary (*cont.*)

Summary of care ratings by phase (%)

Rating	Preadmission	Initial Management and Admission	Ongoing Care	Procedure Care	Perioperative Care	Readmission	Discharge	End of Life	Overall
Excellent	11.7%	15.6%	14.2%	11.1%	25.0%	5.9%	20.7%	13.9%	8.9%
Good	36.2%	53.3%	30.1%	27.8%	75.0%	47.1%	15.5%	26.7%	33.1%
Adequate	28.7%	18.0%	29.2%	41.7%	0.0%	17.6%	20.7%	24.8%	20.2%
Poor	19.1%	8.2%	21.2%	11.1%	0.0%	17.6%	29.3%	24.8%	29.8%
Very Poor	4.3%	4.9%	5.3%	8.3%	0.0%	11.8%	13.8%	9.9%	8.1%

There are four key phases of care on which to focus improvement activity on. These are:

- Preadmission
- Ongoing Care
- Discharge
- End of Life.

There were only a small number of perioperative cases (4). Readmissions related to 17 cases, although of these, 5 cases (32%) were assessed as having provided poor or very poor care.

Executive summary (*cont.*) – Excellent care case studies

There are five example case studies below where the overall rating provides insight into where excellent care was provided.

These cases demonstrate the ability to provide timely, planned and system-wide coordinated care, with engagement with both family and patient in end of life decisions.

Case study 1

Patient was receiving good care for her end stage chronic liver disease with symptomatic treatment from the specialist nurse. Quick and thorough assessment and investigations for emergency presentation.

Clear documentation of the decision not for theatre and palliative care only. Patient's wishes accommodated with same day assessments and discharged with medication and equipment as necessary.

Died at home two days later in accordance with her wishes.

Case study 2

Excellent; a lot was achieved for this patient by a coordinated approach to care and the final wish to die at home honoured.

Case study 3

Rapid assessment, diagnosis of sudden, unexpected stroke.

Appropriate tertiary advice sought. Rapidly communicated to family that this was not treatable and likely terminal. EoL pathway started immediately and ReSPECT form completed. Anticipatory prescribing done.

Accommodation made during Covid to allow husband to sleep in second bed in her room. Excellent documentation of clear conversations with family to ensure that they understood that she was dying.

Case study 4

The initial assessment of the patient was clear and comprehensive with senior review immediately and appropriate management of presumed sepsis.

It is not clear why this was not on an active sepsis pathway.

Ward care was in accordance with her ReSPECT form and involved both oncology and palliative care teams.

There is comprehensive assessment and advice from palliative care and there is evidence that the Consultant left their personal phone number to contact over the weekend for symptom control issues.

The discharge summary to the hospice is exceptionally detailed and includes the names and involvement of the various specialist teams, contact numbers and ongoing plan.

Case study 5

The referral and initial assessments are appropriate and the diagnosis reached quickly with early senior review.

There is discussion on the day of admission regarding the possible need for ventilation etc. and a ReSPECT form done to document patient's wishes. There is evidence of involvement in clinical trials of Covid therapeutics.

The notes show a clear progression of care from the ward, then Critical Care Outreach to ICU admission. Each stage is anticipated and planning is in place. On ICU there is clear documentation of progression and patient and family are documented as informed.

EoL stage is signposted as a possibility and family were made aware. When EoL identified, family are in agreement and allowed to attend before withdrawal of ventilatory support.

Executive summary (*cont.*) – ICU and emergency care

ICU and emergency care – case studies

Clear examples of high quality, prompt and compassionate emergency and ICU care management are described below.

Case study 1

He was managed in ICU for all of his stay. Regular and impressive evaluation with exclusion of other organ issues were undertaken as well as respiratory issues. He was intubated on two occasions and received a tracheostomy. Episodes of delirium and AKI managed well. Good evidence of end of life issues being discussed with relatives.

Case study 2

ICU notes are comprehensive and legible. Good record of any intervention and justification of.

Case study 3

Ward 32C side room which is clinically indicated for query sepsis/infective exacerbation of bronchial asthma and a patient who is high risk Covid-19. Seen regularly, reviewed by SPR, ICU review 20.00, 2 hourly obs, EWS escalation frequently and appropriately. ReSPECT form completed at appropriate stage.

Case study 4

[April 2020] treated as possible Covid-19 appropriately and ongoing – Covid positive. Treated in emergency department swiftly, with decision to admit by medics within 2 hours. Critical care outreach review early in stay, ICU review and started on CPAP. Excellent multidisciplinary (MDT) involvement with medics, ICU.

Case study 5

The patient was rapidly admitted with severe sepsis arising from rapidly advancing necrotising fasciitis of the leg and abdomen. Raised blood glucose suggested undiagnosed T2DM. Immediate resuscitation and taken to theatre for debridement. Appropriate use of immunoglobulin, antibiotics and circulatory support. Intubated and transferred to ICU from theatre.

Case study 6

Patient was seen in Resus – full resus team ready for arrival of patient including ICU and anaesthetist. CT head and neck were arranged. Mother was seen and spoken to by the Consultant.

There was an appropriate response to the alert – full team was assembled and ready for patient arrival. Family was spoken to at the earliest point.

Executive summary (*cont.*) – Very poor care

Very poor care case studies

There are seven example case studies below where the overall judgement provides insight into the characteristics of care judged to be very poor.

Case study 1

Poor preadmission care – safeguarding concern raised.

Good initial assessment, documentation and treatment, but active treatment and interventions continued despite acknowledgement that patient was dying. No EoL care plan made.

Not catheterised for eight days despite initial request to do so. Catheterised on day 8 and large volumes drained.

Communication with the relatives about deterioration very delayed – six hours before death. No further review by dementia nurse to support patient despite periods of distress.

Case study 2

Delay in following up high grade dysplasia – four months later lung and bony metastases diagnosed. No Duty of Candour recorded. No clear plan of management or palliative/EoL care plan despite admission two weeks earlier.

Case study 3

Diabetic control was an issue both pre- and between admissions with regime advice given that could not be delivered in the community and such poor discharge planning that he had to attend A&E the following day to have insulin administered as District Nurses had not been given instructions.

Final hospital admission where he died is so poorly documented that full assessment is impossible with no evidence of review over the weekend after admission on a Friday and very poor nursing documentation.

Case study 4

His assessment on admission was brief and inadequate and his blood sugar not checked with admission bloods despite longstanding control issues.

He was medically fit for discharge as noted on multiple occasions from day 3 to day 17 with no plan in the notes and no explanation for the delay and this missed opportunity meant that he died in hospital.

His changed insulin regime delays discharge as it cannot be delivered three times a day by the District Nurse.

Patient developed hospital-acquired Covid and generally deteriorated.

There is a protracted issue with feeding as he aspirated and then had an NG tube which he pulled out – the suggested Best Interests meeting for this is not evidenced.

His diabetic control was poor and not well managed while NBM.

The ReSPECT form is done late and is not clear, causing issues when he deteriorated. EoL care is not started until within 24 hours of death and there was a missed opportunity for advance care planning which concluded that it was "too soon".

Case study 5

The patient lived in a care home and suffered from bipolar, severe depression, atrial fibrillation, hypertensive, asthma and previous ICU admissions for COPD. Not known to MPFT. Known to SCHCT under respiratory medicine. Last respiratory notes refer to an annual nebuliser review in February 2020.

A patient who suffered from depression appeared to have been allowed to self discharge. There are no notes to suggest this was done safely with due regard to safeguarding a vulnerable adult five days before the patient died.

Executive summary (*cont.*) – Very poor care

Case study 6

All interventions were fully recorded and patient had maximum input from full cardiac resus team in the emergency department.

The patient received maximum input and all efforts were made to restore the patient. Could not maintain cardiac output, family were informed and given the chance to see him on ICU. Therefore, although the outcome was death there was very good care offered to the patient and family.

However, there was a statement from the patient's mother that the family believed he should have been sectioned. The patient self-referred to MPFT [November 2019], the Trust wrote to the patient on the day after self referral offering an appointment ten days later with the community interventions pathway – this was five days before the patient committed suicide. The patient had multiple contacts with MPFT over the course of November and December 2019 – with documented increasing dark thoughts and suicidal ideation, inability to cope, pointlessness of life. Patient did not attend appointment made after self referral – crisis intervention booked for six weeks after contact – documented as not attended – can't see why this patient was booked for an assessment slot already under [Consultant Psychiatrist] due appointment on [January 2020] – patient completed suicide just into the New Year.

There was an abject failure to intervene with the patient's clearly deteriorating mental health. No intervention was attempted once the patient had waited for six weeks for an appointment and then DNA'd despite numerous documented contacts demonstrating patient's suicidal ideation.

Case study 7

Lady living alone with known palliative diagnosis.

Two admissions in 14 days before death – no plan in place for community support.

No palliative community support – request made only five days before death despite prognosis and deterioration.

No EoL plan until 12 hours before death.

Referred to hospice on day of death.

These case studies of very poor care demonstrate clear concerns in relation to:

- mental health support (see page 17 and 18 for overall assessments in relation to mental health care);
- diabetic management and control;
- delays in diagnosis/clinical treatment; and
- delays in instigating end of life care plans.

We discuss these issues further in subsequent pages.

Executive summary – Notable themes

Initial Management and Admission

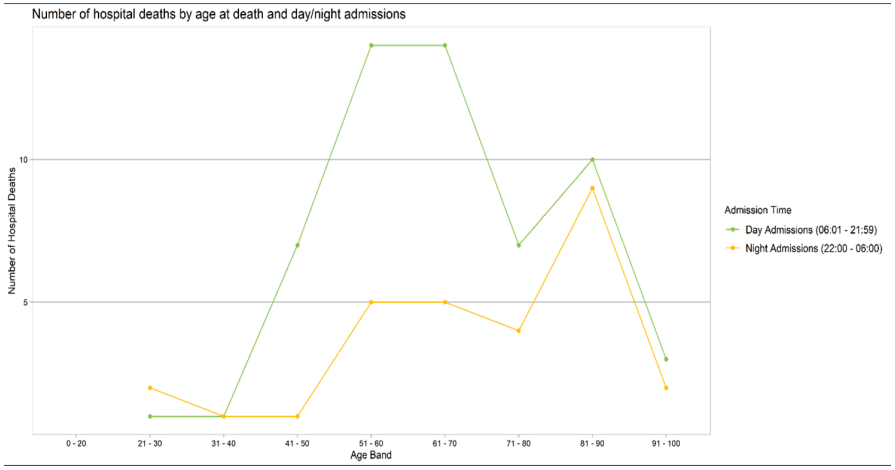
This was the highest rated phase of care with 87% of cases rated as adequate, good or excellent. These cases included rapid initial assessment, good sepsis management and good documentation. However, caring for patients with a variety of mental health needs raised a number of issues for this patient group including capacity assessment.

ICU care and timely emergency care

A number of cases where patients required ICU support feature in the excellent ratings. These cases include pre-alerts, immediate emergency preparation and emergency operations all promptly and efficiently delivered. Involvement of critical care outreach and multidisciplinary team input were also characteristics of these cases and fast access to diagnostic scanning was also apparent.

Late admissions for older patients

There is evidence that the very elderly (and those more likely to be suffering from dementia) are experiencing delays in the admission pathway. The older the age band, the greater the proportion of patients who are admitted between 22:00 and 06:00. This is suggestive of delays in preadmission pathways.



Diabetes management across the system

23 patients were identified as Type 2 Diabetes. 39% of cases were rated as poor or very poor care overall. The breakdown of care ratings by age shows the poorest quality of care among the very elderly. See charts overleaf. See pages 20, 21 and 22.

Discharge arrangements

25 patient cases showed a poor level of discharge planning which included poor documentation, lack of engagement with primary care and an apparent lack of documented engagement with community or social services. This may be due to Covid restrictions limiting access to patients and wards.

Day of admission

More admissions of patients who subsequently died occurred on Tuesdays. There is no clear reason for this evident from the review. However, it may be an impact of weekend care requiring Monday review before patients are admitted. See pages 33, 34 and 35.

Clinical monitoring

Fluid balance and blood glucose monitoring in particular were areas that reviewers commented on as requiring improvement. Nursing documentation on the wards was noted as being of generally poor quality.

Care of people with dementia/confusion

There was some evidence of a poorer quality of care delivered to people with or showing signs of dementia. See page 15.

Care of people with a severe mental illness

There is a marked difference in the quality of care of patients with a severe mental illness. See page 16,17 and 18.

Delays in instigating end of life care plans

This was a clear theme in cases across the cohort with delays in end of life care planning, including multiple missed opportunities for advance care planning or cases where end of life plans were instigated very late in the care episode.

Presence of memory problem or confusion

Summary of care ratings comparing patients with and without memory problems or confusion

Presence of memory problem or confusion	Very Poor Care	Poor Care	Adequate Care	Good Care	Excellent Care	Total
No	7	17	15	30	8	77
% of care score ratings for people without confusion or memory problems	**9%**	**22%**	**19%**	**39%**	**10%**	
Yes – but without clear diagnostic definition	0	4	2	4	1	36
Yes – clear diagnostic definition of the confusion/memory problems	3	9	5	6	2	
% of care score ratings for people with confusion or memory problems	**8%**	**36%**	**19%**	**28%**	**8%**	
Total	10	37	25	41	11	

Commentary

- Ratings for patients with memory problems (either diagnosed or without a clear diagnosis) were lower than for those without a memory problem.
- 44% of patients with a memory problem or confusion had poor or very poor care, compared with 31% without a memory problem.
- 49% of patients without a memory problem in contrast received good or excellent care (compared with 36% with a memory problem).
- While these are relatively small numbers to draw conclusions from, patients with memory problems represented 30% of patients reviewed and given an overall rating.

Care ratings: learning disability or severe mental illness

Summary of care ratings comparing patients with and without a learning disability

Presence of a learning disability	Very Poor Care	Poor Care	Adequate Care	Good Care	Excellent Care	Total
No indication of a learning disability	9	35	25	39	11	119
% of care score ratings for people without a learning disability	**8%**	**29%**	**21%**	**33%**	**9%**	
Yes - clear of possible indications from the case records of a learning disability	0	2	0	2	0	4
% of care score ratings for people with a learning disability	**0%**	**50%**	**0%**	**50%**	**0%**	
Total	10	37	25	41	11	

Summary of care ratings comparing patients with and without a severe mental illness

Presence of significant mental illness (other than confusion/memory problems)	Very Poor Care	Poor Care	Adequate Care	Good Care	Excellent Care	Total
No	5	22	16	37	11	91
% of care score ratings for people without a significant mental illness	**5%**	**24%**	**18%**	**41%**	**12%**	
Yes – clear diagnostic definition of the mental illness	4	3	3	1	0	11
% of care score ratings for people with a significant mental illness	**36%**	**27%**	**27%**	**9%**	**0%**	
Total	10	37	25	41	11	

Commentary

- Six patients (4%) had an identifiable learning disability. Four could be assessed: care was poor in two cases and good in two cases.
- While 33 patients in the cohort were known to MPFT, 11 were identified as having a severe mental illness. The quality of care was poor with only one patient in this group rated as receiving better than adequate care. However, numbers are too small to draw any definitive conclusions.

Case studies – Mental health poor care cases

Mental health

11 patients (6%) had a diagnosed severe mental health care need. Not all were identified as having care under MPFT.

3 of the patients known to MPFT were reviewed in detail, as their mental health diagnosis was relevant to the episode of care before their death. The overall care was described as adequate to poor.

Case 1

Early discussion with patient about probable cancer diagnosis. Referred day 4 to palliative and CNS lung. Patient low in mood, regular Seretide was not prescribed from 5 days into admission after referral to mental health team. Good nursing care as inpatient including SKIN bundle, CNS lung, palliative care daily visit – patient lives alone. No ReSPECT form found.

Case 2

There was a reluctance early on to establish if the patient had the potential to recover. His mental health needs were eventually addressed over 3 weeks after admission (see MPFT entry). This followed an earlier decision for a ReSPECT form to be agreed and filed but no EoL was forthcoming until the end of January.

Case 3

The mental health issues are often not preeminent where there are significant physical ones present. While these may be seen as second order, when they impact on the ability to deliver care effectively a mental health assessment should be made.

The care of this patient was generally adequate responding to ongoing and often multiple problems. A decision was made to not resuscitate him as his prognosis was so poor and all senior clinicians agreed.

Case 3 [cont]

The patient was however reluctant to have a DNAR but remained non-compliant with treatment. There is no record of a palliative care referral which would have been appropriate to help resolve the patient's concerns (or at least attempt to) There was also no assessment of mental health capacity (formal) but notes state he was able to contribute to decisions, although a DOL was requested. [the completed DOL] explains that the medical opinion was that the patient didn't have mental capacity to undergo formal assessment of his mental health and the DOL came into force for 7 days.

He had been referred by his GP for an anxiety avoidance personality disorder in Dec 19 with significant concerns about his mental health. There is no evidence in the MPFT notes of a contact being made but a letter post death stated attempts to engage had been made.

In all three cases the physical needs were addressed before mental health needs and this was reflected in the care rating.

Other case studies where mental health issues were not addressed and that received poor care ratings are shown below.

Case 1

Assessment of mental capacity undertaken [but] patient didn't want to engage in treatment – wanted to go home to die. No mental health referral. Patient deteriorated with ?aspiration pneumonia and PE and chest sepsis over the 2 weeks prior to her discharge. Decision was made for fast track palliative care as per her and family wishes. She suffered a fall on the ward and her general care felt unmanaged and uncoordinated, the patient should have been identified sooner as EoL care and care planned accordingly.

Case studies – Mental health (*cont.*)

Case 2

Emergency department (1) attendance with head injury – stated punched by boyfriend. Ambulance crew state "found in bed surrounded by alcohol bottle". MARAC (Multi-Agency Risk Assessment Conference) form done for domestic violence referral. patient refused to see police.

Emergency department (2) arrived peri-arrest after drinking all day and had haematemesis. Was seen by ICU Consultant and emergency department and ICU SPRs – decision made not suitable for ICU as had end-stage liver failure and multiple co-morbidities. ReSPECT form was done and she was given (brief) palliative care and died quickly.

From GP record – long history of alcohol addiction and associated liver disease…

Patient and friend requested detox referral. Assessed by mental health worker and onward referral to the Redwoods Centre for psychosis pathway. Is put on psychosis pathway and offered phone number to access alcohol services but hung up phone. Discharged by them as not a mental health problem.

Difficult to assess – patient was not willing to engage with addiction services and when she briefly approached for help no note of this happening. Rated as poor care as it is difficult to see what her route to help was if she engaged.

Case 3

[Cause of death – suicide] There was an abject failure to intervene with the patient's clearly deteriorating mental health. No intervention was attempted once the patient had waited for 6 weeks for an appointment and then DNA'd despite numerous documented contacts demonstrating patient's suicidal ideation.

Case 4

GP records – Diabetic – poor control stated in record poor self-management at times.

Schizophrenia, end stage renal failure – on dialysis.

Had admission in December/January for confusion and diabetic management.

There is a letter to the patient informing him that he has been removed from the renal transplant list – had been suspended before this.

Mental Health Record (there are only two letters and a one-page summary of contacts)

Last contact entry – patient was inpatient on medical ward, states he was confused but had understanding of need to restrict his fluid and diet – diagnosis states drug controlled psychosis and delirium. Did not respond in December to appointment letter. There is a DNA letter from consultant psychiatrist. Patient was in care home that day and admitted to hospital the day after.

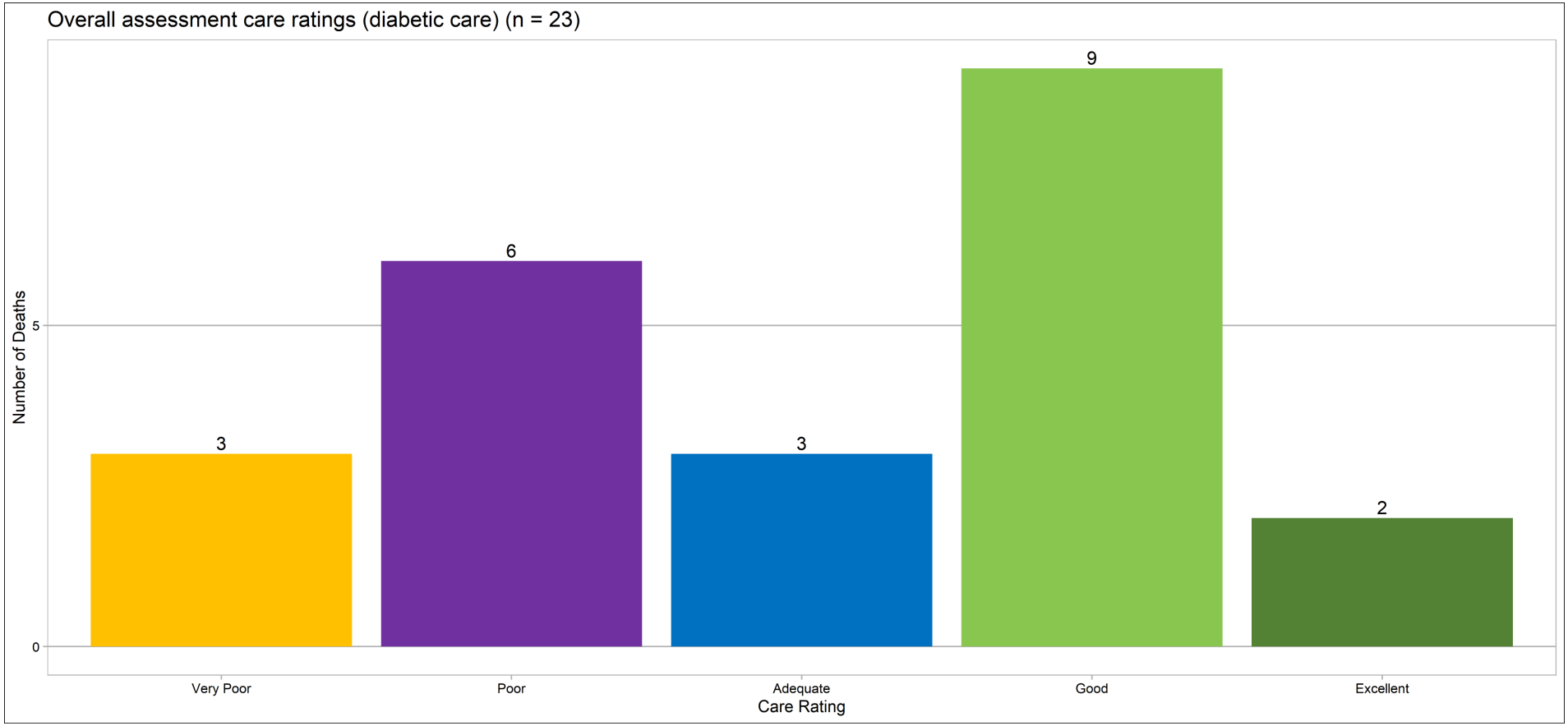
Case 5

GP record only available.

Multiple GP contacts – patient had addiction to opiates, cocaine and benzodiazepines – refused referral to Recovery services. Had issues with requesting Oramorph and other pain medication repeatedly. Multiple discharge summaries found for emergency department attendances with overdoses. Difficult consultations evidenced – patient refused to give practice his address and would not wear a mask.

Hospital admission emergency department summary only available – states small bowel obstruction and Covid-19. Was sent to HDU from emergency department [died].

Overall assessment care ratings (diabetic care)



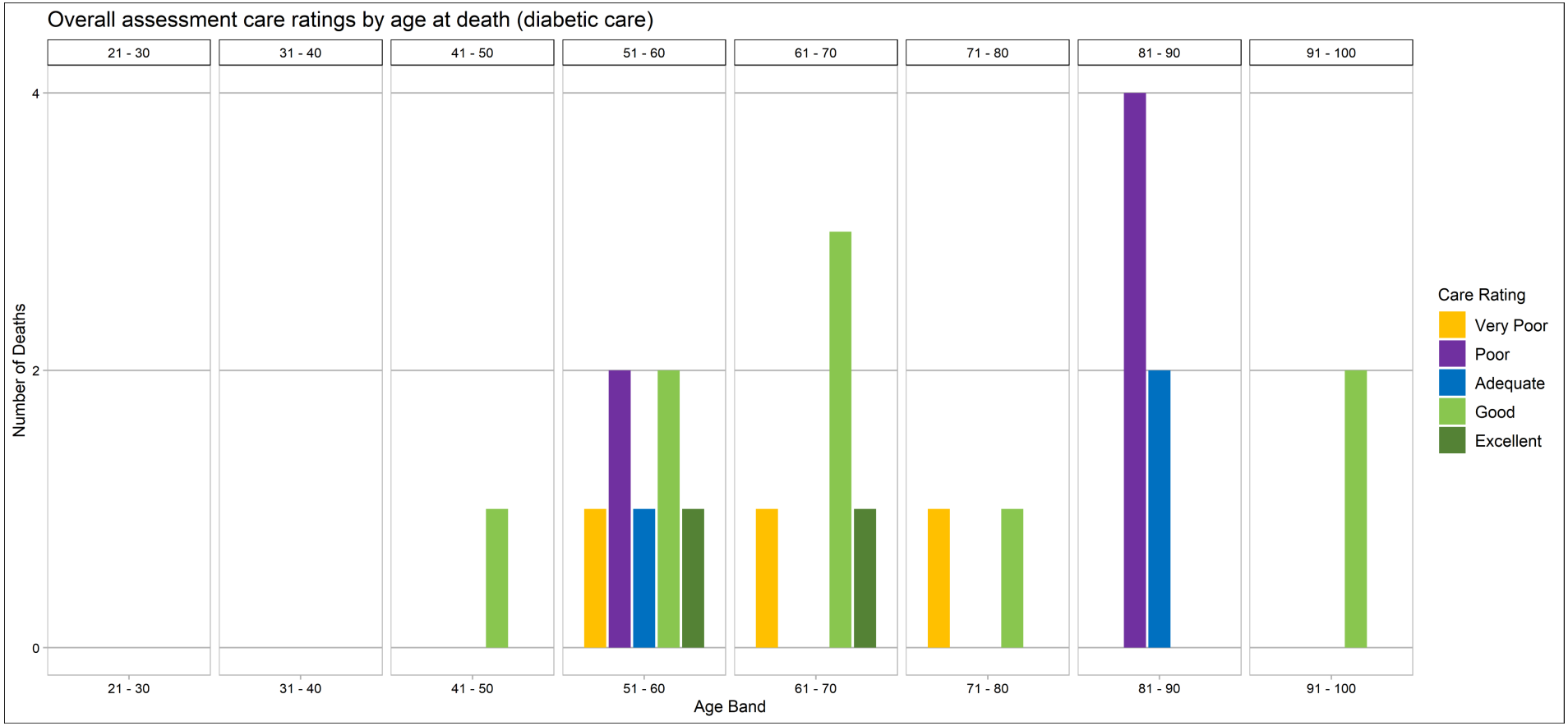
Commentary

- 23 patients had Type 2 diabetes. Of these 11 (48%) had good or excellent care. However, 9 (39%) experienced poor or very poor care.

Points for confirmation

- Further review of diabetic management on transfer between providers would be appropriate to refine these findings.

Overall assessment care by age at death (diabetic care)



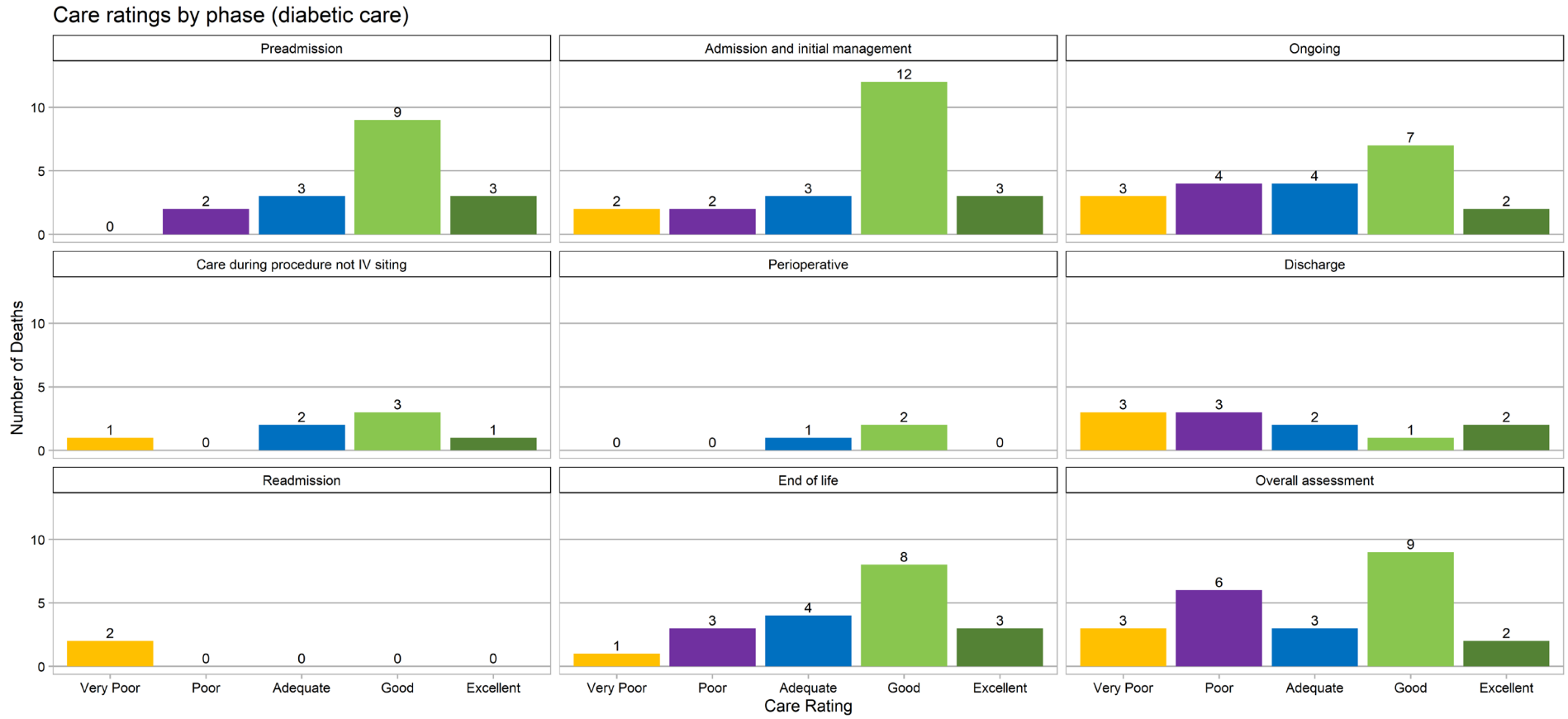
Commentary

- Patients over 80 had poorer overall care when diabetic care was required.

Points for confirmation

- A review of diabetic management of very elderly patients in particular may refine these findings.

Care ratings by phase (diabetic care)



Commentary

- The aspects of the pathway with poor/very poor care relate to initial management and admission, ongoing care and discharge phases.
- This suggests that handover of diabetic management and changes in care provider could be a risk for some patients.

Points for confirmation

- A review of diabetic management throughout a patient's care episode should focus on the management of care when transferring between departments and providers.

Case studies – Access to records

The following case studies are highlighted to demonstrate key cases forming the basis of our recommendations.

41 patients (25%) in the cohort did not have their overall care rated by the reviewers due to the lack of medical records for the entire patient care episode (25%). This is, in itself, a finding and represents a recommendation for improvement.

The difficulty in providing recent records to the review raises concerns about the availability of clinical records for clinical treatment, mortality review and other governance process. It also highlights concerns in relation to access to the quality of medical records management, in particular for SaTH.

Case study 1

Unable to assess as no SaTH RSH notes. GP EMIS record is good. SCHCT record helpful in review but has no specific detail of the circumstances just before or immediately around the patient's death.

Case study 2

There are excellent notes in EMIS including correspondence from SaTH and the ambulance crew, specialists in the region. RiO SCHCT notes show significant input from respiratory team, OT and private carers. No SaTH notes available other than those found on EMIS.

Case study 3

Known to SaTH for lung cancer but no hard copy notes available. Unable to access EMIS. RiO notes suggest patient was admitted after a fall at home into SaTH in [July 2020]. Died 3 days later, assumed in hospital but no notes. No alerts on system.

Case study 4

The notes for this patient could not be located, therefore information was obtained from the GP record and RiO only.

Case study 5

There appears to have been a good acute episode of care for this patient but ongoing care on the ward by the medical team was infrequent. Discharge appears to have been successful but no record of this patient's EoL is known from the records available. An incomplete medical record for this patient.

Case study 6

There were no SaTH notes found. There was no GP EMIS access enabled and SCHCT did not identify this patient as theirs, however they have been caring for the patient in their home. RiO notes however are comprehensive and appear to show family-focussed frequent care. The use of ReSPECT here, assuming it indicated not for DNACPR, was appropriate as patient was palliative.

Case study 7

No hard copy SaTH, SCHCT or EMIS records available.
On Vital Pac documentation, it appears that on day of death [May 2020] they underwent exploratory laparotomy where ascites were drained and decision to proceed to ureteric stenting as a post op note. No other data is available so how, where and when death occurred that day is unknown.
Operating note was not dated but uploaded on day of death.

Case study 8

No GP EMIS access, no hard copy SaTH notes, not known to SCHCT on RiO, not known to MPFT. Clinical portal for SaTH: Past medical history of headaches which were reviewed by neurology at SaTH and an emergency department attendance. No pathology found. Emergency department letter to GP states brought in by ambulance [June 2020] with self harm and arrived in cardiac arrest. States safeguarding concern. Transferred to ICU. ReSPECT form for hypoxic brain injury by ICU Consultant. Died on day 4 of ICU stay after emergency department attendance in cardiac arrest. No other notes available for this patient to review.

Lessons learnt and reflections

Lessons learnt: access to records

The review using Structured Judgement Review methodology required considerable engagement and agreement between all parties. The effort by all involved is gratefully acknowledged, and without it the review would not have been possible. Access to hard copy and electronic records and systems, provision of secure logins and facilities required cooperation between a wide number of organisations and individuals and were key to the review success. There were lessons learnt from the process of accessing the records across this health system. We reflect these to support future similar exercises and to identify potential risks to accessing full patient records in the clinical setting when needed. These included:

- Records for SaTH are in multiple parts despite being in hard copy. There is a risk that clinical staff may not be able to access full patient histories as a result. In particular:
  - Many records were missing the latest episode of care and we established that older volumes of records are archived and therefore separated from the current volume.
  - The current volume of records were sometimes not available despite all patients having been discharged between 6 and 12 months earlier.
  - Emergency department records are not kept together with the remainder of a patient's records and have to be accessed separately.
- System-wide information governance protocols are not in place to facilitate patient care reviews. Different organisations took different views of the requirements for accessing deceased patients' records. The significant variation in interpretation of information governance regulations by the different organisations has implications both for unnecessary restrictions when sharing essential information between professionals and for future reviews of this type.
- Access to GP record systems (such as EMIS) is complex and direct engagement with primary care practices was required. There was a lack of knowledge in the CCG of the ways in which appropriate access could be provided for the review. Locality, practice managers and GP partners were very supportive of the process but this was late in the day.

Reflections

Making a judgement across a system of care is subjective and based on the specific review team's perspective. It is well documented that various teams rate care differently. Having a team approach to reviewing all cases helps ensure a fair and reasonable assessment of each case and the themes arising for the purposes of overall improvement.

The key themes arising from our work are described below and we focus on system aspects in this summary. Areas to note and issues arising in specific phases of care are described in the more detailed sections of this report. There were several reflections on the review which frame the findings throughout the report. These include:

- The ability to look at the whole-system approach to individual patient care was restricted due to the availability of health records for patients from SaTH, SCHCT and GPs. This is possibly one of our most significant findings as it evidences the lack of ability for anyone to have complete oversight across the system and effectively assess and improve care at present.
- The representative nature of the patient sample taken reflects deaths from January to June 2020. This covered a period before and during the Covid-19 pandemic.
- The time period of the patient cohort selected for the review included the period of the NHS response to the first wave of the Covid-19 pandemic. The review comments reference this directly, for example, the excellence in the management of patients in the initial admission phase with respect to infection prevention control, and the effects of the pandemic potentially skewing the representative nature of patients presenting in the emergency department.
- Nationally, visits to emergency departments fell by 29% in March and 57% in April (compared with the same time in 2019) – the latter representing an absolute reduction of 21,000 patient attendances per major emergency department. https://www.nuffieldtrust.org.uk/news-item/where-are-the-patients-the-factors-affecting-the-use-of-emergency-care-during-covid-19

Recommendations

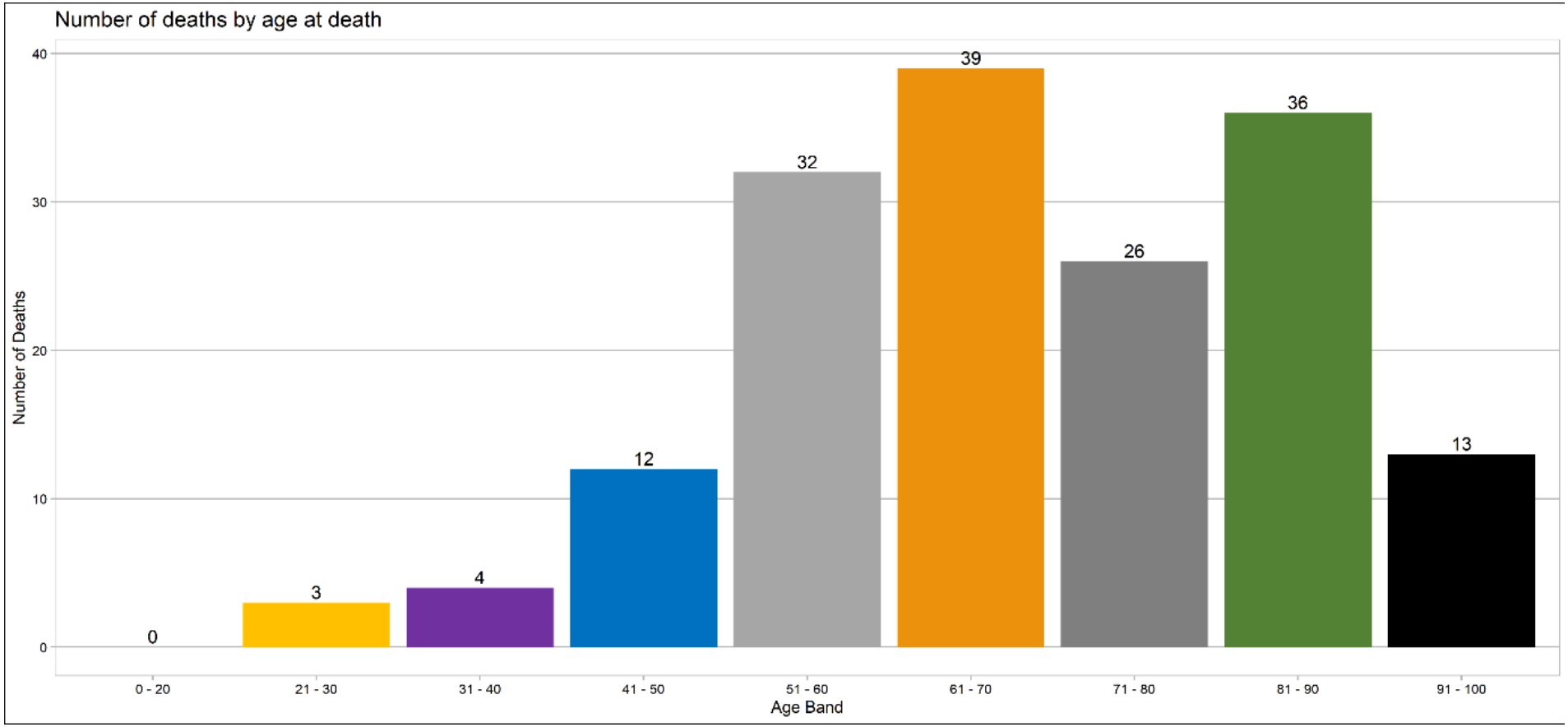
No.	Advised action	Risk level	Priority
R1	**Records management** • There is a need to ensure that there is a robust process in place to identify all inpatient deaths reliably and all deaths within 30 days of discharge from all providers. • All organisations should agree system-wide information governance protocols for future case reviews. • SaTH should review medical records management in relation to ensuring complete patient records are archived together. • Undertake an assessment of why final episode records are not available up to 12 months post death. • Complete a review of the impact of lack of access to complete records to support adequate mortality review. • Emergency department records need to be archived/available for review alongside the remainder of the patient notes. • The secure transportation of hard copy medical records should be reviewed by SaTH and SCHCT.		H
R2	**Pathways** • The availability and use of admission avoidance schemes should be reviewed in the community. • Review the direct access pathways for oncology patients and other sub-specialties (e.g. respiratory patients) to prevent emergency department admission. • Review the utilisation of the Fast Track discharge pathway for SaTH patients. • A wider analysis is required of admissions on Tuesdays and other days of the week to establish if the finding here is replicated in a larger set to inform any necessary actions. • Request that ShropDoc undertakes an audit of all cases where immediate intervention is required following discharge or to expedite direct admissions to inform improved pathways.		M
R3	**Safeguarding and the application of the Mental Capacity Act 2005** • Recommunicate the importance of and processes relating to the safeguarding of vulnerable adults across the system. • Audit the application, training and implementation of the Mental Capacity Act 2005, in particular in relation to recording capacity assessments in all settings.		M
R4	**Mental health care** • The quality of care of patients with mental health needs at end of life and through emergency admission must be subject to a dedicated review and analysis to refine the system-wide understanding of the needs of people presenting with mental health difficulties. This should include the provision of care for those with an alcohol-related dependency who are facing end of life.		H
R5	**Cumulative care of the very elderly** • Consider expediting the emergency admission of patients with advanced age to reduce the number of admissions after 22.00 hours. • Review the factors at play in relation to the quality of care of patients with dementia facing end of life and the factors that would limit unnecessary presentation of these patients in the emergency department.		H

Recommendations (*cont.*)

No.	Advised action	Risk level	Priority
R6	**More timely implementation of end of life care plans and palliative care team involvement** • Palliative care involvement should be subject to assessment to understand the factors at play in securing earlier engagement in the care episode in SaTH when the patient is considered EoL, and seamlessly continued into the community. • Review the availability of senior decision makers 7 days a week, 24 hours a day in ward areas in SaTH. **ReSPECT** • Continue to promote the early use of ReSPECT to support timely advance care planning and implementation of end of life care preferences and wishes.		H
R7	**Diabetic care management** • Urgently review care of the diabetic patient in the community and during transfer between providers to improve diabetic control and management through focussed blood glucose monitoring practice. This review should include an assessment of all patient incidents involving failure to administer insulin. Arrangements for administering insulin and monitoring dependent patients in the community should be clearly developed.		H
R8	**Clinical monitoring** • Continue to improve the screening of patients at risk of developing sepsis and the implementation of the sepsis pathway. • A concerted improvement in fluid balance management, using case studies presented here to improve the hydration of patients at end of life and at risk of developing acute kidney injury. Recording of fluid balances on the wards and during patient transfer is a high priority in fundamental nursing care.		H

Analysis of the patient cohort

Number of deaths by age



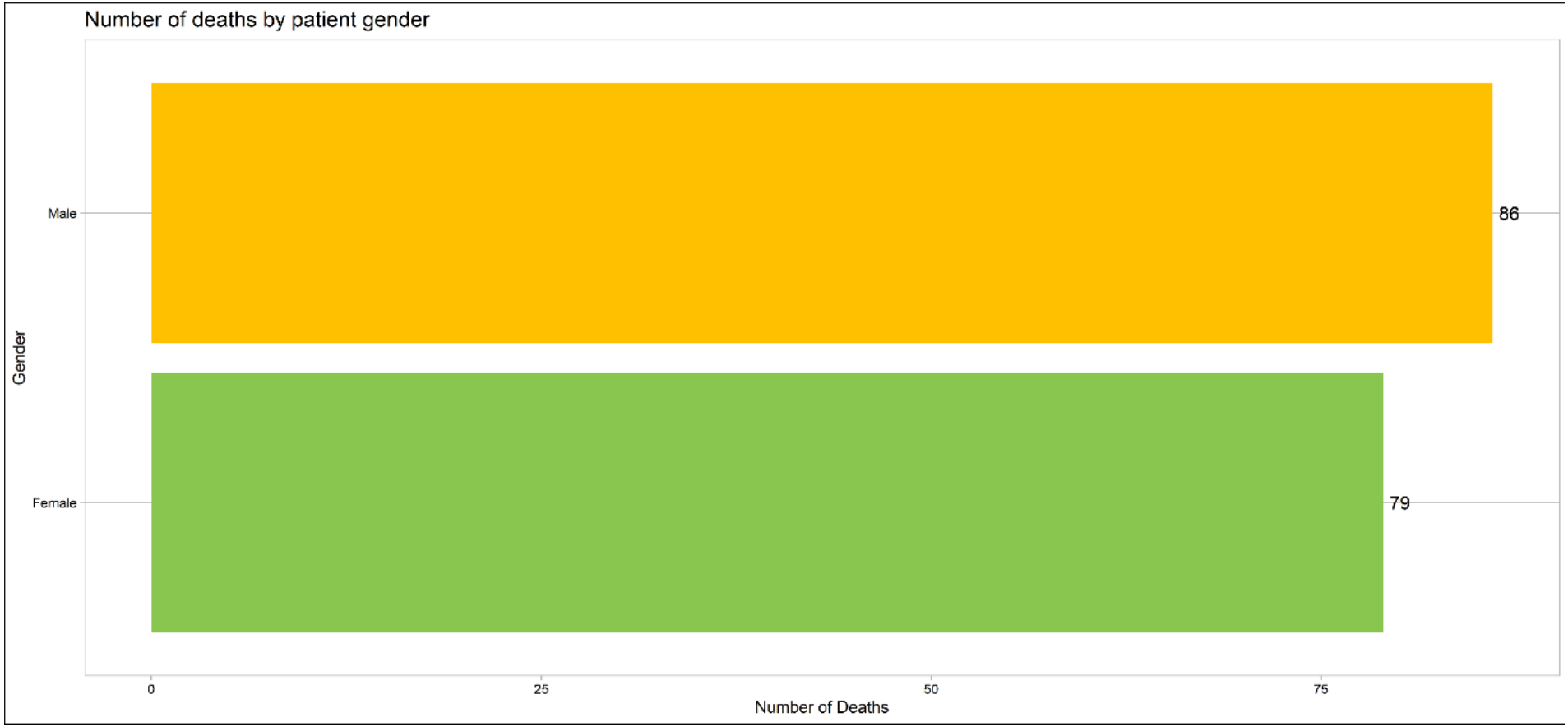
Commentary

- The age distribution of the 165 cases is represented by the chart above.
- 7 patients were under 40.
- 83 patients were aged between 41 and 70.
- 75 patients were 71 or over.

Points for confirmation

- This distribution will not reflect the population of Shropshire and Telford and Wrekin by age due to the way the cohort selected proportionately fewer deaths in older age groups.

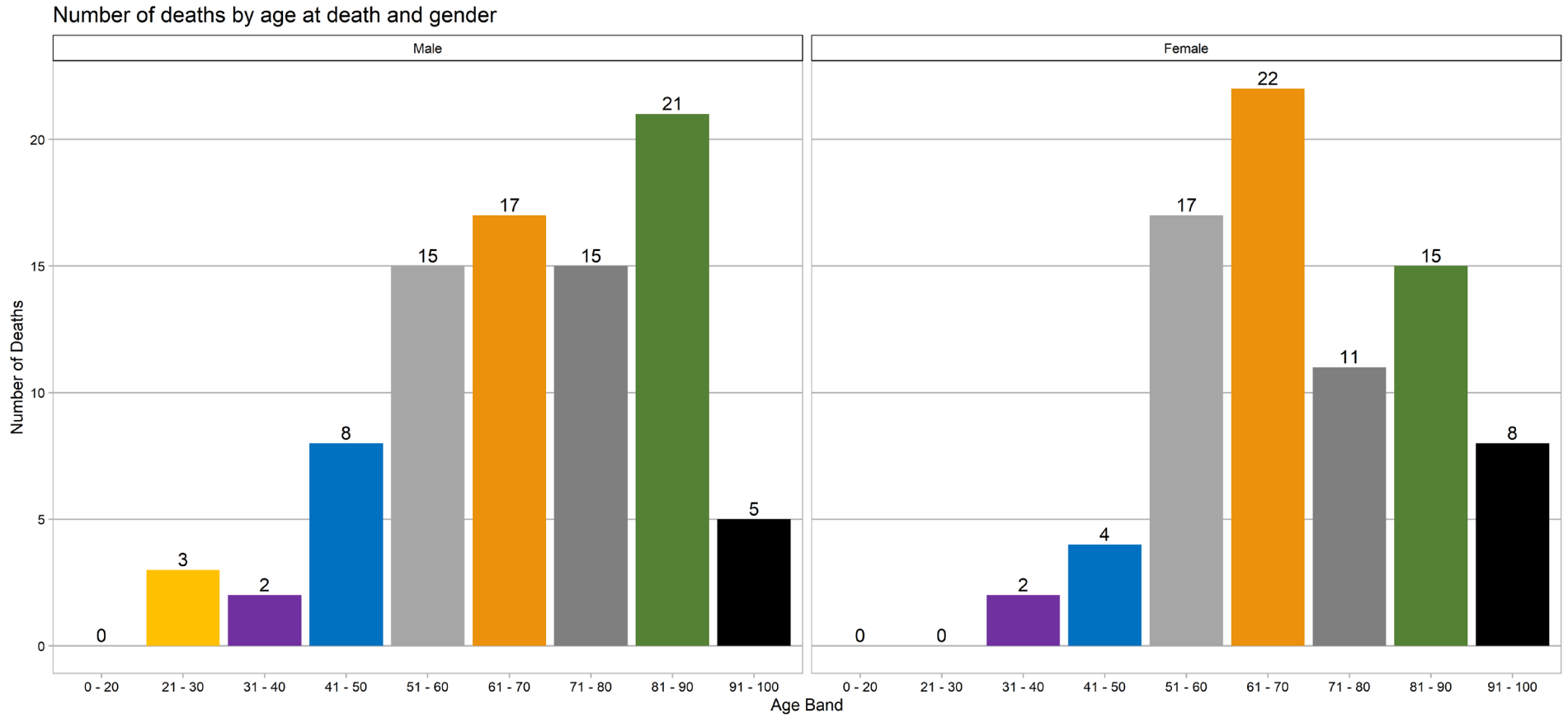
Gender of patients



Commentary

- The patient cohort was evenly split by male and female (52% and 48% respectively).

Number of deaths by age at death and gender



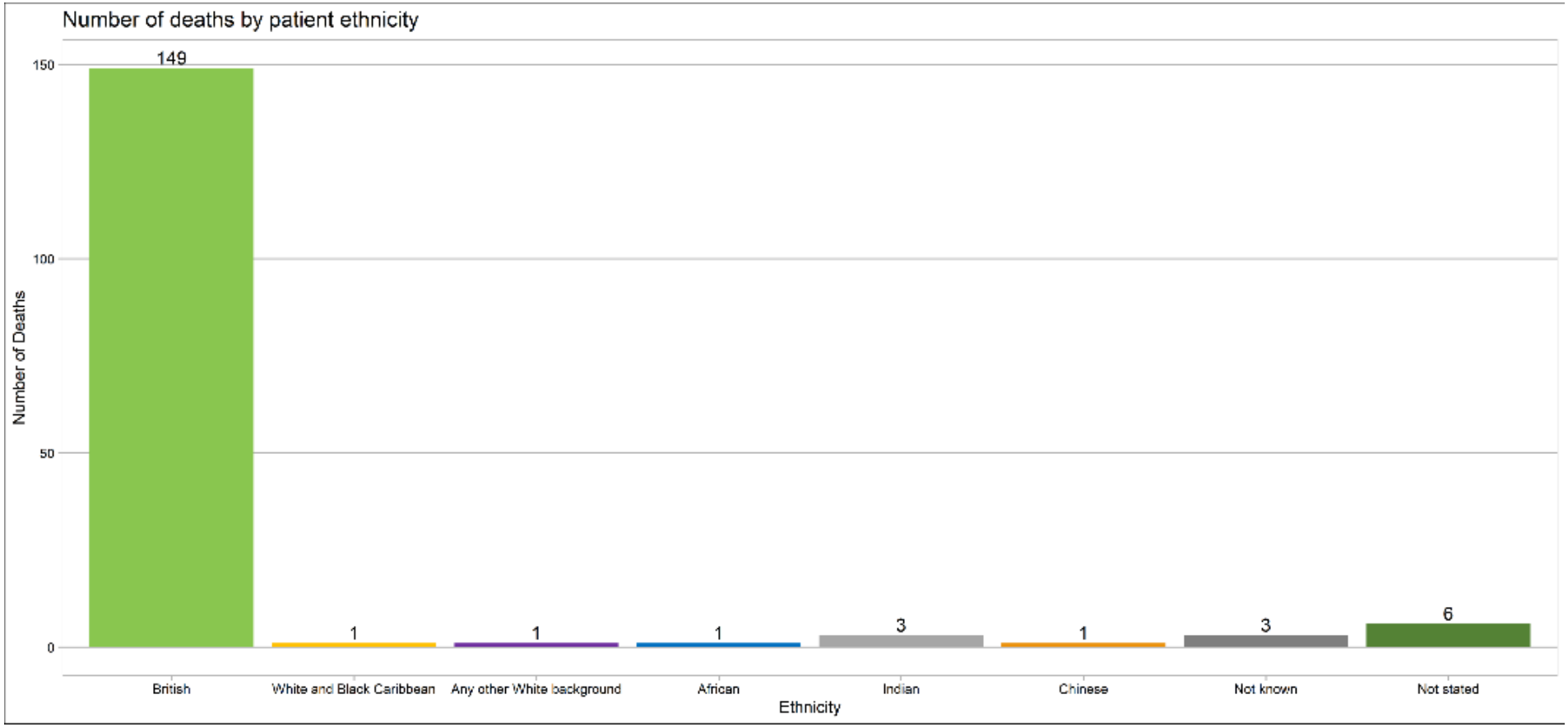
Commentary

- Of the 19 deaths of people under 50, two thirds (13) were male and 6 were female.

Points for confirmation

- Is the age differential of younger male deaths recognised?

Ethnicity of the patient cohort



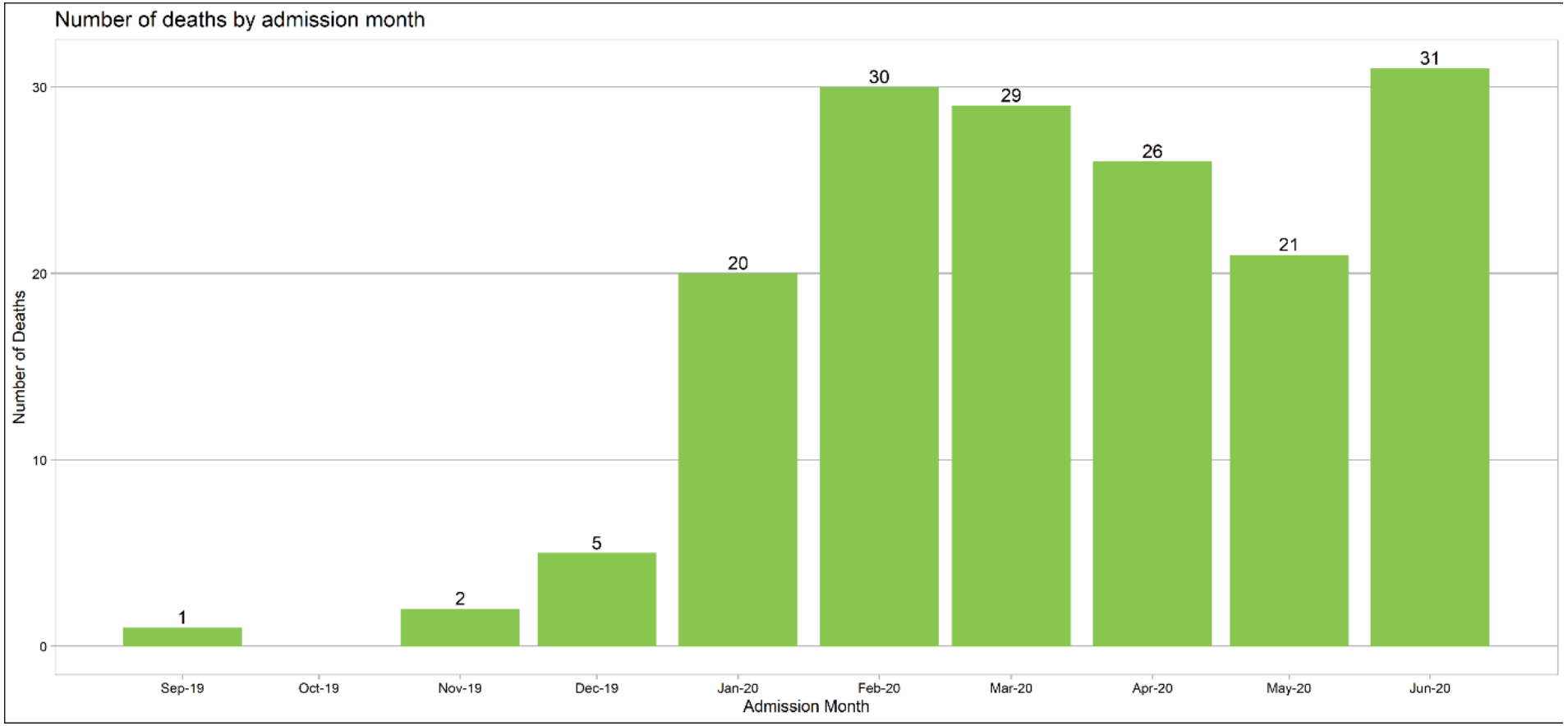
Commentary

- The patient cohort's ethnicity was split as per the graph above, with six patients without a recorded ethnicity. The profile is representative of the ethnic diversity for Shropshire from the latest census data of 2011, with 90% British.

Points for confirmation

- The Trust should establish whether these are the correct ethnic categories applied.

Patient deaths by month



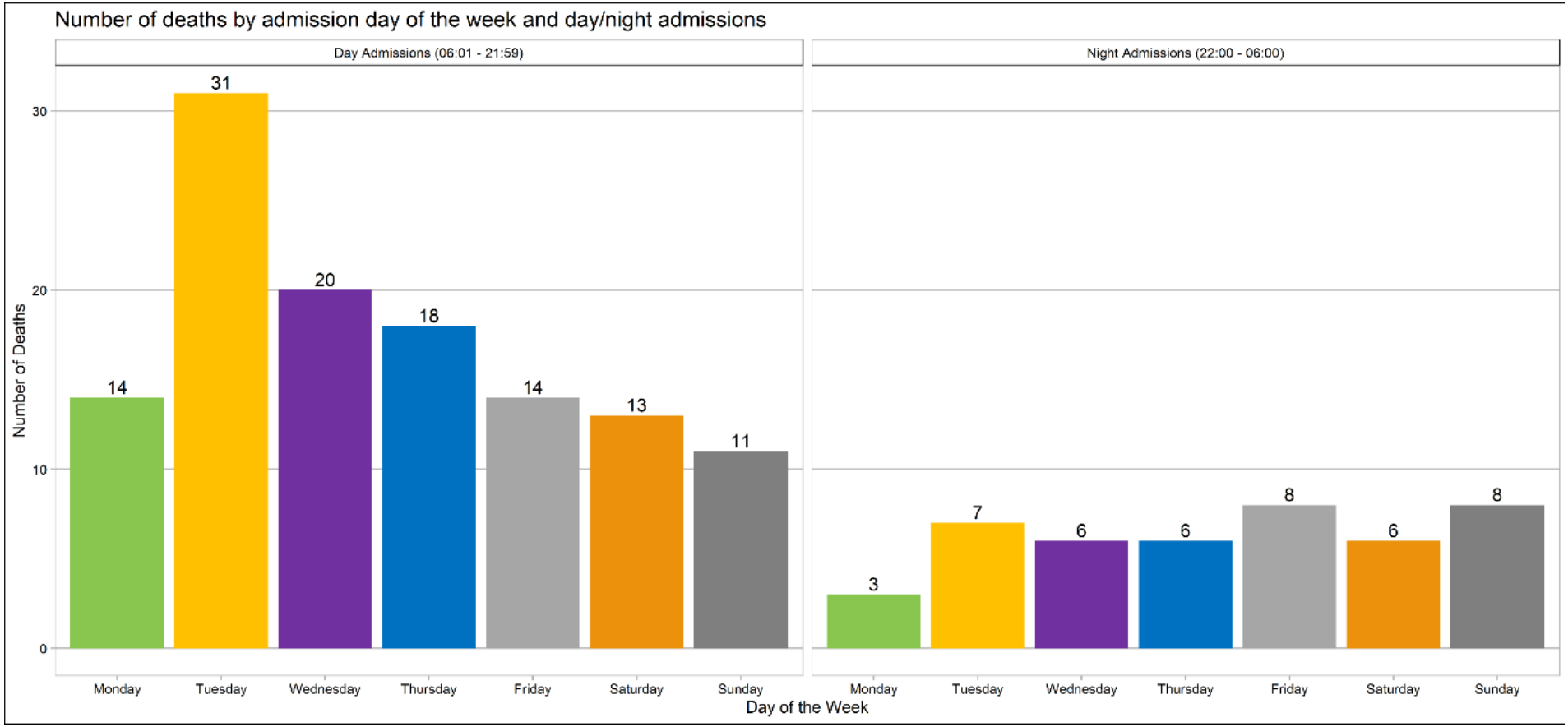
Commentary

- Patient deaths by month are represented in the graph above.
- A small number appeared on review to be prior to January 2020.

Points for confirmation

- The Trust needs to confirm whether its data systems can reliably identify patient deaths by date.

Patient deaths by day of the week and by day/night admission



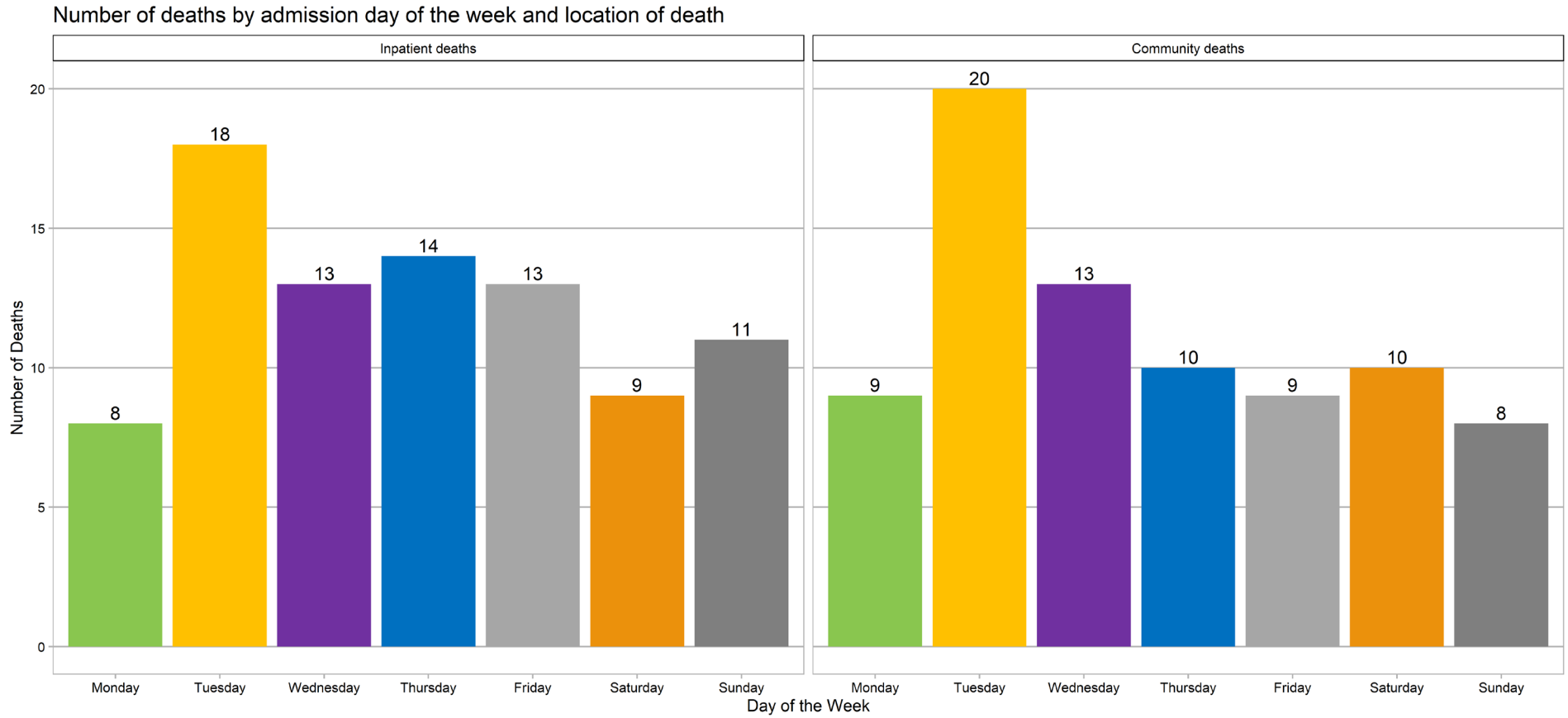
Commentary

- The graph above suggests that the number of patients admitted at night who subsequently died was significantly lower than patients admitted during the day. There appears to be a difference in deaths if the patient was admitted into SaTH on a Tuesday. This may be indicative of reduced input at home to patients over the weekend resulting in a deterioration in health when finally admitted.

Points for confirmation

The distribution of deaths of patients depending on the day of the week they were admitted may warrant further review.

Number of deaths by day of the week and location of death



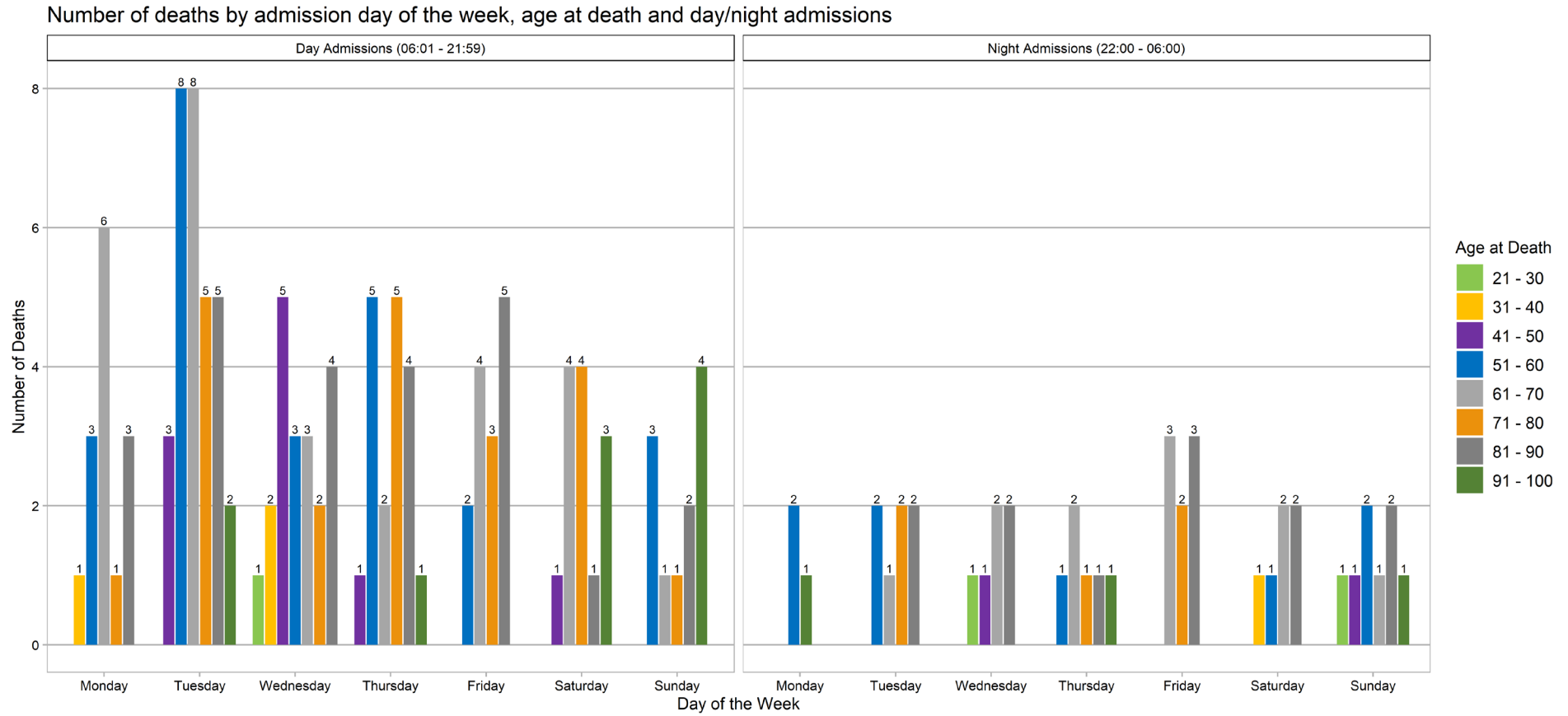
Commentary

- The number of admissions which result in subsequent deaths is highest on a Tuesday regardless of location of death (inpatient or community post discharge).
- This may relate to delayed admissions from the weekend, but we could see no discernible explanation in the cases.

Points for confirmation

- Has this pattern been observed elsewhere in the health system?

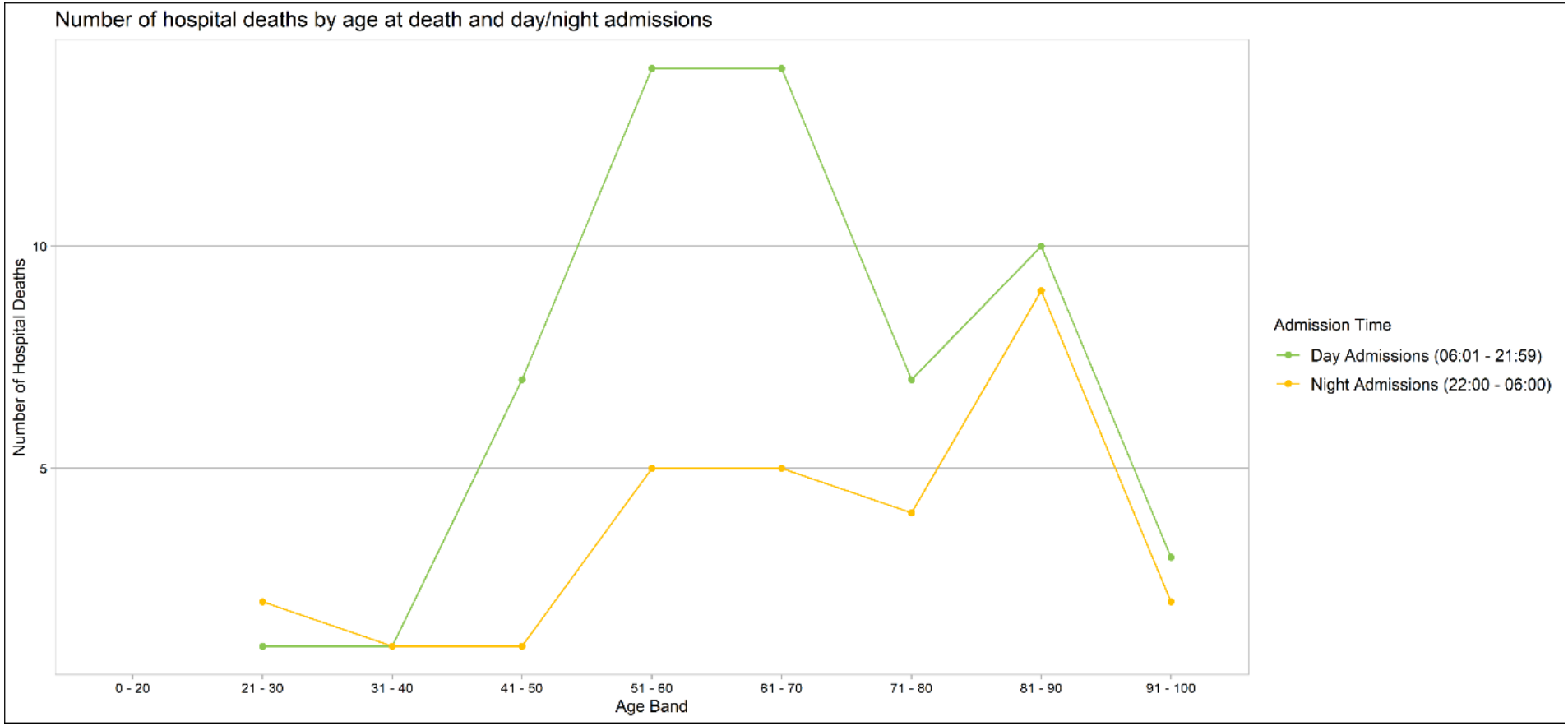
Deaths by admission day/week, age and day/night admission



Commentary

- There are a larger number of deaths in cases of admissions on Tuesdays compared with other days of the week.
- Tuesday admissions occur predominantly across age groups over 50 years of age.

Deaths by age and admission time (day/night)



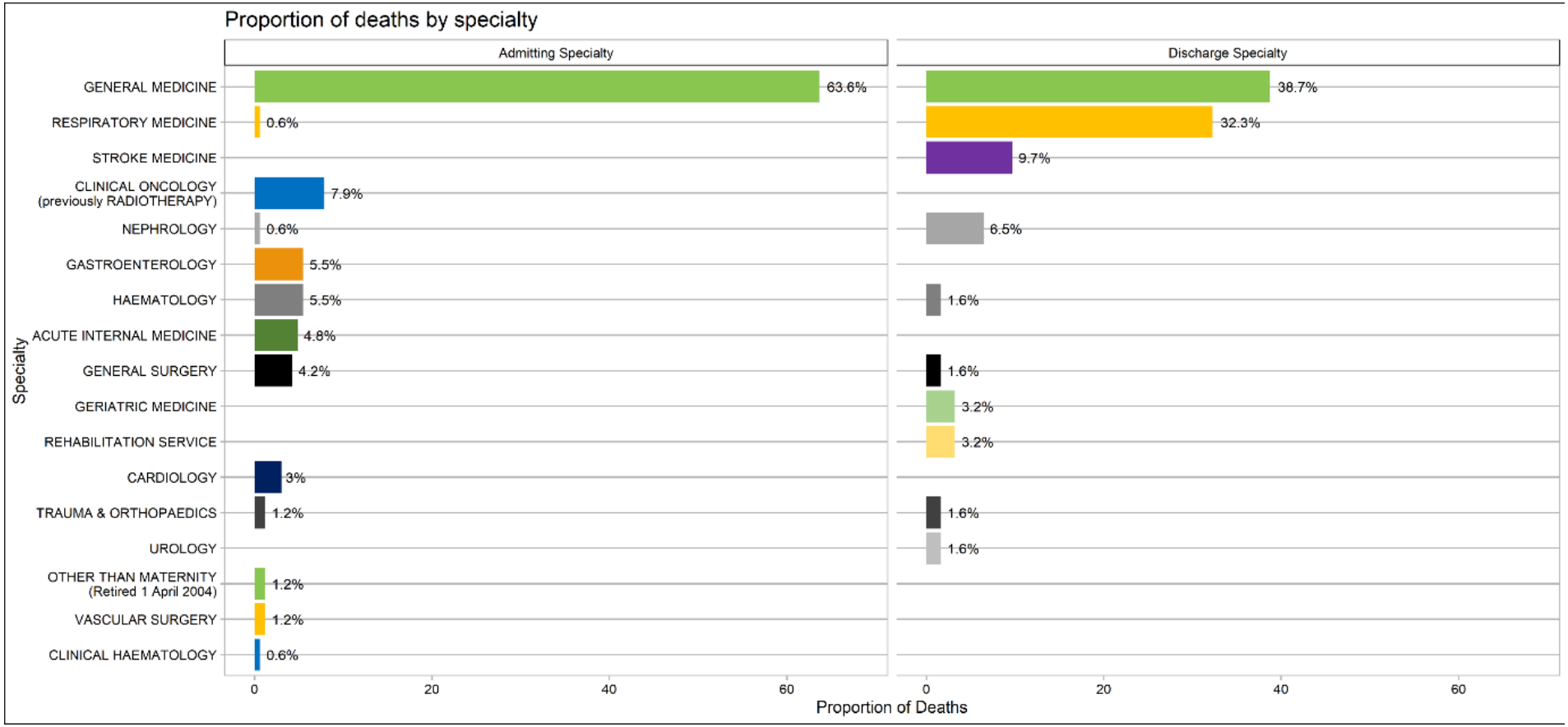
Commentary

- The data above suggest that the older the patient, the later in the day that the admission occurs. This could be related to transport, degrees of urgency or cumulative pathway delays.
- Patients in the 81–90 age group are more likely to be admitted during the night, in comparison with younger age groups (under 70s) who are significantly more likely to be admitted during the day and in normal working hours.

Points for confirmation

- Has the CCG seen this pattern before? It suggests that decisions to admit should be expedited or prioritised by healthcare personnel in the community with patients in this age group, and the risk of extended cumulative times to admission should be focussed upon. Extended times for admission for the elderly can result in longer periods with lack of nutrition/hydration and monitoring, as well as unnecessarily late clerking (without relatives' support) in the early hours.

Deaths by admitting and discharge specialty



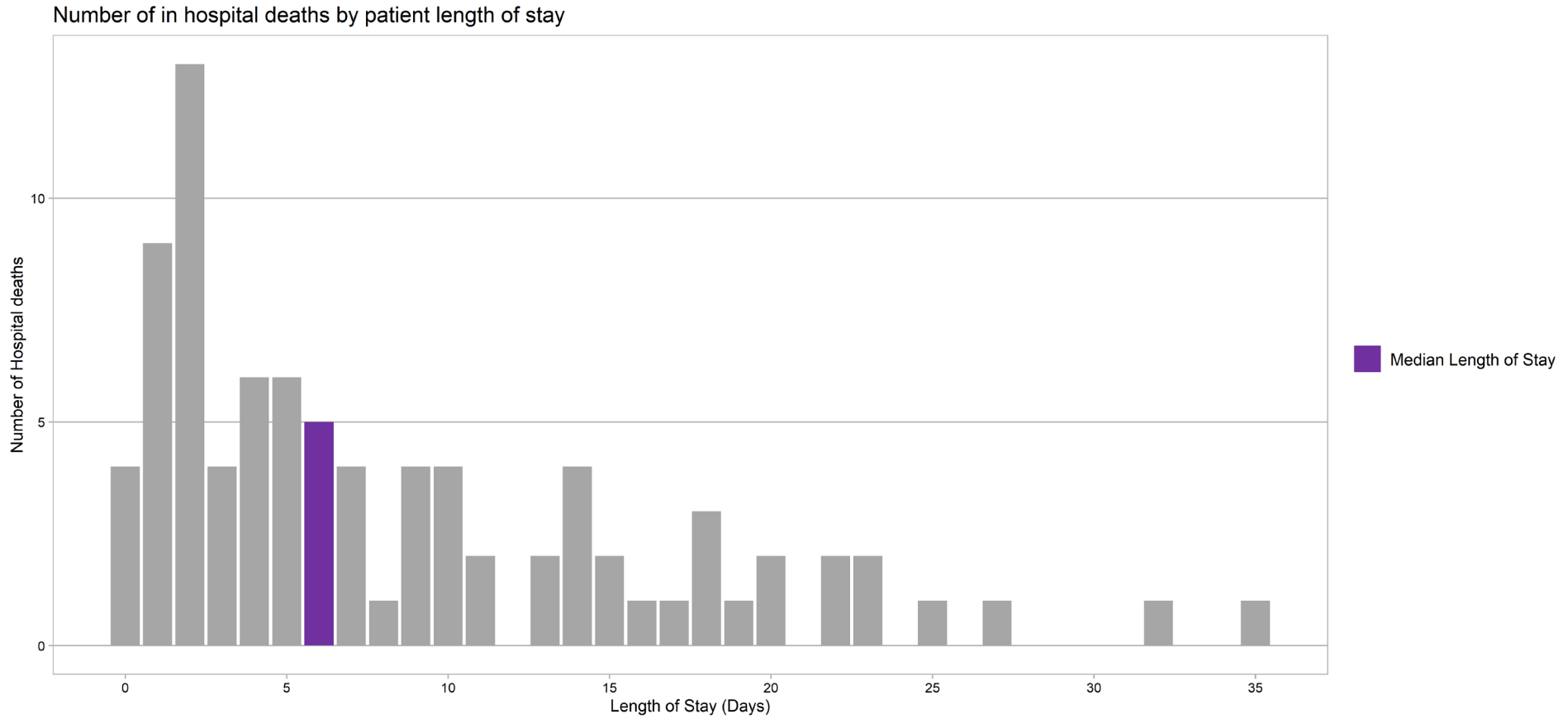
Commentary

- When comparing admitting specialty to discharge specialty, the data suggest a higher proportion of inpatient referrals from general medicine as the admitting specialty, compared to respiratory, stroke medicine and nephrology. This would suggest appropriate use of sub-specialty opinion and ongoing care requirements while an inpatient. The findings for respiratory medicine in this period may not be representative of normal patient demand for this specialty, due to Covid-19.

Points for confirmation

- Does the Trust recognise this pattern?
- Specialty-based data is not wholly reliable in this data set, as identified in Phase 1.
- A review of the data for a more usual period would be suggested.

Deaths by length of stay



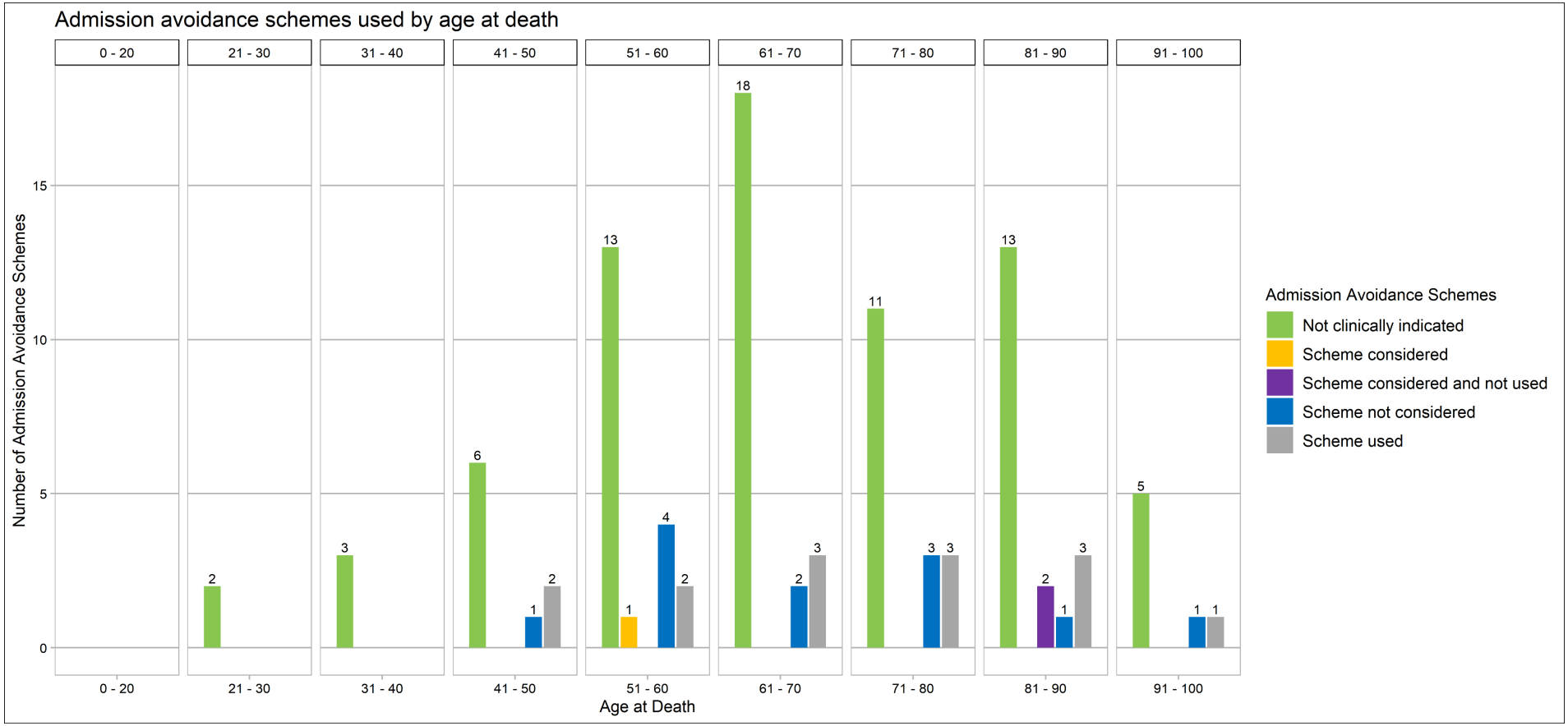
Commentary

- The median length of stay for patients was 6 days (n = 86) with a range of 0 days to 20 days for most patients, with a length of stay of more than 21 days for 8 patients.
- The majority of patients (72%) were in hospital for less than 10 days.

Points for confirmation

- Is this pattern of length of stay commensurate with expectations?

Admission avoidance schemes by patient age



Commentary

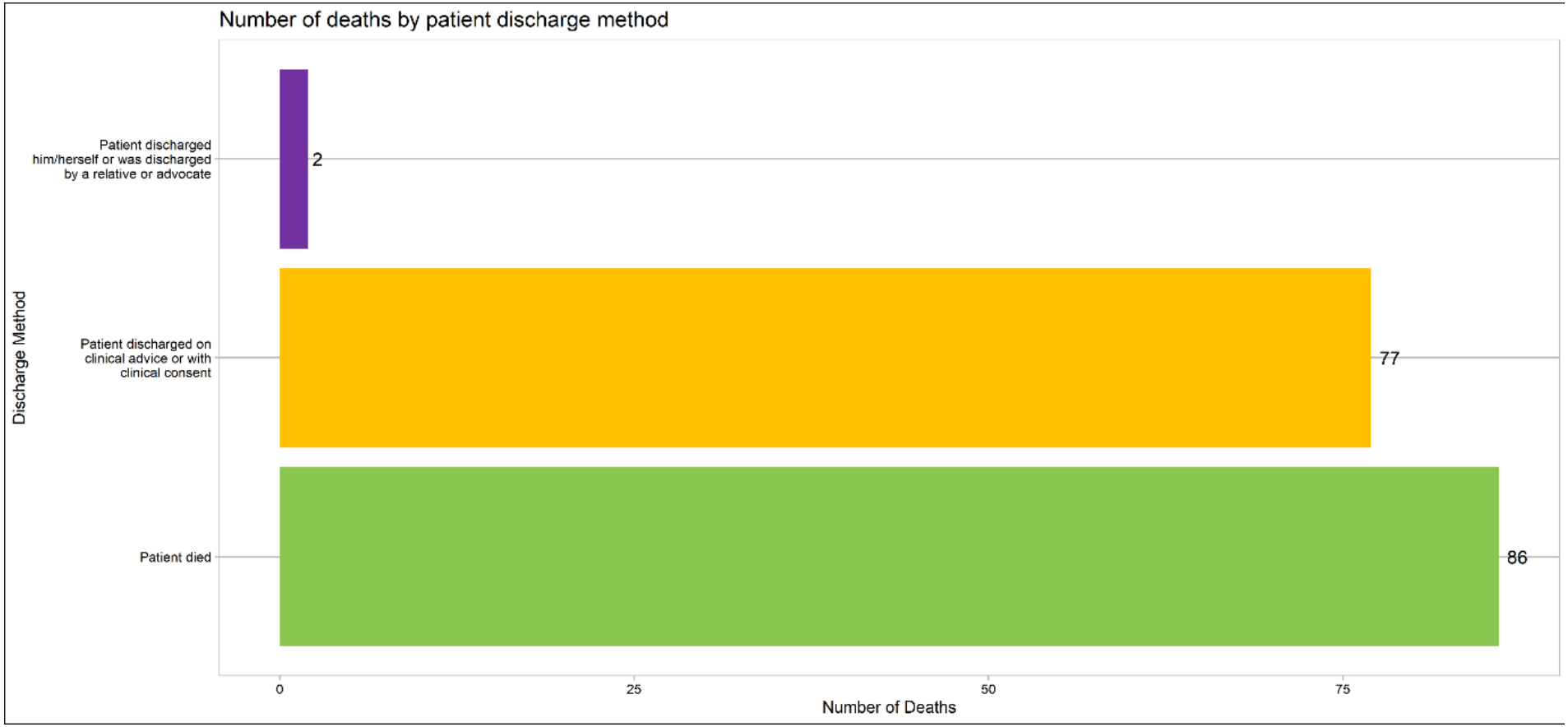
- There was little evidence of the use of formal admission avoidance schemes.

Points for confirmation

- We were not aware of specific admission avoidance schemes in place in Shropshire and, if used, there was little explicit evidence in the records.

Deaths by discharge method

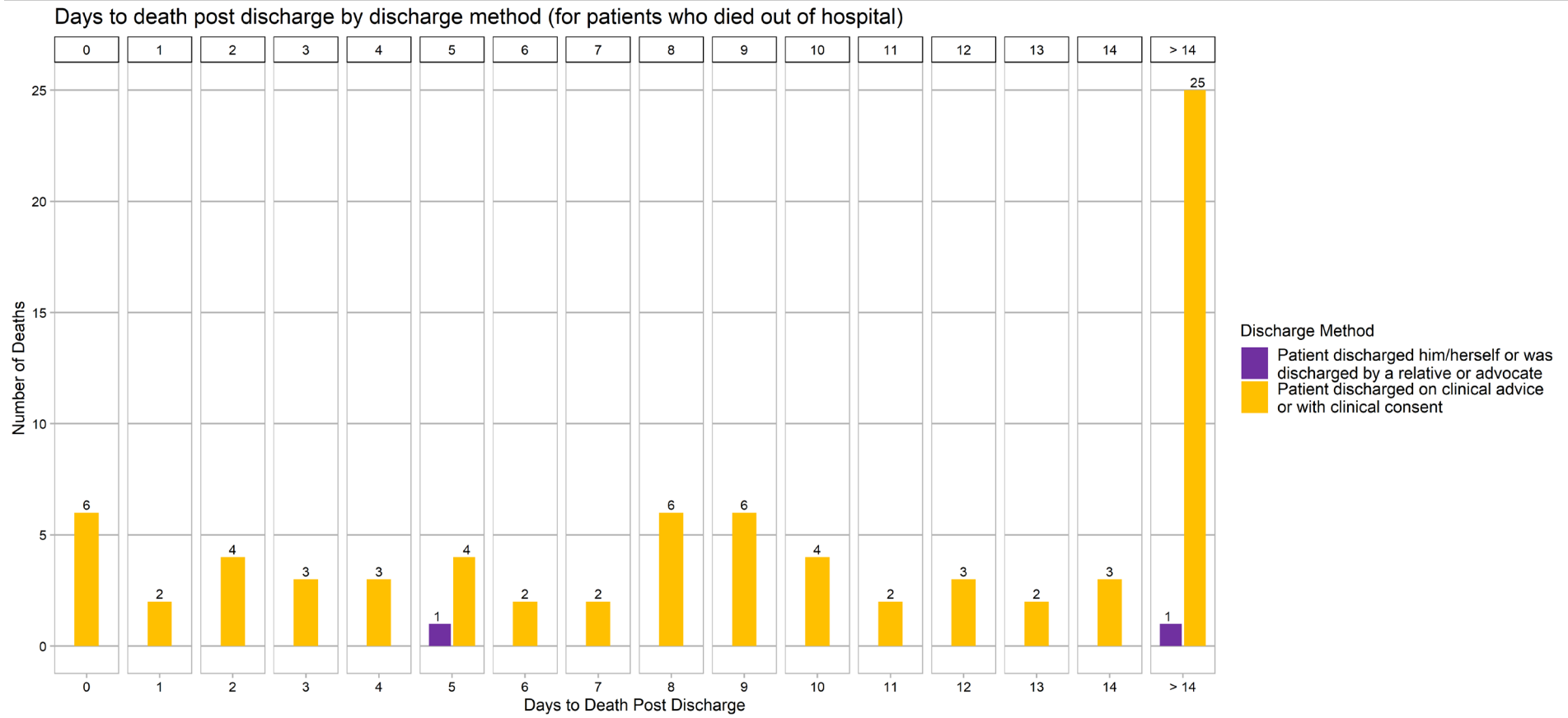
p



Commentary

- 86 patients (52%) from the cohort died in SaTH and 79 patients (48%) were discharged and died subsequently in the community.

Days to death post discharge by discharge method



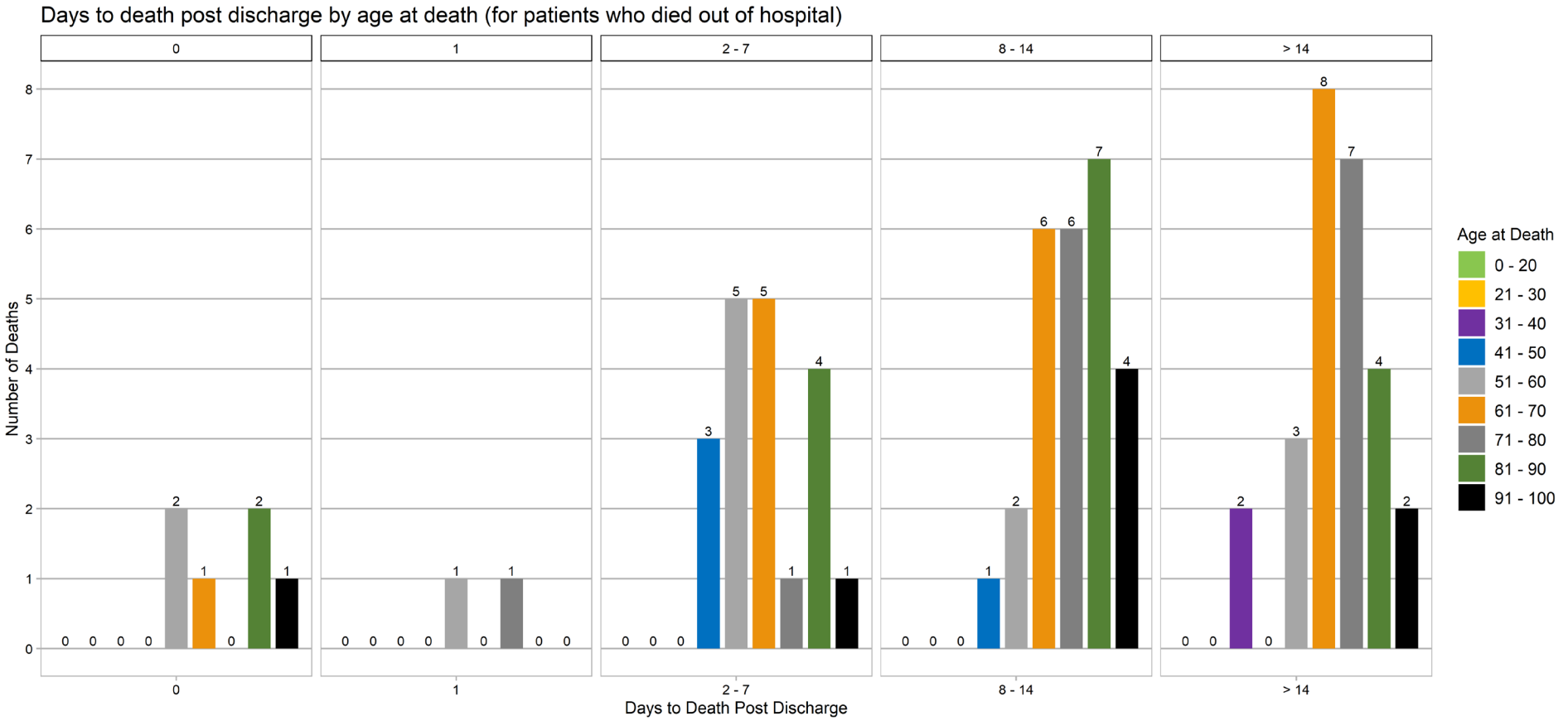
Commentary

- 69% of patients died within 14 days of discharge.
- 31% died over 14 days after discharge.

Points for confirmation

- Is this an expected finding?
- There were too few cases where Fast Track discharge was clearly evidenced to assess whether the timeliness of discharge was appropriate.

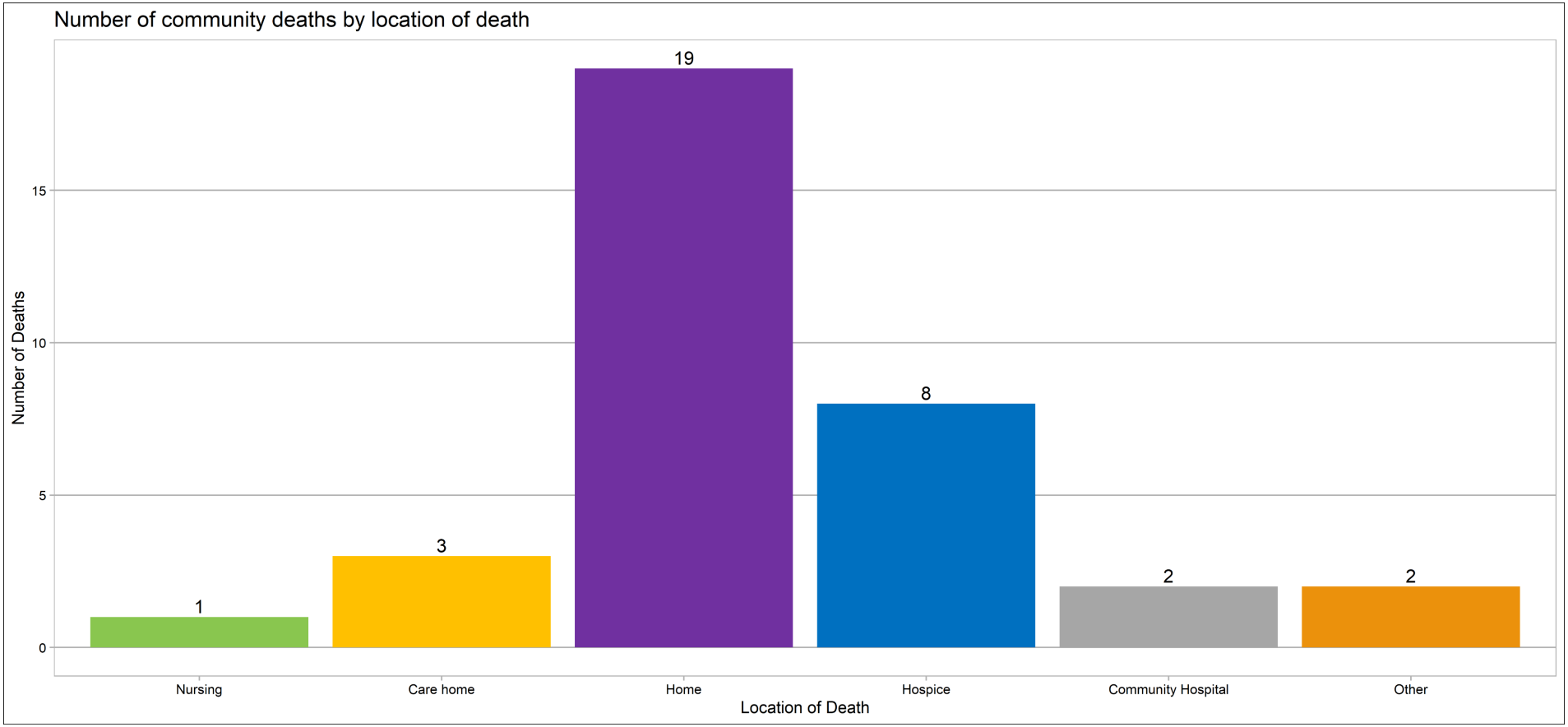
Days to death from discharge by age



Commentary

- The age of the patient and the number of days after discharge that they died are shown in the above table.

Location of death



Commentary

- The setting for the patient death in the community cannot be reliably reported on, due to the lack of access to SCHCT and GP medical records. However, the analysis we could make suggests a majority of patient deaths in the community have happened at home. This is a positive finding in line with the 2008 End of Life Care Strategy for the NHS.

Points for confirmation

- We could evidence 35 (of 77) locations of death. A more reliable data source might be able to provide a wider analysis of whether patients die in their preferred location after discharge.

Summary of the overall quality of patient care

Summary of the overall quality of patient care

The overall quality of care assessments are judgements made based on the care ratings provided from preadmission to end of life. We recognise that there is a greater emphasis on the acute episode in the overall review as a result of the availability of records and notes.

We reviewed 165 cases overall, but could only provide an overall rating in 124 cases due to the lack of information to support ratings in all relevant phases.

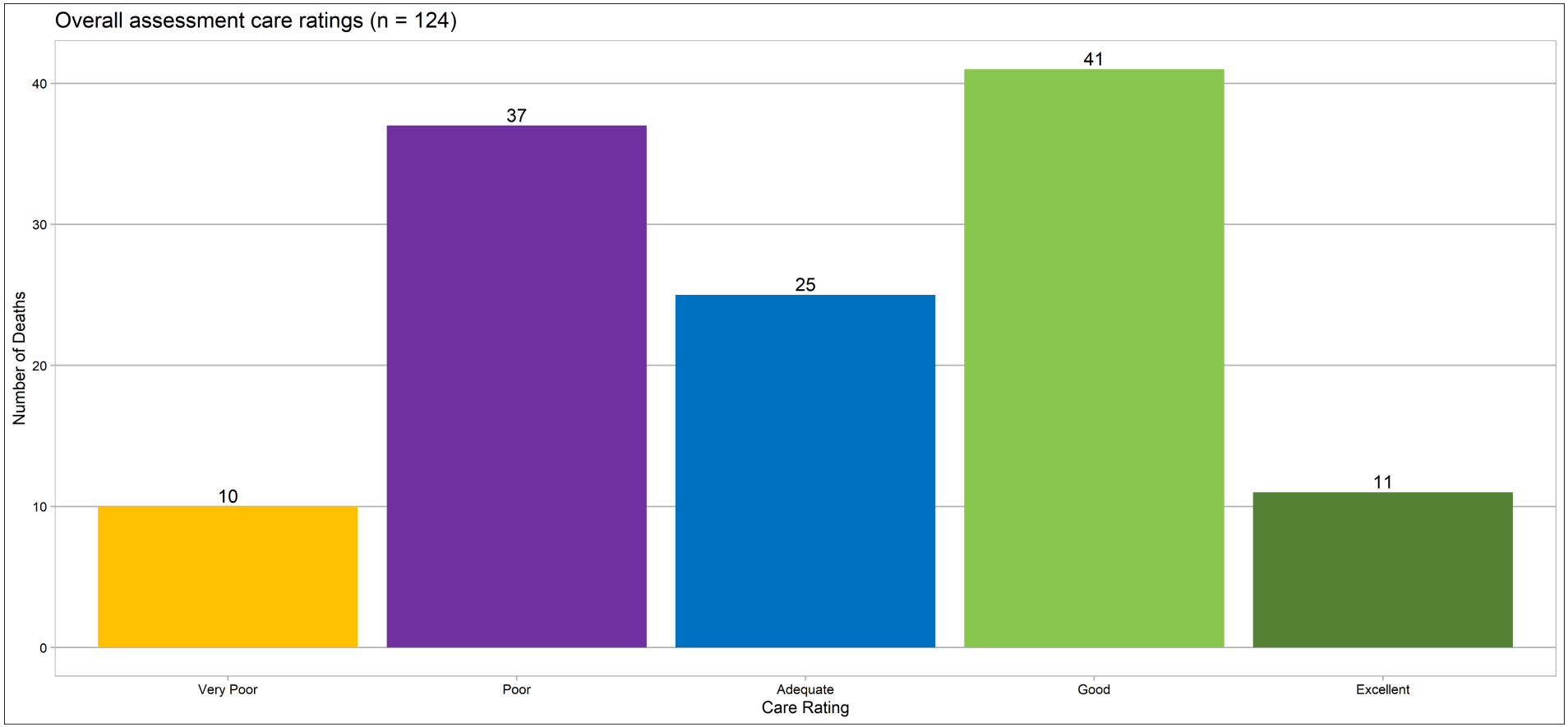
Overall observations

- The excellent and good ratings in all phases indicate that systems, processes and resources are able to deliver services required for some patients. Patient and family involvement is also noticeably excellent in these cases.
- Where ratings are adequate, poor or very poor, there were themes presenting of deficiencies in diabetes care in the acute and community services, deficiencies in nutrition and fluid balance management (often associated with patients living with diabetes), issues with late involvement of the palliative care team and problems with late commencement of end of life care planning.
- There was a general system-wide lack of care coordination.
- Cross-system working demonstrated little evidence of continuity for chronic conditions and non-acute care such as chemotherapy.
- Poor community and discharge planning and lack of evidenced discussion regarding ongoing care needs for patients, especially if these needs extended past pure medical management.
- We noted there were very few cardiac deaths and deaths from major disease groups (e.g. stroke).
- Effective communication between the services is significantly hampered by the quality of the records (incomplete documents, poorly filed and stored) and their availability (hard copy notes only in SaTH which do not include the emergency department episode of care, and partially electronic records for SCHCT). When EMIS could be accessed, there was often found to be excellent communication with the GP from the emergency department and Shropdoc. But this was not replicated in the SaTH or SCHCT records.

Key points:

- 41% of cases were rated as good or excellent overall.
- 41% of cases were rated as poor or very poor overall.
- 60% of cases related to RSH.
- 40% of cases related to PRH.
- Poor or very poor care judgements were more common in older patients.
- There was a direct correlation between excellent care records and excellent care ratings.

Overall care ratings



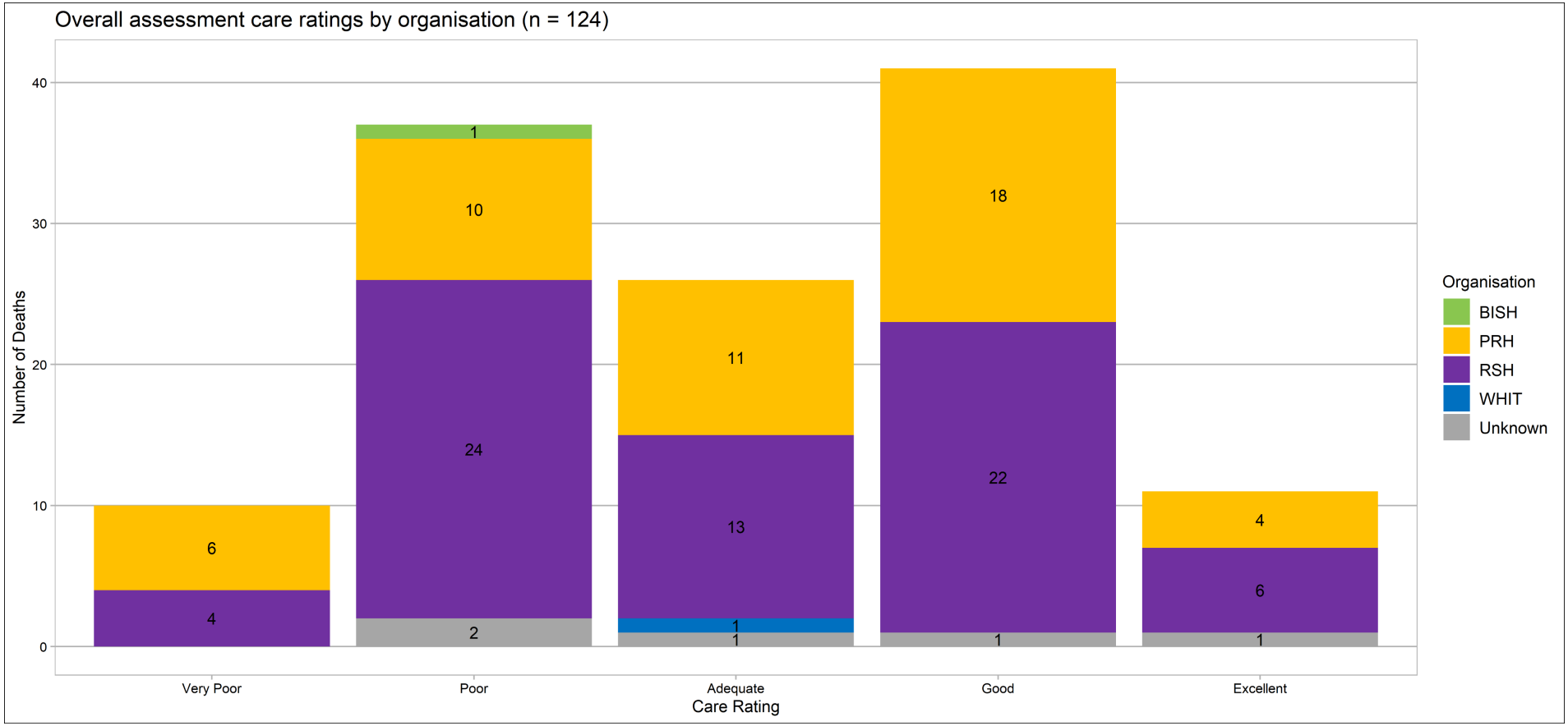
Commentary

- Of those patients where a rating was possible, i.e. 124 patients, 52 (42%) had a good or excellent care experience while 47 (38%) patients had a poor or very poor experience of care. 25 patients (20%) had an adequate rating.
- Examples of all of these ratings for each phase of care are discussed in detail in the sections that follow.

Points for confirmation

- These ratings were for the full patient care across all providers in the relevant period prior to death.

Overall assessment care ratings by admission site



Commentary

- 69 patients were admitted via Royal Shrewsbury Hospital, with 28 (41%) rated good or above and 28 (41%) poor or below.
- 49 patients were admitted via Princess Royal Hospital, with 22 (45%) rated good or above and 16 (33%) poor or below.

Points for confirmation

- Overall, 38% of cases came from PRH and 60% from RSH. Is this reflective of overall workload and patient demand?

Overall assessment care ratings by admission site

Care rating	Royal Shrewsbury Hospital (RSH) Number	Royal Shrewsbury Hospital (RSH) %	Princess Royal Hospital (PRH) Number	Princess Royal Hospital (PRH) %
Excellent	6	9%	4	8%
Good	22	32%	18	37%
Adequate	13	19%	11	22%
Poor	24	35%	10	20%
Very Poor	4	5%	6	12%
Total	69		49	

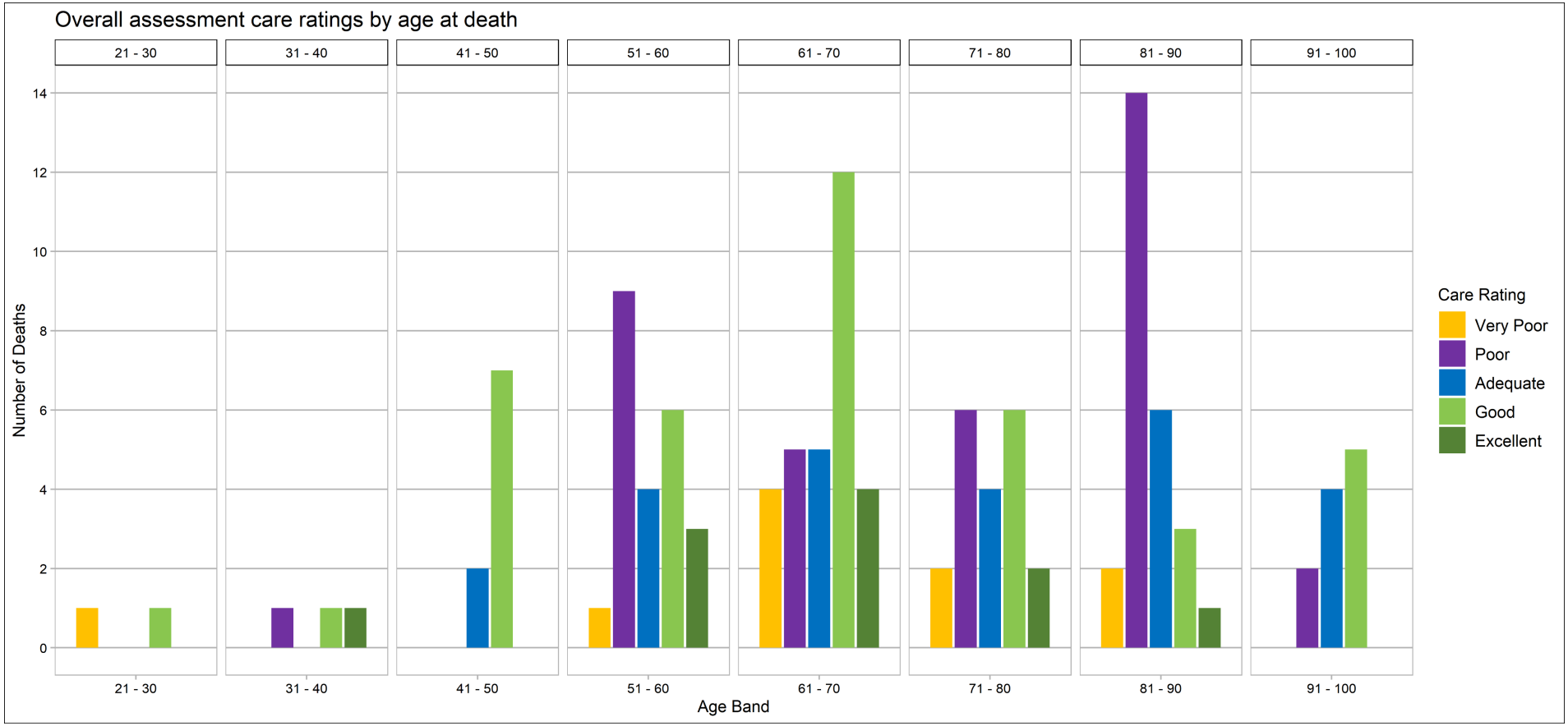
Commentary

- 69 patients were admitted via Royal Shrewsbury Hospital.
- 49 patients were admitted via Princess Royal Hospital.
- Care ratings are largely comparable between the sites, although these data suggest a slightly more positive profile for patients admitted through the Princess Royal Hospital.

Points for confirmation

- Rounding affects total percentages.

Overall care ratings by age at death



Commentary

- There appears to be a correlation between good care in the 61–70 patient age group and poor care in the 81–90 patient age group.

Points for confirmation

- The level of poor care ratings for the 81–90 patient age group needs further review.

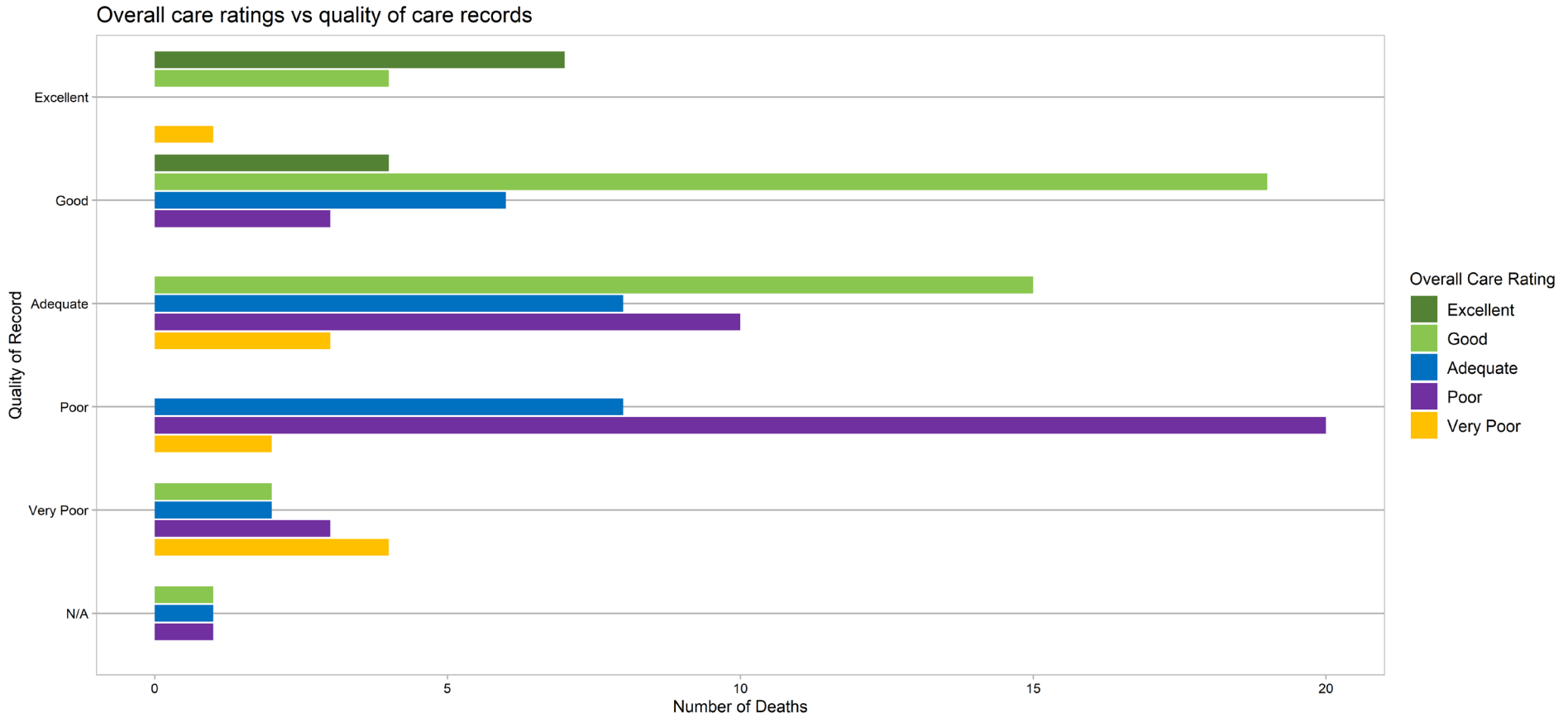
Overall care by age group – comparison under 70s/over 70s

	Number of deaths		Percentage of deaths in each care rating	
Rating	70 and under	Over 70s	70 and under	Over 70s
Excellent	8	3	11.9%	5.3%
Good	27	14	40.3%	24.6%
Adequate	11	14	16.4%	24.6%
Poor	15	22	22.4%	38.6%
Very Poor	6	4	9.0%	7.0%
Unanswered	22	18		
Not applicable	1	0		

Commentary

- The above table shows the number and % of care ratings for the 70 and under and over 70 age groups.
- 52% of patients aged 70 and under had their care rated good or excellent, compared to 30% of patients aged over 70.
- 31% of patients aged 70 and under had their care rated poor or very poor, compared to 46% of patients aged over 70.

Overall care ratings vs quality of care records



Commentary

- There was a direct correlation between ratings of good and excellent care and the quality of the records available. This might affect the overall results and judgements but clearly demonstrates that good or excellent care is supported by the availability of good or excellent records.

Points for confirmation

- Availability of records for all parts of the care system was an issue in this review.

Analysis: Individual phases of care

This part of the report presents the reviewers' findings on the 165 reviews completed. This includes their ratings for each phase of care. In the sections that follow we examine the key positive characteristics of each phase, drawing out the key issues that resulted in excellent and good ratings. We also identify the key negative characteristics and identify areas for improvement from the poor/very poor judgements of care. All phases of care include examples of anonymised individual case narratives to illustrate the quantitative findings.

Analysis: Preadmission Care Phase

Preadmission Care Phase

Number assessed and ratings for Preadmission Care Phase

The reviewers assessed preadmission care in 94 out of the 165 patients in the cohort. Where preadmission could not be assessed, it was due to an absence of relevant health records. These were notably emergency department records in the hard copy SaTH records, and inability to gain access to GP records for 40% (65 of the 165) of the patient cohort, from the 42 GP practices identified.

The reviewers learned that emergency department records of this episode of care are not printed and included in the SaTH hard copy patient medical record at any stage during the patient stay or at discharge. There were letters from the emergency department found on EMIS, however.

GP issues ranged from being given the incorrect level of access, or no permission at all (44 patients), and access to the GP records of 26 patients was given up to two weeks after the review end date. As a result, much of the preadmission information had to be collected from multiple other sources.

Most of the patient admissions into the acute hospital were through the emergency department or directly to assessment units in SaTH. Ratings for this phase were rated as:

- adequate for 27 patients (29%);
- good for 34 patients (36%); and
- excellent for 11 patients (12%).

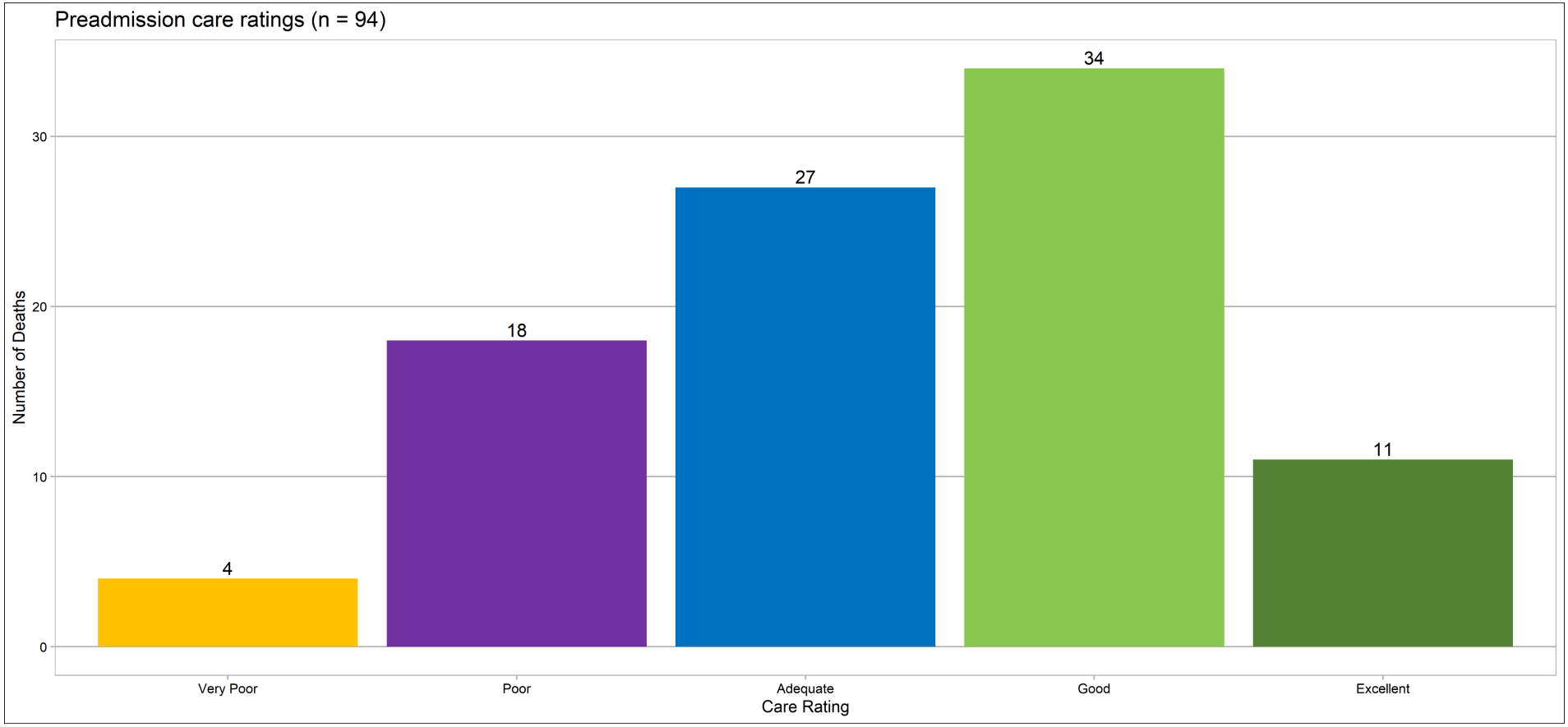
At the other end of the scale:

- 22 (23%) patients were assessed as having received poor (19%) or very poor (4%) preadmission care.
- One in four patients were rated as having poor or very poor preadmission care.

Overall observations

- There was a lack of coordination of care, even where patients were clearly known to the system.
- There was a lack of ongoing planning for patients with known chronic diseases, especially for oncology patients where there was ineffective access to care noted.
- There is a limited use of admission avoidance processes and these are not streamlined across the county.
- The structure for specialist nurses was not clear and the use of the specialist nurse appeared to be haphazard.

Preadmission Care Phase ratings



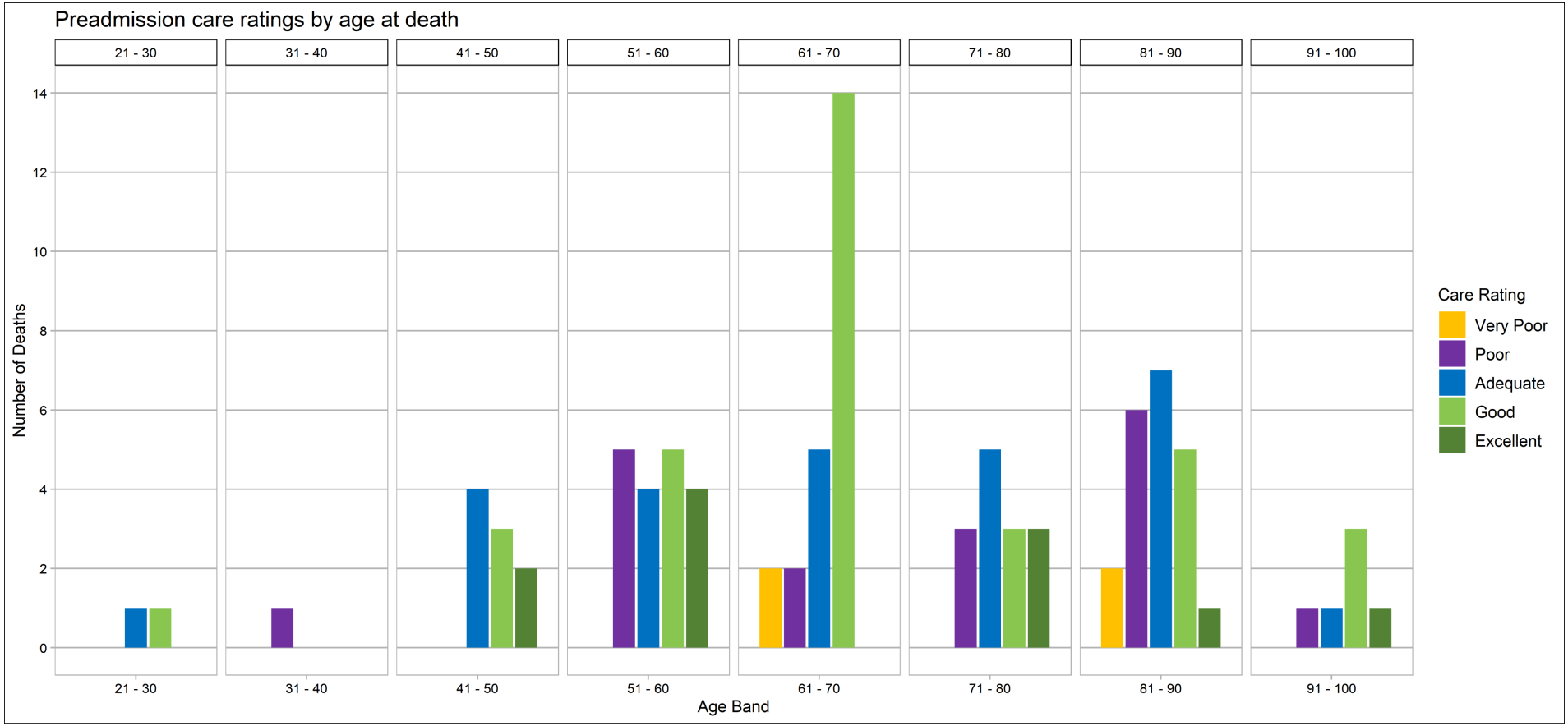
Commentary

- Preadmission care was rated good or excellent in 48% of cases.
- However, 22 (23%) of cases were judged to be poor or very poor.

Points for confirmation

- This rating includes primary care and care from West Midlands Ambulance Service (WMAS) where records were available in the SaTH records.

Preadmission Care Phase ratings by age



Commentary

- Marked differences between ratings of care and age are only distinguishable for the 61–70 patient age group where good ratings were predominant.

Preadmission – excellent or good care characteristics

The rating of care as excellent or good for this phase of care was apparent in half of the cases assessed (49% – 46 patients out of 94). These ratings reflected:

- the quality of coordination of patient care between care providers in the system;
- the quality of the patient medical record and communication between care providers;
- the appropriate use and sharing of ReSPECT or Do Not Attempt Resuscitation (DNAR) orders; and
- the effective intervention of Shropdoc in 4 of the 11 excellent care ratings, with facilitation of a direct ward or assessment unit admission.

Case 1

Appeared to have care organised between chemotherapy unit at the hospital and the hospice and community nursing teams. Admission avoidance used, rapid response and rapid syringe driver request.

Case 2

There are excellent letters communicating between medical staff and the patient.

Case 3

Appears to have had significant SCHCT input from [January 2020] including diabetes checks, pressure relieving mattress and specialist input from podiatry and SALT. Bloods taken at home requested by GP. Total care is equal to full care package and attempt at admission avoidance (referral form in RiO from emergency department at PRH for admission avoidance).

Case 4

From RiO: DNAR for patient notes as per EMIS [April 2020]. Known to respiratory service, full care package including Fast Track home. Full equipment supplied to home for mobility.

Case 5

Shropdoc assessed and arranged for a transfer to RSH within two hours. There was good documentation of the patient history, examination, management plan and communication with the patient and his wife. The doctor spoke to surgical assessment unit (SAU) coordinator to arrange admission to SAU and organised ambulance transfer. The patient and his wife were given a contingency of calling 999 should symptoms worsen before the ambulance arrived.

Case 6

The patient was under the care of MPFT for Parkinson's disease. There was evidence of good ongoing care and anticipatory care for any decline including EoL care.

Case 7

Multiple emergency admissions to emergency department from home with breathing difficulties. Pulmonary fibrosis on home oxygen. Under care of SCHCT and in-reach respiratory referral [February 2020] and palliative care team in Sheffield. Rescue pack initiated. Wish was to die in hospital not at home.

Preadmission – adequate care characteristics

Themes for an adequate care rating for this care phase include:

- a lack of coordinated care;
- poor communication within and between providers in the system;
- lack of direct access to specialty care; and
- care for patients who have interacted with mental health services.

Case 1

Patient had been seen in Telford emergency department the day before – notes not available. Apparently had bloods and discharged home. Results either not checked or not actioned as potassium was low.

Case 2

Only record in mental health records is patient is not open to access – no other clinical records available. Checked RiO and GP records no MH entries. Rapid response visits at various times to try and prevent admission and visit on day of visit but ambulance crew on site. This would have been good but there was no ReSPECT form and discussion with the patient about EoL/palliative care despite multiple admission.

Case 3

Known [patient living with Schizophrenia] – under care of MH team for medication administration and checks – increasing memory problems over past year and admission in and out of hospital and NH for falls. No evidence of falls prevention/[occupational health] or any other scheme to support patient and care package. Multiple admission for falls at home – family unhappy with the care package in place and requested further input due to increasing needs and need for home equipment. No evidence this was actioned from Jan/Feb prior to admission, but unlikely to have prevented the terminal admission.

Case 4

Regular follow-up for metastatic breast cancer. No referral to lymphoedema team despite gross problem for patient.

Case 5

The patient had good care while an inpatient, with clear management plans in place, however, there was no clear plan of support indicated for patient on discharge. This patient had already had an episode of apyrexia following the last round of chemotherapy and had been admitted. It was unclear what the patient should expect or do should this occur again. There was no indication that signs and symptoms of neutropenic sepsis was discussed or if additional support was arranged on discharge.

Case 6

Discharged home with equipment and care by Macmillan. Indication that community palliative care team involved before this admission. Under haematology for CMML. Not clearly a cancer direct pathway admission.

Preadmission – poor or very poor care characteristics

Themes for poor and very poor ratings for this care phase varied and included:

- the lack of palliative or end of life (EoL) care planning, especially with oncology patients;
- multiple hospital admissions;
- a lack of coordinated care planning between acute, primary and community care;
- issues with management of their disease for a patient living with diabetes in the community; and
- a lack of long-term care planning for patients with known chronic diseases.

Case 1

This was rated poor as information given to patient on discharge from hospital insufficient about diagnosis and prognosis. No palliative care support arranged until son not coping and patient becoming distressed and needing further medication.

Case 2

Four times daily package of care put in place after May admission. 9 previous admissions to emergency department in 12 months. Palliative radiotherapy 1 month before admission. Previous admission, 7 and 14 days previously. No EoL or palliative plan made. Patient struggling at home with ADL plus eating and drinking. Poor end of life care and support.

Case 3

The patient was discharged from hospital and was not seen by the Telford Respiratory Team despite referral. There was a focus on the patient's urinary problem and although [shortness of breath] was noted on two occasions no re-referral to the respiratory team was noted.

Only one patient was considered to have had an avoidable admission (DKA arrest at home – see below):

Case 4

Emergency department notes: Patient admitted as cardiac arrest due to DKA (high lactate but blood results not seen, un-recordable blood sugar). CPR continued in Resus area.

Died in emergency department. Hx: Acute deterioration at home for five hours before came in. Reviewed by paramedics but not brought in. Possible ReSPeCT knowledge but DKA [query] reversible. Unable to see paramedic notes. On EoL pathway from 3.30 am.

The above case was escalated on site to SCHCT.

Preadmission Care Phase – notable themes

Use of admission avoidance

To the question 'Were any admission avoidance schemes used or considered?', in a very small number, 13 (8%) cases, they were used, and in only 3 (2%) cases they were either considered or considered and not used. In 70 (42%) cases they were not clinically indicated, but it was found that in 12 (8%) cases a scheme was not considered where there was an opportunity to do so. In 65 (39%) cases there were insufficient data to answer the question.

In the case of one patient whose preadmission care was rated poor or very poor, an admission avoidance scheme was used. For eight of these patients, they were not felt to be clinically indicated, and for seven patients they were either considered and not used or not considered. For the excellent rated care patients, four of the 11 had a documented use of an admission avoidance pathway which included total care packages, escalation before calling an emergency ambulance and just-in-case medicines (JIC). Four were unavoidable and the remaining patients' admissions were not rated.

The name or type of admission avoidance scheme available was not explicit in the medical record or obvious to the reviewer. Reviewers commented where better community support might have prevented an admission. Two case examples are shown below:

Case 1

Patient admitted from nursing home via ambulance/Shropdoc with sepsis, but no referral letter sent so limited information available to A&E for an elderly patient with advanced dementia. Unclear if any admission avoidance scheme was considered. Relatives unhappy patient transferred to hospital.

Case 2

Several emergency admissions for neutropenic sepsis/infected chest drain/UTI x 3 since January 2020. There is a concern re frequent admission and if admission avoidance was effective? SCHCT patient, known to them since [September 2019].

Ambulance provision

The reviewers noted several points in relation to ambulance provision: ambulance conveyance was timely and appropriate treatment and documentation by the crews was of good quality; delays in emergency department were infrequent, possibly representative of the timeframe of the patient cohort reviewed coinciding with the initial national Covid-19 pandemic response.

Case 3

Timely transfer to hospital *Suspected stroke – Ambulance 999 to hospital – handover noted – Aspirin given. Transferred to hospital within an hour. Treatment on ambulance – appears excellent and IPC involved for possible Covid-19 infection.*

Case 4

Effective handover from ambulance crews *Patient was conveyed to emergency department with an emergency passport and transfer documentation giving information on patient's normal baseline, history, and patient preferences. ReSPECT form with patient. 111 call and ambulance attended for direct admission to ward 23 (Oncology) RSH.*

Case 5

Effective decision making by ambulance crew *Elderly gentleman refusing any care package, brought in by ambulance as thought to be unsafe at home and at risk of deterioration. Overdose at home. Patient called ambulance – ambulance attended with police who broke down door – patient in cardiac arrest – chest compressions commenced and transferred to emergency department (pre-alert issued).*

Case 6

Delay in emergency department *80-year-old with renal cancer, liver and lungs metastases arrived in emergency department by ambulance with generalised weakness – no handover at 19:48. Clinical review at 21:25.*

Preadmission Care Phase – notable themes (*cont*.)

Shropdoc

There was evidence of appropriate and effective involvement by Shropdoc on numerous occasions.

Case 1

Shropdoc note on EMIS [April 2020] at 9.33 called to see patient and called 999 ambulance to RSH emergency department.

Case 2

Shropdoc arranged ambulance transfer to SAU within 2 hours. Patient was admitted 07:04 and clerked on SAU at 07:40.

Case 3

Shropdoc assessed and arranged for a transfer to RSH within 2 hours as agreed with patient and his wife. There was good documentation of the patient history, examination, management plan and communication with the patient and his wife. The doctor spoke to SAU coordinator to arrange admission to SAU and organised ambulance transfer. The patient and his wife were given a contingency of calling 999 should symptoms worsen before the ambulance arrived.

Dehydration/Fluid management

Fluid balance was reviewed in six patients for this phase of care. Four of the six were considered not to have had appropriate fluid management.

Case 1

Admitted three weeks previous with same issue – fluid overload. No advanced care plan in place and no evidence of anticipatory meds. Known to heart failure team.

Case 2

Patient in end stage of [a degenerative genetic disease] – stated as for palliative care only. This admission was for decreasing oral intake – why was there no plan in place for managing this anticipated deterioration in the community if the patient was not for I/V fluids or PEG feeding?

Case 3 (also see sepsis below)

The patient was medically reviewed within two hours of arrival and not started on IV fluids and Abx until 22:25 – no sepsis screen was completed and the working diagnosis was ?sepsis.

Case 4

Had the patient's sepsis screen been completed and IV fluids and antibiotics commenced sooner then this would have been assessed as good care.

Sepsis

The assessment and treatment of sepsis was recorded for 16 patients under this phase. 14 were recorded as admitted for possible treatment of sepsis. There was no relationship found between timely assessment and treatment and whether sepsis screening and management was rated good or not. Reviewers comments include the following:

Case 1

The patient was medically reviewed within two hours of arrival in emergency department and not started on IV fluids and antibiotics until 22:25 – no sepsis screen was completed and the working diagnosis was ?sepsis. Should have been given an immediate sepsis screen and fluids and antibiotics should have been given sooner.

Case 2

There was no indication that signs and symptoms of neutropenic sepsis was discussed or if additional support was arranged on discharge.

Case 3

62-year-old lady with Cancer of the breast and bone metastases. Sepsis screen was partially completed but not started on the sepsis pathway.

Preadmission Care Phase – notable themes (*cont*.)

Care of patients living with diabetes

16 patients were identified in this care phase as living with diabetes. For those known to SCHCT, there was a complete lack of documented monitoring of blood glucose in all the RiO medical records. While this may have been documented on another electronic or paper record, they were not available to the reviewers for any patient reviewed. One patient was admitted and died from a diabetic ketoacidosis (DKA) arrest, despite having almost daily SCHCT input at their home. Case examples are listed below:

Case 1

End stage renal failure – on dialysis. Had admission in December/ January for confusion and diabetic management. There is a letter to the patient informing him that he has been removed from the renal transplant list – had been suspended before this.

Case 2

Patient or Care Home called 111 – struggling with diabetic management as had no sliding scale written to self-manage and had called hospital who could not help – was given emergency advice and told for GP to follow up.

From RiO – care home had a discharge summary that stated to give between two and 16 units of Novorapid insulin – but no instructions of how to decide amount – as above, they tried both the hospital and NHS 111 for help – patient was then re-admitted to hospital the next day. Patient in emergency department by ambulance next day – notes not found.

Case 3

Appears to have had significant SCHCT input [January 2020] including diabetes checks, pressure relieving mattress and specialist input from podiatry and SALT. Bloods taken at home requested by GP. Total care is equal to full care package and attempt at admission avoidance (referral form in RiO from emergency department at PRH for admission avoidance).

Lived alone and required District Nurse to administer insulin – last found Specialist Nurse review is [January 2020] in foot clinic and states needs three to four readings a day to improve control – no indication if this was practicable.

Care of patients living with cancer

26 patients had a known cancer diagnosis. Only three patients had a documented direct admission plan to an oncology ward. There did not seem to be any reason why direct admission was not an option for more oncology patients. For two patients, the reviewers questioned this in their comments.

Case 1

Patient had metastatic breast cancer and recently diagnosed liver and brain metastases. Seen by Oncology team – new moderate ascites and pleural effusions recorded and management planned if no response then for ascitic drain – patient given Oncology helpline number for advice/ worsening symptoms. The patient should have been given direct access to the Oncology ward in the event of deterioration/concern.

Case 2

Discharged home with equipment and care by Macmillan. Indication that community palliative care team involved before this admission? Under haematology for CMML. Not clearly a cancer direct pathway admission.

Preadmission Care Phase – notable themes (*cont*.)

Care of patients living with respiratory disease

Four patients were on home oxygen for advance respiratory disease. Only one patient did not have any SCHCT health records available to the reviewers. The care rated by the reviewers in three cases was poor and suggests work is required to improve referral pathway and admission avoidance for this patient group.

Case 1

Patient Hx: diabetic, pulmonary fibrosis, long term oxygen, hypertensive. Ambulance care appropriate for presenting findings of hypotension and hypoglycaemia after a reported fall at home, due to reduced oral intake and infective exacerbation of pulmonary fibrosis.

Case 2

This patient was known COPD, CCF, AF, Hypertension. Had an admission for infective exacerbation of COPD and was discharged. There was a record that the patient was seen by the respiratory clinical nurse specialist and referred to the Telford Respiratory Team post discharge. Patient was on long-term oxygen therapy. RiO notes record that patient was booked for a visit by the Telford Respiratory team, however they were told his breathing was ok and therefore discharged him. The patient had multiple visits by the Telford Community Nursing team throughout February 2020 – for urine/catheter support. Patient was noted as SOB on the [date] and sleeping in chair due to SOB [date] – focus on wait for TURP for urine problems.

The patient was discharged from hospital and was not seen by the Telford Respiratory team despite referral. There was a focus on the patient's urinary problem and although SOB was noted on two occasions no re-referral to the respiratory team was noted.

Case 3

Known Cancer spine and chemo. Under ICT for home oxygen and Respiratory Nurse support. Home visit [Feb 2020] from OT and discharged from caseload. Under D/n team for pressure area care. Admitted and died two days later. No indication on RiO as to why admitted and no other notes available to review so unable to comment on care.

Case 4

Multiple emergency admissions to emergency department from home with breathing difficulties. Pulmonary fibrosis on home oxygen. Under care of SCHCT and in-reach respiratory referral and palliative care team in Sheffield. Rescue pack initiated. Wish was to die in hospital not at home. ShropDoc called ambulance – no letter – SOB and pyrexial.

Pressure area care

Pressure area care was specifically recorded by the reviewers in five patient cases and was noted as being comprehensive and well delivered in the community by SCHCT. Three cases are presented below.

Case 1

Appears to have had significant SCHCT input including diabetes checks, pressure relieving mattress and specialist input from podiatry and SALT. Bloods taken at home requested by GP. Total care is equal to full care package and attempt at admission avoidance (referral form in RiO from emergency department at PRH for admission avoidance). Urinary catheter in place in community for urinary incontinence secondary to diabetes insipidus, immobile, with poor skin integrity.

Case 2

Known cancer spine and chemo. Under ICT for home oxygen and respiratory nurse support. Home visit from OT and discharged from caseload. Under D/n team for pressure area care. Admitted [March 2020] and died two days later. No indication on RiO as to why admitted and no other notes available to review so unable to comment on care.

Case 3

PMHx: malignant mesothelioma, on home oxygen. From RiO: SCHCT patient, known to them since [September 2019]. Clear plan with family to get back home in RiO. Frequent visits including pressure ulcer review, mattress acquired, physiotherapy.

Analysis: Initial Management and Admission Care Phase

Initial Management and Admission Care Phase

The care of 122 patients (out of 165) was able to be assessed for this care phase. Most patients (84 out of 122 – 69%) had this care episode rated as having received excellent or good care, in emergency departments, medical or surgical assessment units (MAU and SAU). The absence of emergency department medical records in any SaTH hard copy patient records was a significant contributory factor in the ability to review care in this phase. The emergency department does not appear to provide hard copy patient records when transferring patients to wards, and the medical records department, although able to do so, does not print emergency department notes to complete the patient hard record before storage or archiving. In EMIS, the GP medical records system, there were multiple examples of the emergency department writing to the GP, however.

Overall observations

- There was some good initial management in the emergency department, with the exception of sepsis screening and sepsis bundle initiation which could be improved.
- There were some excellent and outstanding management plans demonstrated in the acute medical unit and surgical assessment unit but these were not always followed through when admitted to ward care.
- There was evidence of some good documentation recording ceilings of care.
- Records also demonstrated good access and use of investigations and diagnostics to inform decision making.

Notable themes

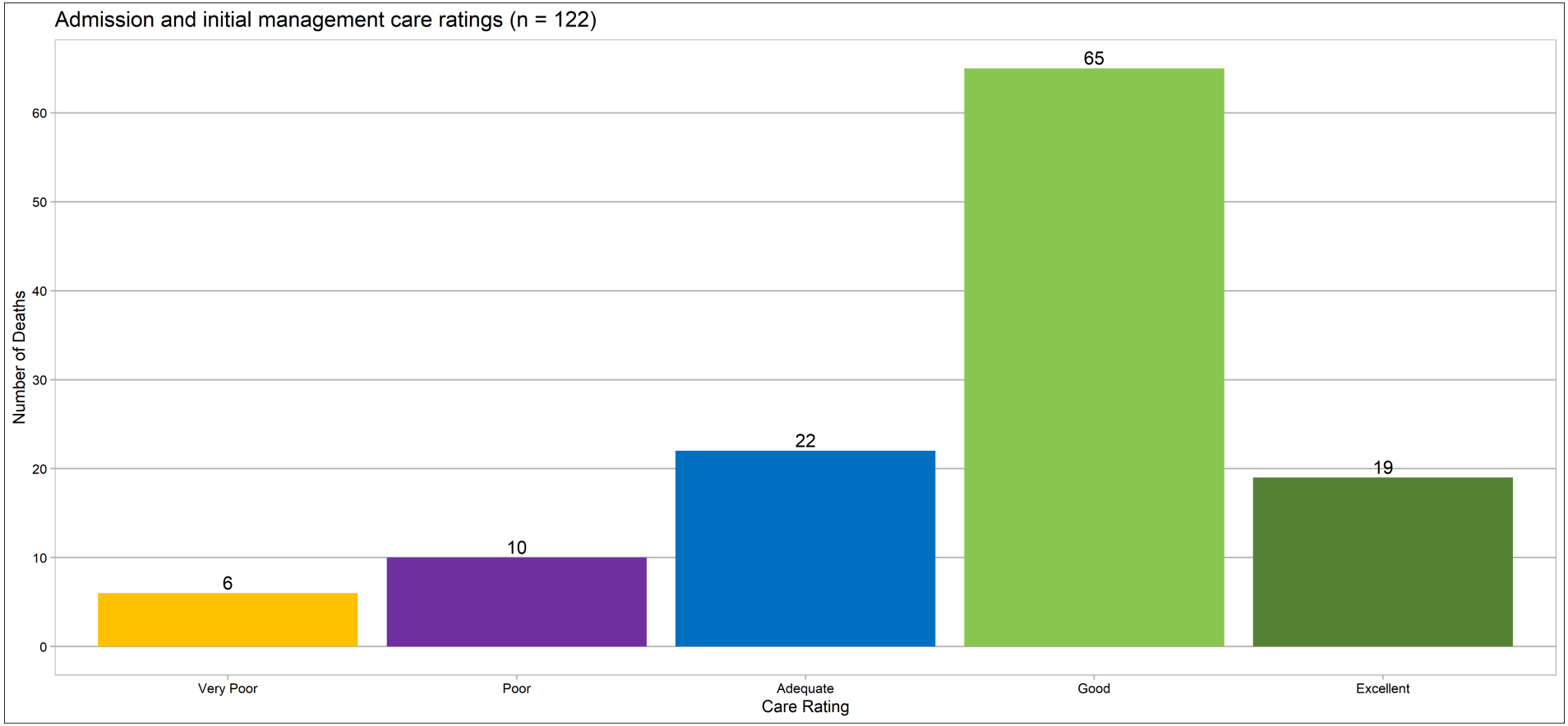
The outstanding characteristics of care in this phase included:

- rapid initial assessment;
- early inclusion of the multidisciplinary team (MDT);
- excellence in the stroke care pathway (5 patients);
- when early sepsis screening occurred (37 out of 84); and
- sensitive inclusion of the family when an end of life prognosis was considered.

There was a clear record of the appropriate management of infection prevention and control with regards to Covid-19 in the majority of the patients' notes in this phase, which is commendable.

The ratings for this phase of care are shown on the pages that follow.

Initial Management and Admission Care Phase ratings



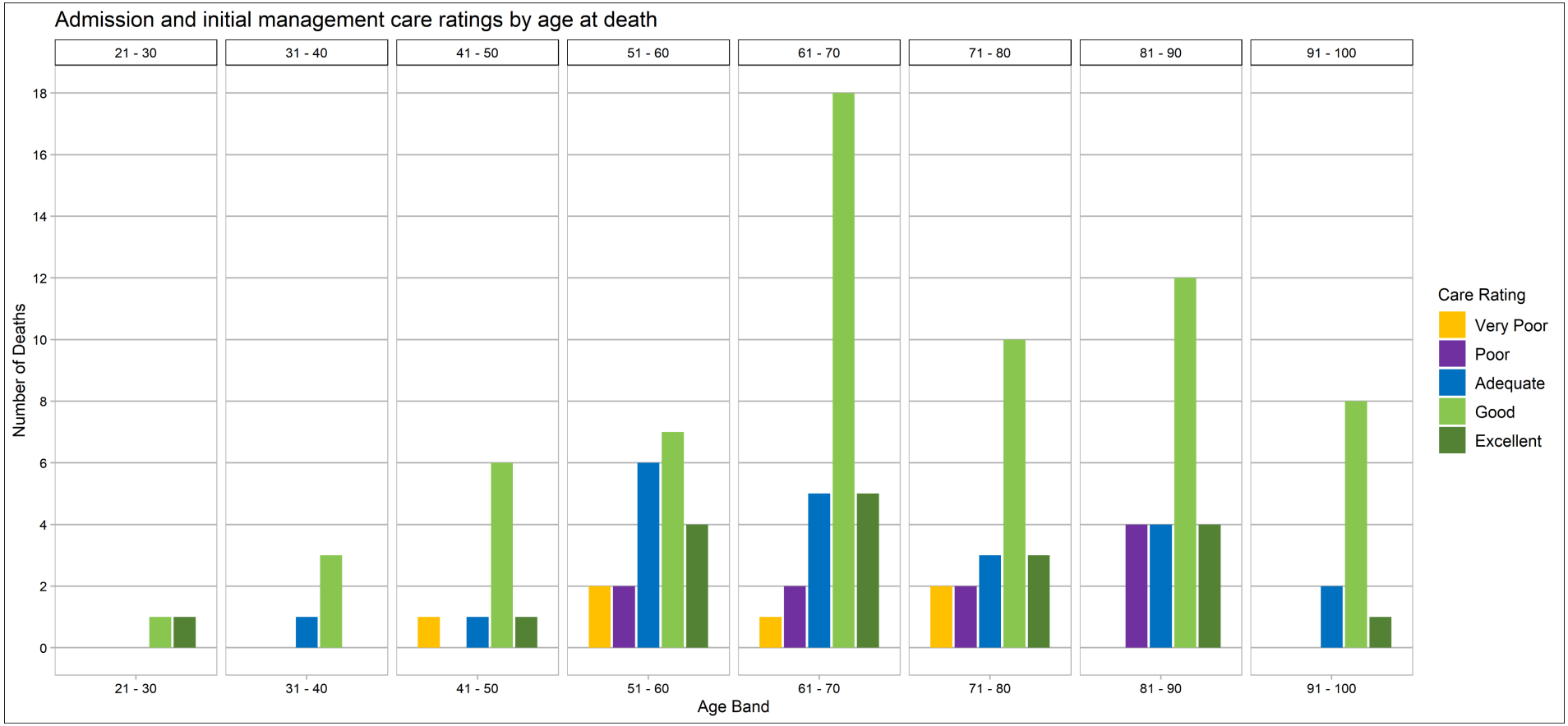
Commentary

- A significant number of patients were rated as having received good (53%) or excellent (16%) care in this phase.

Points for confirmation

- This episode reflects care largely in the emergency department and on direct admission to wards, acute medical unit or surgical assessment unit.

Initial Management and Admission Care Phase ratings by age



Commentary

- Again, a good care rating is predominately seen in the 61–70 age group, as was seen in the Preadmission Care Phase; although this is the predominant rating in all age groups.

Initial Management – excellent care characteristics

The excellent ratings for the Initial Management and Admission Care Phase were predominantly prompt treatment and inclusion of the MDT.

Examples of cases where care was rated as excellent are listed below:

Case 1

Pre-alert to emergency department – full team ready for arrival – emergency department Reg, ICU, Medics, CSM and Hospital at Night. Full chronology of care documented of each intervention and decision from 04:34 to 05:30. Patient readied for ICU transfer. All interventions were fully recorded, and patient had maximum input from full cardiac resus team.

Case 2

Seen swiftly in emergency department and MDT involvement throughout. Patient's wishes discussed and appropriate NoK involvement. ReSPECT form in place.

Case 3

Reviewed on ward within 20 minutes of arrival. Full septic screen unremarkable and Covid-19 negative. Patient known to ward, and direct referral reduced bed moves and unnecessary clerking.

Case 4

Emergency department care timely and well documented. CT scan done urgently. Appropriate advice sought initially from Neurosurgery and then referred to Stroke Team. Clear documentation of conversations with family regarding poor prognosis and decision not for ICU or CPR. ReSPECT form done and EoL pathway started.

Case 5

Excellent clerking in emergency department including sepsis screen. Assessed and streamed in emergency department for Covid-19.

Case 6

… treated as possible Covid-19 appropriately and ongoing – Covid positive. Treated in emergency department swiftly, with decision to admit by medics within two hours. Critical care outreach review early in stay, ICU review and started on CPAP. Excellent MDT involvement with medics, ICU, H&N.

Initial Management – adequate care characteristics

The rating of adequate in Initial Management and Admission largely equated to the lack of a complete health care record or poorly completed records. Examples of cases are listed below:

Case 1

The nursing assessment booklet is mostly blank with only some of the first page filled in. Important areas of the core care plan are not done including those directly related to presenting complaint – nutrition, death and dying, elimination, etc.

Case 2

Patient should have had direct access to Oncology instead of having to wait at home, be reviewed and wait in AMU and then transferred.

Case 3

Sepsis screen is not filled in. Initial plan appropriate and appropriate referral made to medical team. Post-take ward round notes have no time stamp – plan was reasonable.

Case 4

Patient nursing notes only available for view. Admitted with SOB (asthma chronic respiratory disease) and multiple ongoing pathologies including renal disease, asthma, and hypertension. The standard of care cannot be fully ascertained but the nursing notes suggest this was adequate.

Case 5

There is no documented consideration of/investigations for PE – this patient had stopped warfarin herself 2 weeks earlier and has a new prolonged episode of fast AF.

Case 6

No emergency department notes, AMU nursing assessment completed sufficiently, Respect form completed on arrival, care planning NOT completed. Multiple moves in emergency department, AMU, ward, orthopaedic ward – four moves.

Initial Management – poor or very poor characteristics

Conversely, for patients where the Initial Management and Admission care was rated poor or very poor, the reviewers found issues which include:

- long waiting time for care in the emergency department;
- long waits to be transferred onto a ward from emergency department and assessment unit;
- late sepsis screening and subsequent response to the findings; and
- management of fluid balance.

Case 1

Sepsis screening is incorrect from arrival observations – this should have been high and triggered sepsis pathway. Failure to do this delayed antibiotics until 5 hours from arrival.

Record is unclear when first medical assessment occurred as this is not timed – EWS was 7 on review – it is not clear how regular review was. Once chest sepsis identified, plan was reasonable.

Case 2

Decision for ward-based care. No escalation – nursed in corridor in emergency department. For catheter insertion – aborted attempt but not followed up. Remained un-catheterised (16hrs later) and bladder scan result not documented despite possible retention of urine.

Case 3

No observations for 3 hours despite being on Sepsis pathway.

Case 4

The patient waited 2 hours 35 mins to be triaged then another 2 hours 30 mins to be clerked. Urethral catheter inserted for acute retention. Antibiotics for suspected LRTI.

Nursed in emergency department due to bed capacity in the hospital – on trolley in surgery corridor for over 24 hours. SB medical team 10 hours after arrival into emergency department; possible sepsis due to UTI/LRTI.

Case 5

Diabetic patient. The emergency medical assessment proforma is mostly blank.

There is a consultant ward round filled in – time not stated, with a brief history but there is no detailed review. There is no blood glucose filled in for the admission bloods despite a capillary reading of 29.6. History of difficult to control and complaint of increased urinary frequency. There is a diagnosis of UTI and antibiotics given but no review of diabetic control.

Case 6

Patient had been referred the day before from the Oncology helpline and told to attend AMU on [March 2020]. Patient not reviewed and transferred in a timely manner to appropriate ward for management. Following previous discharge there should have been a plan for patient to access into Oncology as required via the helpline and for direct admission given that the patient had only been discharged on [February 2020].

Initial Management and Assessment – notable themes

The themes are outlined in more detail below:

Fluid balance monitoring

There were ten patients where care was rated for fluid balance monitoring as poor due to fluid overload (five patients), dehydration (one patient), and poor recording of fluid management (four patients). No pattern was found between the findings and ward or specialty.

Surgical care

Eight patients had a recorded admitting and discharge specialty of general surgery. There were no recorded elective surgical deaths. Three patients' notes were not available to the review team. Generally, the care for the five patients reviewed was good, with one rated as a failed discharge into community care from SaTH. Two patients where care was not rated as good for all phases were cared for on non-surgical wards. Examples of reviewers comments are below.

Patients admitted and discharged by general surgery specialty

Case 1

The patient was rapidly admitted with severe sepsis arising from rapidly advancing necrotising fasciitis of the leg and abdomen. Raised blood glucose suggested undiagnosed T2DM. Immediate resuscitation and taken to theatre for debridement. Appropriate use of immunoglobulin, antibiotics, and circulatory support. Intubated and transferred to ICU from theatre. Excellent or good care throughout stay. (Rated excellent or good for all phases of care.)

Case 2

There were no SaTH records for this patient so information was gleaned from EMIS and RiO. It appears the patient had very good EoL care with a hospice placement at time of death. It is unclear how well the episode of care in the acute Trust for the patient's cancer surgery was or when they were discharged. Despite this, it appears discharge planning was effective and person centric. (Varied rating of phases of care due to lack of medical records.)

Case 3

There was good documentation in the SAU. The consent forms, clear procedure and decision making for OGD and stent and well-documented rationale for not undertaking. The patient on transfer to the ward for EoL care was all contemporaneously recorded on the EoL Care Plan and all assessment and interventions were recorded. (Overall rated good in all phases of care.)

Case 4

Patient immediately required support from Shropdoc on returning home. Shropdoc arranged for the patient to go into hospice care, arranged syringe driver and for the patient to be admitted to the hospice on the [June 2020] – where the patient died. All of this felt very reactive and should have been planned as part of the discharge plan from the hospital. (Good care in the admission phase of care on SAU but poor-rated discharge phase of care.)

Case 5

The treatment was appropriate and the family were kept fully informed of ongoing plan. The patient was already very unwell on admission to ICU and it was documented from admission on SAU that this patient was likely to deteriorate despite high dose filtration being started. (Good rating for all phases of care.)

Initial Management and Admission – notable themes (*cont.*)

Ward moves while an inpatient in SaTH

Ward moves were not found to be either unnecessary or excessive in most cases. There were three examples of a poor patient experience of ward moves, which are listed below:

Case 1

There were three ward transfers and an initial move from emergency department to AMU – these were often in the late evening and not in line with best practice. In addition, the patient was noted as requiring frailty input, seen by the Geriatrician who asked for a move to ward 27 – this did not occur.

Case 2

This patient waited for an Oncology bed and Nurse stated that the patient was unsuitable for ward 31 but patient remained there for two days.

Case 3

Patient was being treated for hospital-acquired pneumonia when died which may have been linked to fracturing hip while in hospital and four ward moves.

Safeguarding

The reviewers noted safeguarding discussions found in the medical records, or questioned when it appeared a safeguarding concern should have been raised, in nine patients. There is significant variation in the documentation and practice of safeguarding which may be worthy of further review.

Examples of cases are listed in the next column.

Case 1

There is a safeguarding concern as the patient wished to go home whereas the family were keen on a nursing home discharge plan. The patient records end with a note on RiO of community therapies discharging patient on the request of the NoK, despite patient having assumed capacity.

Case 2

Emergency department letter to GP – attended [June 2020] at 20.23 with self-harm and arrived in cardiac arrest. States safeguarding concern. Transferred to ICU. ReSPECT form for hypoxic brain injury [three days later] at 16.00 by ICU Consultant. Died [the next day] on day 4 of ICU stay and day 4 of emergency department attendance in cardiac arrest. No other notes exist for this patient to review. It is recommended that the safeguarding alert was raised and followed through.

Case 3

A patient who suffered from depression appeared to have been allowed to self-discharge. There are no notes to suggest this was done safely with due regard to safeguarding a vulnerable adult five days before the patient died.

Case 4

Referred to palliative care community team but no on-ongoing documented plans. Palliative not made aware of patient after discharge so no input before patient dies at home. Significant safeguarding concerns that were not identified during inpatient stay.

Case 5

There were safeguarding concerns logged on RiO – this did not appear to be communicated to the patient's hospital records. This was important as there was consideration of sending the patient home for EoL care and the community staff experience was relevant.

Case 6

Poor preadmission care – safeguarding concern raised.

Analysis: Ongoing Care Phase

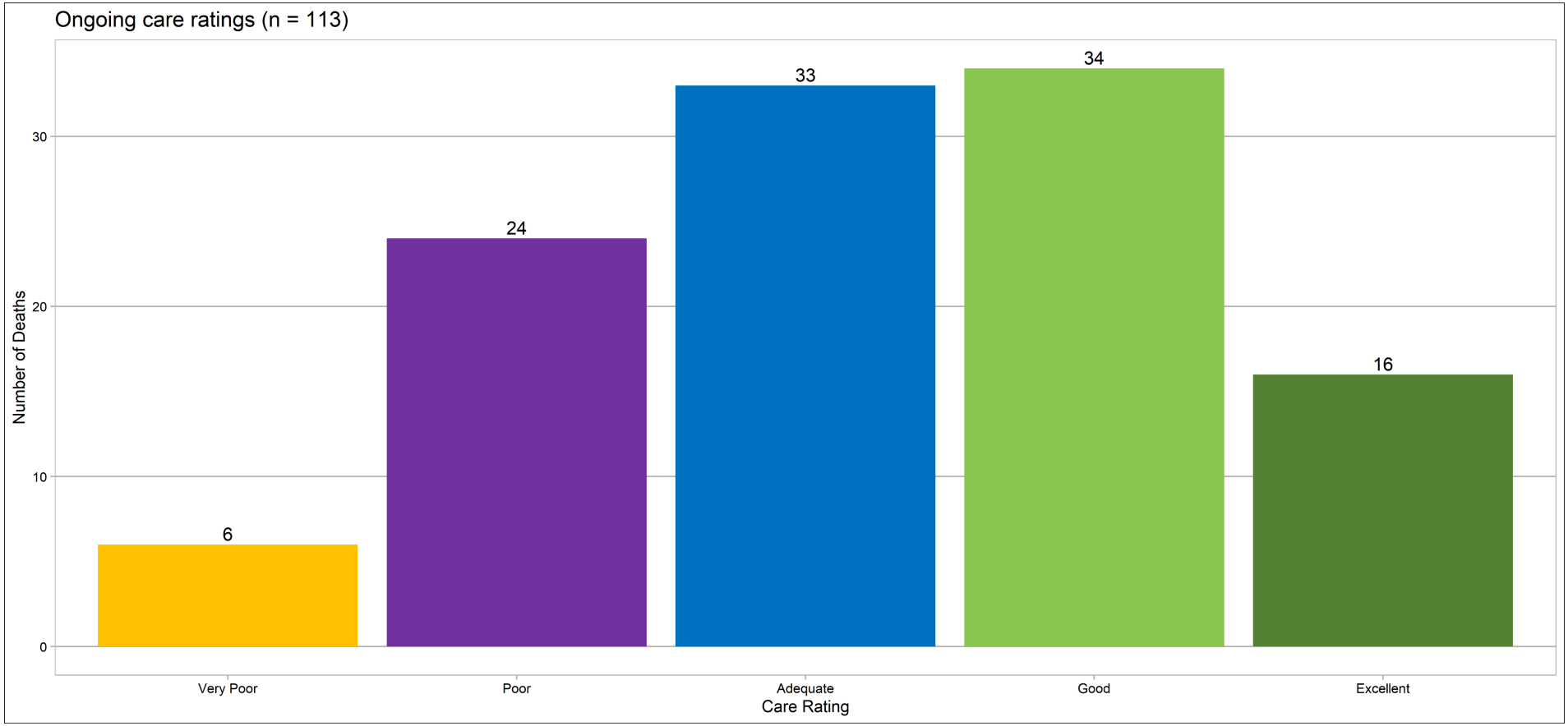
Ongoing Care Phase

Overall observations

- There was some excellent care delivered on ICU with clear management plans, documentation and discussions with the family evidenced.
- There were some good examples of clear ceilings of care for Covid-19 patients' management.
- There was timely end of life care implementation in those cases rated as good or excellent.
- There was a lack of ongoing care planning and clear forward management plans for patients on the general wards including Oncology.
- There was a lack of weekend cover, with no plans for the weekend demonstrated in some specialities which indicates there may be a lack of a standard approach in the Trust.
- Nursing documentation was routinely poor quality, with missing assessments, incomplete documentation and nursing entries that were substandard.
- There was a failure to demonstrate adherence to the medical plan, noted especially where this related to fluid balance. This extended to consistently poor fluid balance management, with evidence of fluid overload and dehydration.
- Moves for patients with dementia late at night occurred which did not take account of the patients condition.
- There was unclear use of a range of specialist nurses and how their expertise was utilised to optimise patient care, particularly the lack of involvement of the end of life facilitator, including in cases when an end of life care plan was in place.
- There was a lack of capacity assessment and best interest assessment documentation.
- There was poor assessment and documentation of pain management, including for oncology patients, and lack of anticipatory pain management plans,
- There was poor access to investigations and diagnostics outside the emergency department or acute medical unit.

The ratings for this phase of care are illustrated below.

Ongoing Care Phase ratings



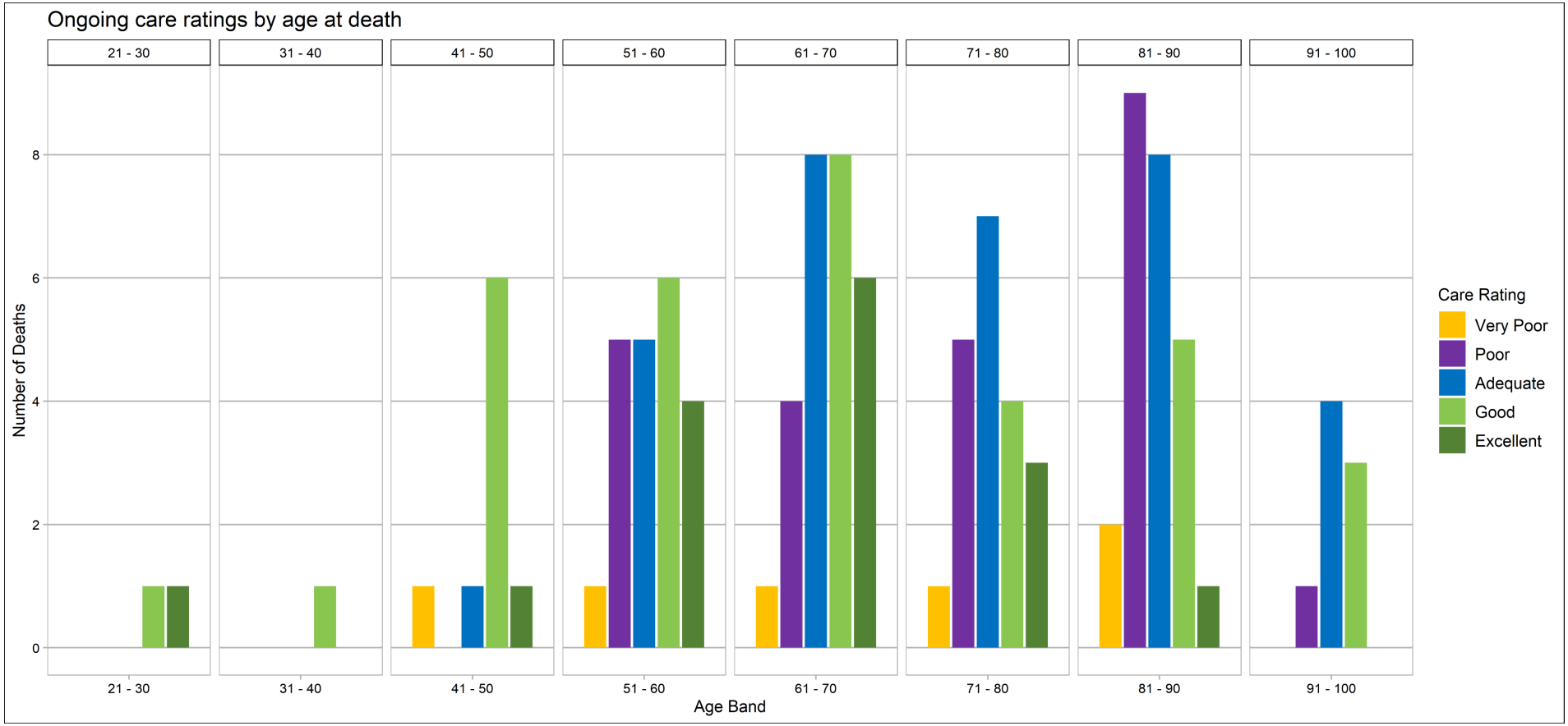
Commentary

- 113 patients (68%) of the 165 patients were reviewed for this phase of care.
- A majority of the patients, i.e. 83 of 113, received adequate, good or excellent care (73%).

Points for confirmation

- These ratings relate to the ongoing care provided on wards in Royal Shrewsbury Hospital or Princess Royal Hospital.

Ongoing Care Phase ratings by age



Commentary

- Unlike the first two phases of care, no single age group experienced better care, but there were proportionately more patients in the 81–90 age group who received poor care. This is illustrated in the graph above.

Ongoing Care – excellent or good care characteristics

Notable themes – excellent or good care

Some themes were strongly represented in this phase. The timely initiation of EoL care pathway and palliative care team input was the largest distinguishing factor between the excellent/good and poor ratings for this episode of patient care. This was seen in all inpatient areas, including medical, surgical, oncology and intensive care. 16 were either cared for on, or had input into their care from, the intensive care unit (ICU) and team.

Some case examples are listed below:

Case 1

Prompt investigations and treatment. Once diagnosis confirmed prompt communication with family about poor prognosis and discussion about CPR. Prompt decision to place patient on EoL pathway and communicated with relatives. EoL plan and patient preferences discussed. Prompt referral and review by palliative care. Fast Track discharge to [Community Hospital] booked for following day.

Case 2

Surgical review and continued for palliative care only and for discharge home with full package of care. Reinstated as before admission. ReSPECT form in place.

Case 3

One day after admission, MDT and significant clinical input. Husband called by nursing and medical staff to discuss care and deterioration and asked to come in. Died day 2 with family at side.

Case 4

There is a clear management plan and levels of escalation anticipated and stated. Initial ward management appropriate and clear progression and rationale documented to limits of ward care then admitted to ICU for CPAP and the intubation and ventilation. Patient is consented and enrolled onto a clinical trial of Covid therapy. The documentation is clear and states both the reasons and limitations of care.

The ICU notes – nursing, physio and medical – are easy to follow and document the plan and anticipate next steps. There is a clear identification when deterioration seemed irreversible and regular documentation of discussion with the family. It is clearly stated when it is felt EoL care begins.

Case 5

DNAR in put in place. Decision made for EoL care – reviewed by EoL team. Police contacted to find NoK, and then kept updated on a regular basis of deteriorating condition and prognosis. Good nursing care documented. Identified multiple pressure sores – Datix completed.

Ongoing Care – adequate care characteristics

Notable observations – adequate care

Themes for the 35 patients rated as having received adequate care include:

- poor documentation in the medical record;
- frequent patient moves;
- no medical review over the weekend;
- delays in investigation results;
- lack of full patient records;
- lack of multidisciplinary review.

Examples of adequate cases are listed below:

Case 1

There is documentation of discussion with the palliative care consultant – there is advice to talk to patient about probable disease progression – there is no record of this happening. There is a plan to facilitate discharge with a syringe driver and home management. There is no entry confirming that the patient is ready to discharge.

Case 2

Overall the patient was reviewed by an appropriate range of senior consultants and had input from MHL, medication review, SALT, dietetic support. However, there were a lot of moves for this agitated, confused patient with dementia and some very late at night which given the overall clinical condition was sub-optimal. The Geriatrician had specifically asked for the patient to be moved to his care on ward 27 – this did not occur.

Case 3

No medical review over weekend. Routine care – general slow deterioration in condition.

Case 4

Delays in blood results to inform decision making. Four days to insert chest drain.

Case 5

There is no medical entry for the day after admission but otherwise daily consultant review. Cellulitis management clear. Appropriate adjustment to antibiotic regime and further diagnostics.

It is not clear what the plan was for the patient's fluid balance or how this was being monitored – the charts are incomplete and only totalled on three occasions. The patient is recorded as being dehydrated, on fluid restriction of 1500mls, to encourage fluids and increase diuretic – this is confusing and there is no indication that fluid balance was checked.

Ongoing Care – poor or very poor characteristics

Notable themes – poor or very care

Themes emerging from the 30 patients rated as poor or very poor included:

- the absence of or delay in the commencement of an end of life (EoL) pathway;
- the absence of or delay in the involvement of the palliative care team;
- two patients with poor care from the surgical team who were cared for on non-surgical wards; and
- documentation and management of fluid balance was a significant issue in nine patients.

Three patients had inadequate control of their diabetes while an inpatient. However, no significant patterns of care emerged in those patients rated as receiving very poor or poor care in terms of the time of day or day of the week of the patient admission.

Case 1

Significant delay in diagnosis with no medical entries for nearly 20 hours until CT abdomen report next day. This showed perforation and urgent referral to surgeons is made. Decision for full surgical treatment is made and patient is taken to theatre 2 hours later but is then too unstable for GA. Decision is made for no surgery – for conservative/palliative care on ward. EoL care plan is not done for a further 6 days and is incomplete with sections blank. The Consultant Oncologist had thought that surgical treatment was appropriate – the delay in diagnosis/surgical assessment missed the opportunity for this.

Case 2

Reviews by MDT. Diagnosed with bowel obstruction – surgical team had to be chased for review and refused to see despite escalation to Reg. Treat as constipation with laxatives. No NG tube in-situ as patient unable to tolerate. Reviewed by consultant medics – CT abdo showed small bowel obstruction and large bowel collapse. Poor management of fluid balance. Formal surgical review – undertaken by phone – conservative management advised. Patient vomited and aspirated faecal contents and was "screaming" for help. Palliation commenced 10 hours prior to death.

Case 3

There are reasonable ongoing investigations including procedures such as lumbar puncture [in May 2020]– consent is not addressed and a capacity assessment is not done until a week after admission when patient is assessed as unable to consent. ReSPECT form is not considered until a week after admission and DOLs noted to be required – this is not found in notes. Episodes of agitation are not addressed for several days and hospice transfer is delayed as a result. EoL pathway and care plan are not done (or not found). Patient is found on USS to have a full bladder and is catheterised – without reference to consent. There are no entries to indicate what urine output had been – patient was very agitated and this urine record would have been appropriate.

Case 4

Transfer to ward delayed by 24 hours – reason not stated. Clear documentation of consultation with Oncology and family. Delay in clearly stating need for palliative care – entry states if deteriorates for palliative care – at this stage EWS 15 and patient was unresponsive. Fluid and electrolyte balance poorly managed – on [February 2020] states he had over 10 litres I/V fluid in < 36 hours – fluid balance chart [the day before] is incomplete but has entry stating rate of 1500mls / hour through I/V lines (0.9% saline). Sodium was normal on admission but high at 155 at this point. Chart from [February 2020] missing.

Case 5

Diabetic control is poor throughout admission… On day 17 – states that patient insulin regime is 3 times a day and as patient cannot self-inject that this is too frequent for District Nursing.

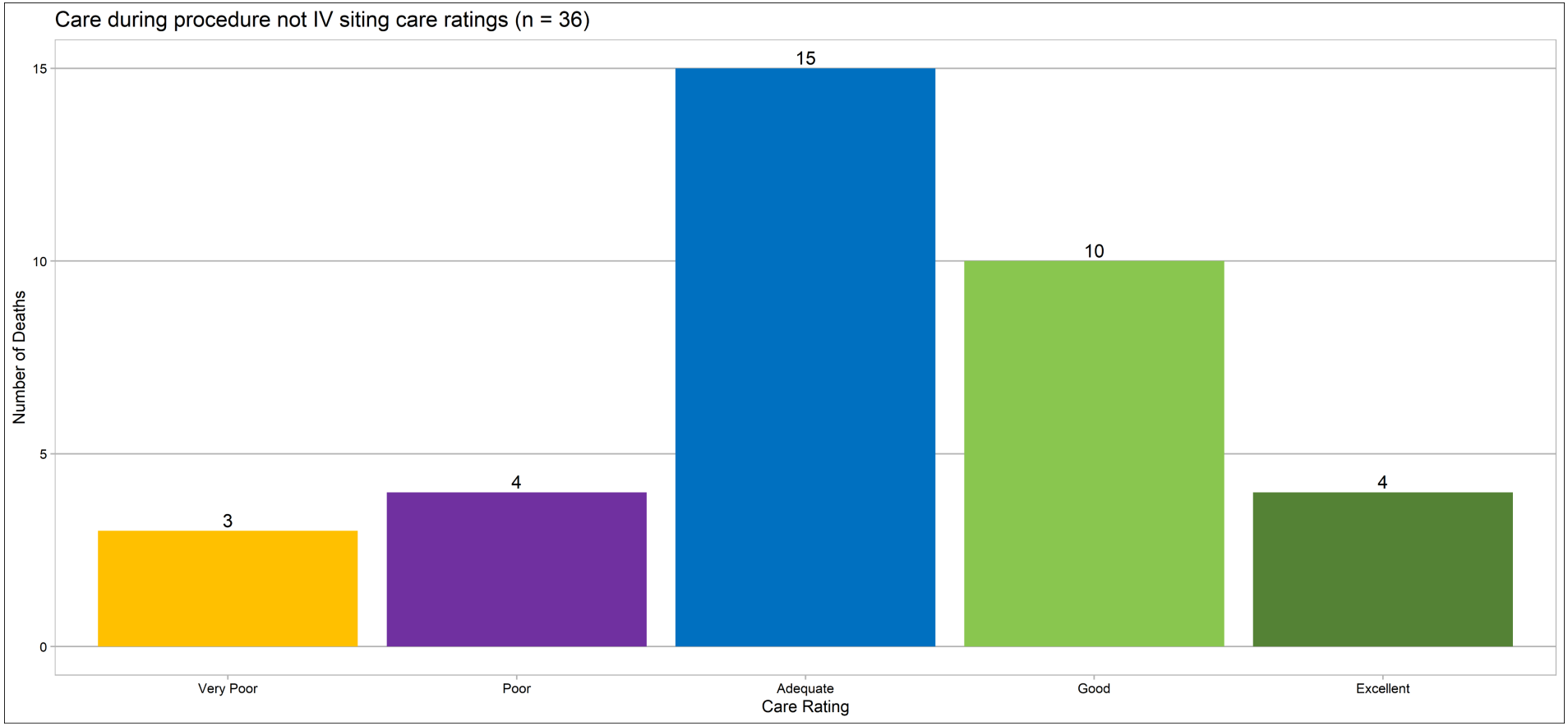
Note: patient usually has a glucometer which calculates the nova rapid dose with patient's meals but this is unavailable in the hospital.

Case 6

Stroke patient – diabetic control not planned, insulin was stopped in response to "low glucose" (7.6 pre-meal) when patient not receiving nutrition. No instructions or plan for this ongoing.

Analysis: Procedure Care Phase

Care during a procedure



Commentary

- 36 patients (21% of the 165 total) were reviewed for this phase of care.
- 14 received good or excellent care (39%).
- 7 received poor or very poor care (19%).

Points for confirmation

- This does not include minor procedures, e.g. IV cannulation.

Procedure Care – Notable themes and characteristics

36 patients (21%) were reviewed for this phase of care. 15 patients were rated as having received adequate care, 7 had reviewer's comments indicating that care in parts was good but the entire experience was not.

Good or excellent care

Case 1

The patient required an ERCP with stunting. Consent and evidence of understanding of the procedure recorded.

Case 2

All investigations/procedures were clearly documented with appropriate demonstration of need. The refusal to undertake the OGD and stent in the best interest of the patient lifted this to excellent.

Case 3

Required ascitic drain which was agreed with evidence of informed consent and good follow-up care.

Notable themes – poor or very poor care

Four patients' care was rated as having received poor care in this phase. Two of these were delays in the insertion of ascitic drains, one was due to poor recording of fluid balance, and one was when a second chest x-ray was not performed as requested.

Three patients were rated as having received very poor care. These were all issues of poor or absent informed consent, and lack of capacity assessment for a naso-gastric tube insertion, urethral catheterisation and a lumbar puncture.

Very poor care

Case 1

Lumbar puncture. There is an entry describing the technique used. The patient was confused and this is not addressed – the capacity assessment is not done at this point and consent is simply not mentioned. There is no record of discussion/explanation to the patient or whether any accommodation or support was offered.

Case 2

Naso-gastric tube for enteric feeding. There is an entry that states that a capacity assessment was done and that he does not have capacity – not found in notes. Patient did not want the NG tube and there is no indication of what was done to support him, make accommodation or whether he accepted the procedure, etc.

Case 3

Catheterised. No mention of consent for this. It is noted at this time that the patient was combative and uncooperative. Another entry states he was cannulated with assistant holding his arm. There is no evidence of a capacity assessment or best interests documentation.

Poor care

Case 1

Fluid management recordings poor and critical to management. Delay in taking bloods due to difficulties in access, no bloods for two days. Delay in ICU team initially to support.

Case 2

Delay in ascites drainage. Patient waited for three days for ascitic drain to be sited [June date] (radiology). Documentation of procedure noted.

Analysis: Perioperative Care Phase

Perioperative Care Phase

Four (2%) of the cases reviewed had a surgical intervention. In this phase, the ratings were three good and one excellent, and a sample of the comments are below:

Case 1

Two visits to theatre fully documented with evidence of good pre and intra operative processes. Clear plan of care and explanation of the severity of the illness at all stages. Good record keeping and care plan.

Case 2

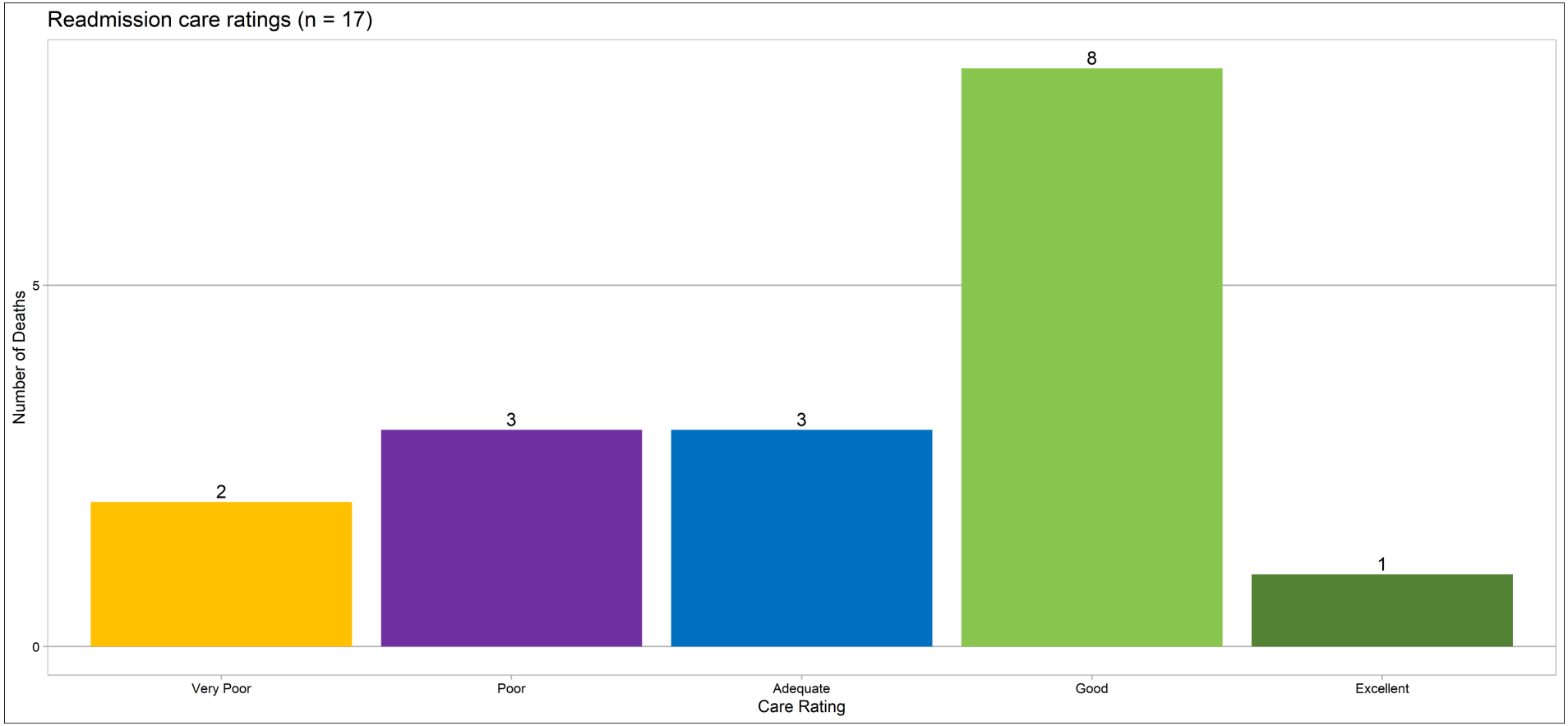
Theatre documentation mostly complete with consent form and World Health Organisation (WHO) checklist found and complete. Post-op instructions clear. Analgesia recorded as effective in recovery and ward.

Case 3

No issues during this phase of care found.

Analysis: Readmission Care Phase

Readmission Care Phase ratings



Commentary

- 17 of the 165 cases (10%) cases involved readmission.
- 9 cases were good or excellent (53%).
- 5 cases were poor or very poor (29%).
- Failed discharges are apparent in some cases, due to poor planning.

Readmission Care – notable themes and characteristics

Notable themes

There were a number of readmissions in a very short timescale due to failed discharge/insufficient discharge plans.

One patient's care was rated as excellent, eight good, three adequate, three poor due to failed discharges, as were the two very poor rated care episodes. Key themes for this phase include:

- where the rating was excellent or good, there was coordinated care between all parties involved;
- readmissions may not include consideration of the ongoing EoL or Advance Care Plan wishes of the patient; and
- readmissions within a very short timescale were mainly due to failed discharge planning or medical optimisation.

Characteristics of excellent/good and poor/very poor care cases

Examples of excellent and good ratings for Readmission phase

Case 1

The care given by the teams involved in the acute hospital admission appeared to be very efficient. Although not clear why the patient was sent to the hospital, the care received and discharge planning were excellent.

Case 2

This was <48hrs after discharge and there was evidence of good admission processes and immediate continuity of care following the ill-advised and patient-initiated discharge.

Case 3

Admitted twice within 2 weeks for the same issue. The nature of the clinical problem necessitated this and it appeared that direct admission was possible on the second occasion. This was good practice.

Examples of poor and very poor ratings for Readmission phase

Case 1

From GP record and RiO. Failed discharge. Was discharged from surgical ward on [March date] with ischaemic diabetic foot – insulin regime had been changed. District Nurse states very poor discharge – no information came with referral – stated for medication administration twice daily but no indication of what or route. Notes state she spent 2 1/2 hours trying to contact ward staff to find out what the insulin instructions were without success. GP surgery closed. Does not appear medication given. Next day BM was 23, could not contact GP surgery by phone so ambulance called and patient sent to emergency department – insulin given and discharged same day.

Case 2

From GP record and RiO – patient was discharged from hospital after an admission for poor diabetic control and confusion. Care home had to call hospital and NHS 111 as his insulin instructions stated 2 to 16 units – they had no way of calculating what the appropriate amount was without a written sliding scale. He was readmitted the next day – appears to be a failed discharge.

Case 3

This readmission appears to be a direct result of poor discharge planning. GP care was excellent and GP tried to find out whether another admission was appropriate but ReSPECT form inadequate, nothing in hospice notes, no Advance Care Plan and despite calling the hospital doctor who did the form, still unclear.

Case 4

Fast Track, EoL and Hospice at Home – should have been considered from last admission with increased support at home following discharge on [June date] when the Urology MDT confirmed that the patient was for palliative care only.

Readmission Care – notable themes

Relationship between patient discharge and readmission

The relationship between the discharge of the patients readmitted and their most recent preceding discharge highlights two cases where poor discharge planning was directly related to readmission and one case where it was not. Comments made by the reviewers were:

Case 1

Insulin regime had been changed. Discharge summary states – will need some assistance in community and no details. There is a handwritten note in notes stating "to nurses in community" patient's insulin should not be delayed – it is unclear how this would be communicated in any useful way to the community team. District Nurse entries state referral received stating only for medication administration twice daily – no indication of what or route. Despite spending hours trying to contact the ward for information – no response. Next day patient has emergency admission to the emergency department with BM of 23.

Case 2

Discharged [March 2020] and readmitted [four days later]. Discharge summary was inadequate – there is no indication of forward management planning, EoL care planning or palliative care planning. There is no documentation found that indicates what the care plan for the nursing home was or what input the hospice team were to have. Patient was referred to hospice but declined and advice was for nursing home with outreach but there is no evidence of what this involved. Transfer delayed by a day as nursing home unable to take patient after a 5pm deadline.

Case 3

The patient was in hospital for 13 days and made a good but not full recovery. Clear decision making on return to home and end of life care. The patient was admitted to the emergency department two days later with a life-ending haemorrhage.

Diabetic management

There were four patients rated as having received overall poor care through different phases of their care with regards to diabetes management. The number of incidents is low. However, two of the patients' diabetic treatment regimes on discharge were not deliverable in the community, resulting in failed discharges. The care pathways available to patients in the community is worthy of review and repeat communication to SaTH staff. Examples are outlined below:

Case 1

Patient's changed insulin regime delayed discharge as it cannot be delivered three times a day by the district nurse.

Case 2

Diabetic control was an issue both pre- and between admissions with regime advice given that could not be delivered in the community and such poor discharge planning that he had to attend A&E the following day to have insulin administered as District Nurses had not been given instructions.

Analysis: Discharge Care Phase

Discharge Care Phase – notable themes

General themes include:

- There was some evidence of discharge planning with coordination of care at a very granular level.
- Where the rating was adequate, inadequate information sharing was a factor.
- There was poor communication and consideration of how care was to be delivered in the community, with evidence of community staff spending considerable time trying to contact hospital for information and readmission/emergency department attendances as a direct result.
- There was poor communication from the Trust to primary care on ongoing medication and changes to existing medication.

Written discharge communication and planning

- There was often inadequate written communication demonstrating clear discharge plans.
- Discharge summaries and communications from the Trust to primary care regarding ongoing medications and changes to existing medications were sometimes poor.

Liaison with primary care

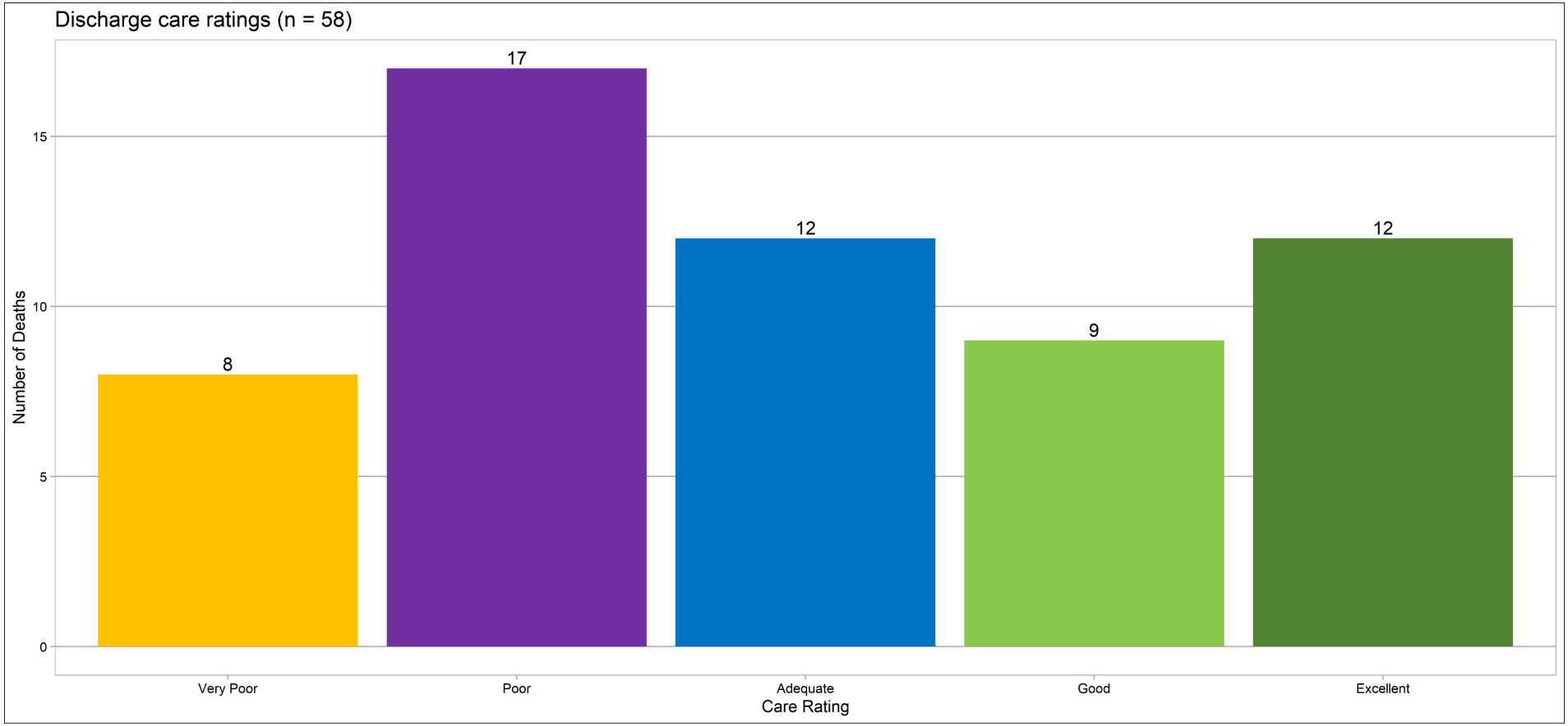
- There was poor communication of immediate post-discharge management, with primary care and out-of-hours teams having to respond to patients' needs within 24 or 48 hours of discharge where no plan was in place.

Lack of system or community/social services engagement to promote prompt discharge

- Patients who were medically fit for discharge were not optimised for home, which resulted in an extended and unnecessary length of stay.
- There were no discharge planning meetings evident and no community in-reach into plans; this may be due to Covid-19 arrangements.
- Lack of acknowledgement of community safeguarding concerns in some instances when trying to discharge patients.
- Lack of any social services input into patients' care.

The ratings for care in this phase are depicted overleaf in two graphs: by care rating and care rating by age band.

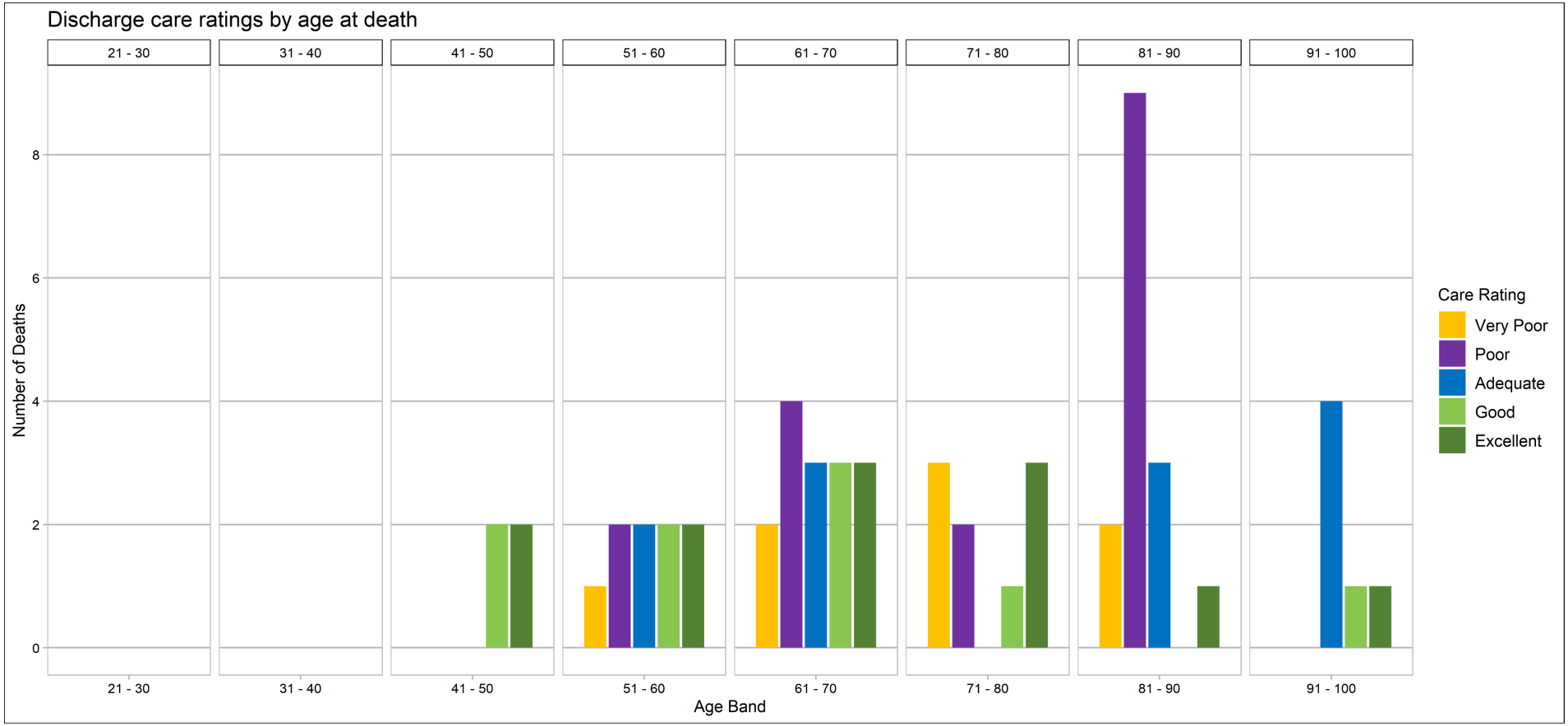
Discharge Care Phase ratings



Commentary

- 79 patients were discharged from hospital and 58 (73%) of those patients were reviewed for this phase.
- 21 cases were good or excellent (36%)
- 25 cases were poor or very poor (43%)

Discharge Care Phase ratings by age



Commentary

- Patients in age group 81–90 experienced a significantly poorer standard of discharge care.

Discharge Care – good or excellent care characteristics

12 patients were rated as having received excellent care. Fast Track discharge was successfully completed with two of these patients, and the theme for this rating was excellent, timely and coordinated care, supported by excellent written records and sympathetic family involvement. It is noted that two of these patients were returned home on the same day, which may suggest insufficient admission avoidance plans for a deterioration in the patient's condition in the community.

Nine patients were found to have received good care. The difference in ratings of excellent and good is mainly due the adequacy of health records and some elements of the discharge. In two cases there was lack of availability of syringe drivers in the community which delayed discharge or treatment.

Discharge Care Phase – characteristics of good/excellent care

Case 1

All assessments were done on the day of admission and same day discharge to die at home was facilitated. Equipment sent home with patient. Anticipatory medication prescribed to take home. EoL care stated – but death anticipated within days.

Case 2

Discharged home from PRH [February 2020] – palliative care for Cancer colon and liver metastases at home. Full package in place.

ReSPECT form completed in hospital. Clearly recorded that it exists in the progress notes stored on EMIS. Successful referral to Hospice at Home for night care, GP visit, JIC meds, and CN referral for palliative at home. Died at home as patient requested.

Verified death by Registered Nurse – respectful and enabled death at home and family advised of 'Tell us Once' scheme and funeral director contacted.

Case 3

Discharge is delayed as there needs to be an increase in funding for syringe driver care at the rest home – this is particularly distressing for the patient who has learning difficulties and needs a familiar environment. EoL pathway care plan is started and sent back to care home to try to avoid further admissions. ReSPECT form done.

Case 4

Anticipatory medication discussed and prescribed. Community palliative care team referral. District nursing team referral. GP informed.

Case 5

This discharge was well managed. Patient wish to return to care home immediately was accepted and expedited. There are copies in the notes of a new comprehensive ReSPeCT form and an Advance Care Plan that make it very clear what care she wants to receive going forward. Discharge summary not found and discharge ward checklist is blank. NB – all notes from this admission are loose and falling out of records.

Case 6

Patient discharged to hospice as was the patient's preference. The discharge summary is reasonable and contains important information about family concerns and communication. There is no nursing discharge documentation found. A hospice complementary therapist had attended the day before to do reflexology and introduce herself to patient. Bed was available the next day after referral.

Discharge Care – adequate care characteristics

Of the nine patients that received an adequate care rating, a theme of the quality of discharge planning information emerged. Case examples are given below:

Examples of adequate ratings where the quality of discharge planning information could be improved to reduce risk of poor care delivery

Case 1

There is a discharge summary with a reasonable level of information but no advance planning or EoL care referred to. There is an entry stating that she is going to [] Nursing Home – this is not her admission address but there is no record of decision that she will go to a nursing home found other than the Fact-Finding Form. Home oxygen is arranged for the nursing home.

Case 2

From Acute to Community Hospital – Transfer sheet complete. Waited 5 days for a bed. Reasonable level of transfer information given.

From Community Hospital to home – 2 days from "medically optimised" stamp in notes. Discharge checklist complete. District Nurse appointment made and recorded. Follow-up plan is clear in therapy notes but the Fact-Finding Assessment – which appears to be the discharge summary has few details.

Case 3

Discharge summary is clear and anticipatory prescribing done. Patient unable to go to hospice as there is no bed. Not clear on discharge when community services would see or assess. GP informed. No mention of ReSPECT form done.

Case 4

The discharge letter to the GP was comprehensive and stated the history, presentation, clinical features of care in this episode and discussion regarding end of life care. However, there was an identified action for the GP to support at home – with no reference to what this might be. There should have been an end of life care plan with anticipatory management discussed.

The discharge plan was referral to [] hospice for domiciliary CNS team support as discussed with patient and husband – this was not referred to in the discharge summary to the GP. There was no access to GP record and therefore no evidence of support provided post-discharge for patient from primary care.

Fast Track

Fast Track was initiated in the care of five patients, and for one patient it was noted that the instigation of Fast Track discharge would have facilitated a discharge home. Considering this is 8% of the patients reviewed for this phase, a further review of the utilisation of this process would be appropriate.

Discharge Care – poor or very poor care characteristics

Eight patients were rated as having received very poor care. These indicated deficiencies in documentation and communication, and in one patient's case, there was a safeguarding concern. 17 patients had poor care, in which deficiencies were largely indistinguishable from very poor care, but coordination between services was slightly improved. Case examples are given below:

Examples of poor or very poor care

Case 1

A patient who suffered from depression appeared to have been allowed to self-discharge. There are no notes to suggest this was done safely with due regard to safeguarding a vulnerable adult five days before the patient died. Patient appears fully competent but no capacity assessment undertaken formally but not indicated. Wishes to go home. Family expressed a wish for nursing home.

Case 2

Discharged to Lung Cancer Nurse in community [April 2020]. No progress notes found in RiO. Note from community physio that patient has 4 times daily care but not clear from whom. No notes from [early April 2020] until date of death [mid-April 2020]. No GP EMIS access made available so cannot confirm EoL care.

Case 3

The discharge area in the care plan and the discharge checklists are both blank. There is no evidence that patient nursing needs were communicated. Patient was not eating or able to communicate on the ward and had pressure care needs that should have been communicated and planned for. Patient insulin had been stopped and there was no indication of whether this should be restarted or instructions to the GP. The discharge summary does not detail how the stroke has affected patient, whether there has been any change since admission or what patient current mobility and communication issues are. Summary states that "[patient] has no rehab potential" but does not indicate why this decision was made or whether the patient and family were involved.

Case 4

There is a discharge summary from orthopaedics to orthogeriatric only found – including in GP record. No discharge planning is found and patient record simply ends abruptly with a ward round note that patient is asleep in chair.

There is a single entry in nursing notes that patient missed tea as ambulance arrived and to let [nursing home] know. [This was] a nursing home with a specialised dementia focus. There is no indication in notes of a transfer there or a discharge summary. There is no record in Shropshire Community found for this period. There are no GP records after the admission.

Case 5

The discharge planning checklist is blank. The discharge summary has some information and states that the patient and palliative care team both want to avoid future admissions but there is no indication of whether this has been actioned with appropriate Advance Care Plan or ReSPeCT forms.

The prescription for the syringe driver medication was rejected by the chemist as not completed correctly. The patient's spouse rang the ward the next day after going to the GP to try to get it amended – there are entries that suggest some back/forth with GP but appears to be resolved – it is not clear if patient was without medication because of this.

Case 6

Discharged [March 2020] and readmitted [four days later]. Discharge summary was inadequate – there is no indication of forward management planning, EoL care planning or palliative care planning. There is no documentation found that indicates what the care plan for the nursing home was or what input the hospice team were to have. Patient was referred to hospice but declined and advice was for nursing home with outreach but there is no evidence of what this involved. Transfer delayed by a day as nursing home unable to take her after a 5pm deadline.

Analysis: End of Life Care Phase

End of Life Care Phase

101 patients were reviewed for this phase of care. 14 were rated as having had excellent care in this phase. This rating was given mainly for the quality of communication with the patient and their relatives. 27 patient cases were rated as good, with various reasons for the rating not being excellent which included:

- the availability of health records;
- lack of palliative care team involvement; and
- one case where a patient was transferred to the ward in the very early hours of the morning; this patient had a Butterfly Scheme initiated which should have alerted staff to the negative effects that a move at such a time might have for a patient with dementia.

25 patients were rated as having poor care and ten as having very poor care. The themes for both scores include late instigation of palliative and EoL care, poor care (where treatment was absent or active treatment was ongoing despite EoL prognosis known) and missing documentation.

One case was escalated to SaTH for further review as the patient was found dead on the floor in the ward with no cardiopulmonary resuscitation commenced despite no 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation being completed.

A theme among the 25 cases rated as adequate appears to be the lateness in the patient care episode of the decision to initiate the EoL pathway.

There were two discussions with families about organ donation.

Ratings for this phase of care are represented overleaf.

Overall observations

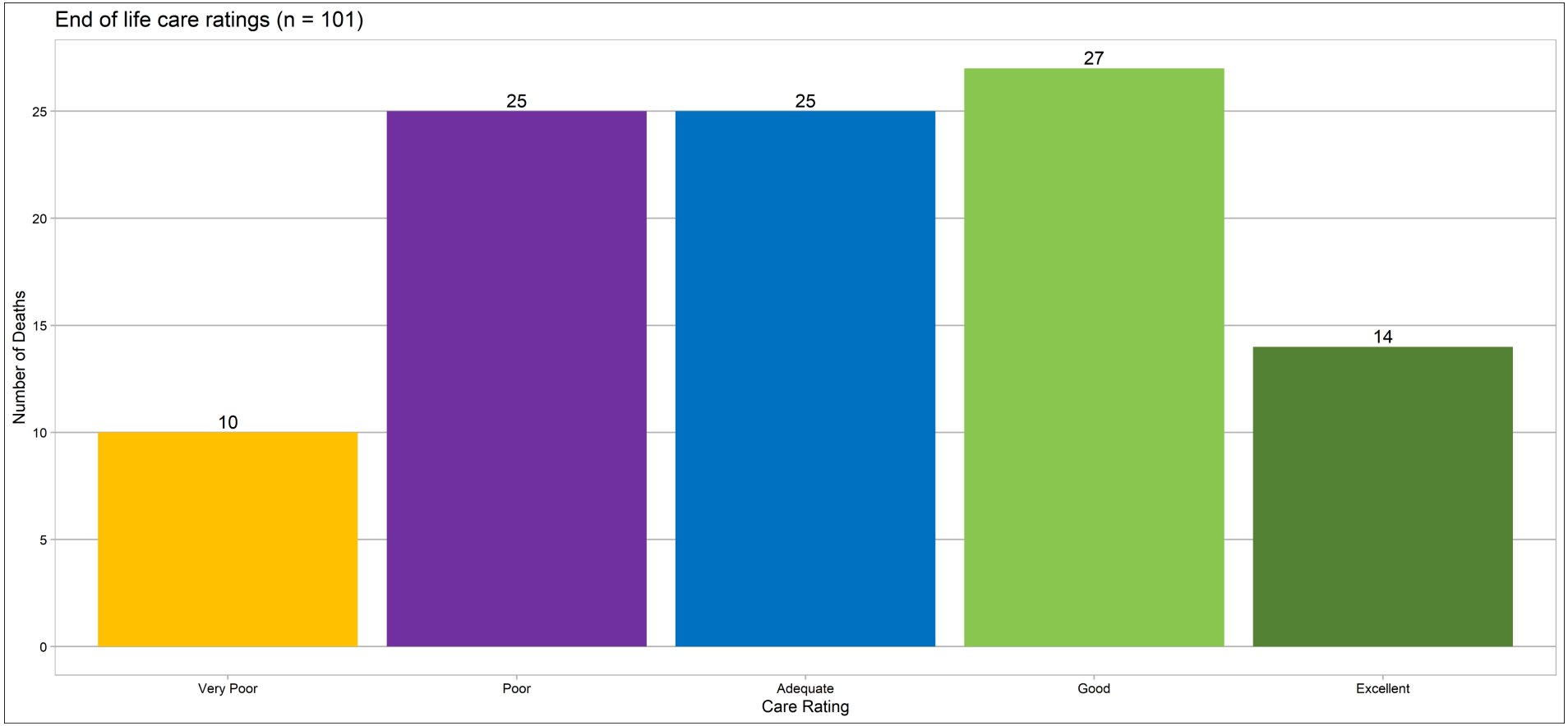
In cases of adequate, poor or very poor care there was:

- evidence of some very good EoL care, particularly information sharing with relatives and patient;
- poor recognition of when a patient was 'end of life' and waiting for a patient to deteriorate before instigating end of life care plans;
- poor documentation of decision making and patient/family involvement in this phase;
- lack of capacity assessment for some patients who were dying;
- late move to EoL care pathway;
- inconsistency in the involvement of the palliative care team;
- ReSPECT forms being completed as a replacement for DNAR, being of poor quality and focussed on ceilings of care and not patient preference or care options.

ReSPECT forms

- There were 79 patients where a ReSPECT form could be evidenced.
- 47 of these were recorded as good quality and 19 were not of good quality.
- We could evidence five patients that had both ReSPECT and DNACPR on EMIS when a patient was at home and five that did not as access to EMIS was limited.
- Some ReSPECT forms had been completed as a replacement for DNACPR and were poor quality and focussed on ceilings of care not patient preference.

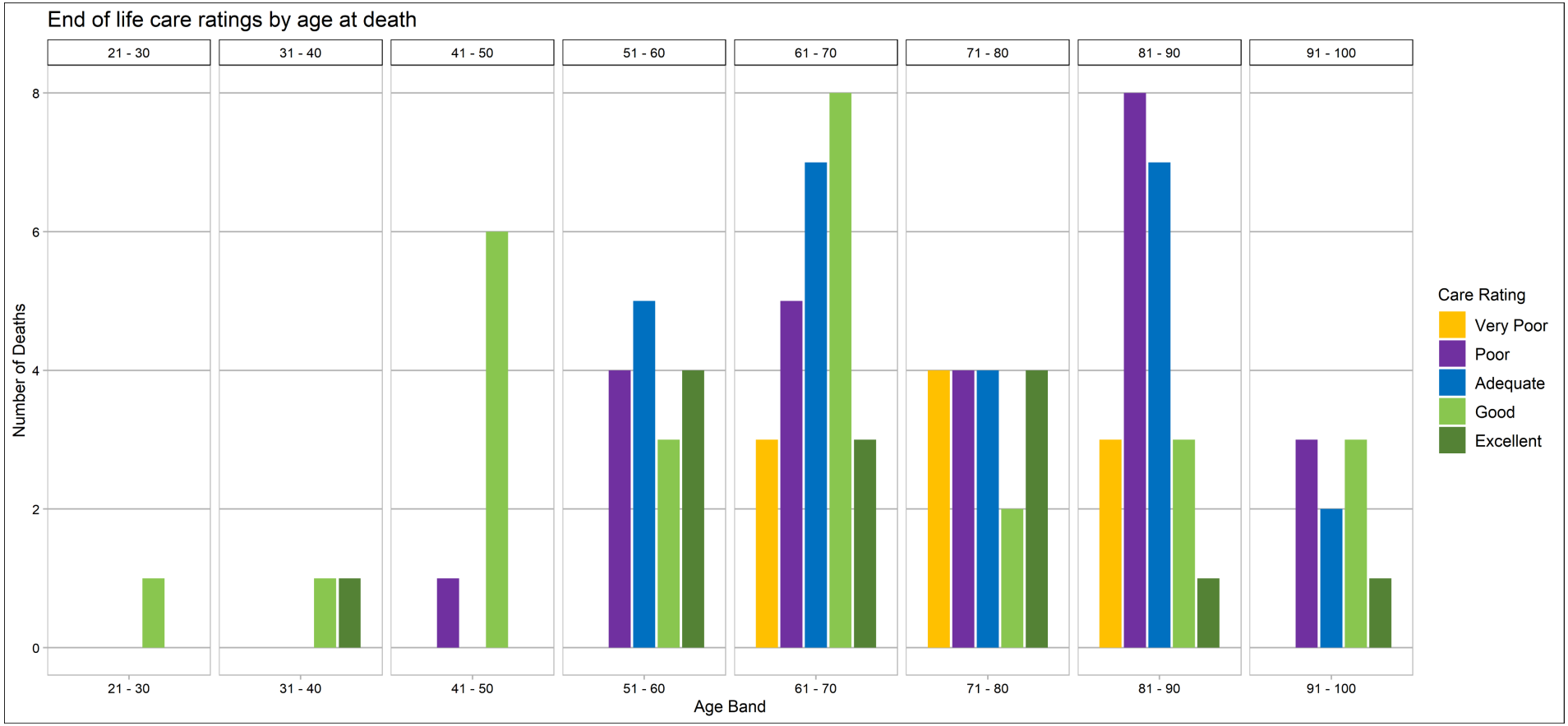
End of Life Care Phase ratings



Commentary

- 101 of the 165 cases (61%) involved end of life care.
- 41% were rated as good or excellent care.
- 35% were rated as poor or very poor care.

End of Life Care Phase ratings by age



Commentary

- Poor and very poor ratings were apparent in older age groups especially in the 81–90 age band.
- The very elderly would appear to have fewer good or excellent care ratings.

End of Life Care – good or excellent care characteristics

A sample of the cases are listed below:

Examples of End of Life Care Phase rated good or excellent enabling a respectful death

Case 1

This was a sudden, unexpected haemorrhagic stroke in a previously fit [late 50s]-year-old. Condition was recognised and communicated as terminal quickly and EoL pathway started immediately. Accommodations (during Covid-19) for spouse to sleep in patient's room were made and anticipatory prescribing done. Unnecessary antibiotics stopped and patient received comfort care only.

Case 2

ReSPECT form was done on admission and contains good level of information. EoL care identified after patient had cerebral haemorrhage on ICU and appropriate decision to withdraw support made. Family accommodated with mask fitting assessment and protective clothing provided – daughter with patient as support withdrawn. Clear documentation of staff explaining equipment and environment to family to help them to feel supported.

Case 3

Patient's wishes observed. [] Hospice and Macmillan OT review of home undertaken. Community Nurse involvement for syringe driver daily, JIC drugs in place and GP spoke with NoK to check they were aware of what to do.

Case 4

Seen day after arrival back home. Full care package in place at home including daily visits, syringe driver management, GP and Shropdoc involvement as required, hospice, pressure area checks. Also managed to attend planned outpatient appointments. Management of increasing confusion. Datix for [June 2020] as no [Community Nurse] available to visit – no harm.

Case 5

Appears to have had MDT enabled death at home with wife and child. ReSPECT fully completed and available. From discharge home from PRH [February 2020] for palliative care at home for cancer of colon and liver metastasis, a full package of home care was in place including a ReSPECT form completed in hospital five days earlier (known to GP but not on EMIS), input by Hospice at Home for night care, GP visits, JIC meds, and Community Nurse daily input. Admission avoidance used rapid response TIC and rapid syringe driver request which precipitated good care at patient's home including daily home visits documented on RiO and hard copy. Not all hard copy notes are on RiO so full care episode not in one place, which is represented in score.

Case 6

Patient was transferred to ward 35 on [April 2020] for EoL care – this was not timed but patient was seen on arrival on the ward and had a second review at 06:45 meaning the patient was transferred in the very early hours of the morning despite the Butterfly scheme being initiated on [four days earlier].

There was excellent demonstration of the EoL life care plan being used, syringe driver for pain relief, mouth care, comfort charts fully completed, medical, palliative care team and EoL facilitator involvement with checklist completed for the verification of an expected death, confirming staff and family fully aware of imminent expected death.

Rated good, would have rated care as excellent had the patient not been transferred in the early hours of the morning. The care demonstrated was very responsive to the patient's need and patient was noted to have vomiting under control, was pain-free and settled in the days and hours before death.

Case 7

Generally, well managed. Very good record of regular updates with family and patient. Decision to change from active treatment to end of life one could have been made earlier as obviously failing. That said, good coordination and symptom control measures were put in place early in the admission.

End of Life Care – adequate care characteristics

Care rated as adequate in all phases include comments about the ReSPECT form, as shown in the case examples below:

Case 1

Early consultant review – on emergency department – reasonable plan includes need for ReSPECT form but this is not done until the next day.

Case 2

Discharge summary is brief and does not state whether ReSPECT form or DNACPR done.

Case 3

ReSPECT form done on admission only addressed CPR and did not discuss any other wishes or ceilings of care with patient – had morbid obesity as reason stated on form.

Case 4

A ReSPECT form was completed on the [December 2019] sometime before EoL issues were agreed.

Case 5

ReSPECT form and Advance Care Plan both indicate his wish to go home – there is evidence of discussion with patient and partner that patient's oxygen requirement would not allow for this.

Case 6

There was good evidence of ReSPECT form being used and ceiling of care being documented in emergency department. However, there is no link to what if anything this patient would require post-discharge.

Case 7

ReSPECT form and patient passport are put in place – have to be changed as LD liaison points out that the reason "Down's syndrome" for DNACPR is not appropriate.

Case 8

ReSPECT form re-done but still does not state what patient wishes are regarding admissions despite the issues this caused. Patient is distressed and SOB – there is some evidence of trying to control this – no evidence of palliative or EoL care advice this admission.

Last ward round entry states "[spouse] present" and "[spouse] agrees to keep her comfortable" – however, patient was not married and lived with a friend. EoL pathway started three hours before death

End of Life Care – where care could be improved

End of Life Care Phase – poor or very poor rated care

A sample of the cases are listed below:

Examples of End of Life Care Phase rated as very poor or poor, where improved care at the end of life could have resulted in a more respectful death

Case 1

Continued active treatment and observations despite prognosis and noted to be dying. Relatives not contacted with deterioration until 6 hours before patient died. No EoL plan made. Nurse contacted Doctor when EWS 10 asking to reduce observations as it is documented that patient is dying. Doctor went to review and found patient deceased.

Case 2

Referred to palliative care community team but no ongoing documented plans and palliative not made aware of patient after discharge so no input before patient dies at home. Significant safeguarding concerns that were not identified during inpatient stay.

Case 3

Palliative care consultant review [January 2020] – patient wants to go home to die. Fast Track home – this was noted at every review from the [four days]. Patient deteriorated, had not passed urine for two days and was catheterised – EWS increased to 8 despite this plan for discharge home still being documented but not actively implemented.

The ReSPECT form was completed and was particularly poor quality – ceilings of care were only addressed on [very late] – not for ICU and no further active treatment. There was no end of life care plan although there was acknowledgement of best supportive care. This patient's care was adequate, however, there was no attempt to deliver this in the place requested by the patient – home.

Case 4

Poor arrangements for EoL care initially and lack of support. Son called to ask for a home visit as mother deteriorating. Arranged for rapid response and D/N to visit [July 2020], so not initiated on discharge as it should have been and was planned. A week later identified that palliative care was required and ReSPECT needed in the house. Unclear if referral made. Home visit on [after a further week] and oral meds changed. Visit then to set up syringe driver – patient died later that day.

No palliative care support arranged until son not coping and patient becoming distressed and patient needing further medication.

Case 5

EoL not recognised early and when this is documented as likely, there is no EoL care plan done or palliative opinion sought despite clear respiratory distress.

Case 6

There is no record of conversations with the patient regarding EoL care. The confusion over whether there was a ReSPECT form caused distress. There is therefore no clear documented plan when patient was discharged to the nursing home despite worsening metastatic disease and an expectation of terminal nature.

Case 7

EoL not recognised as soon as it could have been – family wished to take her home and Fast Track application started. Palliative team assess as unable to go home but it takes a further three days for EoL plan – this is against a background of concern from the community team which is not documented in hospital records. EoL plan is then well filled in and followed.

End of Life Care – notable themes

Engagement with families at End of Life Care Phase

Engagement with families varied considerably but few were rated as excellent.

Where it was excellent, staff could not have done more, for example enabling a husband to sleep in his wife's room when death was predictably near. At the other end of the scale, in one example palliative care support at home was put in place only after next of kin was not coping and the patient was distressed. The care was seen to be equally variable whether the patient was cared for in SaTH or in the community.

End of Life for patients with confusion/memory problems

Only one patient was found to have a recorded inclusion on the Butterfly Scheme, despite 36 patients in the cohort having had a confirmed or unconfirmed diagnosis of dementia/memory problems.

Involvement of Coroner

Four patients were referred to the Coroner (adequate to excellent care in all phases). Three of the four patients arrested in the community and received overall good care in the emergency department and ICU. One patient who also arrested at home was referred to the Coroner by the GP in March 2020. The patient was living with diabetes and appeared to have had a DKA arrest at home. As there was no record in the SCHCT numerous health records for this patient of glucose monitoring results, the Trust may find there is significant learning from the patient's death.

DNACPR and EoL plans

There was found to be very little distinction between ReSPECT and DNACPR plans in the EoL discussions with patients. It is recommended that this is reviewed in further specific ReSPECT and DNACPR audits. Where there was a ReSPECT and a DNACPR form noted, very poor practice was observed, identifying the reason for a DNACPR as "Down's syndrome".

Organ donation

Three patients had a discussion regarding organ donation with the family, of which two had good and one excellent care in the EoL phase.

DoLS / Capacity assessment

Capacity was an issue identified in patients with a known MH diagnosis, dementia or at end of life. Care was not always optimised as a result, as identified in the case examples below:

Examples of care where patients may not have capacity

Case 1

Assessment of mental capacity undertaken [mid-May 2020] patient didn't want to engage in treatment. Patient had very low mood and stated wanted to die [a week earlier onwards] with no mental health referral.

Case 2

Exceptionally difficult case where the physical issues were addressed well but there could have been a mental capacity assessment earlier in patient care pathway and some input from palliative care.

Case 3

Patient arrived from the emergency department at 21:00 and was clinically assessed at 23:45. An Assessment for Mental Capacity was completed – no capacity. On [May 2020] a DoLS form was completed as the patient required specialist assessment within a inpatient setting as NoK can no longer cope. Patient referred to RAID. The patient was seen on the PTWR and referred and reviewed by the Consultant Geriatrician who requested that patient be transferred under his care on ward 27 – this did not occur.

Case 4

It states that patient had been in decline but had capacity and had refused most help offered and had carers but would not allow them to do very much. No records found on RiO for this time period.

End of Life Care – notable themes (*cont.*)

ReSPECT

In 78 cases a ReSPECT form was present and in 33 no form was available. The ratings given for patient care in all phases, where ReSPECT forms were present, appeared to influence a good or excellent rating. Some case examples are listed below:

Case 1

There are copies in the notes of a new comprehensive ReSPECT form and an Advance Care Plan that make it very clear what care she wants to receive going forward.

Case 2

DNAR discussed with son. ReSPECT form discussed with patient and for ward-based care.

Case 3

ReSPECT form is noted in emergency department.

Consultant review same evening, plan agreed and ReSPECT form again stated to be present and noted must be followed.

Case 4

Patient clerked by Med Reg at 01:40 await side room as ?Covid-19 – anticipatory plan commenced, family aware of poor prognosis and plan. ReSPECT form re-completed.

Case 5

ReSPECT form [February 2020] and copy on EMIS. Patient wishes hospital admission for reversible causes.

Case 6

ReSPECT form discussed and patient given time to consider and discuss with family.

Case 7

There is a new ReSPECT form and Advance Care Plan done which clearly states that she does not want any further admissions as she finds it distressing and wishes to have symptomatic care in her familiar environment only.

Case 8

ReSPECT form discussed but not done as states patient was coming to terms with terminal diagnosis.

End of Life Care Phase – ReSPECT in poor/very poor care

Throughout poor and very poor care ratings ReSPECT is referenced. The ReSPECT comments can be seen below:

Case 1

Reviewed again on the [January 2020] – ReSPECT form completed (very poorly).

Case 2

On [July 2020] identified that palliative care was required and ReSPECT form needed. Unclear if referral made. Home visit [July 2020] and oral meds changed.

Visit then to set up syringe driver – patient died later that day. No palliative care support arranged until son not coping and patient becoming distressed and needing further medication.

Case 3

The discharge planning checklist is blank. The discharge summary has some information and states that the patient and palliative care team both want to avoid future admissions but there is no indication of whether this has been actioned with appropriate Advance Care Plan or ReSPECT forms.

Case 4

Frail [90s]-year-old patient with Alzheimer's – no ACP/ EoL or ReSPECT forms. Patient died two days after transfer to community hospital. States patient was found peri-arrest and CPR started. This was discontinued by paramedics as states there was a DNACPR in effect.

This is not found on RiO or GP notes – there is a DNACPR in hospital record but this is seven years old.

Case 5

It states that a ReSPECT form was done in the summary but there is no reference to this being completed in patient notes.

Case 6

There is no record of conversations with the patient regarding EoL care. The confusion over whether there was a ReSPECT form caused distress to her. There is therefore no clear documented plan when she was discharged to the nursing home despite worsening metastatic disease and an expectation of terminal nature.

Case 7

ReSPECT form done on admission, unfortunately did not address what the patient wanted but just stated not for ICU or CPR.

Case 8

There is a ReSPECT form done by the Consultant on day 2 – states patient did not have capacity but no capacity assessment done and no family input recorded. ReSPECT form is not considered until a week after admission and DOLs noted to be required – this is not found in notes. Episodes of agitation are not addressed for several days and hospice transfer is delayed as a result.

Case 9

However, Hospital at Night were called to attend as no DNAR was documented. On [early January 2020] the ReSPECT was completed – this was very poor quality as it did not focus on patient's needs but what the hospital plan was – ward-based care, stop medication and for limited observations.

Case 10

The DNAR/ReSPECT was completed on [June 2020] post discharge. This should have been completed during the patient's inpatient stay as the patient was deteriorating.

Appendix 1: GP practices represented

The practices with patients in the reviewed cohort are listed below. There were 42 practices.
Access to the records of these patients was extremely variable:
permission was given by 31 practices to view 100 patients' records;
for 44 of these 100 patients we were not able to access their medical record because access was either not fully activated or when repeatedly activated did not work.
There were a further 26 patients where permission to access was given to view GP records but this was after the review had been completed.

Practice	Number of patients in cohort
ALBRIGHTON MEDICAL PRACT	1
BEECHES MEDICAL PRACTICE	6
BELVIDERE MEDICAL PRACT.	6
BISHOPS CASTLE SURGERY	1
BRIDGNORTH MEDICAL PRACTICE	2
BROSELEY MEDICAL PRACTICE	2
BROWN CLEE MEDICAL CENTRE	2
CAMBRIAN MEDICAL PRACTICE	4
CHARLTON MEDICAL PRACTICE	10
CHURCH STRETTON MEDICAL CENTRE	2
CHURCHMERE MEDICAL GROUP	4
CLAREMONT BANK SURGERY	4
CLIVE MEDICAL PRACTICE	3
COURT STREET MEDICAL PRACTICE	6
DAWLEY MEDICAL PRACTICE	4
DONNINGTON MEDICAL PRACTICE	7
HODNET MEDICAL PRACTICE	2
HOLLINSWOOD SURGERY	1
IRONBRIDGE MEDICAL PRACTICE	1
LINDEN HALL SURGERY	6
LUDLOW - PORTCULLIS	2
MARDEN MEDICAL PRACTICE	1
MARKET DRAYTON MEDICAL PRACTICE	4
MUCH WENLOCK & CRESSAGE MEDICAL F	1
MYTTON OAK MEDICAL PRACTICE.	6
PONTESBURY MEDICAL PRACTICE	4
PRESCOTT SURGERY	1
RADBROOK GREEN SURGERY	6
RIVERSIDE MEDICAL PRACTICE	10
SEVERN FIELDS MEDICAL PRACTICE	9
SHAWBIRCH MEDICAL CENTRE	2
SHIFNAL & PRIORSLEE MEDICAL PRACTIC	2
SOUTH HERMITAGE SURGERY	4
STATION DRIVE SURGERY	3
STIRCHLEY MEDICAL PRACTICE	8
TELDOC	17
THE CAXTON SURGERY	3
WELLINGTON MEDICAL PRACTICE	7
WELLINGTON ROAD SURGERY	3
WEM AND PREES MEDICAL PRACTICE	2
WESTBURY MEDICAL CENTRE	1
WOODSIDE MEDICAL PRACTICE	3

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NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

M12 Finance Report

2020/21

REPORT TO: **Governing Body – 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.016	2020/21 Month 12 Financial Position

Executive Lead (s):	Author(s):
Laura Clare Acting Director of Finance laura.clare@nhs.net	Laura Clare Acting Director of Finance laura.clare@nhs.net

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

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

Executive Summary (key points in the report):

The combined CCGs 20/21 total financial position for the year (subject to audit) is a £0.6m deficit (£1.3m deficit Telford and Wrekin, £0.7m surplus Shropshire).

The £0.6m deficit includes an assumption that we will receive final HDP (Hospital Discharge Programme) retrospective income of £0.9m for the year.

There has been an overall improvement to the forecast outturn since last month of £1.1m. The main reasons for the in-month movement are:

- (£0.4m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and HDP income in relation to extra staffing costs.
- (£0.4m) improvement in acute expenditure due to the final agreement on partially completed spells adjustments in line with the latest guidance and an improved position on non contracted activity.
- (£0.3m) improvement in Primary Care Co Commissioning due to reduced dispensing and premises costs
- £0.2m increase in running costs/other costs due to cost of organisational change and increased BCF expenditure.

- (£0.3m) improvement to the system reserves position allocated to the CCG

The forecast position includes total QIPP delivery of £6.7m.

The CCGs carry forward a cumulative deficit from previous years of £130.1m (£6.1 m Telford and Wrekin and £124m Shropshire), the current forecast deficit for 2020/21 of £0.6m would take the cumulative deficit to a total of £130.7m.

As part of the annual accounts process each CCG Governing Body member must make certain declarations and these are outlined in paragraph 25.

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

Recommendations/Actions Required:
The Governing Body members are asked to: **Note** the information contained in this report. **Approve** the declarations in paragraph 25 for the annual accounts

Tables included in this report:

T*able 1: Financial Performance Dashboard* 6
Table 2: Combined financial position Month 12 7
Table 3: System Financial Position Month 12 8
Table 4: CCG combined financial position Month 12 (excluding system allocations) 8
Table 5: Underlying Position 2020/21 10

Graphs included in this report:

No table of figures entries found.

Schedules appended to this report:

Appendix	**Content**
Appendix A	Summary of M12 COVID expenditure return

2020/21 Month 12 Financial Position

Introduction

1. The combined CCGs 20/21 total expenditure for the year was £887.2m (£290.8m Telford and Wrekin, £596.4m Shropshire).

2. The combined 20/21 annual budget was £902m. This was based on a plan submitted by the CCG in October 2020 and included £15.4m budget in excess of what had been identified by NHSEI. This budget was never signed off by NHSEI and we had been asked to work on reducing our spend in order to move towards a breakeven position. The total budget without the deficit plan adjustment was therefore £886.6m.

3. The final position (subject to audit) therefore produces a deficit of £0.6m spend in excess of break even (£1.3m deficit Telford and Wrekin, £0.7m surplus Shropshire).

4. The £0.6m deficit includes an assumption that we will receive final HDP (Hospital Discharge Programme) retrospective income of £0.9m for the year.

5. This position also includes an underspend on the system reserve position of £1.8m, therefore the CCG deficit excluding system reserves is actually a £2.4m deficit. (£1.3m Telford and Wrekin, £1.1m Shropshire)

6. The CCG deficit position includes the £1.1m cost pressure created from the last minute change to the COVID expansion fund allocation from NHSEI, if this fund had been increased to the level originally notified, the CCG position would have improved by this value.

7. There has been an overall improvement to the forecast outturn since last month of £1.1m. The main reasons for the in-month movement are:

- (£0.4m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and HDP income in relation to extra staffing costs.
- (£0.4m) improvement in acute expenditure due to the final agreement on partially completed spells adjustments in line with the latest guidance and an improved position on non contracted activity.
- (£0.3m) improvement in Primary Care Co Commissioning due to reduced dispensing and premises costs
- £0.2m increase in running costs/other costs due to cost of organisational change and increased BCF expenditure.
- (£0.3m) improvement to the system reserves position allocated to the CCG

8. The forecast position includes total QIPP delivery of £6.7m.

9. System allocations have been administered through Shropshire CCG. Providers have received these payments through adjustments to their block contracts. At a system level there has been close monthly monitoring of both COVID and winter expenditure to ensure that funding flowed across the system to where it was required. The system agreed the final redistribution of system reserves between organisations at Month 12.

10. The CCGs carry forward a cumulative deficit from previous years of £130.1m (£6.1 m Telford and Wrekin and £124m Shropshire), the current forecast deficit for 2020/21 of £0.6m would take the cumulative deficit to a total of £130.7m.

Financial Performance Dashboard

11. The CCG financial performance dashboard is shown in Table 1.

12. At Month 12 following the expected retrospective top ups, the CCGs at a combined level will be operating below the YTD plan and FOT plan submitted to NHSEI in October. The plan delivers a total £15.4m deficit compared to the allocations provided in 2020-21 and the final position (subject to audit) is a £0.6m deficit (including system underspends). However, it is important to note that this plan has not been accepted by NHSEI and the target that we should have been working to is a position of break even. During this year there has been significant non recurrent support provided to the CCGs due to the COVID pandemic so the underlying position for 2020-21 is a key consideration when thinking ahead to future years and is explained later in the report.

13. The CCGs are required to adhere to the Better Payment Practice code to pay suppliers within 30 days. Both CCGs continue to exceed this target with current performance in excess of 99%.

14. The cash target is to have a cash balance at the end of the month which is below 1.25% of the monthly drawdown or £250,000, whichever is greater. This was met for both CCGs in Month 12.

Table 1: Financial Performance Dashboard

Target/Duty	Target	CCG	RAG
Statutory duty to break-even	Break-Even	SCCG	G
		TWCCG	R
		COMBINED	R
Control Total	FOT £11.781m deficit	SCCG	G
	FOT £3.575m deficit	TWCCG	G
	FOT £15.356m deficit	COMBINED	G
Cash	1.25% monthly drawdown	SCCG	G
		TWCCG	G
Better Payment Practice within 30 days (Number of invoices)	>=95%	SCCG	G - 99.0%
		TWCCG	G - 99.4%

Summary Financial Position

15. Table 2 shows the summary year to date financial position for both CCGs combined. The final position is an underspend against total budget of £14.7m, if the planned deficit budget is removed, the position is £631k in excess of break even. Tables 3 and 4 show this split between allocation that is held by the CCGs for use by the whole system and that which is fully attributable to the CCG.

Table 2: Combined financial position Month 12

Combined			
Category	**YTD Budget**	**YTD Actual**	**YTD Variance**
	£'000	**£'000**	**£'000**
Allocations received	834,890	834,890	0
Anticipated HDP Income	958	958	
System allocations	50,747	50,747	0
Planned Deficit	15,356	15,356	0
Total Allocations	**901,951**	**901,951**	**0**
Acute	431,718	429,822	1,897
Community	74,741	74,333	408
Individual Commissioning	77,864	66,436	11,428
Mental Health	81,385	80,450	935
Primary Care	110,489	109,836	653
Other	38,909	38,057	852
Running Costs	11,635	12,773	-1,138
Primary Care Co Commissioning	75,210	75,520	-310
Total Expenditure	**901,951**	**887,227**	**14,725**
Deficit/Surplus	**0**	**14,724**	**-14,725**

Table 3: System Financial Position Month 12

System			
Category	YTD Budget	YTD Actual	YTD Variance
	£'000	£'000	£'000
System- COVID	18,361	18,361	0
System - Growth	4,954	4,954	0
System - Top Up	27,432	27,432	0
Total Allocations	**50,747**	**50,747**	**0**
SATH	37,817	39,240	-1,423
RJAH	6,072	4,012	2,060
Shrop Comm	4,214	3,358	856
CCG	2,644	2,338	306
Total Expenditure	**50,747**	**48,948**	**1,799**
Deficit/Surplus	**0**	**1,799**	**-1,799**

Table 4: CCG combined financial position Month 12 (excluding system allocations)

CCG Only			
Category	YTD Budget	YTD Actual	YTD Variance
	£'000	£'000	£'000
Allocations received	832,246	832,246	0
Anticipated HDP Income	958	958	0
System allocations	2,644	2,644	0
Planned Deficit	15,356	15,356	0
Total Allocations	**851,204**	**851,204**	**0**
Acute	389,510	388,251	1,260
Community	70,527	70,975	-448
Individual Commissioning	77,864	66,436	11,428
Mental Health	81,335	80,400	935
Primary Care	108,982	108,329	653
Other	36,141	35,595	546
Running Costs	11,635	12,773	-1,138
Primary Care Co Commissioning	75,210	75,520	-310
Total Expenditure	**851,204**	**838,279**	**12,926**
Deficit/Surplus	**0**	**12,925**	**-12,926**

Financial Position

16. Following the release of the system financial envelopes and the M7-12 financial framework guidance, a system wide forecast outturn position was submitted to NHSEI in October 2020. This included a £15.4m deficit (£11.8m Shropshire CCG, £3.6m Telford CCG) for the CCGs which is the plan that has been uploaded to our ledgers and upon which our budgets have been set.

17. During Month 12 an overall improvement was made to the forecast of £1.1m, this takes the overall deficit to just £0.6m, a £14.8m overall improvement since the plan was set.

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

- (£0.4m) Individual Commissioning improvement due to reduced activity and cost in Broadcare and HDP income in relation to extra staffing costs.
- (£0.4m) improvement in acute expenditure due to the final agreement on partially completed spells adjustments in line with the latest guidance and an improved position on non contracted activity.
- (£0.3m) improvement in Primary Care Co Commissioning due to reduced dispensing and premises costs
- £0.2m increase in running costs/other costs due to cost of organisational change and increased BCF expenditure.
- (£0.3m) improvement to the system reserves position allocated to the CCG

19. COVID expenditure for the year totalled £33.8m, (see Appendix A). Note that at Month 12 the COVID system reserve of £1.7m held by the CCG was transferred to SATH due to the increases seen in their COVID related costs.

20. The position includes QIPP delivery for the year of £6.7m.

Run Rate and Underlying Position

21. The underlying position of a £71.1m recurrent deficit for the CCGs has been discussed at the system Chief Executive Group and been agreed as the startpoint for the development of the 2021/22 plan. This is shown in table 5.

Table 5: Underlying Position 2020/21

Combined	2019/20 Underlying	2020/21 Underlying	% change
	£'000	£'000	
Allocation			
Programme	645,962	675,593	4.6%
Primary Care Co Commissioning	68,716	71,569	4.2%
Running Costs	10,396	9,178	-11.7%
Anticipated Income		4,200	
TOTAL	**725,074**	**760,540**	
Spend with system organisations (SATH, RJAH, ShropComm):			
Acute	- 310,118	- 321,383	3.6%
Community	- 64,848	- 66,277	2.2%
System total	**- 374,966**	**- 387,660**	
Spend outside of system organisations:			
Acute	- 77,166	- 81,573	5.7%
Community	- 11,446	- 11,618	1.5%
Mental Health	- 70,504	- 78,070	10.7%
Individual Commissioning	- 58,672	- 65,100	11.0%
Primary Care	- 13,391	- 16,110	20.3%
Prescribing	- 79,545	- 80,760	1.5%
Other	- 25,512	- 27,960	9.6%
Running Costs	- 10,267	- 9,178	-10.6%
Primary Care Co Commissioning	- 68,911	- 73,600	6.8%
Non System total	**- 415,414**	**- 443,969**	6.9%
TOTAL EXPENDITURE	**- 790,380**	**- 831,629**	5.2%
Deficit	**- 65,306**	**- 71,089**	8.9%

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

23. Individual Commissioning has recently been subject to a deep dive review as the position has been extremely complicated this year with the introduction of the Hospital Discharge Programme. All key assumptions have been tested with independent partners and benchmarked with other CCGs to provide further assurance around the underlying position reported.

24. Progress around the development of the sustainable financial plan for both the CCG and the system and guidance around the financial arrangements for the first 6 months of 2021-22 are presented to Governing Body this month in a separate paper.

Annual Accounts Process

25. As part of the accounts process each governing body member must:

- Declare that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

- Accept that the CCG is operating as a going concern.

- Accept that disclosures around pensions and salaries will occur for each governing board member.

Conclusion

26. At Month 12 the CCGs are collectively reporting total spend for 2020/21 of £887.2m which results in a £14.8m lower deficit than the submitted plan. This includes £13m improvement attributed to the CCG and also £1.8m of improved system spend. This still represents a £0.6m overspend against the NHSEI required break even position for the year.

27. It is also important to note that this position is dependent on receiving the M12 retrospective HDP claim of £0.9m, without this the overall deficit would be £1.5m.

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

Appendix A: Covid System Funding

Covid System Envelope

Original system Covid financial envelope M7-12 published:	£18.4m
Spend plans agreed for Covid across all system organisations:	£13.5m
Variance (agreed to be used for other expenditure across organisations and top up system growth funding):	£4.9m

Breakdown of agreed £13.5m Covid budget by organisation:

SATH	£8.5m
RJAH	£1.5m
Shrop Comm	£1.5m
CCGs	£2.1m
TOTAL	**£13.5m**

CCG Covid expenditure for months 1-6 for all organisations has been retrospectively reimbursed by NHSEI (month 6 re-imbursement was made in month 8).

For months 7-12, CCG's have received a proportion of the national Covid allocation, equal to £13.506m.
Payments to SaTH (£8.473m), RJAH (£1.452m) and Shrop Comm (£1.516m) comprise the majority of this allocation.
In addition a further sum of £2.065m was made available for 'Other' CCG Covid costs, £1.694m of this sum was transferred to SaTH in month 12 to cover wider system pressures.

Hospital Discharge Programme (HDP) costs for months 7-12 are excluded from the Covid system allocation and are funded on a reimbursement basis in line with our monthly Non ISFE submission. We have now received reimbursement for months 7-10, and a provisional allocation in respect of months 11-12 . Based on our HDP outturn, we are anticipating a further £959k across both CCG's as a final allocation adjustment.

Appendix A : Covid System Funding

At month 12, across both CCG's ,there is total Covid expenditure of **£33.825m**.
£13.135m of this expenditure relates to provider organisations within the health economy (SaTH, RJAH, Shrop Comm) for months 7-12.
£17.6m relates to Hospital Discharge Programme costs (both CCG commissioned and Local Authority commissioned).

Summary of Covid Costs for April 20 - March 21

	Non ISFE category	TWCCG £	SCCG £	Total £
A	**Acute Services**			
	Local Maternity Services	-	-	-
	Recovery Beds	-	125,158	**125,158**
	SaTH	712,000	9,455,000	**10,167,000**
	RJAH	-	1,452,000	**1,452,000**
B	**Mental Health Services**	56,569	33,717	**90,286**
	Section 117 CHC	482,258	55,265	**537,523**
C	**Community Health Services**			
	SCHT	-	1,516,000	**1,516,000**
D	**Primary Care Services**			
	Prescribing	-	-	-
	General Practice - Community base services	239,826	946,163	**1,185,989**
	General Practice - IT	21,923	12,315	**34,238**
	Hot Sites - Infrastructure	-	301,075	**301,075**
	Hot Sites - Staffing	-	328,505	**328,505**
	Care Home Support (CHAS)	29,520	86,000	**115,520**
	Phlebotomy	65,254	65,254	**130,508**
	Other	33,803	63,648	**97,451**
	Patient Transport	445	59,835	**60,280**
E	**Running Costs**	26,716	85,899	**112,616**
F	**Continuing Care Services**			
	LA commissioned	3,725,356	5,186,376	**8,911,732**
	CCG directly commissioned	3,067,804	5,203,759	**8,271,562**
	CHC team	45,602	342,359	**387,961**
G	**Risk Reserve**	-	-	-
	Total	**8,507,077**	**25,318,328**	**33,825,404**

Appendix A : Covid System Funding

Total Covid spend for the year is **£33.825m**.

This includes ;

i) months 1-6 reimbursed expenditure,
ii) the full month 7-12 system Covid allocation
iii) HDP costs and reimbursement for months 7-10 and
iv) HDP costs and a level of provisional reimbursement for months 11-12.

	M1-M6 Covid expenditure £000	M7-M12 Covid system allocation £000	M7 -M12 Hospital Discharge Programme (HDP) £000	Centralised PPE reimbursement £000	**M1-M12 Total allocation £000**	M12 HDP reimbursement outstanding £000	**Total Budget £000**	Scheme 2 HDP costs in excess of 6 weeks £000	Over/ (Under) spend against allocation £	**Outturn £000**
Telford	5,099	984	1,917	7	**8,007**	325	**8,332**	199	(24)	**8,507**
Shropshire	7,643	12,523	4,317	13	**24,497**	634	**25,131**	199	(11)	**25,319**
Total	12,742	13,507	6,234	20	**32,504**	959	**33,463**	398	(35)	**33,825**

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.017	Update on Progress Against our ICS Pledges

Executive Lead (s):	Author(s):
Claire Skidmore Interim Accountable Officer claire.skidmore@nhs.net	Claire Skidmore Interim Accountable Officer claire.skidmore@nhs.net

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Information was shared with system Chief Executives at their meeting on 14th April 2021	14.4.21	A,I

Executive Summary (key points in the report):

The attached document was presented to a recent meeting of the system's Chief Executives to provide an update on work within the 10 pledge areas that we have signed up to as a system. It is shared with the Governing Body to provide an insight into the progress that is being made in these areas and to allow members of the Governing Body to seek further information on this work if required.

Highlights to note are:

- Considerable progress in the development of system governance for Quality as well as our system quality strategy
- A refresh of overall system governance to better support both our oversight/assurance and operational requirements
- Furtherance of our thinking around 'place' and population health management and commitment to drive this work forward at pace
- Recruitment of a Director of Communication and Engagement for the ICS
- Significant progress to establish an assurance structure and gain leadership support for our sustainability agenda and driving the system towards financial balance

It is acknowledged that by the time of the Governing Body meeting this report will be a number of weeks old and therefore where we have made additional progress since the time the report was written this will be highlighted at the meeting.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? No, the report is for information only, requires no decision and does not generate any potential areas where conflict may arise/be perceived	No
2.	Is there a financial or additional staffing resource implication? No. If actions described in the report do have a resource implication this would be reviewed and managed through usual CCG process	No
3.	Is there a risk to financial and clinical sustainability? No, the actions described in this report seek to contribute to improvements in financial and clinical sustainability	No
4.	Is there a legal impact to the organisation? No, this report is for information only. No decisions requiring legal advice are required	No
5.	Are there human rights, equality and diversity requirements? No, if any part of the work programme is identified to impact on these areas, this would be reviewed and managed through existing process	No
6.	Is there a clinical engagement requirement? Not for this report. Clinical engagement occurs at all relevant parts of our work programme. This is supported by Jane Povey, System Medical Director and Deborah Shepherd, CCG Medical Director	No
7.	Is there a patient and public engagement requirement? Not for this report however as with other areas noted above, there will be requirements in a number of areas of the work programme. The recruitment of a Director of Communication and Engagement for the system will help to mitigate risks in this area	No

Recommendations/Actions Required:
NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to **receive** the attached report and **note** the work being done in delivery of the ICS's 10 pledges.

Update against 10 Pledges

System Chief Executives 14th April 2020

Pledge 1	**Improving safety and quality – making sure our services are clinically safe throughout the system, delivering the System Improvement Plan and tackling the backlog of elective procedures as a system. Specifically this pledge commits us to ensure SATH is rated 'Good' by CQC and that the Ockenden Review's findings are implemented. Across all of our services we aim to use digital innovation and data to enable our workforce to drive improvements in quality and safety and improve outcomes.**
Drive collective system wide performance improvement and accountability by setting clear expectations on accountability for delivery and analysing, evaluating and responding to quality, financial and operational issues. Create an environment and culture that assures system safety, taking a new approach based on Quality Improvement methodologies and concepts of mutual assurance. Build a system-wide quality and performance self-assurance framework.	• The System Quality and Safety Committee has now met for the initial meeting. • The Quality Strategy is nearing final version – it's had wide system engagement and minimal updates and changes are required. This is expected to be signed off at the next Quality Surveillance Group (QSG) on 5th May and will then be recommended to Quality and Safety Committee (QSC) for adoption/approval on the same day. • The QSC will need to recommend to ICS Shadow Board for approval. • A number of subgroups of QSC are in development • ToRs for both QSC and QSG and also the sub-groups are to be finalised. • A temporary Quality Governance Lead has been appointed. • The 2021/22 priorities and operational planning guidance gives specific expectations in relation to the resumption of elective activity and the system is working through the planning assumptions. • Discussions are progressing with regional team about joint chairing the SOAG. The intention is that this will soon be chaired by region and system.
Pledge 2	**Integrating services at place and neighbourhood level – developing local health and care hubs to improve not just the physical but mental health of people, building on the assets of individual communities and the principles of one public estate, enhancing the integration of services at neighbourhood level to manage hospital admissions and establishing new models of care during 2021.**
Finalise our Operating Model confirming work and functions at System, Place and Neighbourhood levels to deliver integrated care pathways. Place based models will be	• A paper has been drafted that sets out a proposed approach for the next steps in place-based working in STW. • The paper has been based on discussions from a small working group drawn from across the system which met three times in March 2021.

developed by working through locality JSNAs and by working with the VCSE to develop an offer at place that takes a person-centred approach, building on what communities and people can do for themselves first.	• The paper was presented to the CE group in March. • Integrated Place Partnerships have been set up in both Shropshire and Telford and Wrekin (SHIPP and TWIPP) • Next steps will be to take the paper to the ICS board and to the SHIPP and TWIPP boards. • Admissions avoidance via community and Place based working is one of the 6 big ticket items
Pledge 3	**Tackling the problems of ill health, health inequalities and access to health care – working with the public and the voluntary and community sector, we will agree measurable outcomes for accelerated Smoking Cessation, improving respiratory health, and reducing the incidence of type 2 diabetes and obesity. We will have a strategy for the implementation of segmented population health management (PHM) approach by April 2021 and undertake a post COVID-19 review of access to all services by September 2021.**
Organising ourselves with effective governance, an operating model and leadership and behaviours provides the foundations for the kind of partnership approach that is crucial for tackling health inequalities.	• An outline approach to population health management will be presented to the April ICS board meeting - Andy Begley. • A system review of ill health and health inequalities has been completed. • An initial strategy in relation to digital access was presented to the CEO Group in March • Megan Nurse – non exec director at Midlands Partnership Trust – has been appointed to be Non-Executive Lead on Health Inequalities.
Pledge 4	**Delivering improvements in Mental Health and Learning Disability/Autism provision – through our transformation programmes, working through whole system approaches, we will deliver improvements in quality of life for people with learning disabilities by March 2022 and meet the national milestones for mental health transformation by 2023/24.**

We will strengthen our provider collaborative arrangements.
 	
Develop a refreshed financial plan, combined with development of the contracting and financial infrastructure necessary in an ICS world, including capitated budgets, long term contracts, and risk share principles.
 	
Create an environment and culture that assures system safety, taking a
	• An update with regard to progress in delivering Improvements in Mental Health, Learning Disability & Autism provision was presented to the ICS Board in February
	• Target dates for delivery of key milestones are as follows:
	  o to deliver improvements in quality of life for people with learning disabilities by March 2022
	  o to meet the national milestones for mental health transformation by 2023/24.
	• The Mental Health, Learning Disabilities & Autism Programme Delivery Board has senior leadership representation and meets monthly. It has four main work-streams that it oversees, responsible for the delivery of the strategic ambitions:

new approach based on Quality Improvement methodologies and concepts of mutual assurance. Finalise our Operating Model confirming work and functions at System, Place and Neighbourhood levels to deliver integrated care pathways.	○ Adult and Older Adult Mental Health ○ Children & Young People Mental Health ○ Learning Disabilities & Autism - all age ○ Prevention & Resilience
Pledge 5	**Economic regeneration – we recognise that economic regeneration will be essential throughout the pandemic and thereafter. For the citizens of Shropshire, Telford**
Commence review of estates strategy progress and development plan to complete	• A paper is due to be submitted to the Chief Executive meeting by the end of April. • The paper is scheduled to be discussed in May/June at the ICS Board outlining priorities and next steps
Pledge 6	**Climate change – we will consult on a multi-agency strategy setting out our response to the threat of climate change by 30th June 2021. This will be designed to create a social movement across our system by agreeing and delivering carbon reduction targets.**
Strategy presented to Board February 2021 in support of 2040 Carbon Net Zero planning to include: - contributing to an interim 80% carbon reduction by 2028-2032 - green vehicles including road-testing zero-emission fully electric ambulances - reducing the number of single-use and consumable products - ensuring hospitals and NHS buildings are more energy-efficient delivering patient care at or closer to home	• A presentation in relation to climate change was developed jointly by both local authorities and presented to the February ICS board. • Target date – draft strategy for consultation by 30 June 2021. • The Strategy will cover the entire STP system and geography and will include: ○ Shared vision ○ Consistent target (e.g. system carbon neutral by 2030) ○ Join up individual organisations' strategies & action plans • Next steps will include the establishment of an STW Climate Change Group • A bid has been submitted for funding from Midlands Region to support NHS targets on carbon reduction. • The outcome of the bid is awaited.
Pledge 7	**Governance – we recognise that how we deliver and make decisions needs strengthening throughout and therefore we will review and revise our ICS Governance arrangements with a particular emphasis on place, neighbourhood and provider collaborative arrangements**

	by 1st April 2021.
Formalising our governance as an ICS, specifically looking at culture, decision making and accountability.	• ICS assurance governance committees are now all in place. • ICS delivery boards are being put in place before the end of April. • A rationalisation of CCG and ICS governance has been undertaken to reduce duplication. • A paper has been drafted that sets out a proposed approach for the next steps in place-based working in STW. • Provider collaborative arrangements are being led by Chief Executive of SaTH – awaiting update paper.
Pledge 8	**Enhanced engagement and accountability – we will increase our engagement, involvement and communication with stakeholders, politicians and the public and develop a plan for this by March 2021. This will include ways of making the ICS more accountable to the citizens of Shropshire, Telford and Wrekin including committing to an annual report by September 2021 and starting to hold ICS Board meetings in public.**
Hold Shadow ICS Board in public Hold first Annual General Meeting	• Edna Boampong has been appointed interim director of comms and engagement for ICS. Permanent post recruitment has also now commenced. • Planning has commenced for delivery of the AGM. • Discussions are ongoing with VCSE around the development of an MOU with the ICS. The aim is to bring this to the board in July.
Pledge 9	**Creating system sustainability – building upon the work included in our LTP, we will produce a sustainable ICS Financial Recovery plan by April 2021 alongside a System People Plan, committing to recruiting and retaining the best people in a supportive working environment. This Pledge will ensure we have system wide arrangements agreed for financial control and future financial allocations.**
Develop a refreshed financial plan, combined with development of the contracting and financial infrastructure necessary in an ICS world, including capitated budgets, long term contracts, and risk share principles. Formalising our governance as an ICS, specifically looking at culture, decision making and accountability. Undertake focused OD to build the right system leadership and collaborative working behaviours.	• David Stout has been appointed as system sustainability director – commenced 1/4/2020 • The 'big ticket' items have been identified and leads identified – MSK, HTP, Workforce efficiencies, Admissions avoidance, Out patients, procurement • A process to identify support from both within ICS and from the CSU and elsewhere is underway with funding from the NIST • A System Sustainability Committee in place and operational. • An investment plan process has been agreed and a sub-meeting of the System Sustainability Committee set up.

Pledge 10	**Making our system a great place to work by creating environments where people choose to work and thrive and by building system leadership and a flexible co-operative workforce.**
	To be updated

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Digital Tactics and Strategy

Developing an IT and Digital strategy for the new CCG

REPORT TO:

Item Number:	Agenda Item:
GB-21-05.018	IT Strategy / Digital Update

Executive Lead (s):	Author(s):
Steve James, Chief Clinical Information Officer Laura Clare, Acting Director of Finance	Mark Aspinall, IT Strategy Lead

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

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

Executive Summary (key points in the report):
This report sets out the progress to date and the structure that we are implementing as we move forwards to create a new strategy for digital services, technology and information management across the CCG and Primary Care. Additionally, it provides a first look at the tactical projects that will be undertaken (to complete by March 2022) to stabilise our technology platforms, improve how we work and to maintain business-as-usual operations.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *There may be additional spending required to procure and provide new equipment, procure and provide new software; these will usually be met by reduction in other cost; each spending decision will need to address where the funding is to be found*	Yes
3.	Is there a risk to financial and clinical sustainability? *(if yes give details)*	No

4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *When addressing matters that impact on Primary Care – such as technology change, data management or patient access routes*	Yes
7.	Is there a patient and public engagement requirement? *When addressing matters that impact on Primary Care – such as patient access routes*	Yes

Recommendations/Actions Required:
Note the progress and plan around the development of a CCG IT strategy and the key tactical projects in place for 2021/22. Regular updates will be provide as development progresses

Introduction

This document sets out the steps being taken to formulate and develop a digital and IT strategy for the new CCG. Neither legacy organisation had a recently reviewed IT strategy or work programme in place. This document, therefore, additionally sets out short-term (tactical) workstreams, many of which are 'foundational' or essential to provide a stable digital and IT platform; some are required to make the new, more agile, working arrangements that have been developed over the preceding year more stable, reliable and seamless.

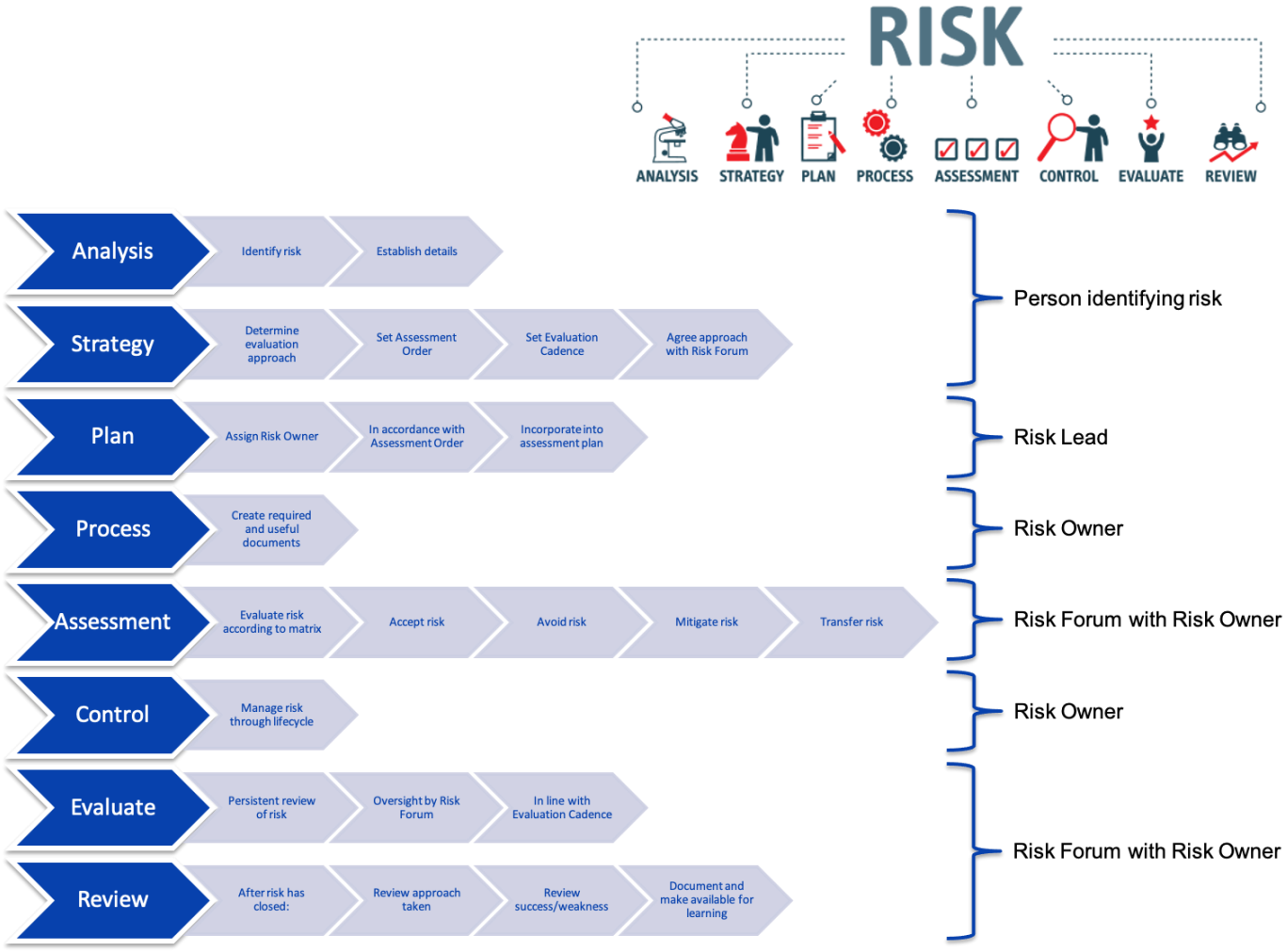
This report details work-in-progress. It is not definitive, and it is expected that both the tactical and strategic elements will develop over the next 4-6 months, through discussion and evaluation.

Management of risk

A part of the work being undertaken in this space includes looking at how risks and issues are identified, managed and controlled in the digital and IT space.

A Risk Management workshop is planned for mid-May so that the current Digital Services (IT) team can formally identify, and make management recommendations, for risks. Once identified, those risks will be taken to a wider forum for discussion, and agreement, on the proposed management approach.

An overall IT risk register is in development and will be discussed regularly at the Digital Operational Group.



Tactical works

Although the digital strategy is being crafted over the next few months, it is vital that some critical projects are commenced and well-controlled in the interim. In order to create a 'bright line' between those which are tactical and strategic projects, the following parameters have been defined:

Tactical

- The project must be necessary in order to provide stable platforms upon which our digital and IT capability can be built (such as networks, infrastructure or 'line of business' systems) – or
- The project must be necessary in order to stabilise or replace existing technology or infrastructure – and
- The project must be estimated to end by 31st March 2022

Strategic

- The project is estimated to end after 31st March 2022

Identified tactical projects

Primary care only

Project	Target	Our lead	
Domain controller installation	31st May 2021	Antony Armstrong (with MLCSU)	• Deployment of Domain Controllers (key network security infrastructure) into GP practices; essential infrastructure work to provide secure networking and access to HSCN • ***UPDATE:*** **on target for completion in May 2021**
Fibre to the Premises (FTTP)	31st May 2021	Antony Armstrong (with MLCSU and RedCentric)	• Deployment of fibre-optic broadband directly to all GP practices • ***UPDATE:*** **on target for completion in May 2021**
Digitisation of records	30th September 2021	Antony Armstrong	• Options appraisal for the digitisation of patient records, notes, correspondence and documentation • Options appraisal for how digitised notes are stored, accessed and recalled; how they are transferred as legitimately required • **Includes planning for procurement of systems and technoloy**
Enhancing the patient experience	31st December 2021	Antony Armstrong	• Channel shift for advice, guidance and – where appropriate – initial consultations (includes GP IT Futures and video consultation procurement) • Embedding changes brought about by the technology provisions made during the pandemic; stabilising and improving functionality, reliability and availability

CCG corporate only

Project	Target	Lead	

Mobile device review	31st May 2021	Corrine Ralph / Sara Spencer	• Identification of mobile devices currently deployed
			  ○ In active use
			  ○ Not in active use
			• Proposal for management
			• Cessation of defunct lines/contracts et al
			• ***UPDATE:* on target for completion in May 2021; data gathering underway**

Physical space changes; digital elements	30th June 2021	Sara Spencer / MLCSU	• Decant from William Farr House (WFH) • Transitions between WFH, Ptarmigan House and Halesfield
Publication of core digital policies	31st August 2021	Sara Spencer	• Telephony (all) • Device deployment • Endpoint (user device) management • Data retention & management (inc. DPA2018/GDPR) • Acceptable use (inc. Microsoft Teams) • Information governance (review in light of other policies) • Agile/remote working technology

Across Primary Care and CCG corporate

Project	Target	Lead	
Endpoint (user devices) refresh and management (device updates etc.)	31st August 2021	Mark Aspinall (with Digital Services colleagues)	• Review of technology inventory – deployed and stock • Evaluation of user-type -v- device needs • Creation and approval of endpoint (user device) refresh cycles (i.e. how often devices will/should be routinely replaced? How will that be funded?)
Infrastructure (servers, network devices, WIFI, storage, cabling, printers etc.) refresh and management	31st August 2021	Sara Spencer	• Review of inventory – deployed and stock • Creation and approval of refresh cycles (i.e. how often will refresh and/or replace occur?)
Data management	30th September 2021	Sara Spencer	• Refresh of data in line with Data retention & Management policy • Cleanse of data in line with same • Archive of data in line with same • (in any event, prior to either Outlook or OneDrive elements of N/M365 project)
Print Management	30th September 2021	Mark Aspinall	• Development of a print strategy (to reduce un-necessary printing) • Options appraisal for management of

			remaining printer estate.
Deployment of Microsoft 365 technologies (N365/M365)	31st December 2021	MLCSU TBC	• Office 365 applications (Word, Excel, Powerpoint, Outlook etc.) • Outlook in the cloud (Exchange online) • OneDrive for personal folders (replacing 'H' drive with a cloud-based tool) • OneDrive for Business/Sharepoint (replacing shared folders with cloud-based tool) • Deployment of Intune Mobile Device Management (MDM) and Application Presentation platform • 31st March 2022 for Intune/MDM, Application platform and OneDrive for Business/Sharepoint elements
Remote access	28th February 2022	Antony Armstrong	• Replacement or recommissioning of VDI for both CCG and primary care use • (ties to deployment of Application Platform in M/N365 project)

For all tactical projects, we will develop a light-touch governance model that ensures delivery takes place in both cost and time-effective manners; thus providing assurance to stakeholders. As part of this governance, a work programme will be produced over the coming weeks to provide a timetabled road-map for delivery of the tactical projects. This will be discussed regularly at the Digital Operational Group.

Planning for the delivery of a Digital Strategy

A strategy is being developed that will have a direct lifespan of 3-years with a further 2-year 'tail' period during which it should be reviewed, refreshed and – if necessary, based on circumstances at that stage – re-written for the next 3-year period.

It is expected that the new 3-year strategy will be published in the latter part of 2021 (August / September). We will work with partners across the wider-system (including the System Digital Lead, Rebecca Gallimore) to ensure that our strategy is fully aligned and joined to the ICS and wider system digital strategies.

Inputs and approach

In order to make this strategy as robust as possible, the following key areas are being considered:

- **Overall organisational strategy**: the digital strategy, in all elements, must have clear links to the wider CCG and system strategies (nationally, regionally and locally); it must play into the goals of the organisation and not vice-versa
- **Tactical necessity**: notwithstanding the immediate tactical projects identified above, the Digital Strategy must also be flexible enough to allow for ongoing tactical projects to take place – where needs dictate, in emergencies or where – as with the pandemic – a thoughtful but rapid approach is required to novel change
- **Current state**: the strategy must carefully incorporate a realistic view of what the current state is so that it can be clear about the scale, scope and need of any change; it also has to be realistic (so far as is possible) about what the environment in which we operate will look like during its own lifetime

The inputs that we will, therefore, require as an essential ingredient to deliver the strategy are:

- CCG organisational strategy, roadmaps etc.
- STP system strategy
- NHS Digital, NHSX and NHSE&I strategies as appropriate
- Details of the current state of the digital and IT technology estates
- Details of what the future may look like (for example, the recent white paper on ICS)
- A view of what technology is available and how it may align with needs and goals
- A view of what is technologically possible with the technology available; does what is possible (including financially and practically) align with needs and goals; what are the gaps and deltas?
- A view of what is digitally desirable; what would the best case be – how close can we come to it, exceed it? What happens in the spaces where we can't attain the ideal?

This information is being gathered via a series of meetings with stakeholders and through a series of workshops that will commence in April 2021:

Workshop 1: Setting out the basics

Scheduled for 27th April 2021

- Establish the overarching goals and purpose of the digital strategy: why does the CCG need one? What is it intended to achieve? How will it be used?
- Identify and capture opportunities that may form the basis of discussions around what must be, should be and could be done or accomplished using digital capabilities
- Identify and capture risks to both the digital and IT estates and to the development of the strategy
- Define principal choices to be made

Workshop 2: Evaluating the current state, art of the possible and art of the practical

Planned for mid-May 2021

- Review and consider the current state of, and possibilities for:
    - Information, data and storage
    - Technology in use day-to-day
    - Hardware – infrastructure, cloud, SaaS, IaaS, PaaS
    - Operating environment – challenges, changes and the horizon
    - Software in use day-to-day; who, what, where, when, why and how?

Workshop 3: How to make our strategy come alive?

Planned for mid-July 2021

- What resources are needed to meet the needs and aspirations identified?
    - Are those resources available? How will they be created or provisioned?
- Service engagement
    - How will the digital function engage with services across both the CCG and Primary Care?
- Digital management and leadership
    - What leadership and management essentials are needed?
    - What governance will be needed for projects?
    - How will the organisation maintain assurance that we have secure and reliable technology?
- Procurement and service delivery
    - What model should be used for service delivery?
        - Customer/Supplier (as in CCG and CSU or other vendor)?
        - Shared services in STP/ICS?
        - Something else; a mixture of many?

Recommendation

Governing body members are asked to:

Note the progress and plan around the development of a CCG IT strategy and the key tactical projects in place for 2021/22. Regular updates will be provide as development progresses.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.019	Assuring Involvement Committee (AIC)

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

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

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

Executive Summary (key points in the report):
In the Governance Handbook the CCG outlines a committee called the Assuring Involvement Committee (AIC) which will play an important role in providing assurance to the Governing Body that the CCG is fulfilling its statutory responsibility with regard to engaging with its local population. The purpose of this report is to provide an overview of the Committee's role and composition to ensure that the Governing Body is fully aware of the assurance function the Committee will provide.

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

	The Assuring Involvement Committee's role is to ensure that the CCG meets the public sector equality duty.	
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement? The Assuring Involvement Committee role is to ensure 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	Yes

Recommendations/Actions Required:
NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to note the role and remit of the Assuring Involvement Committee as outlined in this report.

REPORT: Assuring involvement Committee
DATE: 12th May 2021

Background

The CCG's Constitution and Governance Handbook was adopted formally at the CCG's Governing Body meeting on 14th April and prior to that had undergone extensive consultation with both memberships of the then two CCGs and the two preceding Governing Bodies.

In the Governance Handbook the CCG outlines a committee called the Assuring Involvement Committee (AIC) which will play an important role in providing assurance to the Governing Body that it is fulfilling its statutory responsibility with regard to engaging with its local population.

The purpose of this report is to provide an overview of the Committee's role and composition to ensure that the Governing Body is fully aware of the assurance function the Committee will provide.

Report

The terms of reference of the Committee as set out in the Governance Handbook, are attached as appendix 1 for information, but the following should be noted:

- The Committee is a committee of the Governing Body and any amendments to the terms of reference of the Committee require approval at the Governing Body. The Scheme of reservation and Delegation outlines its assurance role to the Governing Body, but it has no delegated decision making ability on behalf of the Governing Body. The Chair of the Committee will prepare, with the assistance of the Director of Corporate Affairs, a report following each meeting to the Governing Body to provide regular assurance.

- Its role is two fold:
    - To ensure that the CCG is involving and engaging with its local population in the planning, development and decisions affecting the commissioning of services.

    - To ensure that the CCG is meeting the Public Sector Equality Duty i.e. the CCG considers discrimination and the needs of people who are disadvantaged or suffer inequality, when they make decisions about how they provide their services and implement policies.

- In essence the role will be to assure the Governing Body that staff acting on its behalf to commission services, have plans in place to engage/involve or consult with the population or groups within the population and deliver on those plans, to ensure that decisions are based upon a robust evidence.

- The Committee's role is <u>not</u> to provide feedback on the service proposals itself, but to check that the CCG officer is actively engaging those people who already receive or may receive these services in the future, to understand their views or the impact on them or their families of the proposals being considered. Also, to seek assurance that members of the public are involved in the design and development of proposals to change services.

- In order to provide a significant element of critical friend challenge, the Committee will be composed of 10 appointed members of the public, 2 of these 10 will be appointed as Chair and Vice Chair and the two Lay Members for PPI and PPI – EDI. Training will be provided to the public appointed members to empower them to fully participate in and contribute to the Committee's function.

- The CCG is currently undertaking an open competitive recruitment process for the appointed members of the public roles. This includes a shortlisting and interview process against a role description, by the Lay Member for PPI and Director of Corporate Affairs.

- The Committee is scheduled to meet monthly and we expect to be convening the Committee's first meeting at the end of May or early June. The meetings will be supported by the Director of Corporate Affairs and the Communications and Engagement Team.

Recommendation:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to note the role and remit of the Assuring Involvement Committee as outlined in this report.

APPENDIX 1 – EXCERPT FROM GOVERNANCE HANDBOOK VERSION 1.3

Assuring Involvement Committee

Terms of Reference

1. Introduction

1.1 The Assuring Involvement Committee (the committee) is established by the Governing Body in accordance with NHS Shropshire, Telford and Wrekin 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 committee.

1.2 The Assuring Involvement Committee (the Committee) is responsible for the oversight and monitoring:

a) 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

b) that the CCG meets the public sector equality duty.

1.3 The Assuring Involvement Committee may meet 'in-common' with other CCG's Committee if this is required to support collaborative Commissioning.

1.4 The Committee has no authority to make decisions on behalf of the Governing Body.

2. Membership

2.1 The membership of the committee will be as follows:

- Chair – Appointed Public Member
- Vice Chair – Appointed Public Member
- 8 Appointed Public Members
- Lay Member Patient and Public Involvement (PPI)
- Lay Member Patient and Public Involvement – Equality, Diversity and Inclusion (EDI)

2.2 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.

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

- Director of Corporate Affairs or Deputy Director of Communications and Engagement
- Head of Communications and Engagement
- Senior Patient Engagement and communications Specialist
- Patient Engagement and Communications Specialist

3. Chairing Arrangements

3.1 The Committee will be chaired by the Chair – Appointed Public Member.

3.2 In the event of the Chair of the Committee being unable to attend all or part of the meeting, the Vice Chair – Appointed Public Member will deputise for that meeting.

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

3.4 In exceptional circumstances, where urgent action is required, the Chair is authorised to take urgent action with prior discussion with two other committee members. A report should be made to the full committee at the earliest next opportunity.

4. Secretary

4.1 Secretarial support will be provided by the CCG Senior Communications and Engagement Administrator. The Director of Corporate Affairs and the Deputy Director for Communications and Engagement 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.

5. Quorum

5.1 The quorum is a minimum of 5 members listed in section 2.1 above.

5.2 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
- 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.

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 Assuring Involvement 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 effectively discharge the role set out in 1.2 above by acting as "critical friend" and will be responsible for exercising the following functions:

- 7.1 Scrutinise and oversee 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;
- 7.2 Scruitinising 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.
- 7.3 Undertaking the CCG self assessment on the Equality Delivery System(EDS) on behalf of the Governing Body using evidence it has been presented with during the previous 12 months.
- 7.4 Scrutinising the action plan and progress of implementation arising from the annual self-assessment of the Equality Delivery System.
- 7.5 Scutinising 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 an robust and identifying any risks and related mitigation.

7.6 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".

7.7 Promoting innovation, best practice and value for money in the collection of patient experience and opinion of CCG commissioned services.

7.8 Scrutinising and approving the content of the annual patient experience report for inclusion in the CCG's Annual Report.

7.9 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

7.10 Overseeing the development of the CCG's membership model, providing expertise and direction to ensure the development of an informed, diverse and active membership.

7.11 Providing general advice and guidance on how the CCG should seek public involvement and engagement.

7.12 Review at the request of the CCG Governing Body specific aspects of patient and public involvement where the Governing Body requires additional scrutiny and assurance.

7.13 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.

7.14 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 Assuring Involvement Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and recommendations made by 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.

10.4 A record of the date and outcome of reviews is kept in the CCG governance handbook

Date of Governing Body approval: 14/04/21

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.020	CCG Mission Statement and Strategic Objectives

Executive Lead (s):	Author(s):
Claire Skidmore Interim Accountable Officer claire.skidmore@nhs.net	Alison Smith Director of Corporate Affairs alison.smith112@nhs.net

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

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

Executive Summary (key points in the report):

In August 2020 the Jointly appointed Governing Body members of both Shropshire and Telford and Wrekin CCGs undertook a series of board development workshops to support the transition into the new single CCG from 1st April 2021.

One of the outputs of these workshops was the development of the NHS Shropshire, Telford and Wrekin CCG's mission statement and strategic objectives which were presented to the March 2021 Governing Body Meetings in common on 10th March 2021. At this meeting the Governing Bodies asked for more work to be undertaken on refining both the vision statement and objectives. A small group was convened to refine the statements and the output of the session is outlined below.

The purpose of the report is to present the mission statement and strategic objectives for approval and adoption:

Mission statement

To ensure that everyone in Shropshire, Telford and Wrekin has the best possible health and healthcare through our planning, buying and monitoring of services.

Strategic priorities

1.To reduce **health inequalities** by making sure services are available when and where they are needed, for everyone in Shropshire, Telford and Wrekin.

2. To identify and improve **health outcomes** for our local population.

3.To improve **joint working** with our local partners, leading the way as we become an Integrated Care System.

4.To achieve **financial balance** by working more efficiently.

5.To ensure the health services we commission are **high quality**, sustainable and value for money.

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

Recommendations/Actions Required:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to approve for adoption the Mission Statement and Strategic Objectives outlined in the report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

2021/22 Financial Plan Update

Governing Body May 2021

REPORT TO: **Governing Body – 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.022	2021/22 Financial Plan Update

Executive Lead (s):	Author(s):
Laura Clare Acting Director of Finance laura.clare@nhs.net	Laura Clare Acting Director of Finance laura.clare@nhs.net

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

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

Executive Summary (key points in the report):

This paper sets out the current progress towards the system sustainable finance plan, the agreed next steps and how arrangements will work for H1 (the first half) of 2021/22.

Sustainable finance plan:

Significant work is currently underway to develop a system sustainable finance plan that spans a number of years and addresses the system financial deficit. The first year (2021/22) is a year of stabilisation with no increase in spend from 2020/21 underlying levels, with transformational years in years 2-5 delivering significant system savings.

At present if all investments were funded there would be a significant gap in the first year of the sustainable finance plan. A number of steps are in place to address this with organisations across the system working collaboratively and ensuring that investments are not approved until efficiencies are robustly identified to pay for them.

H1 finance plan:

Non recurrent financial arrangements will operate in the first half (H1) of 2021/22 due to the ongoing COVID-19 pandemic. NHSEI have issued financial envelopes to the system based on 2020/21 Quarter 3 expenditure.

H1 plans are due for submission on 6th May 2021.

This paper details current progress for the financial element of those plans and highlights the latest

position.

For the CCG only element, the current H1 plan shows the CCG with a planned H1 deficit of £4.9m with further unmitigated risk of £3.2m relating to Individual Commissioning i.e. a risk adjusted deficit of £8.1m.

As a system there is currently a total gap against the H1 financial envelope of £6.0m which is in line with the underlying system sustainability model. This has been discussed with chief executives at their meeting on the 5th May and it was agreed that to comply with the H1 plan guidance, a balanced system financial plan would be submitted but with a clear narrative and risk profile that shows that the 'most likely' forecast position for the system for H1 is a system deficit of £6m.

For simplicity and transparency, it has also been agreed that the adjustment to the plan to break even, as well as any unallocated system reserves will be held with the CCG. This will be reported separately on a monthly basis but will mean that the overall CCG element of the plan submission including the system element will show a plan of £1.7m surplus in H1, and a risk adjusted deficit of £7.5m.

There are £2.5m of efficiency plans built into the CCG H1 plan which will be monitored and reported on regularly by the CCG PMO.

Subject to approval at Governing Body, budgets will now be issued to budget holders for H1 based on the plan submission.

In year reporting will focus on the position against the sustainability plan as well as against the H1 envelope. Recurrent spend will be reported and will be overlaid with non recurrent H1 adjustments eg COVID expenditure. The system position will be shown separately to the CCG position.

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

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

Recommendations/Actions Required:
The committee is asked to: 1. APPROVE the H1 plan submission to be used for CCG budgets for the first half of 2021/22 2. NOTE that the CCG is holding the £6m system adjustment to break even for H1 3. NOTE the level of risk inherent in the plan 4. NOTE the progress and next steps to develop the recurrent sustainable finance plan across the system.

Tables included in this report:

Table 1: CCG figures within current system sustainable plan modelling 6
Table 2: CCG Efficiency Plans in H1 8
Table 3: Current H1 plan position by organisation 9
Table 4: Comparison of H1 non system spend to 1/2 sustainability plan 10
Table 5: Overall CCG plan including system reserves/adjustments 11
Table 6: H1 Proposed CCG Budgets 11

Graphs included in this report:

No table of figures entries found.

Schedules appended to this report:

Appendix	**Content**
Appendix 1	Sustainability Plan Financial Bridge

2021/22 Financial Plan Update

Introduction

1. The Shropshire, Telford and Wrekin Healthcare system exited the year 2020/21 with a recognised in year underlying deficit position of £135m. The CCG element of this deficit is £71m. In order to set a financial recovery plan for the system, the following principles have been collectively agreed.

    - Year 1 2021/22 – Is a Year of stabilisation. The year of Stabilisation – any further spending growth across system is limited to no more than growth in resources received

    - Year 2 to 5 2022/23 – 2025/26 – Transformation Recovery Years. An actual recurrent expenditure reduction by 3% per annum = reducing the deficit by £30m, each year

2. The recent letter to the system received from NHSEI also sets clear financial recovery parameters. A system Investment Task and Finish Group is now meeting on a regular basis to review any system investment decisions to be made and individual organisations no longer have the autonomy to do this unless it relates to a specific ring fenced budget/allocation.

3. Progress towards the system financial recovery plan is underway with all system partners working collaboratively to model the financial position and develop transformational plans.

4. If 2021/22 was a normal year then year one of the sustainable financial plan would form the basis of each individual organisation's 2021/22 financial plan and budgets. However, due to the ongoing COVID-19 pandemic it has been agreed nationally that temporary financial arrangements will continue for the first half of 2021/22 (known as H1).

5. This paper sets out the current progress towards the system sustainable finance plan, agreed next steps and how arrangements will work for H1 of 2021/22.

System Sustainability Plan Update- Year 1- Stabilisation

6. Detailed work has progressed in terms of modelling the recurrent 2021/22 financial position and the steps required to deliver stabilisation. Appendix 1 shows the current stabilisation plan for 2021/22 as a collective system financial bridge. Details of this at an organisational level have been discussed at the CCG Finance Committee as well as at system Chief Executive and Director of Finance meetings.

7. The bridge shows that to achieve stabilisation, system expenditure must be contained at a total of £1,146m which gives an overall system deficit of £115m. The main current issue is that if we were to fund all investments that have been identified, we would need to find significant additional savings, over and above efficiency plans that have been identified so far.

8. The efficiency plans currently identified for the CCG equate to approx. £6m. These plans are rag rated green or amber and have developed business cases. In order to achieve the £13.5m (3%) target set for the CCG a number of actions are underway led by the PMO in the Transformation directorate to rapidly develop additional efficiency schemes. A detailed report on progress on this was presented to Finance Committee in April 2021. This showed a range of schemes being

reviewed/developed with a current rag rating of red. A new CCG sustainability working group chaired by the Director of Transformation meets on 14th May 2021 to ensure that there is pace behind the development of further schemes.

9. In order to develop the sustainability plan, a number of key assumptions have been agreed that relate to CCG expenditure. These include :

- zero growth - underlying cost base is assumed to be 2019-20 activity levels and therefore flat growth is expected. The dip in activity in 2020-21 is at most expected to return to 2019-20 levels. Therefore zero growth to be included in contracts.
- 1% inflation – average 1% inflation across all spend – there will be some exceptions to this that need to be offset with zero inflation in other areas (Prescribing and CHC currently excluded). Therefore wherever possible zero inflation uplift to be applied with maximum of 1%. Areas where this is not possible need to be captured as a risk.
- No investments to be agreed without system and NHSEI sign off.
- 3% efficiency target for all organisations, for the CCG this is 3% on non system spend and equates to approx. £13.5m.
- Prescribing – local growth assumptions modelled based on information from the medicines management team and national benchmarking.
- Individual Commissioning- local growth and price assumptions modelled based on information from the CCG Individual Commissioning team, historic trends in the Broadcare system and independent modelling carried out as part of the system review process.

10. The CCG plan within the current system sustainability model is shown in Table 1. This position is dependent on the CCG delivering the full 3% efficiency target set in year which is currently unlikely.

Table 1: CCG figures within current system sustainable plan modelling

	£m
Total assumed allocations/income (including system efficiency support)	**804.1**
Total expenditure within system (SATH, RJAH, Shropcomm)	(398.4)
Total expenditure outside system providers	(453.0)
Contingency	(2.4)
Total expenditure	**(853.8)**
Total Deficit	**(49.7)**

This is based on the current system model and allocation of income across organisations which is subject to change once published allocations are known and there is an agreed split of allocations as per the IFP arrangements.

11. As part of the recurrent 2021/22 arrangements the system has agreed to move away from Payment by Results (PbR) and instead operate under the Intelligent Fixed Payment Mechanism (IFP). IFP is a financial framework between the health partners who are performance managed within the Shropshire and Telford & Wrekin Integrated Care System (ICS)

12. Rather than using activity and price as the method to determine the amount of contract income paid by the host CCG to the 3 local health Trusts each year, the health partners have agreed to use a simpler method to allocate the CCG Resource Limit between themselves which embraces collaboration rather than competitive values. The IFP is consistent with the principles in the NHS Long Term Plan and the White Paper for NHS Reform 2021.

13. The CCG Resource limit will be fully allocated at the start of each year on the basis of the jointly agreed net expenditure of the 4 organisations (CCG, SaTH, RJAH and ShropComm). Cost and Activity risk will be borne by the 4 spending organisations.

14. The 4 IFP partners will attempt to improve the system financial position over a number of years by working together and individually on improving the cost effectiveness of the health services provided. The system financial position will be the main measure of financial success although individual organisational financial reporting will remain the bedrock of financial governance arrangements.

15. A detailed guide to IFP has been discussed with finance committee members at an informal workshop on 14th April 2021. The IFP arrangements are intended to operate from the second half of 2021/22.

System Sustainability Plan Update- Year 2-5 Transformation Recovery

16. In order to transform and recover over the next few years, the system has agreed on a number of Big-Ticket Items over a 5-year period. The 6 key project themes are outlined below and a number of CCG staff are involved in developing these schemes with system partners.

    - Accelerating aspects of Hospital Transformation Programme
    - MSK
    - Avoiding Hospital Stays
    - Out-Patients
    - Integrated Procurement/Joint Commissioning
    - Workforce

System Sustainability Plan Update- Next Steps

17. A number of next steps are required to agree the sustainability plan:

- All figures being tested especially in light of the latest H1 guidance
- Efficiency plans being rapidly developed across all organisations and tested/reviewed for likelihood of delivery
- Investment task and finish group to agree priority investments for the system in light of efficiency plan delivery
- Mobilisation of resource to support the big ticket items to develop future years saving/transformational plans

H1 Planning guidance

18. If 2021/22 was a normal year then year one of the sustainable financial plan (current version shown in Appendix 1 and Table 1) would form the basis of each individual organisation's 2021/22 financial plan and budgets. However, due to the ongoing COVID-19 pandemic it has been agreed nationally that temporary financial arrangements will continue for the first half of 2021/22 (known as H1).

19. H1 guidance was released at the end of March 2021. There is a requirement for full plans including a detailed narrative plan accompanied by activity and workforce detail to be submitted by the 6th May 2021. This work is being led by the CCG Director of Planning. There is also a requirement for a financial plan submission on the same date.

20. The H1 guidance in terms of financial arrangements states that :

- NHSEI have nationally calculated CCG and provider plans for H1 on the basis of Quarter 3 2020/21 actual positions adjusted for known pressures and policy priorities. Systems have therefore been issued with system financial envelopes for H1 on this basis.
- System envelopes again include non recurrent funding in the form of system top ups, system growth funding and system COVID funding.
- Block arrangements will remain in place with all NHS providers, uplifted from 2020/21 by 0.5%
- Systems will have access to additional funding for the Elective Recovery Fund (ERF), Mental Health Investment Standard (MHIS), additional primary care growth and development funding for community services through Service Development Funding (SDF).
- A system COVID allocation will be in place again for H1.
- All systems are asked to submit a balanced position against the H1 funding envelope

21. There is also a requirement for a detailed Mental Health financial plan, this is being worked on by the system Mental Health group and will be submitted at the same time as the overall financial plan, the mental health expenditure assumptions shown in the H1 overall plan will align to the detailed mental health template which covers a full year and will show that the plan will deliver the Mental Health Investment Standard (MHIS) requirements. Details of the Mental Health Plan will also be discussed at the CCG Strategic Commissioning Committee in May.

22. In order to submit a plan that meets the organisation control totals a number of steps have been taken:

- The startpoint for the plan has been the underlying expenditure levels in the system sustainability plan. (shown in Appendix 1) This has been adjusted for known changes in spend due to the H1 guidance eg block arrangements still in place, no Non Contracted Activity (NCA) etc .
- The 0.5% contingency requirement in the sustainable finance plan has been removed as this is unaffordable within the H1 envelope.
- A total efficiency target of just over 1% (£2.5m) has been included in H1. The breakdown of the efficiency plan for the CCG in H1 is included in Table 2 and represents just under half of the current identified efficiency schemes for the full year. This is currently much lower than half of the overall 3% target and means that the CCG will need to deliver a much bigger proportion of efficiency in H2.

Table 2: CCG Efficiency Plans in H1

Category of expenditure	**H1 efficiency plan total £m**
Individual Commissioning	1.5
Medicines Management	0.9
Running Costs	0.1
TOTAL	**2.5**

23. The financial modelling for H1 across the system has identified a total £6m gap to achieving break even. This is shown in Table 3.

Table 3: Current H1 plan position by organisation

Organisation	System financial envelope (current distribution assumptions)	Other income	Current h1 expenditure plan	Surplus/(deficit)
	£m	**£m**	**£m**	**£m**
CCG	218.1		(223.0)	(4.9)
SATH	175.9	61.8	(241.7)	(4.0)
RJAH	25.0	33.7	(56.6)	2.1
Shropcomm	37.2	8.6	(45.6)	0.2
System reserves still to be allocated	0.6			0.6
TOTAL system H1 position	**456.8**	**104.1**	**(566.9)**	**(6.0)**

24. The CCG row in the table above excludes the spend within system providers to show the net system position.

25. The total system funding envelope for H1 of £456.8m shown above currently excludes SDF (Service Development Fund) funding and the Elective Recovery Fund (ERF) which are being worked up and will be added on to the plan as memorandum sections. The envelopes above include the split of system top up allocations on the same basis as at Q3 2020/21.

26. It is important to note that in this current plan there is also a level of unmitigated risk flagged by each organisation. This risk is being worked through at system meetings but for the CCG the total level of unmitigated risk inherent in the plan equates to approximately £3.2m due to risk around Individual Commissioning expenditure levels.

27. There are currently no mitigations in the plan to offset this level of risk as the contingency has been removed. The only option would be to accelerate the delivery of efficiency schemes from later in the year into H1.

28. Within Appendix 1 and Table 1, the CCG non system expenditure position (including the contingency) equates to £455.4m, for half of the year this would be £227.7m. The current H1 non system expenditure plan for the CCG is £223m (see Table 3), this is therefore £4.7m lower than the first half year spend currently shown in the sustainability plan. The breakdown of this by category of spend is shown in Table 4.

Table 4: Comparison of H1 non system spend to 1/2 sustainability plan

	½ of sustainability plan £m	H1 expenditure plan £m	Difference £m
Acute	41.2	35.4	5.8
Mental Health	40.8	40.2	0.6
Community	5.9	5.6	0.3
Individual Commissioning	36.6	33.4	3.2
Primary care (inc prescribing)	48.5	49.2	(0.7)
Primary Care Co commissioning	38.3	39.1	(0.8)
Other	10.9	14.9	(4.0)
Running Costs	4.4	4.6	(0.2)
COVID	-	0.7	(0.7)
Contingency	1.2	-	1.2
Total	**227.7**	**223.0**	**4.7**

29. The £4.7m lower expenditure is partly due to non recurrent elements of H1 guidance that are also adjusted for in the spend envelope , these are:

- £5.8m lower spend in acute due to continuation of block contract arrangements and no NCAs
- (£0.7)m increased spend due to continued COVID expenditure

30. This leaves a remaining difference in the expenditure plan of just £0.4m so broadly the H1 plan is in line with ½ the sustainability plan. There are however three key points to note that offset each other. These are:

    -Phasing of efficiency plans. This impacts across all categories of spend but is mostly evident in the other expenditure row in table 4. This is a hit in H1 of approximately £4.3m. (£2.5m built into H1 versus ½ of the total 3% target which is £6.8m)
    -Phasing of Individual Commissioning growth. Approximate £3.2m benefit to H1(i.e. assuming compound growth effect and so spend higher in H2 than H1- risk around this is highlighted)
    -Removal of 0.5% contingency in H1 – approx. £1.2m benefit to H1 position

31. As described, the above adjustments net off so that overall spend is broadly the same as half of the sustainability model. A similar exercise has been carried out for each of the other system organisations to demonstrate that the current H1 expenditure plan is in line with the sustainability model.

32. The £6m deficit position across the system has been discussed with Chief Executives/Accountable Officers at their meeting on the 5th May 2021 and it was agreed that to comply with the H1 plan guidance, a balanced system financial plan would be submitted but with a clear narrative and risk profile that shows that the 'most likely' forecast position for the system for H1 is a system deficit of £6m.

33. For simplicity and transparency, it has also been agreed by Chief executives/Accountable officers that the adjustment to the plan to break even, as well as any unallocated system reserves will be held with the CCG. This will be reported separately on a monthly basis but will mean that the overall CCG element of the plan submission including the system element will now show a plan of £1.7m surplus in H1, and a risk adjusted deficit of £7.5m, as shown in Table 5.

Table 5: Overall CCG plan including system reserves/adjustments

	(Deficit)/Surplus £m	**Unmitigated Risk £m**	**Risk Adjusted Position £m**
CCG Position	(4.9)	(3.2)	**(8.1)**
System reserves still to be allocated	0.6	-	**0.6**
System underspend adjustment to break even system plan	6.0	(6.0)	**-**
Overall CCG plan including system adjustments	**1.7**	**(9.2)**	**(7.5)**

34. Once the H1 plan is approved and submitted this will be used for CCG budget setting for the first half of the year.

35. A summary of the plan to be submitted for the CCG which will form the basis of budgets for H1 is therefore set out in Table 6. This position is based on the current system distribution of the envelope between organisations. If this was amended, the deficit/bottom line number would change for individual organisations but remain the same for the system. What is important is that budgets will be set on the expenditure plan indicated in table 6. Any redistribution of allocations/income across the system will be reported to Finance Committee and Governing Body.

Table 6: H1 Proposed CCG Budgets

	£m
Total Allocation (excluding SDF and including system reserves to be allocated)	**456.8**
In system spend (SATH, RJAH, Shropcomm)	(238.1)
Spend outside of system providers:	
Acute	(35.4)
Mental Health	(40.2)
Community	(5.6)
Individual Commissioning	(33.4)

Primary Care (inc prescribing)	(49.2)
Primary Care Co Commissioning	(39.1)
Other	(14.9)
Running Costs	(4.6)
COVID	(0.7)
System underspend adjustment	6.0
Total Expenditure	**(455.1)**
Total Surplus	**1.7**

36. It is important to note that plan delivery will be assessed on the full year recurrent stabilised expenditure position at a system level by NHSEI. The H1 plan is simply a six month plan that fits within the stabilisation framework agreed.

37. The most likely current scenario is that we achieve the sustainable plan for the year but with a £6m deficit position in H1 against the funding envelope provided.

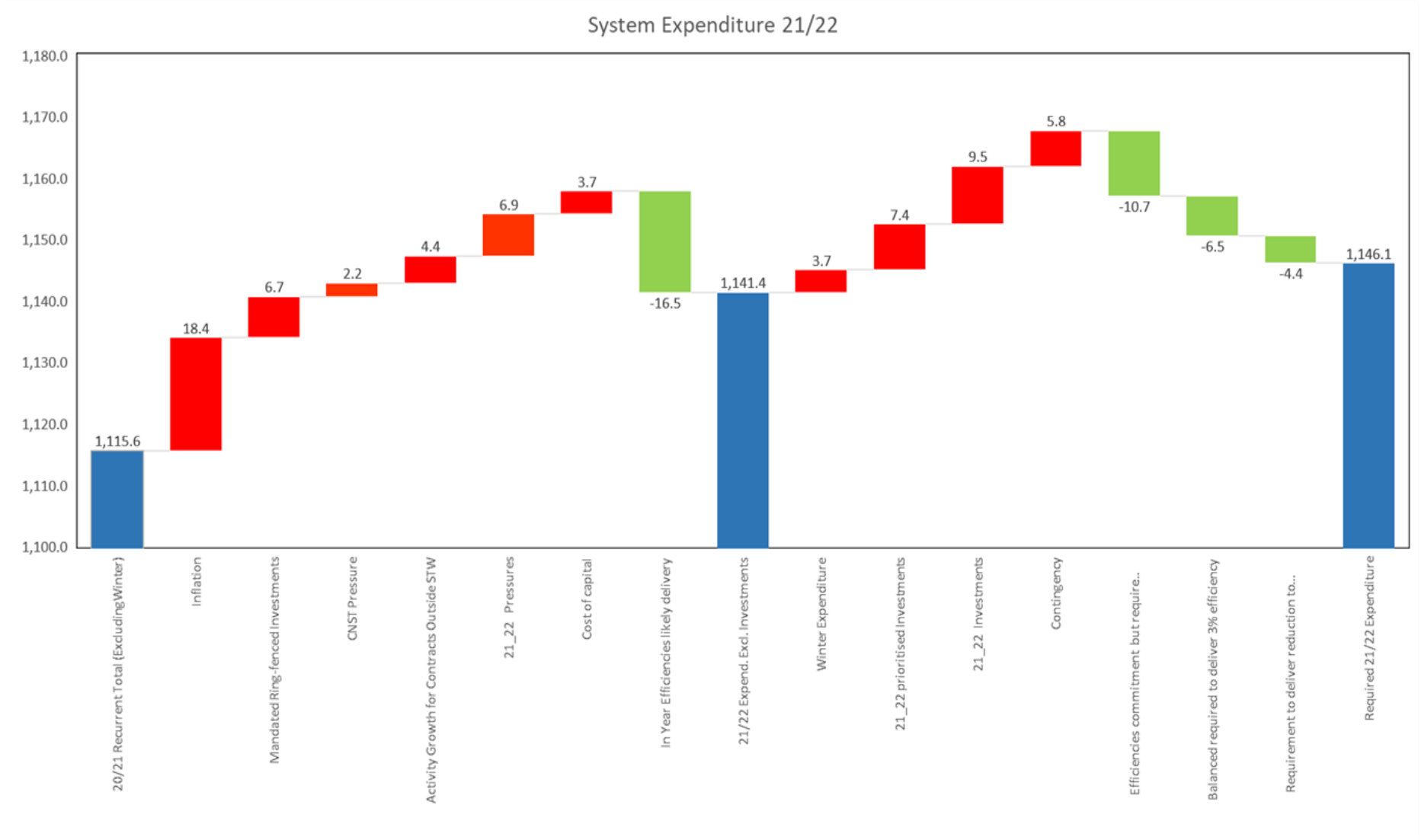
38. For the second half of the year it is currently expected that we will return to normal financial arrangements and therefore the original published CCG allocations.

39. In year reporting will focus on the position against the sustainability plan as well as against the H1 envelope. Recurrent spend will be reported and overlaid with non recurrent H1 adjustments eg COVID expenditure. The CCG and system position will be separated out in reporting.

Recommendation

40. To APPROVE the H1 plan submission to be used for CCG budgets for the first half of 2021/22
41. To NOTE that the CCG is holding the £6m system adjustment to break even for H1
42. To NOTE the level of unmitigated risk that this presents
43. To NOTE the progress and next steps to develop the recurrent sustainable finance plan across the system.

Appendix 1 – Current System Sustainability Plan Financial Bridge 21/22



Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.023	CCG Governing Body Cycle of Business

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

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

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

Executive Summary (key points in the report):

The Annual Cycle of Business attached as appendix 1 has been developed based on that of the previous last two years for each CCG; NHS Shropshire CCG and NHS Telford and Wrekin CCG and its purpose is to enable the Governing Body to focus as a minimum on strategic issues outlined in the Constitution, strategic risks set out in the BAF and decision making as set out in the scheme of reservation and delegation.

The cycle of business is intended as guide for Governing Body preparations and additional business can be added throughout the year.

The annual cycle of business will also allow the CCG to quickly revise its meetings in light of any further COVID-19 pressures during 2021/22.

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

6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to approve for adoption the Governing Body Cycle of Business attached to the report.

Annual Cycle of Business - Governing Body
April 2021 - March 2022 (indicative - in-year issues may result in changes to agenda)

Heading	Sub Heading	Item Description	Director Lead	Paper	Action	April Extra	May	June Extra	Jul	Sep	Nov	Jan	Mar
Introduction		Apologies	Chair	No	Note	X	X	X	X	X	X	X	x
		Declarations of Interest	Chair	Yes	Assurance	X	X	X	X	X	X	X	x
		Introductory Comments by the Chair	Chair	No	Note		X		X	X	X	X	x
		Accountable Officer's Report	AO	Yes	Note		X		X	X	X	X	x
		Minutes from previous meeting	Chair	Yes	Approve		X		X	X	X	X	X
		Questions from the public	Chair	Yes	Note		X		X	X	X	X	X
Assurance and Committee Reports	Quality and Performance	Quality and Performance Report (BAF)	ED Q&S	Yes	Assurance		X		X	X	X	X	X
		Chairs Exception report from previous Quality and Performance Committee	LM PPI	Yes	Assurance		X		X	X	X	X	x
		Safeguarding Board Annual Reports: Shropshire Telford and Wrekin	ED Q&S	Yes	Assurance				X				
	Finance	Finance Report (BAF)	ED F	Yes	Assurance		X		X	X	X	X	x
		Chairs Exception report from previous Finance Committee	LM G	Yes	Assurance		X		X	X	X	X	x
		Sustainable System Finance Plan (ICS)	ED F	Yes	Assurance				X				
		Finance Planning Update	ED F	Yes	Approve		X						
	Audit & Risk	Chairs Exception report from previous Audit Committee	LM G	Yes	Assurance		X		X	X	X	X	x
		Board Assurance Framework (BAF)	D CA	Yes	Assurance				X	X	X	X	x
	Primary Care	Chairs Exception report from previous Primary Care Commissioning Committee	LM P				X		X	X	X	X	x
		Update on Primary Care Strategy	D Partnerships	Yes	Assurance						X		
		Chairs exception reports from Locality Forums	Locality Chairs	Yes	Assurance		X		X	X	X	X	x
		EPRR Annual Assessment	D Planning	Yes	Assurance							X	
	Planning and Restoration	Restoration and Recovery Update (BAF)	D Performance	Yes	Assurance		X	X	X	X	X	X	X
		Flu Plan	D Planning	Yes	Assurance						X		
		Operational Plan	D Planning	Yes	Assurance		X			X			X
		Population Health Management Development (BAF)	D Planning	Yes	Assurance					X			
	Transformation	Chairs Exception report from previous Strategic Commissioning Committee	LM PPI EDI	Yes	Assurance		X		X	X	X	X	X
	Governance	Annual Workforce Metrics	D CA	Yes	Assurance				X		X		X

		Workforce Survey	D CA	Yes	Assurance					X			
Strategic Developments and other reports		Integrated Care System (ICS) Development (BAF)	AO	Yes	Assurance		X		X	X	X	X	X
		Annual LEDER Report	ED T	Yes	Assurance			X					
		IT Report / Digital Update	ED F & CCIO	Yes	Assurance		X		X				X
		Quarterly HR Metrics	D CA	Yes	Assurance				X		X		X
		Grant of Merger	D CA	Yes	Note	X							
		Staff Transfer Schemes	D CA	Yes	Note	X							
		Property Transfer Schemes	D CA	Yes	Note	X							
		Primary Care Scheme of Delegation	D CA	Yes	Note	X							
Decision Making		Annual Report and Annual Accounts	ED F & D CA	Yes	Approve			X					
		Corporate Mission Statement and Objectives	AO	Yes	Approve		X						
		WRES Annual Assessment Submission	D CA	Yes	Approve					X			
		Commissioning Strategy (SORD & SSC)	D Planning	Yes	Approve		X						
		IT Strategy	Ed F	Yes	Approve		X			X			
		Procurement Strategy (SORD & SSC)	ED F	Yes	Approve				X				
		Communications and Engagement Strategy (SORD & SSC)	D CA	Yes	Approve		X						
		HR and OD Strategy (SSC)	D CA	Yes	Approve		X						
		Risk Management Strategy (SORD)	D CA	Yes	Approve		X						
		Conflicts of Interest Policy (SORD)	D CA	Yes	Approve		X						
		Health and Safety Policy (SORD)	D CA	Yes	Approve		X						
		Annual Review of Constitution and Governance Handbook	D CA	Yes	Approve							X	
		Adopt Constitution and Governance Handbook	D CA	Yes	Approve	X							

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.024	Transition to NHS Shropshire, Telford and Wrekin CCG – adoption of key strategies and policies

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Alison Smith Director of Corporate Affairs alison.smith112@nhs.net Tracy Eggby-Jones Corporate Affairs Manager Tracy.eggby-jones@nhs.net

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

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

Executive Summary (key points in the report):

The purpose of the report is to:

1) Present to the Governing Body four key strategies for approval for the new CCG:

- Commissioning Strategy
- Communications and Engagement Strategy
- Organisational Development Strategy
- Risk Management Strategy

2) Present the following two key policies that require approval by the Governing Body under the scheme of reservation and delegation:

- Conflicts of Interest Policy
- Health and Safety Policy

3) Outline in appendices 7 and 8:

a) those previous CCGs' policies (marked in green) that have already been aligned and approved in April or plan to be in aligned and approved in May by the CCG Governing Body or a Committee for noting; and

b) those previous CCGs' policies (marked in yellow) that require post May, review, alignment and approval with the proposed completion dates reflecting priority, that will require the Governing Body to adopt them for the interim period for the respective staff groups or geographical populations until such time these are approved by NHS Shropshire, Telford and Wrekin CCG

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

Recommendations/Actions Required:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to:

1) approve the:

- Commissioning Strategy – appendix 1;
- Communications and Engagement Strategy – appendix 2;
- Organisational Development Strategy – appendix 3;
- Risk Management Strategy – appendix 4;

2) approve the Conflicts of Interest Policy appendix 5 and Health and Safety Policy appendix 6 for the new CCG;

3) note those policies marked as green in appendix 7 that have already been or plan to be reviewed and approved by the Governing Body or a committee of the Governing Body by 30th May 2021; and

4) approve the policies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as outlined in appendices 7 and 8 that are marked in yellow for the respective staff groups and registered patient populations, until such time these are reviewed and revised policies can be presented to the Governing Body/or a Committee for approval.

Report: **Transition to NHS Shropshire, Telford and Wrekin CCG – adoption of key strategies and policies**

Meeting: **12th May 2021**

1. Introduction

As part of the process of transition from the two previous CCG's to the new NHS Shropshire, Telford and Wrekin CCG post 1st April 2021, a number of key documents require formal adoption and approval by the Governing Body.

There are two key types of documents that are presented with this report and they are outlined below.

2. Key Strategies

2.1 As part of the application process for becoming a single CCG from 1st April 2021, the then CCGs had to develop a number of draft strategies across a number of different areas:

- Commissioning Strategy – appendix 1
- Communications and Engagement Strategy – appendix 2
- Organisational Development Strategy – appendix 3

2.2 In addition, the Governing Body reserves the approval of the CCG's Risk Management Strategy – appendix 4, which is has been scrutinised and is recommended for adoption by the Audit Committee at its extraordinary meeting in April

2.3 Given the publication of the White Paper which sets out the planned dissolution of CCGs in a year's time and the creation of statutory ICS, these documents are presented acknowledging they have a finite lifespan, but have been written to provide the strategic infrastructure the CCG needs in its last year of operation.

3. Key Policies

3.1 The two previous CCGs; Shropshire and Telford and Wrekin had numerous policies in place to guide how their respective organisations and staff operated. These policies were based upon key legislation and NHS guidance. In support of the transition to a single CCG and as part of due diligence process, these policies have been risk assessed with the aim to provide full policy coverage to NHS Shropshire, Telford and Wrekin CCG.

3.2 The following policies have been reviewed and are presented to the Governing Body for adoption and approval by the CCG:

- Conflicts of Interest Policy – appendix 5
- Health and Safety Policy – appendix 6

3.3 A number of policies have been or will need to be rewritten, either incorporating latest guidance or a policy from one CCG that exemplifies the policy requirements has been rebadged as a replacement for NHS Shropshire, Telford and Wrekin CCG with a view that these are presented to the Governing Body or a Committee for adoption and approval as per the Scheme of Reservation and Delegation. In appendix 7 and appendix 8 the full list of NHS Shropshire and NHS Telford and Wrekin CCGs' policies are outlined, together with an

indication of when the review and approval process will be completed for each. The Governing Body is asked to note that those policies marked as green in appendix 7 have already been reviewed, aligned and approved or plan to be by the end of May by either the Governing or a Committee.

3.4 Appendices 7 and 8 also identify those CCG policies that have not yet been assessed and had a new CCG replacement drafted and approved which are marked in yellow. This is due to, in some cases capacity issues related to staff being redeployed to Covid 19 activities or the priority assigned to the policy. In order to ensure that the new CCG has adequate policy coverage, it is proposed that the new CCG would adopt the policies and frameworks of the two legacy CCG's for those staff and registered populations to which they apply where they have not yet been reviewed, aligned and will be approved by the end of May 2021. This would be until such time as consolidation was completed, successor documents were approved, or they were no longer required. This approach would be consistent with many other CCG's that have merged in the past and based upon advice sought from Mills and Reeve with regards the CCGs proposed approach to those policies that had not yet been aligned.

3.5 A master control document is held but the Corporate Affairs Team, to ensure that adoption of policies is undertaken as planned in appendix 1. This master control document will also be presented to the Audit Committee for assurance purposes.

4 RECOMMENDATIONS:

4.1 **NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to:**

1) approve the:

- Commissioning Strategy;
- Communications and Engagement Strategy;
- Organisational Development Strategy;
- Risk Management Strategy;

2) approve the Conflicts of Interest Policy and Health and Safety Policy for the new CCG;

3) note those policies marked in green in appendix 1 that have already been or plan to be reviewed and approved by the Governing Body or a committee of the Governing Body by 30th May 2021; and

4) approve the policies of NHS Shropshire CCG and NHS Telford and Wrekin CCG as outlined in appendices 7 and 8 that are marked in yellow for the respective staff groups and registered patient populations, until such time these are reviewed and revised policies can be presented to the Governing Body/or a Committee for approval.

NHS Shropshire, Telford & Wrekin Clinical Commissioning Group

Clinical Commissioning strategy

Version tracker

Version Number	Date	Author	Details of Update
0.1	1 October 2019	Fran Beck	Early draft collating information to address KLOEs
0.2	20 February 2020	Sam Tilley	Updated with additional information following feedback
0.3	13 March 2020	Angela Parkes	Format changed following feedback Restructured to provide an overarching narrative Added Implementation and monitoring section Redesigned Population health management section
0.4	18 March 2020	Angela Parkes	Updated vision and values section Updated benefits realisation section Added operating model as appendix Added full benefits realisation document as appendix
0.5	20 March 2020	Angela Parkes	Updated contracts model section Updated operating model appendix Update Implementation and Monitoring impact graphs
0.6	April 2020	Angela Parkes	Added Covid-19 impact statement Added milestones appendix Added organisational development section Added future provider landscape section Updated financial strategy section and impact graphs Updated population health management section Updated governance section
0.7	September 2020	Sam Tilley	Update to slides to reflect development of system working and further impact of Covid-19 Updated System Governance Updated (draft) finance section pending submission of finance Strategy on 5 October 20

Version Tacker

Version Number	Date	Author	Details of Update
0.8	18 December 2020	Sam Tilley	Full re-drafting of Strategy utilising NHSE/I feedback
0.10	January 2021	Angela Parkes	Amendments to quality slide
0.11	March 2021	Angela Parkes	Updated financial section to match financial strategy Added Big Ticket items section including roadmap Minor updates to Population Health Management section Updated next steps section
012	March 2021	Zena Young	Update to Quality section

Contents

Foreword
1 Summary
2 Our Vision and values
3 System Priorities
4 Delivery environment
5 Strategic Commissioning
6 Population Health Management Strategy
7 Design and Delivery of clinical care
8 Financial Strategy
9 Benefits Realisation
10 Implementation and Monitoring
11 System Big Ticket items
12 Next Steps

Appendix 1 – Operating Framework
Appendix 2 – Benefits Realisation
Appendix 3 – System Improvement Plan

Foreword – Clinical Chair

(Julian Povey , Joint Chair of Shropshire and Telford & Wrekin CCGs)

Our Clinical Commissioning strategy sets out how NHS Shropshire and Telford & Wrekin Clinical Commissioning Group aim to develop and improve health services for our population over the next three years. We want to ensure the right help is available to people when they need it, achieving the best health outcomes we can and making the best use of our resources, within a landscape of constrained financial resources, advances in medicine, and increasing life expectancy.

The future of both the commissioning and provision of healthcare is changing in a positive way. The development of integrated models of care through provider collaboratives, supported by strategic commissioning (working at a larger scale) has been identified as a future model for the NHS. This way of working means that a greater level of care will be provided to patients in their home or within their community, by a Place Based Multi-Disciplinary team of professionals. Our aim is to reduce reliance on hospital based care, but when patients do need hospital treatment they will receive the same seamless care delivered by an integrated community team. This strategy describes the aspirational journey we plan to take to improve the health and wellbeing of the local population.

Our strategy has been developed in alignment with national and local policy:

- The NHS Long Term Plan
- The Shropshire, Telford & Wrekin local Sustainability and Transformation Partnership and Long Term Plan
- Five Year Forward View
- General Practice Five Year Forward View
- Mental Health Forward View
- Transforming Care Programme
- National Cancer Strategy
- Shropshire Health and Wellbeing Strategy / Telford and Wrekin Health and Wellbeing Strategy
- STW System Improvement Plan

NHS Shropshire, Telford & Wrekin CCGs will endeavour to lead the local health and care system to ensure stronger strategic commissioning, a system approach where collaboration and partnerships underpin delivery as well as ensuring more personalised care, closer to patients homes with improved outcomes. Our strategy will align to these goals and is further informed by key health improvement areas identified by our quality and performance data.

Our effectiveness and success is dependent upon robust commissioning approaches, system collaboration, brave and resilient leadership, clinical engagement, drive, ambition and transformation, sound financial strategy and excellent transparent governance. We will be further developing and improving our approaches to these important underpinning characteristics over the next three years.
Our staff and membership are key to our success. Creating an environment that recognises good work, energy and effort will ensure that staff and our membership feel able and empowered to contribute to the transformation that is required to achieve our ambitions.

National Context

The NHS Long Term Plan (LTP) signalled the direction for health and social care services for the next 10 years. It aspires to provide everyone with the best start in life, deliver world-class care for major health problems, such as heart disease and cancer; and help people to age well with equal life expectancy regardless of social circumstances. The national LTP summarises the challenges faced by the NHS, such as growing demand and workforce shortages and sets out how these can be overcome by:-

1. Doing things differently: giving people more control over their own health and the care they receive
2. Taking more action on preventing illness and tacking health inequalities: increasing the focus on some of the most significant causes of ill health, smoking, alcohol and lifestyle changes to avoid Diabetes type 2
3. Improving care quality and outcomes for major conditions
4. Addressing workforce gaps by increasing the workforce, training and recruiting more professionals and redesigning roles
5. Making better use of data and digital technology
6. Getting the most out of taxpayers investment: reducing waste and duplication of delivery; improving efficiencies and transforming care, and doing things differently, for example, significantly changing Out Patient services.

Our system has prepared a local response to the LTP which provides the full detail of how we will deliver the ambition articulated in the national Long Term Plan. The new Strategic Commissioner will be a system leader to ensure we drive all of the changes planned, and at pace. This Clinical Commissioning Strategy attempts to provide a strategic overview of the plans of the Strategic Commissioner, supported by a set of very detailed programme plans.

Covid-19 Impact

The impact of Covid-19 for the NHS has been, and will continue to be, immense. Much of the planned transformation across the system has been paused or scaled back as the system responds specifically to the tasks of addressing patient need in relation to the pandemic.

Whilst the system addresses restoration and recovery from the impact of the pandemic alongside its ongoing management, the challenges this presents also brings opportunities.

The STW system has had to come together to collectively address a common goal in a way that it has not done so before. This has lead to the implementation of new collaborative structures for tasking as well as decision making and has been a catalyst for developing collaborative ways of working. Staff have stepped outside of their usual roles to deliver priority actions at pace, to develop solutions for wicked problems and to share ideas and innovation

The CCGs are leading the ongoing development of the systems collaborative approach by using the foundations laid during the height of the pandemic to support the building blocks for the future Integrated Care System and Strategic Commissioning. The learning from the pandemic is assisting in re-forming system structures, roles, responsibilities as well as its goals and ambitions

This process has accelerated the work that the system would have needed to undertake on its journey towards becoming an Integrated Care System and stands us in good stead to move forward with a new approach to commissioning, provider collaboratives and a more system focused philosophy for delivering the best patient care and outcomes

Covid-19 Impact

A set of principles to guide future working have been agreed

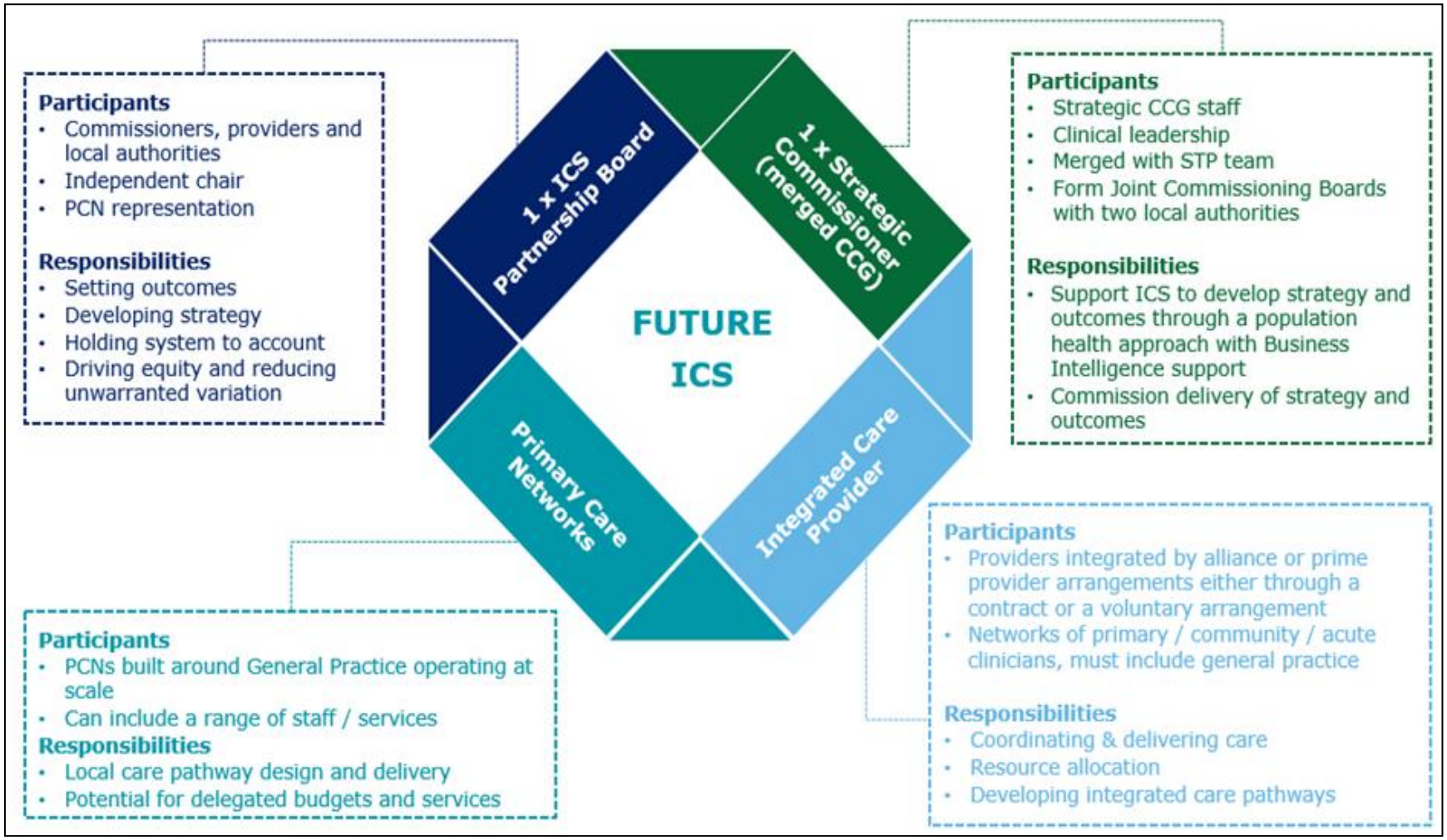
System Principles

- System as default
- Re-organisation of the system around key priorities i.e. directing resource at delivering key priorities and stopping doing those things that do not deliver these priorities
- Maintain pan-organisational governance and ensure it continues to support solution focused, rapid decision making
- Deployment of staff to support priorities – matching skills with tasks and working across traditional boundaries
- Embrace change – the system cannot stay the same and nothing is off the table
- Combine efforts of system restore, prioritised services and winter plan response

These principles will underpin the strategic commissioners approach to its business and its focus on improving the health and care of its population

Moving towards an integrated care model

In implementing the sentiments of the NHS Long Term Plan the commissioner and provider landscape will change. Commissioning will take place at a number of levels; Regional and sub-regional, Sustainability and Transformation Partnership (STP) footprint or at Place level. We are clear that closer working between partners is a crucial ingredient for the delivery of our ambitious plans, we have tested this hypothesis during our Covid-19 response and we have some early indications of the benefits this can bring. For that reason we believe collaboration is better than competition and we want to cement our relationships by creating an Integrated Care System (ICS) by April 2021.



Moving towards an Integrated Care model

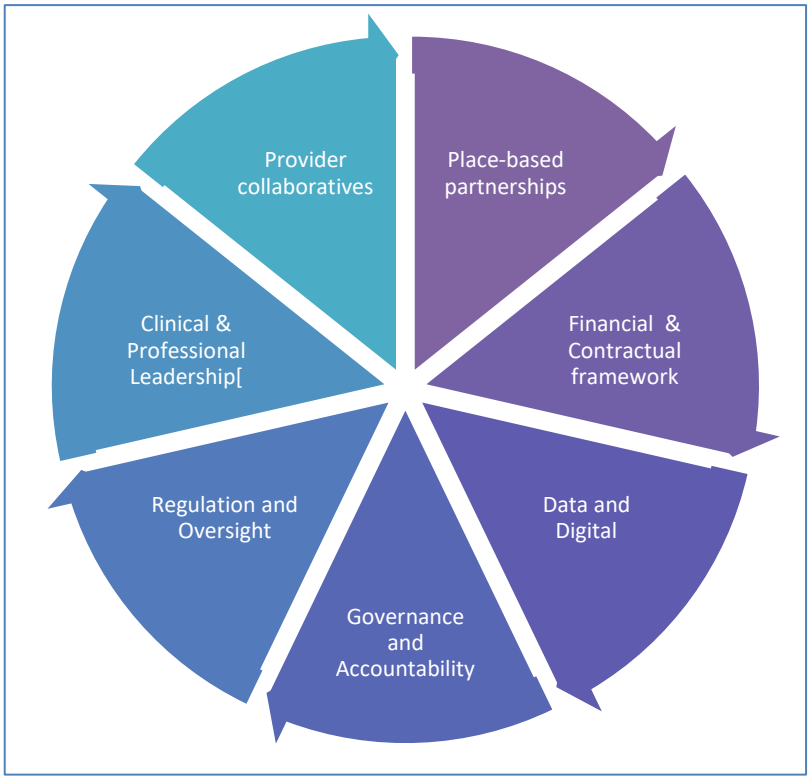
We will build our approach around the following NHSE/I principles:

Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;

Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and

Developing strategic **commissioning** through systems with a focus on population health outcomes;

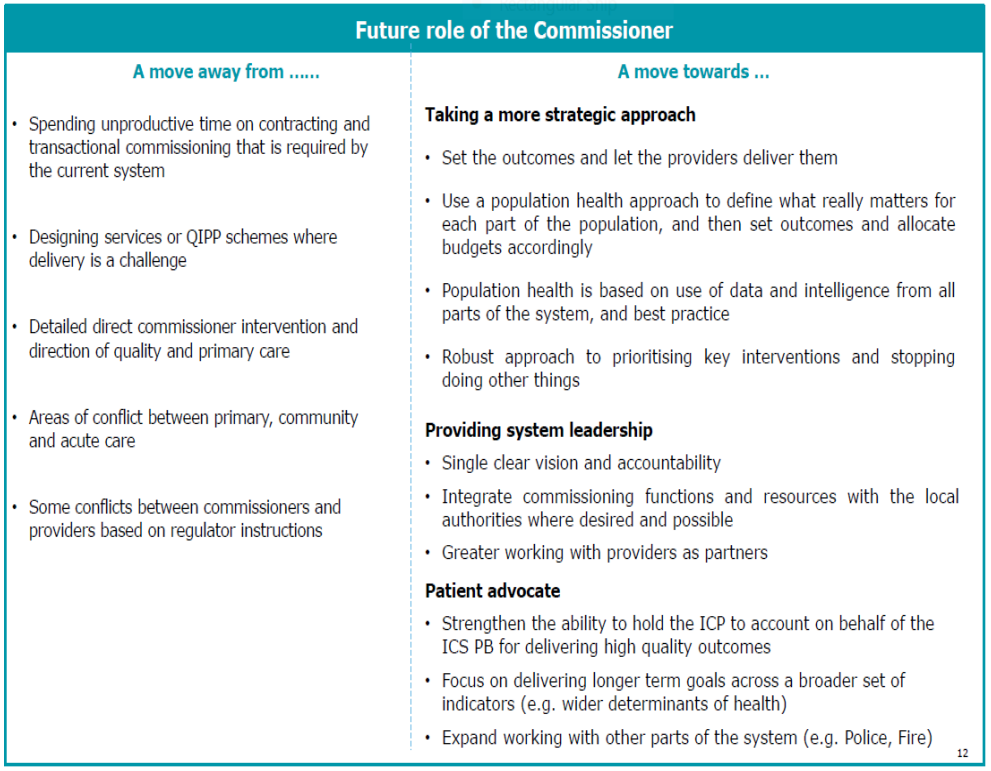
The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.



Future role of CCG

As the ICS develops, we expect that a number of common functions will need to be established:

- Analytics and insight in support of Population Health Management and a wider system approach to Business Intelligence capabilities;
- Oversight and assurance of operational and financial performance and LTP implementation including workforce, estates and digital;
- Management of collective financial resources and identification and delivery of system-wide efficiencies;
- Co-ordination and delivery support for operational and strategic planning;
- Streamlined and robust system-wide decision-making and effective governance;
- Stakeholder engagement, clinical engagement, multi-professional leadership development and partnership working;
- Provider development across the system to support the development of provider collaboratives ,
- Focus on Place based approaches working in neighbourhoods and in particular supporting the development of PCNs ;
- Integration of health and care between NHS and local government at place and at neighbourhood; and
- Quality improvement and sharing best practice, involving all staff groups across the system.



Future role of the Commissioner

A move away from	A move towards ...
• Spending unproductive time on contracting and transactional commissioning that is required by the current system	**Taking a more strategic approach**
• Designing services or QIPP schemes where delivery is a challenge	• Set the outcomes and let the providers deliver them
• Detailed direct commissioner intervention and direction of quality and primary care	• Use a population health approach to define what really matters for each part of the population, and then set outcomes and allocate budgets accordingly
• Areas of conflict between primary, community and acute care	• Population health is based on use of data and intelligence from all parts of the system, and best practice
• Some conflicts between commissioners and providers based on regulator instructions	• Robust approach to prioritising key interventions and stopping doing other things
	Providing system leadership
	• Single clear vision and accountability
	• Integrate commissioning functions and resources with the local authorities where desired and possible
	• Greater working with providers as partners
	Patient advocate
	• Strengthen the ability to hold the ICP to account on behalf of the ICS PB for delivering high quality outcomes
	• Focus on delivering longer term goals across a broader set of indicators (e.g. wider determinants of health)
	• Expand working with other parts of the system (e.g. Police, Fire)

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The future CCG role will include:

- Working Strategically with LA commissioners focusing more on population health need, whole system and population, community and individual patient outcomes
- Retaining statutory responsibilities but with some of these responsibilities to be discharged through working alongside system partners
- Aligning activities with local authorities, aiming to ensure effective integration of the approach
- Working with LAs and providers to shift some traditional commissioning activities (e.g. pathway redesign) to providers who may be better placed to undertake this work
- Increasingly directing CCG resources towards delivery of the necessary system-wide and place based functions.
- Working with neighbouring ICSs to take on greater responsibility in planning and managing specialised and direct commissioning services alongside budgetary accountability.

Case for Change

The key challenges for the system can be broken into the following categories:

Demographics and Geography

- Largely rural county with two main urban centres.
- An aging population
- Pockets of severe deprivation
- Lower wage economy
- Deprivation linked to education, access to employment and housing that need to be considered
- Lack of sound system level data and intelligence to inform delivery

Operational Performance

- Local services struggling to meet demand
- Workforce constraints with NHS providers having high levels of staff vacancy
- Failing to deliver key targets e.g. A&E and cancer targets

Quality

- CQC ratings are 'Inadequate' for care quality and leadership, notably within acute care and maternity services
- Pathways and facilities for Children and Young Persons in need of Mental Health assessment need reconsideration to meet national standards.
- Non delivery of some constitutional and service standards
- Shropshire Ofsted / CQC inspection - we are required to develop a Written Statement of Action (WSOA) for SEND improvements

Workforce

- All providers in health and social care report difficulty in recruiting and retaining staff

Reconfiguration

- The Hospital Transformation Programme (Future Fit) highlights key issues relating to outdated buildings, equipment and service models
- Focus on out of hospital care including prevention agendas
- Development of Primary Care Networks (PCNs)
- Community development

Digital Infrastructure

- Differing levels of technology available to partners which limits the system moving forward towards a truly collaborative digital workspace

In the NHS Long Term Plan the ambition has been set for the NHS to adapt and improve to meet the challenges it faces. In order to fulfil its part in this ambition Shropshire CCG and Telford and Wrekin CCG have made a commitment to form a single strategic commissioning organisation. In doing this we believe that:

- A single set of commissioning and decision making processes will enable reduced variation in outcomes and access to services
- A single CCG will have greater influence with providers through one voice
- A single CCG will be more efficient with a better use of clinical and managerial time on the things that count, reducing duplication and running costs
- This supports the development of a robust Integrated Care System for the county of Shropshire

CCG Mission / Vision

To buy innovative, safe and high quality services that meet the current and future, rural and urban needs of the people of Shropshire, Telford and Wrekin

CCG Values

Our vision and the way we deliver it clearly demonstrate our CCG values:

We recognise the level of transformation required across the system to enable us to deliver our vision. We will lead and drive this transformation through the clinical leadership model we are embedding into our CCG and through our new Strategic Commissioning Framework, using a PHM approach to commission services around patient and population characteristics, rather than providers. Our patients and communities will be better supported to keep themselves well at home, experience shorter waiting times, and receive more holistic patient centred care. We have commenced on this journey and have a collective aspiration to drive change and improvement.

We will have a stronger role as the patient's advocate to hold the ICP to account for delivering the high quality outcomes set, seek to deliver longer term goals for improvement in the local populations health, rather than the current transactional monitoring of sickness related activity. We will also broaden work with the system partners beyond health and social care e.g. police, fire service, schools, employers and housing providers.

Section 2: Our vision and values – what can people expect from the CCG?

Staff	Provider	Public
▪ Always ask "What does this mean for the patient?" and prioritise this in all aspects of service design and improvement ▪ Display active listening, empathy, proactive rather than reactive behaviour ▪ Positive working environment where there is open regular communication, staff feel safe and supported, there is zero tolerance to bad behaviour, mistakes are used as learning opportunities and excellence is encouraged ▪ Clarity of expectations, roles, responsibility, accountability and priorities ▪ Individuals recognise own limitations, support each other, have the freedom to be brave and are motivated to make a difference ▪ Actively hold providers to account ▪ Empower staff with genuine autonomy and ability to develop creative solutions ▪ Be creative and innovative in use of resources ▪ Senior support to deliver schemes ▪ Personal integrity and transparency ensures organisational integrity and transparency ▪ Robust but fair challenge from both sides	▪ Always asking "What does this mean for the patient?" ▪ Being open about challenges, financial constraints and the trade offs required, always seeking to put the patient first ▪ Organisation has empathy for pressures in providers, listens to providers concerns, provides support as well as challenge to enable them to fulfil their roles and sets outcomes but give providers flexibility on how to deliver them ▪ Collaborative approach where ideas for improvement are shared, change is embraced, providers are supported to make changes and continuous improvement is supported ▪ Mutual understanding of positions, shared risks and how these will be managed these together. ▪ Encourages feedback and responds to it ▪ Strive for good governance in all decision making with full transparency ▪ Open regular communications ▪ Set outcomes but hold providers to account for delivery of outcomes ▪ Sharing functions on a system footprint where possible	▪ Open, honest and regular communication with a consistency of approach and language that is jargon and acronym free ▪ Ensure patients have a voice by creating a safe environment where everyone is free to speak, seek to build patient relationships and listen to patients and their families ▪ Consider patients as individuals, acknowledge diversity, understand each others perspective, have open and honest conversations about how the patient contributes to their own care ▪ Develop a more robust focus on equality, diversity and inclusion and utilise the learning from Covid-19 to develop our approaches to support our BAME communities ▪ Be clear on the consequences of decisions, show that acting in good faith, communicate that there are limited resources, acknowledge limitations and where the CCG gets it wrong. ▪ Have clear accountability, make evidence based decisions, provide assurance by seeking evidence of high quality care, continuous review of practice, focus on outcomes, transparency and openness around decisions and their implications. ▪ Be clear on the commissioner 's role in the allocation of the resources its receives ▪ Ensure the public is aware that the commissioner does not deliver services

Model for Executive Team

The Executive Team will be utilising the ten behaviours expected from Governing Body members as outlined in the NHS Leadership Model.

Delivery

The key steps around delivery of the values and behaviours are outlined below:

- Communicate the vision and values at all levels within the CCG. Keep repeating it.
- Ensure senior managers and Governing Body are ready, willing and able to embrace the changes
- Encourage all levels of the organisation to embrace the change using change management ambassadors
- Change management ambassadors morph into staff engagement champions who track delivery of values and gather feedback
- Develop a plan of how the vision and values are going to be implemented, have deadlines and owners for all actions
- Staff survey and 360 degree feedback to gather information around delivery and morale
- Recommunicate the policy around whistleblowing
- Development of talent management approach including appraisals, PDPs, induction, shadowing and training
- Ensure the handover from past objectives / appraisals to future objectives / appraisals is smoothly handled
- Monitor how implementation of the plan and how the change is going on a regular basis
- If the plan isn't working don't be afraid to change it
- Promote flexible and agile working arragements to support staff wellbeing, efficiency and effectiveness

Strategic objectives

The new CCG will focus on 6 key strategic objectives (subject to ratification by the new Governing Body):

No.	Objective	Link to STP
1	Lead the financial transformation needed to identify key shared priorities required to drive both clinical and financial sustainability and ensure these are delivered	Financial: System deficit identified within plans as a priority for address. Improvement to system deficit via transformation programmes, shared functions and system wide approaches.
2	Provide the strategic and clinical leadership in the planning and commissioning of care for the people of STW – this will include developing new transactional arrangements to incentivise providers to take lead responsibility for key cohorts of patients/populations	Financial: Improvement to system deficit via transformation programmes Transformation programmes are a key driver for STP plans and are being led by the CCG Planning to incorporate development of shared functions where possible, based on principle of "System as Default"
3	Reduce health inequalities and demand by deploying a population health management approach to improve the physical and mental health of people living in Shropshire, Telford and Wrekin	Development of a system wide approach to Population Health Management and Business Intelligence. Development of shared resources and capabilities and expertise
4	Reduce variation in outcomes and quality of care	Quality planning underpins the STP governance and includes the requirement to reduce variation. Use system view to highlight areas that require addressing
5	Improve communication with an involvement of patients, public, clinicians and all stakeholders	Development of system wide comms approach, shared resources to support more effective and consistent communications and engagement Co-production is a key feature of the Quality planning that underpins the STP governance.
6	Re-focus on prevention and anticipatory patient centred care	Further develop the STP workstream dedicated to prevention and place based care, driven by sound data and intelligence

Developing our priorities

The commissioning priorities are directly linked to the system priorities that have been developed through system wide collaborative working as part of our Long Term Plan submission and more latterly the System Improvement Plan in the context of national and local policy.

Using a PHM approach we are developing a shared understanding of population need, drawing upon our two Local Authorities Joint Strategic Needs Assessments (JSNAs) and using intelligence and analysis of care needs, patient and population outcomes, patient experience, resource utilisation, analysis of variation and health inequalities.

We are using this intelligence to:

- Agree the **key system solutions** that will enable us to deliver our vision and the aims of the NHS LTP
- Agree the **critical path to delivery**, that will enable us to deliver those solutions
- Segment the resulting activities into clear programmes of work, and agreeing the key interventions and deliverables
- Agree **core priority areas** (Prevention and Placed Based Care, Acute and Mental Health)
- Agree our underpinning **drivers of delivery**
- Understand the outcomes and benefits we expect, and develop our framework to monitor them

This approach is underpinned by clinical engagement, developed in partnership with our CCG clinical leaders and the work of our STP. It is also underpinned by an ongoing programme of patient and public engagement with support from Healthwatch Shropshire and Healthwatch Telford & Wrekin.

Our commissioning priorities reflect our need to develop new models and new pathways of care, underpinned by integrated workforce solutions across organisational boundaries. They also require us to address Clinical Sustainability across fragile services and develop networked solutions across providers both within and outside the STP footprint. In turn we anticipate that this will result in a more financially sustainable position for the system.

We will drive the delivery of our commissioning priorities through:

- Our Strategic Commissioning framework, setting out strategic direction and expected outcomes, with contractual frameworks that address barriers and incentivise delivery
- Supporting providers/place based alliances to respond with proposals to deliver new models of care and integrated pathways, clinically assuring pathway redesign, as well as supporting them to develop robust governance frameworks, for quality, clinical governance and resources/finance
- Developing our ICS operating model, to drive coordinated delivery across service transformation, quality, performance and finance functions

The headline impact of this is set out on the following three slides:

Community and Place Based Care

Community and Place Based Care	
Priority schemes (subject to system wide ratification) 1. The completion and implementation of restoration and Recovery plans for primary care and community services 2. Roll out of case management services across Shropshire, Telford and Wrekin 3. Roll out of community Rapid Response / hospital at home services across Shropshire, Telford and Wrekin 4. Review of end of life care across Shropshire, Telford and Wrekin 5. Long Term Conditions – Pathway re-design 6. Personalised Care, social prescribing and community engagement 7. Review of wider community service model 8. Single Point of Access 9. Children's physical Health 10. Primary Care and PCN Development	Our STW LTP set out an ambition to achieve a 'left-shift' with a greater emphasis on citizens managing their own health, delivering more preventative care, treating people as close as possible to their homes. Reducing demands on acute services and maximising independence. The priorities for Community and Place Based Care were reviewed in July 2020 in light of Covid-19 and are currently subject to ratification .

The Key responsibility of the Community and Place Based Care Programme Board is to agree and oversee delivery of system defined priorities. System assurance will be sought from the STP system design, Prioritisation and Quality Assurance group who will review all implementation plans to ensure they are robust and that interdependencies are properly addressed.

The savings associated with the above priorities are currently being re-modelled. The table below provides an indication of cost reductions as previously submitted within the Long Term Plan, this excludes any investments that may be required.

		Value £000's		
Community & Place Based Care	Efficiency Scheme Name	2021/22	2022/23	2023/24
System Priorities	Telford & Wrekin Integrated Place - integrated Teams	637	850	0
	Telford & Wrekin Proactive Admission Avoidance - Frailty	1,064	1,419	0
	Telford & Wrekin Integrated Place - Care Homes	92	123	0
	Telford & Wrekin - Healthy Hearts	197	152	152
	Shropshire Care Closer to Home - Case Management	2,972	1,469	1,412
	Shropshire Care Closer to Home - Winter Admission Avoidance Scheme	2,175	2,032	0
	Shropshire Care Closer to Home - Phase 3 Roll out of Sub Acute work	1,000	1,407	0
	Long Term Conditions (Respiratory & Diabetes)	521	150	550
Total		**8,658**	**7,602**	**2,114**

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Acute & Specialised Care

Acute	
Priority schemes 1. Elective Care – MSK new model 2. Elective Care – Outpatient redesign 3. Hospital transformation – Future Fit 4. Maternity Care 5. USE (Flow) 6. Cancer Care	We will develop anticipatory care services and our out of hospital services to provide real alternatives to presentation to A and E, alongside improvements in flow through a shift to SDEC, early supported discharge and the delivery of care at home to reduce hospital acquired functional decline and reduced reliance on bedded care. We will implement the IUCS pathway, review our pathway against national standards of care for MIUs and UTCs and review our provision of A and E services across the three acute sites to ensure the optimal use of resources to drive improved delivery.

The savings associated with the above priorities are currently being re-modelled. The table below provides an indication of cost reductions as previously submitted within the Long Term Plan.

The biggest STP scheme in this area is the hospital reconfiguration project- Future Fit, which focusses on the redesign of complex and emergency care

Specific plans are in place in relation to Musculoskeletal (MSK) services and Outpatient redesign. These key projects are being worked up within the system and are anticipated to provide streamlined services for patients in the right place at the right time. A new MSK alliance contract is being developed with system providers with a current 'go live' date of 1st December 2020.

Further details regarding release of net system cost in relation to specific disinvestment plans, commissioning plan changes, activity management changes and cost avoidance which will result in a forecast slow down in targeted spend in specific service areas can be found on slides 31-36 of the Finance Strategy

		Value £000's		
Acute & Specialised Care	**Efficiency Scheme Name**	**2021/22**	**2022/23**	**2023/24**
System Priorities	MSK Alliance Model	2,000	2,500	2,000
	Outpatient Re-design	1,201	1,281	1,281
Other Opportunities and Transactional Efficiencies	Urgent Care Smaller Schemes - eg HISU, Big 6	584	143	138
	Elective VBC	150		0
	Urgent Care - Rightcare Opportunities HF	500	500	500
	Unwarranted Variation Elective & Daycase	2,103	1,051	1,051
	Unwarranted Variation Non Elective	2,278	2,278	2,278
Total		**8,816**	**7,753**	**7,248**

Mental Health

Mental Health	
Priority Schemes 1. All age Mental Health 2. Digital Workforce Integration 3. Parity of Esteem 4. Redesign Rehabilitation Pathways	We will deliver our system strategy for mental health during 2020-21. We will reduce inequality of access to appropriate support at the right time for people with mental health needs. Through our 'transforming community mental health care' test site status we will develop the primary care workforce to work alongside mental health specialists to ensure both physical and mental health needs are met for people with severe mental health illness. We will expand access to specialist community mental health services and through increased investment in urgent mental health pathways we will offer alternatives to A&E and early support including crisis cafes and community services. We will implement IAPT for people with long term conditions, and improve early identification and support for people with dementia.

The Mental Health Investment Standard requires CCGs to increase Mental Health spend by at least the level of their overall allocation growth, plus an additional percentage to reflect any additional funding in CCG allocations. The current plan shown below achieves this through the areas of core Mental Health, Individual Commissioning and Mental Health prescribing expenditure shown in the various categories in this plan.

We plan to meet investment standards for Mental Health services in every year and will aim to do that by a) improving efficiencies* of existing services, plus b) reinvesting resources saved from other areas, e.g. unnecessary hospital attendances/ admissions for MH patients.

The Long Term Plan for Mental Health sets out the expectations for contemporary services to support recovery. As such there are specific requirements for investment, activity and workforce growth that the STP has submitted in its Long Term Plan. The investment required has been prioritised by commissioners to best meet the targets and achieve financial balance.

Further details regarding release of net system cost in relation to specific disinvestment plans, commissioning plan changes, activity management changes and cost avoidance which will result in a forecast slow down in targeted spend in specific service areas can be found on slides 31-36 of the Finance Strategy

	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000
Total funding if LTP funding available	**92,710**	**97,411**	**103,825**	**111,224**
Committed Expenditure	92,710	90,668	93,483	96,553
Investments		7,743	14,342	18,671
QIPP		-1,000	-4,000	-4,000
Total Expenditure	**92,710**	**97,411**	**103,825**	**111,224**

Priorities for Investment
Crisis support for both adults and children
Childrens Mental Health (eg trail blazers, ASD, ED)
Severe Mental Illness (SMI) , including EIP
Recovery and Prevention (IPS, Perinatal, PCN/community support)
IAPT (Improving Access to Psychological Therapies)
Learning Disabilities and Autism

* Some of the Mental Health Efficiency Programmes will impact on Acute Services and so the overall QIPP Benefit will be seen across different categories. Spend in the table above includes all Mental Health spend including that which is categorised in other areas eg acute/primary care etc.

Individual Commissioning

Individual Commissioning
We will implement continuous review of individual commissioning decisions for both adults and children's to enable the system to react more effectively to changing needs of patients and ensure the best value for money with the packages of care implemented. A robust process will be in place to ensure all decisions are fair and equitable. We will continue our work to repatriate people with learning disabilities placed outside of the area. We will implement a Hospice at home service to support our patients and their families towards the end of their life.

Financially, this is an area of significant high risk for the new organisation with a material overspend seen across both CCGs in both 2019/20 and 2020/21. (Appendix 1 provides more information on this) .

We have set ourselves a challenging recovery programme for this area which generates around £10.8m savings across the four years of the strategy in an attempt to 'right size' our spend. However during 2020/21 a number of QIPP schemes had been delayed in the first part of the year due to the impact of the Covid-19 pandemic . Despite this, CCG projects are now starting to return to Business as usual and Bi- Weekly QIPP meetings have been re-established. Improved system partnerships have been formed though closer working with the Local Authority and this is seen as a real benefit in terms of progressing with scheme outcomes.

The Trusted assessor model was conceptualised by Telford and Shropshire CCG's during COVID and piloted during the lockdown, this has since been identified both locally and nationally as the preferred model for delivering CHC remotely. It means that the total time taken to complete a CHC assessment falls from 8 staff hours to 3 hours whilst remaining fully compliant with the NSF for CHC.

During 2019/20 The CCGs set up a programme of work to ensure that care packages are regularly reviewed and matched to the changing needs of patients whilst monitoring and controlling costs more robustly. an Action plan is in place to ensure the same level of scrutiny with regards to eligibility criteria and packages of care is applied across both CCGs. This has previously proved very successful in Telford and the process will continue into future years. A key benefit of creating the new organisation will be the consistent application of the frameworks for CHC and FNC across the county.

Similarly as the complexity of needs continues to grow we will be a stronger organisation to manage the market and ensure that current providers deliver care that will avoid the need for external placements. For example we will ensure that we commission robust assertive outreach for MH patients who otherwise need expensive out of area placements. We are also exploring market management opportunities with our two Local Authorities in order to further strengthen our position.

	Value £000's			
Efficiency Scheme Name	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Hospice at Home	125	0	0	0
CHC Mental Health	1,422			
CHC - Review Programme	377	3,821	2,542	2,525
	1,923	**3,821**	**2,542**	**2,525**

Medicines Management

Medicines Management

We will continue to improve management of high cost drugs to maximise value for money.

We will improve prescribing in respiratory disease, CVD, type 2 diabetes and pain management.

We continue to utilise prescription ordering direct to improve repeat prescribing.

We will continue to support care homes to improve residents care

We will improve appliance services and ordering focusing on wound management and stoma care.

The medicines management teams promote good prescribing practice across Shropshire and Telford through a number of interventions which also contribute to our QIPP plans.

Programmes of schemes are designed to optimise the use of medicines in the delivery of healthcare, for example implementing national guidance on items which should not routinely be prescribed in primary care.

Work continues through the Medicines Management team to contain spend and restrict growth in prescribing. This is linked into system work on Medicines Management across our main providers.

The current QIPP target for Medicines Management is £15.6m across the four years. However during 2020/21 a number of schemes had been delayed due to the Covid-19 pandemic . However, In recent months positive progress has been made as CCG projects are starting to return to Business as usual. Bi-Weekly meetings are now taking place in order to maintain a focus on delivery and the Joint QIPP Programme Board has been re-established. Processes across CCG's are being aligned which will help to harmonise schemes and support more efficient ways of working.

A number of schemes have already been identified for 20/21 and are shown in the table but there is still a significant amount of work being done to address the remaining target through the Medicines Management STP work stream.

	Value £000's			
Efficiency Scheme Name	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Meds Management - POD	1,058		0	0
Meds Management - Drug Switches	280	240	0	0
Meds Management - Care home Prescribing	483	0	0	0
Meds Management - Scriptswitch / Optimise rx	275	360	0	0
Meds Management - Renal Unit Supplies	185	0	0	0
Meds Management - Diabetes	130		0	0
Meds Management - DOLCV	60		0	0
Meds Management - Appliances (Wound)	50		0	0
Meds Management - Respiratory Rightcare	50		0	0
Meds Management - DOLCV	35	0	0	0
Meds Management - Silver Dressings	15		0	0
Meds Management - Ostomy (Continence)	10	0	0	0
Meds Management - Self-Care	5	0	0	0
Meds Management - Rightcare Opportunities	0	0	350	350
Meds Management - Future plans	0	2,378	4,339	4,914
Grand Total	**2,636**	**2,978**	**4,689**	**5,264**

Redesign of community services

Redesign of community services
We will review our community services provisions and redesign to meet the needs of the population and to ensure future services are sustainable and affordable. We will look at new contracting models to support these newly designed services to ensure the whole system benefits from the changes.

Significant community investment is shown throughout the plan and in the table below . This investment will be used to commission integrated care delivery models and pathways through Care Closer to Home and the Telford Integrated Place Partnership. The investment plus the integration of existing hospital, community and primary care teams will base care around delivery of long term conditions and urgent care.

Community Investment	2021/22	2022/23	2023/24
Shropshire	-2,423	-2,755	-1,129
Telford	-1,237	-1,776	0
Total	**-3,660**	**-4,531**	**-1,129**

Resources will be allocated based on new models of care and through contract redesign in order to follow the patient. All investments will be subject to system governance and NHSEI approval.

National investment is also being used to invest in the primary care network infrastructure as primary care networks will be key in delivery of the transformational changes being implemented.

Link to Health and Wellbeing Board Priorities

Telford and Wrekin Health and Wellbeing board priorities	Workstreams
Encourage healthier lifestyles	Acute: Maternity, MSK transformation, Cancer Prevention: Alcohol management, weight management Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways
Improve mental health and wellbeing	Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways Prevention: Alcohol management
Strengthen communities and community based support	Acute: Cancer redesign Prevention: TW Integrated place, Shropshire CCTH, primary care resilience Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways

Shropshire Health and Wellbeing board priorities	Workstreams
Prevention: Health promotion and resilience	Acute: MSK redesign, outpatients redesign, cancer redesign Prevention: Alcohol management, weight management, TW Integrated place, Shropshire CCTH, primary care resilience Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways
Sustainability: Promoting independence at home	Acute: MSK redesign, outpatients redesign, cancer redesign Prevention: TW Integrated place, Shropshire CCTH, primary care resilience
Sustainability: Promoting easy access to joined up care	Acute: MSK redesign, outpatients redesign, cancer redesign Prevention: TW Integrated place, Shropshire CCTH, primary care resilience Mental health: All age mental health, parity of esteem, redesign of rehabilitation pathways

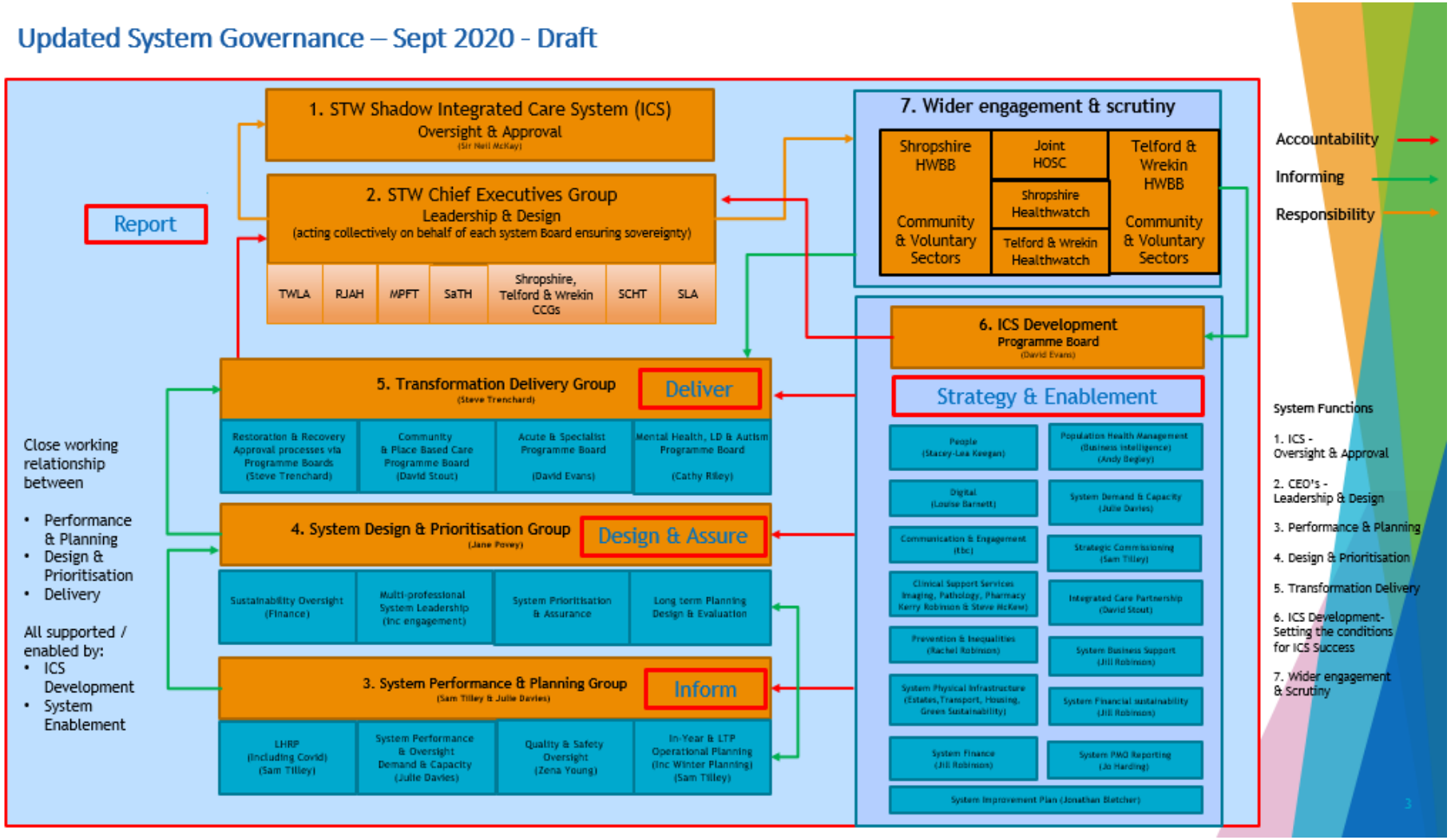
- As the System evolves, its structure has been redefined to take into account:
  - The ongoing shift towards strategic commissioning and ICP working,
  - Covid-19 restore and recover work,
  - Development, management and delivery of transformation programmes,
  - Development and delivery of system long term plan priorities,
  - Winter planning, performance and business as usual,
  - Planned service development projects
  - System Improvement plans
  - Alignment of system finance plan and workforce strategy
  - Surge Planning
  - The requirement to move towards greater financial sustainability

- The commissioning intentions and planned work have been consolidated and apportioned to the STP Programme Boards:
  - Acute & Specialist Care
  - Community & Place Based Care
  - Mental Health, Autism and Learning Disabilities

- The current governance structure and whole system delivery approach is set out below

Governance for interim period

The Local system Governance arrangements are evolving. Below is the most current iteration to put forward for approval

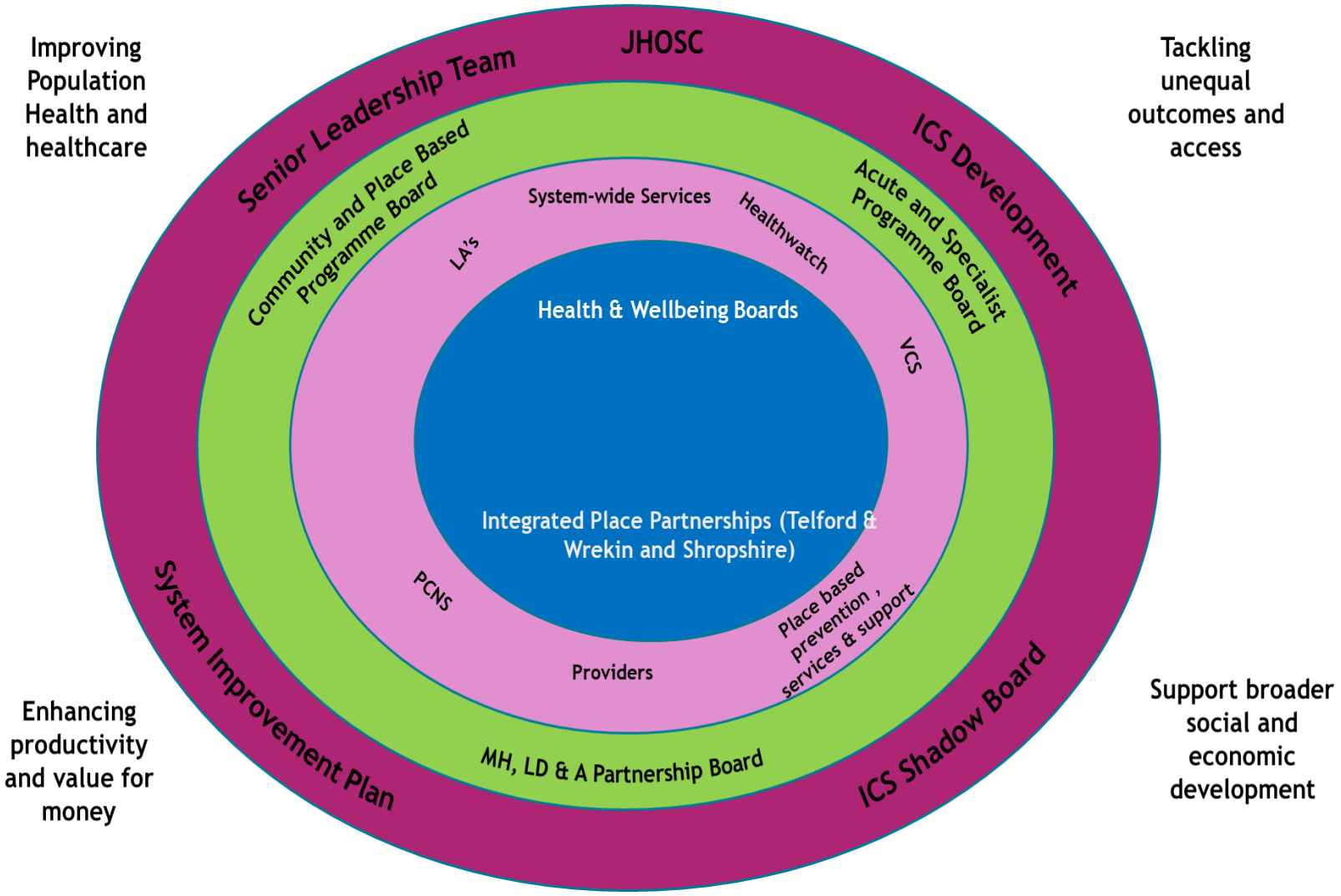


Partnership Working

The CCG will continue to work in conjunction with a wide range of partners to ensure we effectively meet our statutory obligations.

Primary Care Networks	Local Authorities	Integrated Care Providers	Commissioning Support Unit	Regional Partners	Other partners
•7 PCNs across footprint •Focus on Place at heart of approach •Building blocks of new care models •Key partner in transformation •Part of Integrated Care System •Driving redesign of services in neighbourhoods	•Proactive and valued partners •Heavily engaged in designing and delivering approaches to Population Health Management, Place and Locality MDT working •CCG committed to ensuring capacity and structure to deliver integrated health and social care •Review BCF to clarify how to maximise use of shared resources to better meet the needs of the population •Health and well being boards to take on increase responsibility for place based working	•Alliances of providers working together to deliver care (Health, social care, independent and third sector) •All Primary Care Networks will be integral to the ICP	•Review all support services to develop proposals on “do”, “buy” or “share” functions. •Move to more operational and transactional tasks being completed outside of the CCG	•Services outside STP boundaries work with other ICSs and NHS England to ensure effective pathways and services •Working with commissioners within Wales to manage cross border flows and cross charging mechanisms •Work with partners for integrated commissioning frameworks for regional and specialised commissioning. •Work with clinical networks •Work with the cancer alliance •Work with regional specialist working groups	•Work with community and voluntary sector to build on current arrangements and utilise expertise and capacity •Work with care homes to build on current arrangements and utilise expertise and capacity •Work with Healthwatches to ensure we continue to effectively engage with patients and the public

Whole system approach:

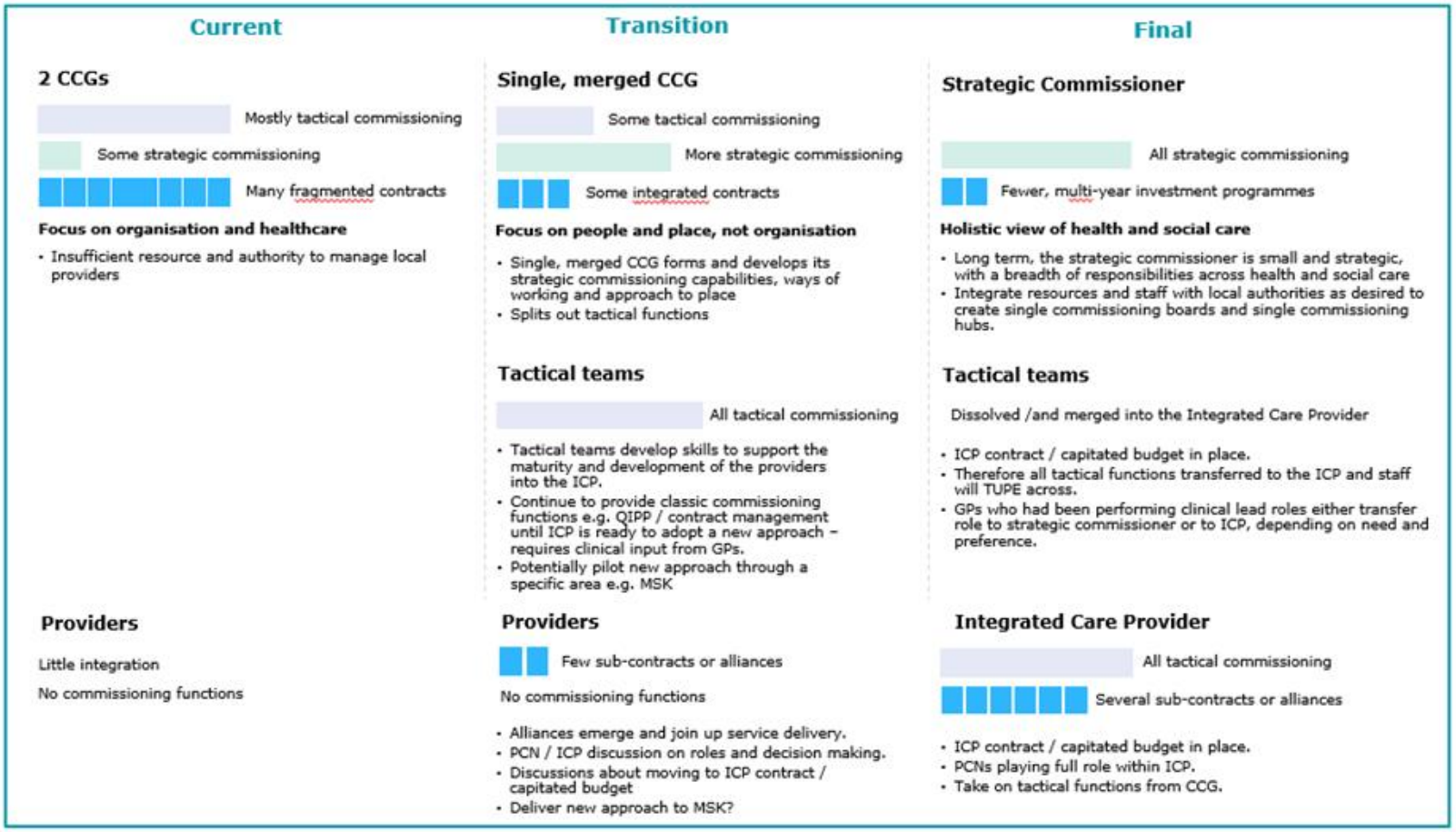


Key: JHOSC =Joint Health Overview and Scrutiny Committee; ICS=Integrated Care System; VCS =Voluntary and Community Sector; PCN=Primary Care Networks; LA=Local Authority

Becoming a strategic commissioner

We recognise that we are on a journey to becoming a strategic commissioner and we have a clear vision for how the new organisation will evolve over time. The NHS Long Term Plan indicates that there should be a single CCG for each ICS, unless there is clear rationale for departing from this model. There is a clear agreement to establish a single CCG to act as a strategic commissioner as part of the wider roadmap towards establishing the ICS across Shropshire, Telford and Wrekin.

The strategic commissioner will assume a leadership role in driving the change required to become an ICS and ensure the maintenance of pace. Below is the current position, the proposed transition including a single merged CCG and the final position of an ICS.



Organisational Development

An organisational development strategy and plan has been written as part of the development of a single CCG. Our aim is to take a planned, whole system approach to building a new organisation with the highest levels of effectiveness and efficiency in meeting the health needs of the Shropshire, Telford and Wrekin population.

Our OD priorities:

Who will we focus on:

Staff: The OD plan commits to providing support to staff to go through the design and restructuring process that lies ahead, while developing skills, personal support and environmental factors required for them to do their jobs effectively both now and in the new organisation.

GP members: The OD plan will outline how GP members will be involved in the design process of building a new organisation, as well as committing to exploring some key issues that will affect GPs such as the development of ICPs and PCNs.

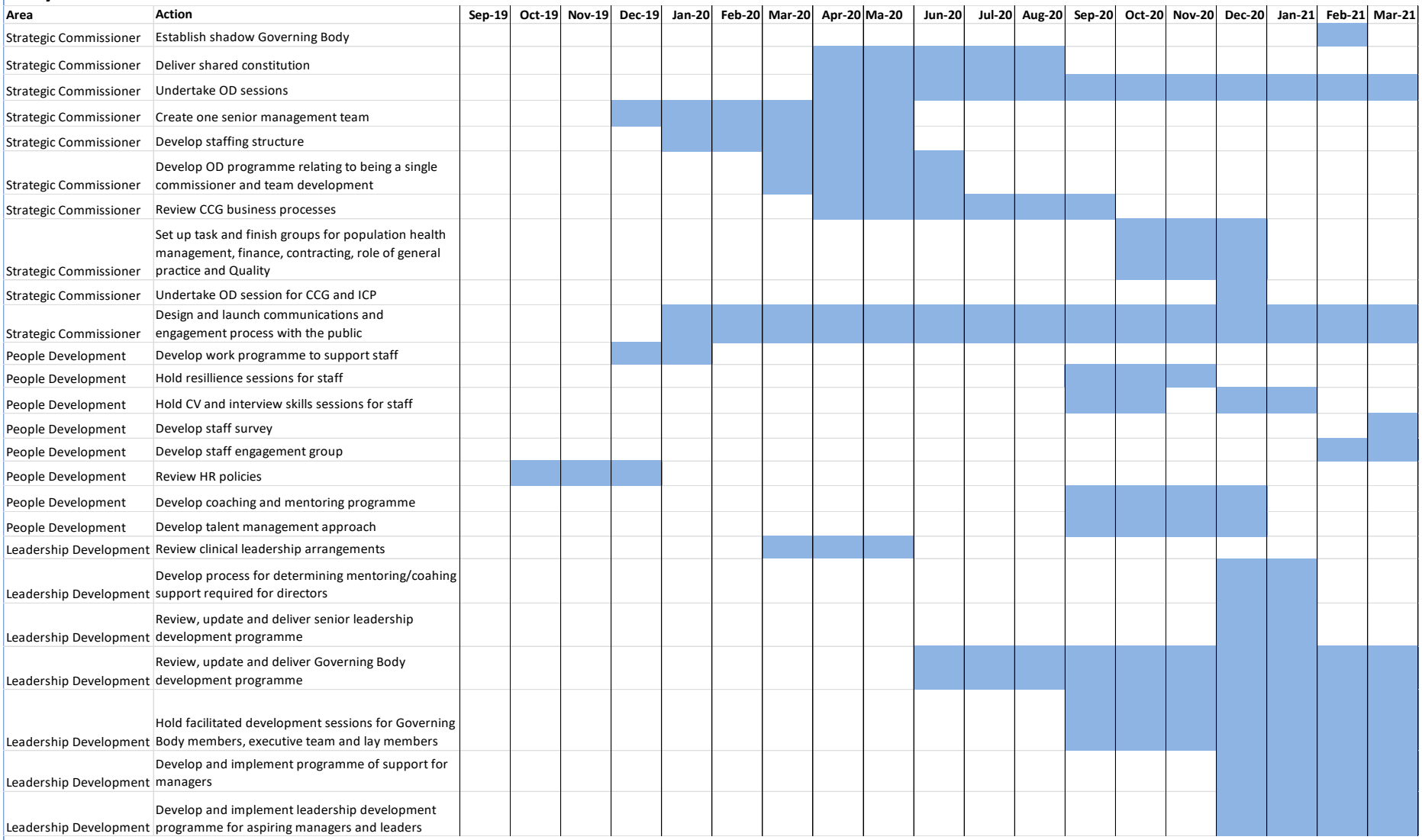
Leaders and Governing Body members: This is a complicated and ambiguous process in some ways and leaders will require support to understand their role, provide support to their staff and GP members, and function as a corporate leadership team throughout the transition process.

Partner organisations: The CCGs cannot deliver transformation by themselves. They need to work with their partners across the Integrated Care System to deliver change. The OD plan provides ways for the CCGs to embrace and engage with partners in a collaborative way to support delivery in the future.

The following slide sets out the timetable and key steps in taking this work forwards. More detail can be found within the CCG's OD Strategy document.

Organisational Development

Key Milestones



Area	Action	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Ma-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Strategic Commissioner	Establish shadow Governing Body																			
Strategic Commissioner	Deliver shared constitution																			
Strategic Commissioner	Undertake OD sessions																			
Strategic Commissioner	Create one senior management team																			
Strategic Commissioner	Develop staffing structure																			
Strategic Commissioner	Develop OD programme relating to being a single commissioner and team development																			
Strategic Commissioner	Review CCG business processes																			
Strategic Commissioner	Set up task and finish groups for population health management, finance, contracting, role of general practice and Quality																			
Strategic Commissioner	Undertake OD session for CCG and ICP																			
Strategic Commissioner	Design and launch communications and engagement process with the public																			
People Development	Develop work programme to support staff																			
People Development	Hold resillience sessions for staff																			
People Development	Hold CV and interview skills sessions for staff																			
People Development	Develop staff survey																			
People Development	Develop staff engagement group																			
People Development	Review HR policies																			
People Development	Develop coaching and mentoring programme																			
People Development	Develop talent management approach																			
Leadership Development	Review clinical leadership arrangements																			
Leadership Development	Develop process for determining mentoring/coahing support required for directors																			
Leadership Development	Review, update and deliver senior leadership development programme																			
Leadership Development	Review, update and deliver Governing Body development programme																			
Leadership Development	Hold facilitated development sessions for Governing Body members, executive team and lay members																			
Leadership Development	Develop and implement programme of support for managers																			
Leadership Development	Develop and implement leadership development programme for aspiring managers and leaders																			

Organisational Development

Our aim will be to create leaders with the capability and confidence to find solutions to new challenges, and develop our individuals to thrive. The kinds of behaviours that may be required are summarised in the diagram to the right

System Development: Future Provider Configuration

Development of the future provider landscape is still under development across the system. The aim is to have Integrated Care Provider arrangements across the system to drive integration and co-ordinated delivery of care for our population. The priority for the ICP will be improving long term health and care outcomes for the population.

The advancements in our system working brought about by the development of a system wide response and associated structure to address the Covid-19 pandemic has provided the opportunity to move more rapidly forwards with the reconfiguration of our system into and ICS and IPC arrangement. However, there continues to be some key elements of work to complete over the next 6 months to finalise these arrangements as set out below. The new collaborative structures we have established will better enable us to do this.

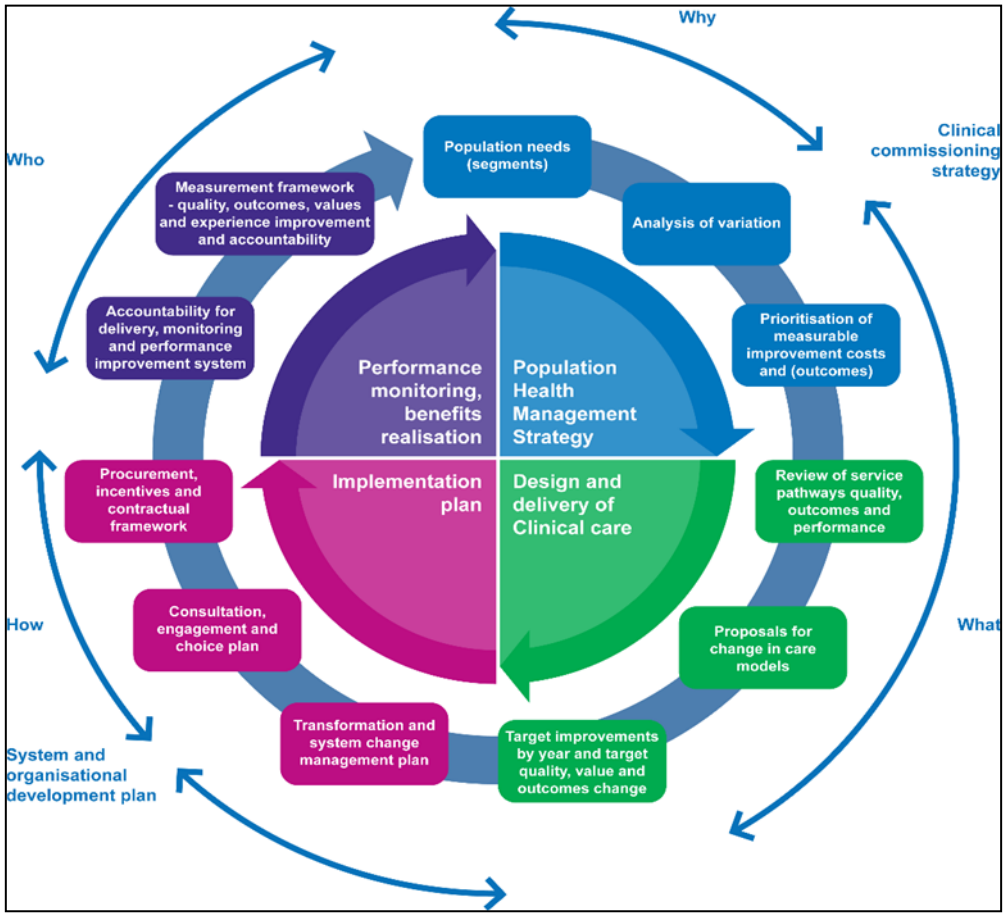
Plans for development:

- Agree which providers are part of the ICP
- Agree lead provider of ICP
- Develop service delivery model for the ICP
- Develop financial arrangements for the ICP
- Develop contractual arrangements for the ICP
- Develop outcomes framework for the ICP
- Develop implementation plan for ICP “go live”
- Implement plan

The recent NHS England/ Improvement publication of ‘Integrating Care – Next Steps for Integrated Care Systems’ builds on the route map set out in the Long Term Plan and details how constituent organisations will accelerate collaborative ways or working. Whilst the document and its contents are still consultative it sets out some principle considerations and will further assist in accelerating STW system discussions and plans in moving towards a fully functioning ICS, building further on the progress and approach set out in the documents

Strategic Commissioning Cycle

Commissioning has traditionally been delivered through detailed contract specification, negotiation and monitoring utilising tendering processes. National payment regimes have not always supported cost reduction or innovation. Strategic commissioning moves towards focussing on outcomes, collaboration, differing financial and contractual models that incentivise providers to deliver benefits for the whole system. The traditional commissioning cycle will be adapted to support our new strategic position.



As a strategic commissioner we will focus on:

- Strategy and planning for the system linking finance, governance and accountability
- Establishing an outcomes framework and monitoring impact against this
- Identifying opportunities for improvements in outcomes, quality and value
- Evolving the focus on prevention and addressing health inequalities utilising Population Health Management methodology
- Utilisation of robust system wide Business Intelligence to drive the agenda for service improvement and transformation and to support sound decision making
- Setting priorities for the system supported by funding agreements
- Planning and programme management and facilitation across the system
- Supporting and facilitating clinical leadership and engagement
- Development of appropriate accountability system that accommodate whole system and place based commissioning and delivery

The new CCG will adopt a number of specific principles, set within the context of the wider system principles set out earlier in this document, to support its approach to commissioning:

- A locality based approach, focused around PCN geographies and local authority boundaries, working at system level where scale matters
- A lean management structure focused in delivery of a key set of priorities.
- Data and intelligence led, value based approaches to commissioning.
- Prevention first, sustainability over the long term.
- Co-designed and delivered across the system (recognising the locality based approach) with genuine patient and citizen involvement throughout the commissioning process
- System thinking to commissioning to produce improvement with a targeted Transformation Programme focusing on the issues that matter most.
- A genuine partnership approach - building bridges not protecting our borders. Organisational boundaries will be more permeable with people at the centre of our approach.

We will be working with these principles as we continue work on the design of the new organisation. We will continue to work closely with our membership, our staff, local authority, PCN and others to finalise our operating model and design our organisational structure.

Shropshire, Telford and Wrekin has a diverse population with areas of deprivation across the whole of the county and therefore differing needs. The new organisation will commission services sensitively to meet these needs, with a strategic focus on reducing health inequalities. The new organisation will have to be flexible and innovative to do this successfully. It will work with its partners and local people to commission services in different ways and at different levels, wherever it makes most sense to do so to ensure that we most effectively meet the needs of our citizens.

This flexible approach will be necessary to ensure local need is reflected in services, as long as a standard set of outcomes are being achieved across the county. We will work with our partners to develop a robust approach to population health and business intelligence to support more informed and effective priority setting and service design based on a sophisticated understanding of needs across the county.

We will ensure that there is genuine patient and citizen involvement throughout our commission processes to ensure that what we do is genuinely co-produced.

The new organisation will have to collaborate at a local level alongside local authority staff and also with other strategic commissioners across a larger footprint

Agreed system priorities will be delivered through System Programme Boards, each led by a CEO SRO
Each Programme Board has agreed priorities, of which the principle priorities are set out here:

- **Community & Place Based Programme Board**
  - Focused on delivery of place based care in Primary and Community Care Settings to support reduced demand on acute

- **Acute & Specialist Programme Board**
  - Focused on reducing out-patient new and follow-up appointments
  - Transformation of areas requiring improvements (Maternity, Cancer)

- **Mental Health, LD& Autism Programme Board**
  - Focused on crisis care (all ages)

All enabled by

System Enablement Programmes
Focus on Digital, Estates & People

ICS Development Programmes
Focus on system capability to strategically design and deliver at scale. Ensuring sound link to financial strategy

SROs have been established for all ICS development work streams and a governance system is in place as set out on slide 24

ICS Development **Setting the conditions for ICS success**	
Population Health Management (Business intelligence)	Andy Begley
Demand & Capacity Modelling	Julie Davies
Strategic Commissioning	Sam Tilley
Integrated Care Partnership	David Stout
System Business Support	Jill Robinson
System Financial sustainability	Jill Robinson
System PMO Reporting	Jo Harding

Additionally, this approach sits within an philosophy of working towards addressing the system's financial challenges to bring the system back into financial balance

System Improvement Plan (SIP)

The SIP provides an opportunity to accelerate many key programmes described in the system LTP and outlines both the immediate priorities and programmes of work for the next 6 months as well as setting out medium and longer term priorities. The SIP will be intrinsic to the systems approach to the commissioning of services over this period, aligned with the system Programme Board Structure and their identified priority areas, as described on the previous slide. The SIP in its entirety is appended to this document.

The SIP specifically sets out a set of zero to six month priorities in relation to Urgent and Emergency Care and Elective Care with longer term priorities building from this. In addition it proposed a number of additional areas of focus for the six to twenty four months period

Outcomes Framework – the SIP articulates the approach to incentivising providers to deliver against 'best practice' services through an outcomes based approach by means of Aligned Incentive Contracts (further details are set out on slide 36). A system of agreed outcome measure, distinct from performance measures, will be supported by a sound evidence base and reflective of the complete cycle of healthcare.

Additional work will be undertaken to develop our outcomes framework further - clustered around the following categories:

Patient Outcomes – those relating directly to patients, for example Patient Reported Outcome Measures (PROM) or the experience of the service provided

Operational Outcomes – those relating to changes in the way providers of services operate. For example, moving to system and population-based monitoring using health improvement measures, working collaboratively to ensure consistent delivery of service models and measuring their outcomes, measuring movements in capacity and demand across the system.

Sustainability outcomes - outcomes that support the sustainability of the system in particularly progressing a sustainable workforce including, delivering better value, sustainable services move to integrated financial approach.

Cultural Outcomes – outcomes that will support cultural changes required across the system. For example, increase clinical engagement in innovation and programme design, improved use of information and evidence-based practice (PHM). Progressing a culture of collaboration and service integration between providers to improve quality and safety and collaborative approach and co-design of clinical pathways

Contracts Incentive Strategy

We have recognised for some time as a system that we need to step away from our transactional relationships and focus instead on collective achievement of patient outcomes and financial balance. As part of this we are working to establish relationships, governance and tools that will enable us to do this.

We have developed our thinking about how we can best use contracts to drive results in the system. A working group has been set up as a sub group of the system DOFs. In this group CCG staff are actively working with key providers to transform current contracting arrangements with a view to implementing our new approach for 1 April 2021:

There is an increasing requirement to contain the cost of the rising demand for healthcare through redesign of services and integration. The CCG is aware that the way that the majority of healthcare is paid for can hinder the transformation needed.

To support system transformation, a new contract and payment approach is being developed which recognises the need for expenditure to be contained within the resources available to the system and focuses on cost avoidance and reduction. Our aim is to create a contract form that minimises contract management bureaucracy and gives a clear framework of expected outcomes alongside associated performance management data.

NHS organisations are working together, in an open and transparent way to deliver improvements to care, population health and use of resources. In recognition of this a contract approach is being developed, taking a collaborative and system-wide approach to agree:

- A system methodology for developing and agreeing the activity and financial baselines, ensuring consistency across contracts;
- A proposition for a type of aligned incentive contract with/without a variable element for some deliverables within the contract. Looking to build on the successes and address any challenges identified from implementation in other NHS systems;
- The principles, terms and condition and governance require to ensure the new contractual form delivers the intended system outcomes;
- A risk-share/incentive mechanism that wraps around different types of activity and also aligns across contracts to drive the behaviours and changes required within the system;
- The use of a risk pool/fund, available for all parties to jointly manage the cost impact of unforeseen challenges/circumstances;

Development and agreement of the aligned incentive type of contract and payment approach requires commissioners and providers to acknowledge that there is a finite sum of money and that decisions on how it should be spent are best taken collectively with risks shared.

One size does not fit all across the healthcare system so it is likely different models will be applied in different situations and consideration is being given to how this would be written into the methodology, mechanisms and incentive models within the aligned incentive approach.

Quality Approach

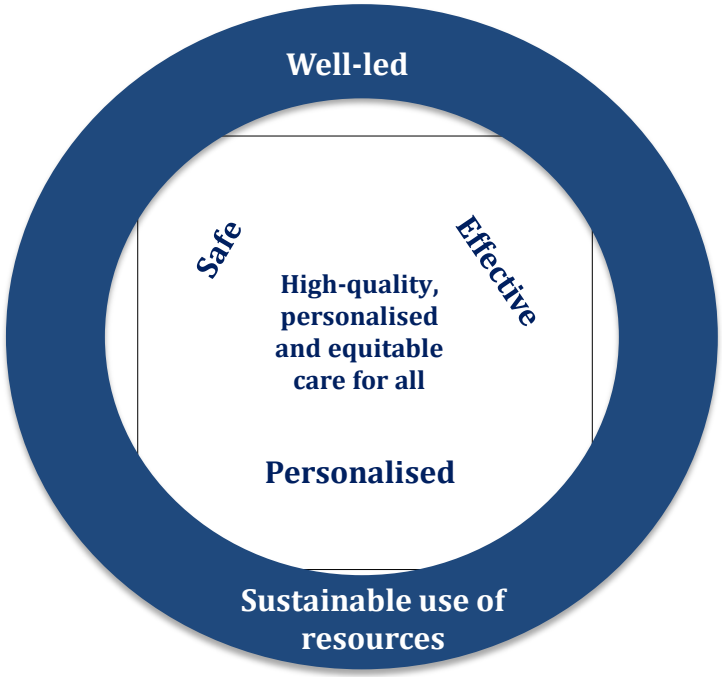
The CCG approach to quality is set out in detail in the Quality Strategy, revised in November 2020 to take account of: feedback from NHSEI Single Strategic Commissioner application panel; issue of phase 3 Covid-19 pandemic response and anticipated revised NQB publication – A Shared Commitment to Quality. The Lead for this Strategy is the Executive Director of Quality. The Quality Strategy is owned and monitored by the CCG's Quality and Performance Committees in Common, chaired by a lay member Non-Executive Director. The Strategy is underpinned by a detailed Operational Delivery Plan and will be delivered in two phases:

- **Phase 1:** 2020/21 will see us setting out the key quality governance framework and developing standard approaches to quality assure the services we commission.

- **Phase 2:** during 2021/2022 we will mature our approach to actively promote and encourage the sharing of best practice and resources across our providers, with the aim of continually raising standards across the system.

A range of associated outcome measures are used to determine quality of services.

We use the Darzi definition and dimensions of quality (patient safety, clinical effectiveness and patient experience) along with organisations ability to effectively lead and manage services in accordance with the CQC Well Led framework and NHSI sustainable Use of Resources assessments.



Quality of care and outcomes

We expect our PHM approach to deliver significant improvements in both quality and outcomes. The benefits to patients will be:-

- Greater ownership of their own health, moving away from the paternalistic model to an NHS that empowers and supports people to look after their health
- The focus on commissioning to meet needs will ensure more timely, tailored services
- There is a wealth of evidence that risk stratification and proactive case management approaches prevent deterioration and/or improve co-ordination of care so patients don't experience duplication, fragmentation and inconsistency
- We will identify which clinical interventions need to be performed in a single way to reduce unwanted variation by adopting a single approach across the system; while encouraging local variation when that is the best way of meeting the diverse needs of different populations/geographical areas
- The Quality Strategy describes how, by working as one organisation, we will apply consistent quality standards and expectations across the system and will be in a stronger position to ensure compliance.

The improved patient outcomes will be:-

- Greater engagement from individuals and each community/cohort of patients at all stages of our new clinical pathways
- Improvement in immediate and future health status at both individual and community /cohort levels. This will include, for example, reductions in adverse outcomes for Diabetic patients at an individual ,community and therefore system level.
- As more patients feel confident and empowered to self-care, capacity in primary care will be released to focus on higher risk patients
- Improved mental and physical health as improvements in one will be linked to improvements in the other e.g. links between anxiety/depression and many MSK conditions; and better physical and mental health outcomes for people with SMI
- Fewer hospital admissions
- Reduction in variation of outcomes between affluent and less affluent areas
- Reduced health inequalities with fewer deaths from cancers and CVD in our disadvantaged communities, particularly the urban hot spots.

Ultimately we aim to improve the health and wellbeing of the populations we serve

ICS Development

Shropshire & Telford & Wrekin STP (STW STP) is currently undergoing NHSEI assurance to achieve designation as an ICS by April 2021

Achievements to date on the path to becoming an ICS:

System Principles agreed:

- **System First** - A recognition that all work programmes cross all system partners
- **Distributed Leadership** is key, SRO roles will be System not Organisational
- All partners will require an **agile approach** to plans as we transition from Restoration to Recovery,
- a philosophy of shared understanding & learning, **effective communication**, transparency of progress and risk will be required.
- The recognition that as a system all programmes of work are **multi-professionally led** through the SDPG
- **Ability to evolve** and make **rapid decisions** as we transition from Restoration to Recovery, we will review Governance arrangements 3 monthly at System CEO Meetings
- All Programmes of work are expected to be **co-produced** with relevant partners, users and stakeholders their implementation plans
- All Programmes are required to **build upon accelerated transformation** as a result of Covid-19 response, particularly digital acceleration **(Digital where possible & appropriate)** and voluntary and community sector partnerships
- Clear SRO responsibilities, with **aligned leadership and programme support**
- All programmes required to work in a system manner with regard **to monitoring & reporting** & will be available to all system partners
- **System Risks will be addressed collectively** through Programmes SRO's in the first instance and escalated to CEO's only if not able to mitigate

ICS Development

ICS Operating Standards: Collaborative Leadership Arrangements

- agreed by all partners – support for joint working and quick, effective decision-making. including;
- a single STP/ICS leader and a non-executive chair,
- clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

Leadership model established

Part-time independent non-executive chair in place and a lead interim CEO with dedicated time

CEO Group, which includes all NHS and LA chief executives, overseeing performance of the system and developing the long term plan

Sub-structure in place with CEOs / senior Executive Directors as Senior Responsible Officers for each area (Programme Boards / Enabling Groups)

Substantive ICS Independent Chair in post since Nov 2018

ICS Lead CEO/Programme Director Post in place (interim)

ICS Shadow Board meeting monthly; ToR established and a workplan has been agreed

Membership includes voluntary and community representatives

Shadow Board oversees system Finance and Performance

Integrated Care Partnership defined with 2 "Place" requirements supported by 7 PCNs

System Operating Model in development to support the system to make decisions and local choices on how we deliver

ICS Development

Organisations within the system coming together to serve communities through a Partnership Board,
underpinned by;

- agreed governance and decision making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on coproduction, engagement and evidence.

Agreed system Priorities

- To develop programmes of work that address the financial challenges of the system
- Delivered through System Programme Boards, each led by CEO SRO
- Each Programme Board has agreed priorities, for the purpose of ICS development, core priorities only are
- highlighted here ie – those programmes of work that will have the biggest system impact

Plans to streamline commissioning through a single ICS/STP approach.

- Establishing a single CCG and strategic commissioning arrangements

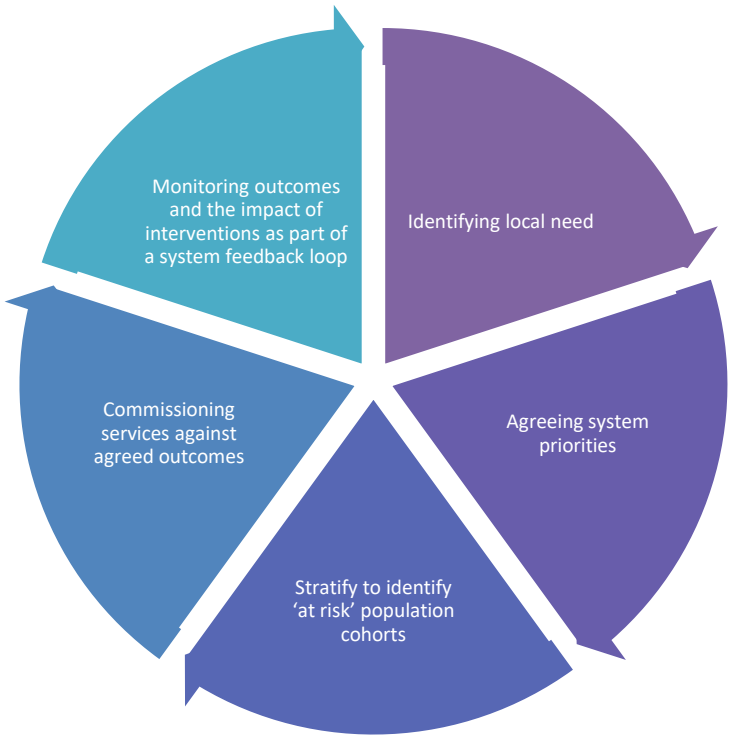
A plan for developing and implementing a full shared care record

- allowing the safe flow of patient data between care settings,
- Development of capacity and capability to embed population health

The STW draft Operating model is attached as an appendices to this Commissioning Strategy. However, as the system further enhances its collaborative working and works towards defining the next steps it will take on this journey, it is currently consulting on the final form of the Operating Model

Population Health Management Approach

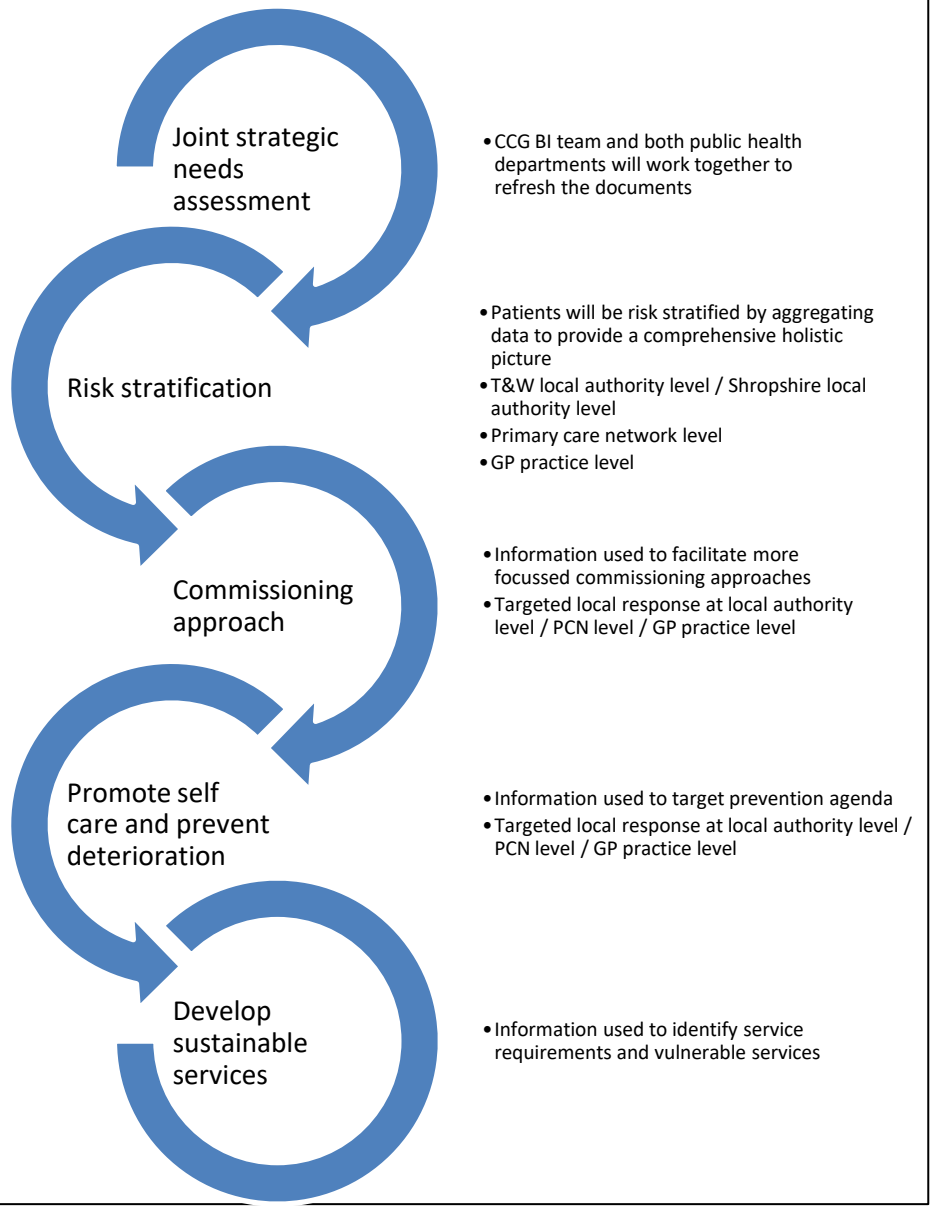
The CCG recognises the importance of Population Health Management (PHM) in delivering effective strategic commissioning including identifying clear priorities, target interventions and monitor the effectiveness of the interventions. PHM is based on a partnership approach across the NHS, local authorities, schools, police, fire service, housing associations, voluntary sector and the public. All have a role to play in addressing the interdependent issues that affect peoples health and well being.



PHM Approach will encompass:

1. Needs assessment to analyse all data to differentiate needs at each level of commissioning (whole system, Local Authority, PCN, practice, specific disease, complex individuals), compare with known prevalence data, gather intelligence about demand and capacity and seek sustainable solutions where gaps are identified
2. Creating a rich picture of the needs of our population and how it is configured across our geography to inform service development, priorities and allocation of resources to affect the biggest improvements and best outcomes
3. Creating the right environment for individuals, families and communities to self care and enable organisations to support self care within both urban and rural systems
4. Work at all commissioning levels to ensure priority is given to both Primary and Secondary prevention. PCNs will be supported to deliver integrated proactive care to prevent medium and high risk patients deteriorating.
5. Place based partners including PCNs will use risk stratification tools to anticipate deteriorating patients to minimise fragmentation and maximise patient experience. Multidisciplinary working will be promoted including outreach from secondary care for physical and mental health
6. Prioritise reaching agreement on lead provider and alliance arrangements
7. Complete demand and capacity planning in collaboration with other commissioners

Population Health Management Implementation



The population health management approach will be utilised to develop a rich source of information at system, local authority, PCN and practice level. This information will be utilised to drive plans including commissioning and contracting approaches.

Traditional commissioning based on cost and volume focuses on individual organisations working separately to treat patients. This can lead to a fragmented approach to care deliver with no overall responsibility for patient outcomes. Through the population health management approach our ambition is to agree not only new clinical models of care but also new transactional models. This ambition relies on providers in the ICS engaging in this new model of delivery and the CCG recognises the facilitation role they will need to play to ensure this is successful across the system.

To enable the CCG to effectively implement services where providers are rewarded for working together to deliver the best outcomes for populations an understanding of the current patient population is required. This can be obtained through population profiling and risk stratifying as part of the population health management approach. Equitable outcomes, targets and budgets can then be set using this information.

As the CCG moves towards models of care that incentivise collaboration, while targeting outcomes for health that matter to the local population, we need to ensure mechanisms are in place to allow data sharing across the system to support a successful population management strategy.

To ensure an effective implementation of a population health management approach in the CCG two joint Population Health Lead posts have been developed in conjunction with the Local Authorities. These posts are integral in ensuring Population Health Management is at the centre of all plans.

Population Health Management Implementation – taking forward our approach

A system SRO has been appointed and work is ongoing to develop a shared staffing resource to support an effective PHM approach.

To deliver our ambitions, to put in place a whole system population health model, there are a number of key deliverables on this work stream. Currently the Local Authorities provide the Joint Strategic Needs Analysis (JSNA) using teams of analysts, and analysts also exist within the CCGs, the Commissioning Support Unit (CSU) and in many of our provider organisations. We will improve our PHM approach by developing a **Decision Support Unit** that will:

- Bring intelligence and business intelligence (BI) teams together to enhance our ability to provide high quality and timely population health and BI to inform change and impact across our entire system and its two places Shropshire, Telford & Wrekin – **Summer 2021**
- Develop a community of practice. Already, our STP governance has allowed us to bring analysts together from across the system for the first time. Creating an analyst network, for sharing, learning and to test out this new way of working across a system through learning on a priority area – **started as part of the PHM regional programme but has been on pause through Covid – will begin again Spring 2021**
- Workforce development – ensuring that PHM skills are embedded through all organisations and at all appropriate levels from leadership through analyst and BI functions. We will work develop skills working with Local Workforce Action Boards (LWABs) to influence spend on leadership and analyst development. This will also consider career progression pathways as part of team structures There is a need to increase capacity and capability to deliver this population health management approach across the system – **ongoing since 2019**
- Jointly fund and recruit 2 x joint PHM officer posts (1 for each council) – **January 2020**

We have already taken steps as a system to test a PHM approach, identifying diabetes as a prototype for this approach. To date we have used this approach to build a population profile, identify barriers and resolve them and build an infrastructure based on positive partner relationships.

The project aim is to: Improve the health outcomes of people newly diagnosed with type 2 diabetes.' The population subgroup is people across Shropshire, Telford & Wrekin who were diagnosed with diabetes between April 2017 and April 2019.' Increasing knowledge and understanding of type 2 diabetes for both practitioners and the public will improve decision making, self-care, take up of screening and structured education resulting in:

- Structured education - increase access and awareness
- Weight management - increase awareness of weight as a risk factor, and access to support
- Attendance at screening and support programmes - increase awareness and access • Population - general knowledge and understanding

This prototype will be used to develop further programmes of work based on PHM principles and for the CCG will be lead by the Director of Planning

- Prevention, self help and wider community wellbeing

- Case identification of individuals and cohorts amenable to interventions

- Population profiling
- Understanding inequalities and variation
- Cohorts and individuals amenable to interventions
- Application and evaluation of effective interventions

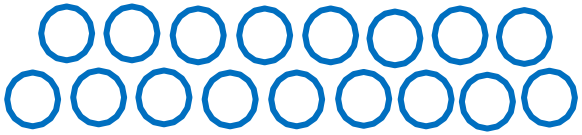
- Whole population profiling and person level analysis for pathway and service planning
- Understanding inequalities and variation
- Cost, activity and outcomes analysis
- Modelling areas of identified need
- Application and evaluation of interventions

- Robust PHM needs assessment to agree system priorities, support resource allocation and set outcomes for contracts and assurance
- Monitoring framework
- Profiling of future population trends
- Population profiling for regional services e.g. specialised services and prevention at scale

Individuals – community, friends, family & carers

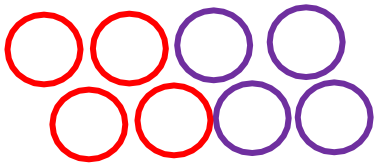
Individuals & community networks

Individual GP Practices



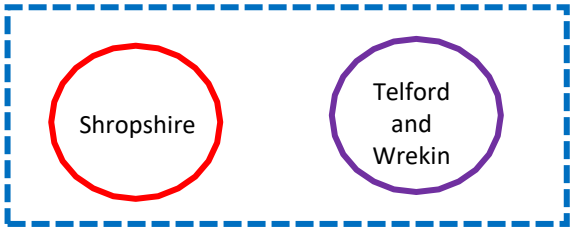
Population c 1,000 – 10,000

PCNs



Population c 30,000 – 50,000

Place Based Alliances
Linked to Health and Wellbeing Board



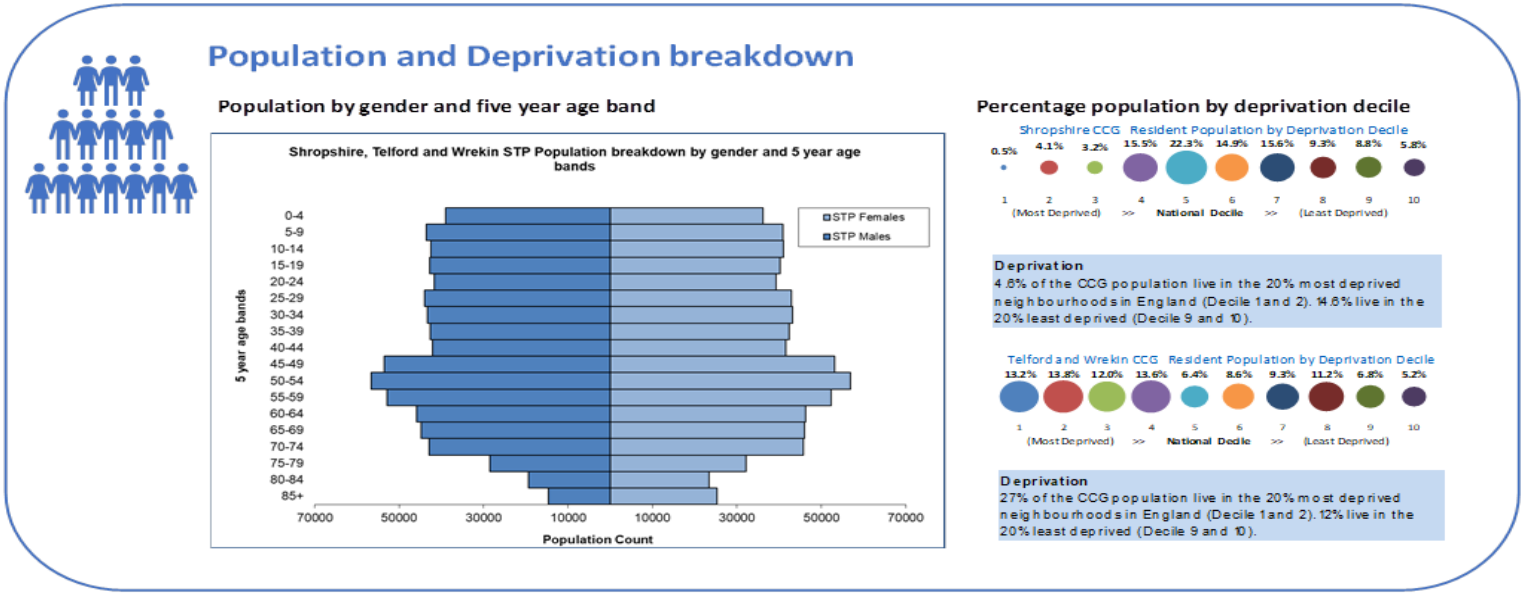
Population c 100,000 – 300,000

Population c 500,000

Alliances with other ICS's and Regional Commissioners

Understanding our population

Population of 481k dispersed over 14th largest geographical area in England and categorised by significant variation in social, health and deprivation profiles. Rural and large urban centres experiencing deprivation and difficulty maintaining sustainable services.



Areas of the county have a large percentage of over 65s and it is expected that 3% will have severe frailty, 12% will have moderate frailty and 35% will have mild frailty. The CCG will need to factor the increase in frail patients into the service models. Key priorities need to be implemented looking at preventing or delaying the onset of frailty and transforming care for this cohort.

Category	2016 Total	2026 Predicted	2036 Predicted
Severe	3,088	3,803	4,789
Moderate	12,350	15,209	19,161
Mild	36,020	44,358	55,885

Health summary

Life expectancy

Life expectancy within Shropshire is higher than the England average while within Telford and Wrekin life expectancy is lower than the England average. Across both areas there is a significant difference between life expectancy in the most deprived areas compared to the least.

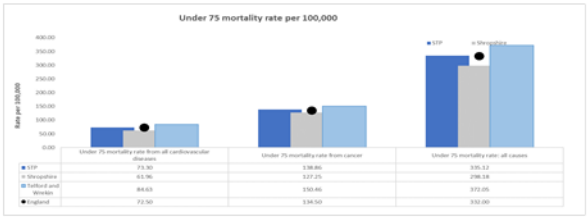
Life expectancy and mortality

Mortality Rate

The rate of mortality for all causes within the STP footprint was **335** per 100,000

With Telford being worse than England at **372** per 100,000

And Shropshire being better than England at **298** per 100,000



Life Expectancy at Birth

79.4 years of age was the life expectancy of Males within the STP, which is in line with the national average age of **79.6**. Telford CCG was lower than the national at **78**, with Shropshire having a male life expectancy of **80** years old

82.6 years of age was the life expectanct of Females within the STP, which is in less than the national average age of **83.2**. Telford CCG was lower than the national at **81.9**, with Shropshire having a female life expectancy of **83.4** years old

Infant Mortality

4.45 per 1,000 is the infant mortality rate

For Shropshire, Telford and Wrekin STP

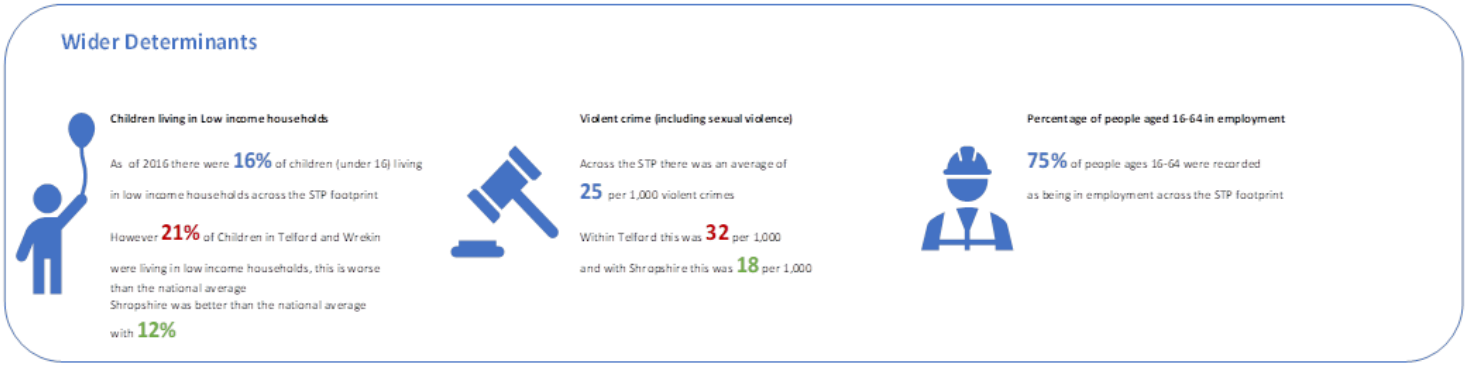
This is simliar to the National rate of **3.90**

Excess Winter Deaths

21% of deaths as a ratio of excess winter deaths to the average of non- winter deaths

This is the same as the Percentage of excess winter deaths nationally

Health summary



Child Health

In year 6 16.9% of children in Shropshire classed as obese whereas in Telford the level is 20.8% of children
Both areas have issues with the rate of alcohol specific hospital stays for those under 18 (27 per 100k in Shropshire and 26 per 100k in Telford)
In both areas smoking at time of delivery is worse than the England average
In Shropshire levels of breastfeeding are better than the England average while in Telford they are worse
Levels of GCSE attainment is worse than the England average in Telford

Adult Health

Both areas have issues with alcohol related harm hospital stays (656 per 100k in Shropshire and 673 per 100k in Telford)
The rate of self harm hospital stays in Shropshire is better than the England average while Telford is worse
Shropshire are worse than the England average for estimated levels of adult excess weight
Telford are worse than the England average for estimated levels of adult physical activity
In Shropshire the rate of people killed or seriously injured on roads is worse than the England average
Rates of sexually transmitted infections are better than average in both areas
Rates of TB are better than the England average in both areas
The rates of hip fractures are worse than the England average in Telford and Wrekin
Rates of violent crime is better than average in Shropshire and worse than average in Telford
Rates of early deaths from cancer and CVD are both better than average in Shropshire and worse than average in Telford

Health summary

Severe and enduring mental health

Significantly higher rates of women with non-psychotic but severe and complex mental health illness, particularly aged 15 to 24 years
Similar rates for males and females for ongoing psychotic episodes, with highest female rate aged 45 to 64 years and highest male rate aged 15 to 44 years
Higher rate of psychotic crisis in males with similar rates between age bands 0.36% (n=1,409): estimated prevalence of psychotic disorder in people over 16 years in Shropshire
Rate of GP prescriptions for psychoses and related disorders is lower in Shropshire compared to England average between 2014/15 and 2107/18
Across Shropshire and Telford & Wrekin there were 95 suicide deaths between 2014 and 2016 (69 men, 27 women)
The local suicide rate (9.7 per 100,000 in 2013-15) has been statistically similar to the England average rate since 2010/12 and the rate has been reducing in recent years.
Suicidal thoughts are the predominant reason why people in Shropshire are admitted to a Section 136 Suite (police based place of safety) or access the Shropshire Sanctuary and Telford & Wrekin Branches (out of hours care suites set up by CCG and voluntary organisations as an alternative to a Section 136)
A&E attendance for deliberate self-harm is strongly associated with those from most deprived parts of Shropshire

Summary

It can be seen from the health summary that there are significant differences in performance against the England average for key indicators. Telford and Wrekin appears to perform worse in areas that are linked to low income and deprivation. The CCG will investigate these areas to determine if these are the determining factors or if there are lessons to be learnt from the Shropshire area to improve performance in Telford and Wrekin. Similarly, learning from improvements implemented in Telford and Wrekin will be considered for the Shropshire area.

It is clear that due to fundamental differences in demographics and rurality that one size will not fit all. The CCG is committed to commissioning at place level to mitigate these differences where appropriate.

Areas of work identified linked to health summary; Weight management, alcohol misuse, frailty, mental health services

Emerging operating model

The new organisation will not continue to work as the current CCGs do now in having very operational functions and micro-managing our providers. Through the Population Health Management Approach our ambition is to agree not only new clinical models of care but new transactional models. This ambition relies on continuing to evolve our system working arrangements where providers in the ICS engaging in new model of deliver and the CCG playing a key facilitation role in this.

The CCG plans to move away from transactional payments and agree capitated budgets that encourage system working across providers delivering co-ordinated support for the physical, mental and social care needs of the population. Care will be provided in line with agreed quality and outcomes standards that have been developed with patient involvement. Commissioners will agree contract values that will include whole system savings (including QIPP) but also risk and gain share agreements to allow providers to benefit from driving service improvements.

As commissioners we will scrutinise the delivery of contracts and will retain a portion of the budget until the lead provider has evidenced that it has fulfilled its responsibilities (including using performance measures). Given our financial position and the need to rapidly transform care in our key priority areas we aim to establish a lead provider for the following:

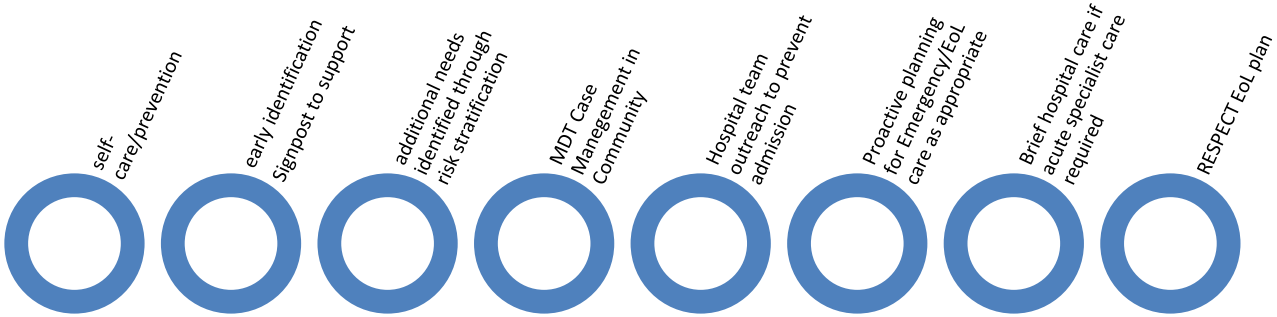
- All patients aged over 65
- MSK patients
- Planned care patients

Other areas will be identified as the operating model develops across the system. Each lead provider will be incentivised to develop clinical networks/sub-contracts with partners to agree integrated arrangements and to manage demand and deliver care in the most effective and efficient way which will in turn deliver efficiency savings for the system.

This move will be as part of a stepped process. Commissioning intentions for 2020/21 have stated that we will be increasing the use of block contract arrangements that include outcomes and intend to further develop a phased approach toward capitated budgets for key priority areas for 2021/22.

Model of service review

The CCG will facilitate the review of existing care pathways and services involving clinicians from all relevant providers to map what is provided at each level. The population health management and other needs analysis will be used to identify gaps in provision, duplication, areas for improvement and good practice. The aim is to implement more effective system working and improve system ownership. A high level example can be seen below:



The new Commissioner will facilitate the development of ***Implementation Plans*** which will have clear ***Transformation and System Change Management Plans*** elements, each with:-

- A clearly defined Service Model
- A clearly defined procurement proposal or Alliance proposal for the ICP
- Financial evaluation of investment/savings
- Proposal for optimal transaction/contractual arrangements
- Actions required for implementation
- Timescales/milestones for key deliverables
- Framework for quality, outcomes and performance monitoring with effective measures/metrics
- Quality and Equality Impact Assessments
- Investment/Savings required
- Communication plans (including engagement/consultation as required)

The CCG, working with system partners has identified a number of priority areas of work. These are set out as follows:

Acute & Specialist Care
Breast Cancer (Cancer transformation)
Outpatients (Elective Care Transformation)
MSK Alliance
Saving Babies Lives Initiative
NHS 111 First
Urgent Care Improvement Plan (SaTH UEC Improvement plan, Discharge and winter)
HTP
Respiratory Pathways - Post Covid

Community & Place Based Care
System Phlebotomy Service
Review of Adult Community Services
Frailty Front Door/ Model
Children's SALT and SEND
CYP Physical Health Pathways
Case Management
Rapid Response
Review of EOL services
Respiratory Pathways Redesign
Primary Care Digital First

Mental Health, Learning Disabilities & Autism
Community Mental Health Transformation
Crisis 24/7 including CYP crisis expansion *
ASD pathways
CYP place of Safety
Perinatal Mental Health (includes Ockenden)
Children & Young People Long Term Plan
Rehabilitation pathway
LD Strategy and Transformation
Autism Strategy and Transformation *
Improvement in IAPT
Suicide Prevention
Trauma Informed Care

These programmes of work, which are also linked to the System Improvement Plan described on slide 36, will be managed via the system governance structure set out on slide 25. This structure will ensure the appropriate clinical engagement as well as input and oversight from all partner organisations.

The Finance Strategy Section is under development as part of the current system sustainability and recovery planning

Outcome and Performance Monitoring Framework

The CCG will be utilising a Performance Monitoring Framework as part of its approach to Benefits Realisation
The Performance Monitoring framework sits within the Governance structure set out on slide 26 and slide 64

All performance framework metrics stratified into:-

- Red, performance deteriorating
- Red, performance improving
- Green, performance deteriorating
- Green, performance stable/improving

- Improvement plans required for all Red metrics and for those that are Green but have deteriorating trend for >3months. These plans will have named senior management leads and executive sponsors
- Detailed exception reporting for improvement plans to the groups identified under the programme boards to focus on delivery of continuous improvement and to manage issues/barriers to that improvement. High level summary exception reporting will then be reported to the programme boards with items for escalation.

A summary of all the performance outcome measures are reported monthly to the CCG's Quality & Performance Committee (Q&P).

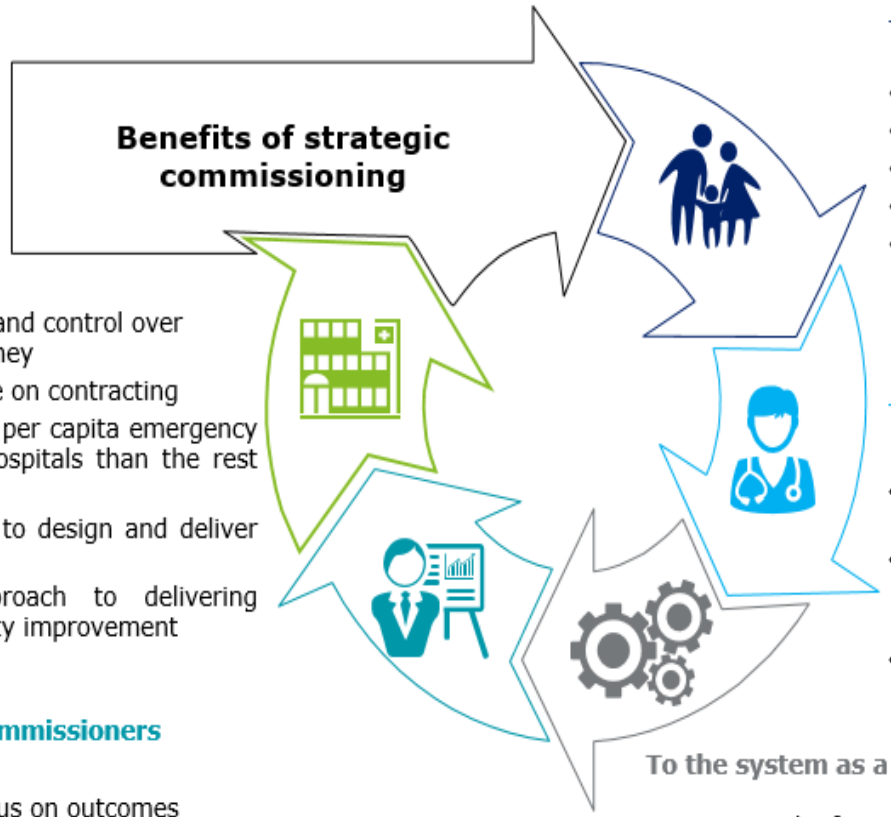
During the next 6 months improvement plans are being refreshed based on the prioritisation outlined above. These plans will be taken through the Q&P committee for sign off in advance of the specific programme boards to maintain the performance oversight function of the new CCG.

New role of performance assurance managers will focus on the delivery of key actions for improvement, help to quantify expected impact of those actions and hold the ring on the individual improvement plans for the CCG and the wider system going forwards. They will provide the updates to the programme boards and narrative for CCG and System performance reporting.

The Q&P committee will also have a performance programme of work for the year that will allow a focus on a particular area e.g. January – Cancer, February – Elective Recovery, March – SEND etc.

This performance monitoring Framework will allow us to monitor the impact of work streams, understand the benefits released as a result and to highlight where changes are still required.

Benefits Realisation – Strategic Commissioning



To providers

- More autonomy and control over services and money
- Less wasted time on contracting
- Lower growth in per capita emergency admissions to hospitals than the rest of England
- The opportunity to design and deliver local services
- Joined up approach to delivering continuous quality improvement

To patients

- Better services and better outcomes
- More joined up services
- More local services
- Improved access to services
- Focus on driving equity to improve services and health for those in the most deprived areas

To Primary and Secondary Care Clinicians

- A central leadership role in setting the vision and outcomes
- Greater autonomy and determination of how services are shaped for their local populations and how money is spent
- More joined up working across professional groups

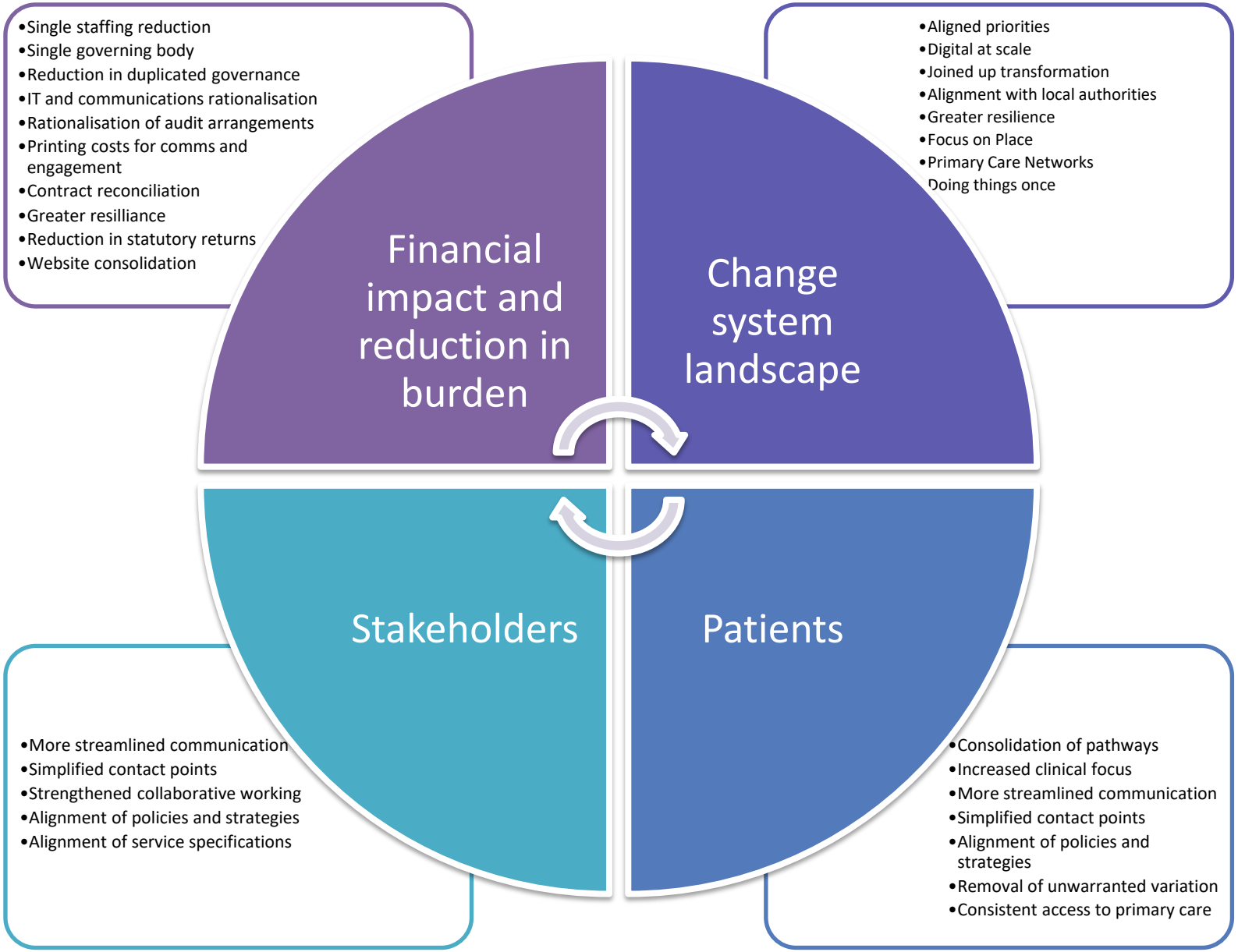
To commissioners

- Focus on outcomes
- Higher quality strategy based on BI and population health
- Stop wasting time on contracting and QIPP
- More chance of delivery given relationships with providers
- Transfer of financial risk to those who hold the vast majority of budget and spending power

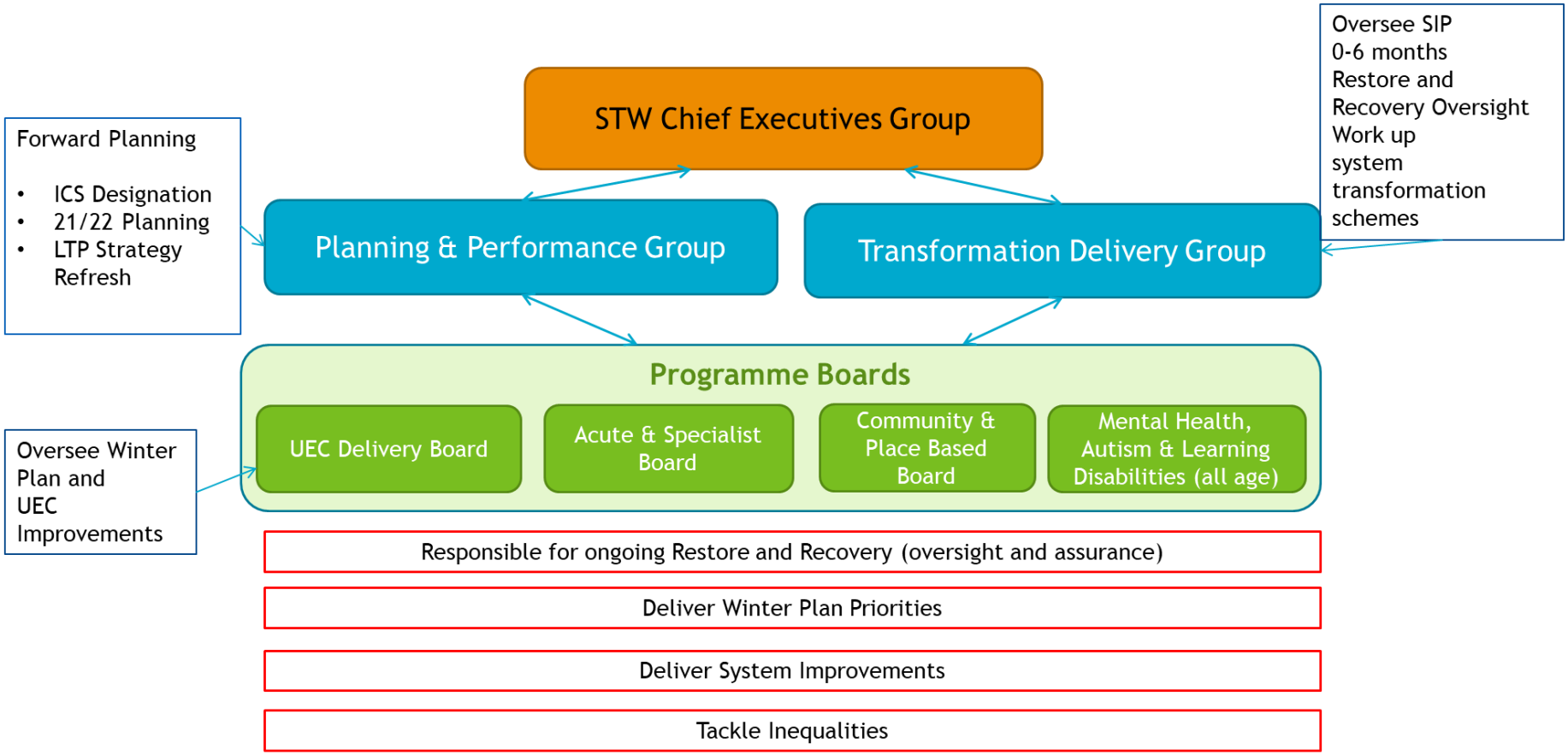
To the system as a whole

- Focus on the financial performance of the system as a whole rather than deficit in individual areas.
- Greater emphasis on prevention and population health
- Opportunity to re-designate and reconfigure acute services
- Opportunity to shift resources into primary care
- Two Local Authorities now working with a single commissioner and set of priorities.

Benefits Realisation – Single Commissioner



Governance for Management of System Priorities and Workstreams



Prevention and place based care

Key changes:

- Joint health and social care rapid response team responding to patients within 2 hours within Telford and Wrekin
- Community based acute and semi-acute responsive services that provide higher level support within Shropshire
- Proactive management of patients at risk of unplanned acute admissions by MDTs across Telford and Shropshire
- Rollout of PCNs to increase primary care resilience and improve access
- Improved alcohol care teams delivering support to patients
- Blue light approach for alcohol targeting high end users
- Improved care pathways for weight management including access to weight management support through social prescribing

Task and finish groups as required

Improved outcomes	Activity impact	Quality impact
• Patients responded to within two hours • Default to community first • Improved access to primary care • Improved alcohol support teams to support patients and prevent future attendances/admissions • Blue light approach for alcohol to support high end users • Patients accessing social prescribing for weight management	• Reduction in ambulance conveyances, A&E attendances and hospital admissions for targeted groups • Reduction in number of people falling • Reduction in average LOS for patients 65+ • Reduction in childhood obesity • Reduction in adult obesity	• Improved patient experience • People feel supported to manage their own conditions • Increase in ANPs in community • Increase retention and recruitment of GPs

Acute and Specialist Care

Key changes:

- More responsive advice and guidance
- Improved ENT, gynaecology and cardiology pathways
- Increase in digital technology to reduce outpatient activity
- System wider clinical strategy developed to deliver Hospital Transformation Programme
- UTC in place on both hospital sites
- SDEC in place 12 hours per day 7 days per week
- Acute frailty in place for 70 hours per week
- Improved flow within wards
- Fully compliant with Saving Babies Lives Care bundle
- County wide smoking cessation service and weight management service for pregnant women
- Maternity hubs model
- Best practice pathways in place for Lung, Prostate, Upper GI and Colorectal
- Rapid Diagnosis Centres established for cancer pathways

Task and finish groups as required

Improved outcomes	Activity impact	Quality impact
• Clinical strategy in place • Reduction in admission conversion rates for over 75s • Increased access to acute frailty support • Reduction in still birth rates • Increase in early diagnosis for cancer • Increase in survival rate of cancer • New MSK model in place • Improved access to alternatives to face to face appointments	• Increase in UTC activity by source • Reduction in 12 hour waits • Increase in 4 hour target • Increase in SDEC activity • Reduction in smoking at time of delivery • Reduction in GP appointments (cancer) • Reduction in MSK surgery / increase in conservative management • Increase in A&G • Reduction in OPA / Increase in non face to face OPA	• Increase in emergency and urgent care workforce • Improved continuity of carer for women during pregnancy • Cancer waiting times targets met • Patient experience improved • Consistency across pathways improved • Increased access to specialist advice for GPs • Reduction in unnecessary appointments for patients

Mental Health, Learning Disabilities and Autism

Key changes:

- Calm cafes in place
- Improved children and young people crisis offer
- Support for people with emotional distress aligned to PCNs
- SIM model in place
- New clinical model for rehab beds in place
- Out of area patients repatriated
- Strategy developed for learning disability
- Strategy developed for autism
- Post diagnostic ASD support in place
- Trauma informed working embedded across the system
- Digital solution in place to ensure professionals can communicate effectively

Task and finish groups as required

Improved outcomes	Activity impact	Quality impact
• Improved self management • People seen earlier • Improved access for people with LD or autism • Reduction in CYP on SEN/EHC plans excluded • Patients to do not to repeat their stories • Reduced duplication • Improved recovery outcomes	• Reduction in A&E attendances • Reduction in s136 • Reduction in demand for GP attendances • Reduction in referrals to BeeU • Reduced LOS in rehab • Increased number of people with LD or autism accessing services • Reduced spend on care packages for complex/challenging behaviours	• Improvement in satisfaction rates • Reduced relapse rate • Reduction in suicide rates • Increases in numbers of people receiving health checks • Reduction in inappropriate prescribing

Section 11: System Big Ticket items

Since the last version of the CCG Commissioning Strategy was developed work has continued to refine the system wide priorities. The Shropshire, Telford and Wrekin system is required to establish robust and credible delivery plans for restoring sustainability across the system over the medium term. The system has agreed that the formulation of these plans needs to be on a finite number of clearly prioritised 'Big Ticket items'.

The six identified Big Ticket items are outlined below:

- MSK Transformation
- Outpatient Transformation
- Alternatives to hospital admission
- Commissioning and procurement
- Workforce
- Hospital Transformation Programme

It can clearly be seen that these Big Ticket items overlap with the priorities identified across the Commissioning Strategy and these will be combined into single workstreams to ensure there is no duplication of effort and maximum impact is achieved.

There are three main components to how the Big-Ticket items contribute towards financial sustainability:

- Removing unsustainable levels of excess cost from expenditure across all system partners
- Preventing further reactive expenditure growth to ensure a portion of the systems growth allocation each year can be set aside to support continuing existing costs which have been incurred in excess of the systems population funding share.
- Leveraging productivity improvements which enable recovery of services (most likely in planned care pathways) with only incremental draw on any new inflows of external funding for recovery.

The initial draft roadmap for the Big Ticket items is shown on the following two slides.

Draft Roadmap (page one of two)

Programme	Action	2020/21	2021/22				2022/23			
		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MSK Transformation	Implementation and consolidation of community MSK provision									
	Implementation and strenthening of rheumatology									
	Design and agree implementation of Midlands Elective Programme									
	Implementation of Midlands Elective Programme									
	Orthopaedics optimisation clinical case and feasibility study									
	Benefits realisation									
Outpatients Transformation	Validate long term plan assumptions									
	Identify priority specialties									
	Develop plan for demand management									
	Develop plan for alternatives to face to face appointments									
Alternatives to hospital admissions	Design Home First (Rapid response / single access point / case management)									
	Implementation of home first									

Draft Roadmap (page two of two)

Programme	Action	2020/21	2021/22				2022/23			
		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Commissioning and procurement	Recruit to invest to save joint posts with the local authority									
	Develop plans for place based commissioning									
Workforce	Develop system level plan to grow our substantive workforce									
	Develop system level plan to manage temporary staff (including one bank)									
Hospital Transformation Programme	Complete clinical review of opportunities to identify early adoption schemes									
	Develop potential design solutions to reflect a continuum of opportunities									
	Develop outline business case (including revenue and capital costs impact of options)									
	Complete system wider benefits assessment of options									
	Preferred option identified									
	Detailed business case developed for implementation									

Next steps:

- Review all plans and deadlines to understand the impact of Covid-19
- Continue to drive forwards the collaborative system approach that has been consolidated during the Covid-19 response phase
- Develop full implementation plan for Population Health Management approach, building on the commitment to develop a shared system resource
- Work with system to develop future provider collaborative model
- Continue to support ICS development programme
- Implement Financial model
- Implement Contractual Incentives Scheme
- Implement and Monitor the System Improvement Plan
- Develop full delivery plan for Big Ticket items by end of March outlining the requirements for delivering the programme including:
    - Programme support
    - Capacity support to SROs
    - Modelling for activity, finance and workforce
    - Next steps including timeline
- Finalise roadmap
- Develop a modelled financial strategy for the Big Ticket items

Commissioning and implementing the key commissioning priorities/ changes will come through :

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

Additionally we will facilitate the development of Implementation Plans with clear Transformation and System Change Management Plans elements to include:

- A clearly defined Service Model
- A clearly defined procurement proposal or Alliance proposal for the ICP
- Financial evaluation of investment/savings
- Proposal for optimal transaction/contractual arrangements
- Actions required for implementation
- Timescales/milestones for key deliverables
- Framework for quality, outcomes and performance monitoring with effective measures/metrics
- Quality and Equality Impact Assessments
- Investment/Savings required
- Communication plans (including engagement/consultation as required)

Appendix one: Operating Model

1 Background

This operating model supports Shropshire, Telford and Wrekin Clinical Commissioning Groups ambition to develop towards an Integrated Care System (ICS). It sets out our proposals to develop new ways of working, governance and supporting infrastructure to enable us to drive partnership working, integration and transformation across the system.

The CCG is committed to making system working the default option, transitioning to a streamlined approach that removes duplication so that this way of working becomes 'business as usual'. While our governing bodies are ready to work together, with greater ownership of system issues, there are still statutory accountabilities that remain in place and this proposed model recognises this and describes how we will work collectively to discharge these.

There is a particular emphasis on ensuring close working with our partners in local government and will seek to strengthen inclusion of council colleagues in our system working. This includes working with our Health and Wellbeing Boards to better align our collaborative approach. Self regulation and assurance are also a key part of our plan and our proposed infrastructure will prepare us to absorb NHSE/I responsibilities as these are devolved with appropriate support.

This document focuses on a period of evolution throughout 2020/21 and sets out how the two CCGs plan to organisation themselves into a single commissioning organisation that is enabled to easily transition into an ICS at a future date. Throughout this period our integrated ways of working will remain focussed on the delivery of our identified objectives providing genuinely joined up, personalised and anticipatory care. The CCG objectives are:

1. Lead the financial transformation needed to identify key shared priorities required to drive both clinical and financial sustainability and ensure these are delivered
2. Provide the strategic and clinical leadership in the planning and commissioning of care for the people of STW – this will include developing new transactional arrangements to incentivise providers to take lead responsibility for key cohorts of patients/populations
3. Reduce health inequalities and demand by deploying a population health management approach to improve the physical and mental health of people living in Shropshire, Telford and Wrekin
4. Reduce variation in outcomes and quality of care
5. Improve communication with an involvement of patients, public, clinicians and all stakeholders
6. Re-focus on prevention and anticipatory patient centred care

2 Our Operating Model

Our developing operating model builds upon our layers of planning and delivery which includes a strong history of integrated working across health and social care which will form the basis for our on-going development.

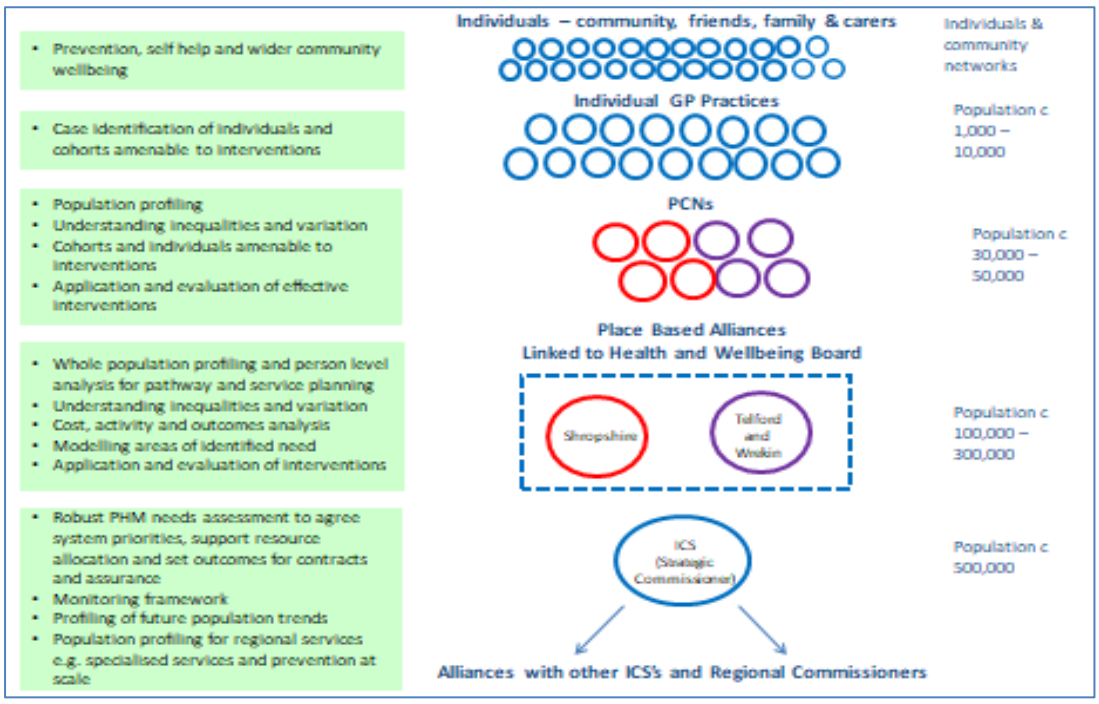


Figure 1: Layers of planning and delivery

While contemporary relationships develop, the new CCG can prepare for the future by dividing itself into strategic and tactical functions as outlined in figure two.

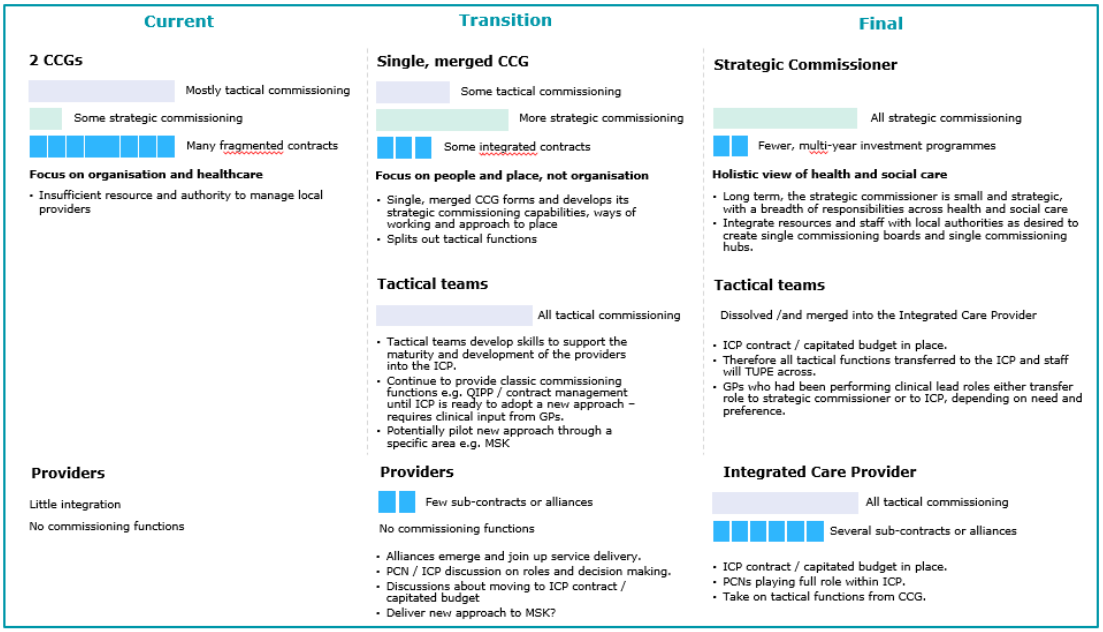


Figure 2: Current position, transition phase and strategic commissioner

3 CCG Development

The following table sets out the changes we anticipate in the historical approach to commissioning as we develop the CCGs into a single strategic commissioning organisation.

Table 1: Future role of strategic commissioner

Future role of the Commissioner	
A move away from	**A move towards ...**
• Spending unproductive time on contracting and transactional commissioning that is required by the current system	**Taking a more strategic approach** • Set the outcomes and let the providers deliver them
• Designing services or QIPP schemes where delivery is a challenge	• Use a population health approach to define what really matters for each part of the population, and then set outcomes and allocate budgets accordingly
• Detailed direct commissioner intervention and direction of quality and primary care	• Population health is based on use of data and intelligence from all parts of the system, and best practice
• Areas of conflict between primary, community and acute care	• Robust approach to prioritising key interventions and stopping doing other things
• Some conflicts between commissioners and providers based on regulator instructions	**Providing system leadership** • Single clear vision and accountability • Integrate commissioning functions and resources with the local authorities where desired and possible • Greater working with providers as partners
	Patient advocate • Strengthen the ability to hold the ICP to account on behalf of the ICS PB for delivering high quality outcomes • Focus on delivering longer term goals across a broader set of indicators (e.g. wider determinants of health) • Expand working with other parts of the system (e.g. Police, Fire)

12

Executive structure

A joint Accountable Officer (AO) was appointed across the two CCGs in October 2019 and following this the AO began developing an Executive structure that would need to:

- Provide Executive leadership for two single CCGs in the interim period leading up to the creation a new single CCG
- Become the new management team for the new single strategic commissioner

Consideration was given to replicating the existing CCG executive structure but implementing this would have required a second management of change process to be undertaken in 12 to 18 months. The structure developed is significantly different from existing CCG structures and links to the emerging roles and responsibilities of a strategic commissioner and some functions of the Integrated Care Provider (ICP). Within figure two posts in blue link to the strategic commissioner and posts in purple link to the ICP.

Figure 3: Single CCG executive structure

Implementation of this structure removes the need for an additional management of change process which will be less disruptive to the organisation. Strategically it is also easier to identify where some STP functions would sit within a strategic commissioner and the system can look to move these sooner rather than later given some of the challenges within the STP.

When the ICS is implemented locally the CCG board will take on some devolved responsibilities from NHSE/I, devolve some responsibilities and ultimately staff to the provider network(s) and increasingly focus on the role of Strategic System Management and strategic commissioning. We anticipate that this will involve developing relationships with other strategic commissioners.

Clinical Input

In designing the new strategic commissioning organisation structure it is important to ensure there is sufficient clinical and medical leadership. Current input into the two CCGs is predominantly through contractual and additional sessions for Governing Body members although there are a small number of specialist sessions provided outside these arrangements.

Currently there are 57 sessions per week across the system (19 in Telford and 38 in Shropshire). This does not include the input of the Medical Director in Shropshire CCG.

Work currently falls into the following broad categories quality assurance/performance management, system clinical leadership work, service improvement work and redesign work.

Table 2: Proposed clinical/medical model

Area	Input required	Future input (week)
Quality assurance / performance management	Corporate clinical voice to represent the CCG position. Work closely with the Quality Team. Attendance at meetings including Safety Oversight Assurance Group, Implementation Oversight Group, Risk summits and follow ups, escalation meetings, A&E Delivery meetings	4-6 session - Medical director
System clinical leadership work	Senior clinical voice contributing to shaping CCG and system strategy and taking a lead in enabling wider clinical involvement. Planning, facilitating and attendance at system design and prioritisation groups, wider system engagement events and system medical leaders meetings	4-6 sessions CCG chair
Service improvement work	Senior clinical voice for contract management and service improvement conversations relating to proposals, risks and progress.	Ad hoc from sessions below
Re-design work	Non specialist clinical perspective on development of proposed new models of care and in helping to engage with clinicians and service users in the work.	6 sessions across 3 board members
Governing Body	Attendance at Governing Body and board development sessions	7.5 sessions

A resource would be allocated to enable additional sessions to be sourced as required. An additional resource in the form of the Locality leads (up to 4 sessions) will be utilised for developing wider membership involvement.

Through the proposal outlined in table one that streamlines the process of clinical involvement and provides greater clarity over individual roles and responsibilities it is felt that the CCG will have sufficient clinical capacity and leadership even with reducing from the current 57 session to the proposed 27.5 sessions.

Governance Structure

The CCG will be in a state of transition during 2020/21 moving from two statutory organisations to one. To enable the CCGs to meet their statutory duties it is proposed that an interim governance structure is implemented within the two organisations (Figure x)

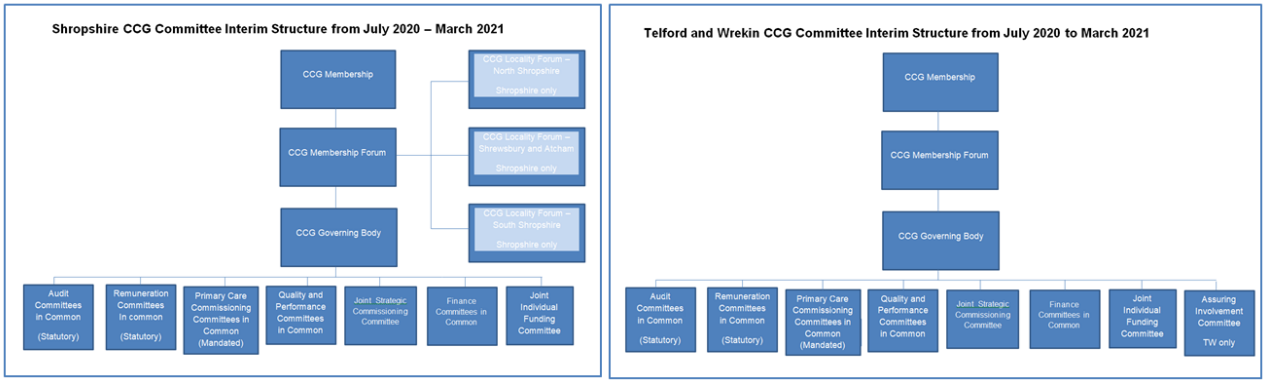


Figure 4: Interim governance structure 2020/21

Once the new single commissioning organisation is in place April 2021 the proposed governance structure in figure 4 will be implemented.

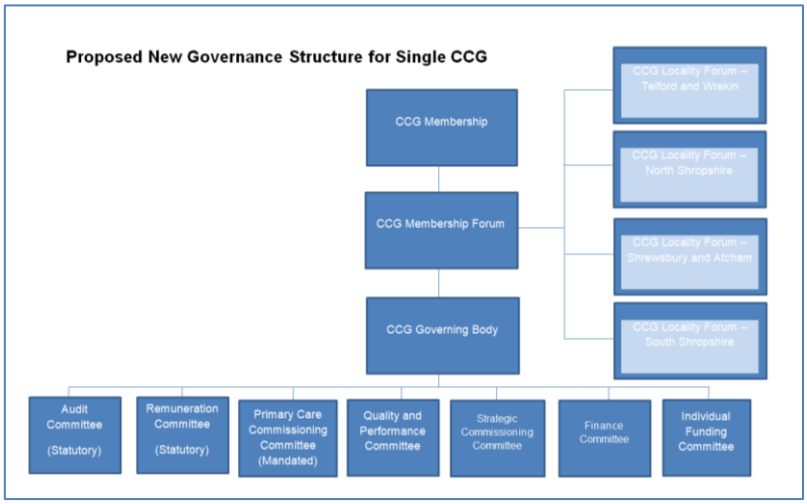


Figure 5: Proposed governance structure for the single commissioning organisation

4 ICS Development

ICS Governance

Our proposed shadow ICS governance structure is shown in figure four.

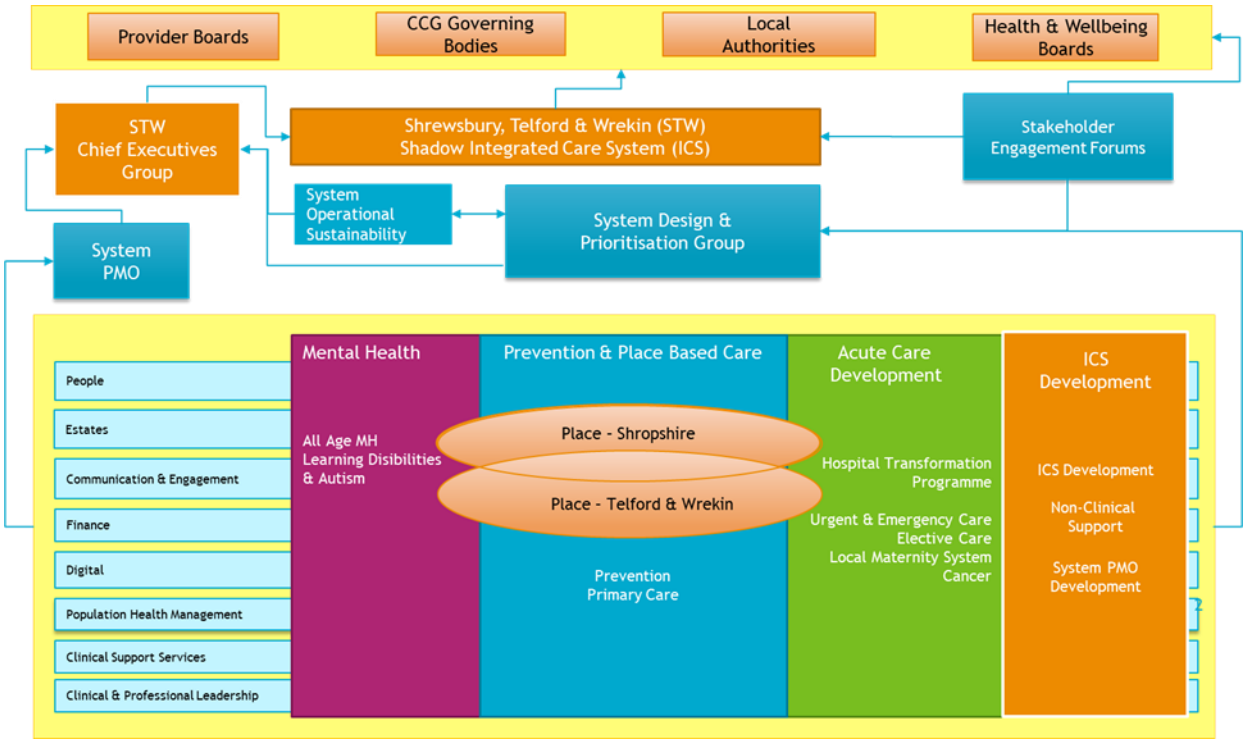


Figure 6: Shadow ICS Integrated Care System Governance Structure

Each of the areas has a defined purpose within the governance structure as detailed below.

ICS Shadow Board

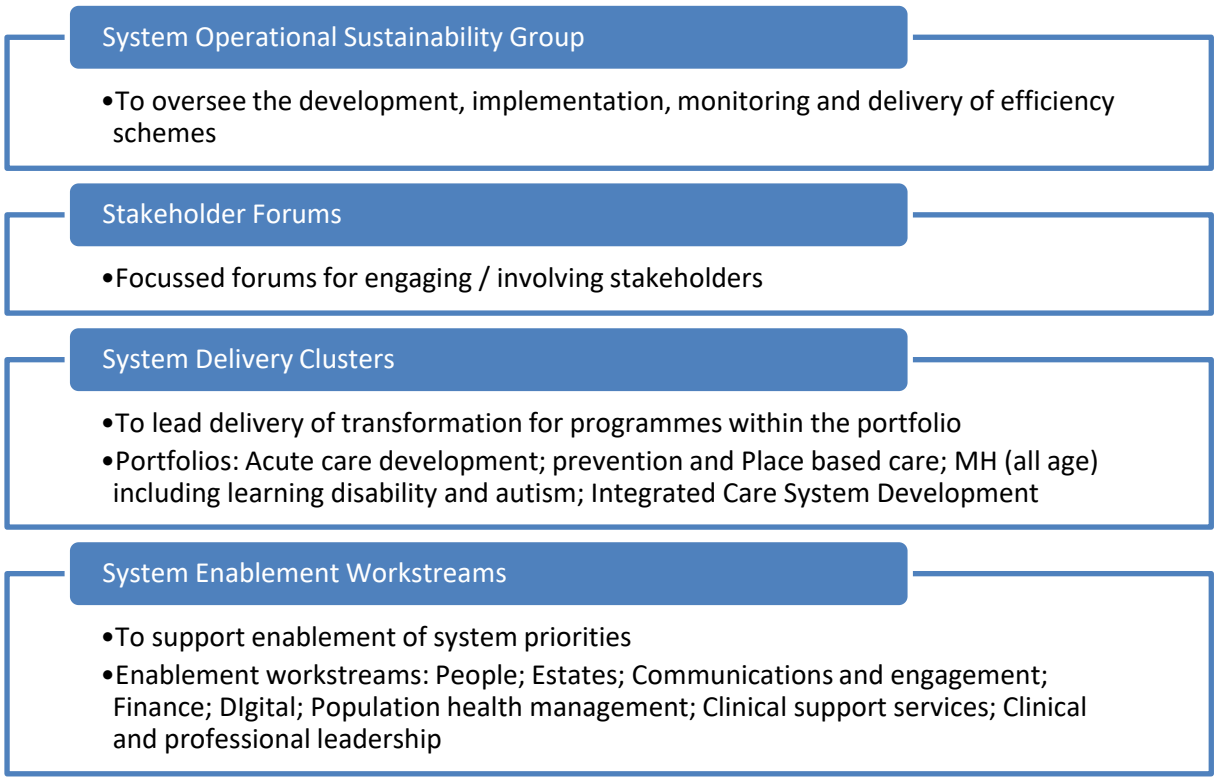
- To maintain strategic oversight of and accountability for the STP
- To provide support to the STP Executives Group

Chief Executives Group

- To provide system leadership of the shadow ICS
- Responsible for setting vision, ambition and direction and ensuring alignment with the aims and objectives of their own organisations
- To provide shared investment in resources needed to deliver the long term plan

System Design and Prioritisation Group

- To lead design and evaluation of system wide design principles and options
- To provide support to workstream specific design groups
- To provide overall clinical, financial and technical assurance
- To review design and delivery plans to ensure they are fit for purpose



The governance will be supported by the System Programme Management Office (PMO). This PMO will provide overarching support to the shadow ICS and its workstreams when developing and delivering their workstream plans. The PMO will ensure that all plans are compliant with the required standards and processes. The PMO will produce ICS wide status reporting including tracking of expected benefits and outcomes, managing or escalating risks and dealing with complex issues across the system

ICS Functions

The CCG undertakes a variety of functions to delivery its statutory duties and these can be grouped into the following categories:

- Commissioning strategy
- Population health management
- Market management
- Financial and contractual management
- Planning and delivery
- Monitoring performance
- Stakeholder engagement and managment

The functions of a CCG will be split across the Integrated Care System, Strategic commissioners and Integrated Care Providers.

Figure six sets out the current range of functions undertaken by the CCGs and where they will be performed in the future as our Integrated Care System (ICS) develops.

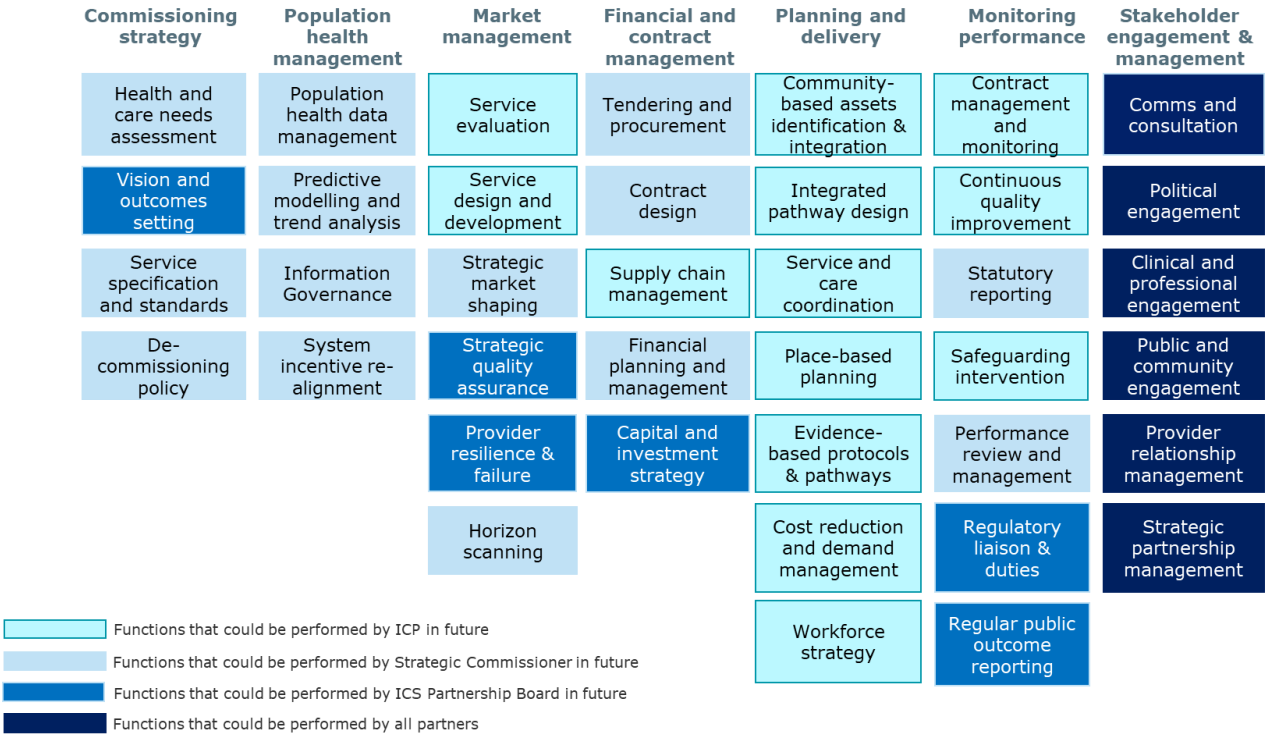


Figure 7: CCG Functions mapped to ICS

The speed at which this happens will depend on the speed of the development of the ICS and the appetite from partner organisations to take on new responsibilities. The strategic commissioner will assume a leadership role in this regard driving through change and ensuring the maintenance of pace.

5 Primary Care Networks

Eight primary care networks are established within Shropshire, Telford and Wrekin (four within the previous boundary of Telford and Wrekin CCG and four within the previous boundary of Shropshire CCG):

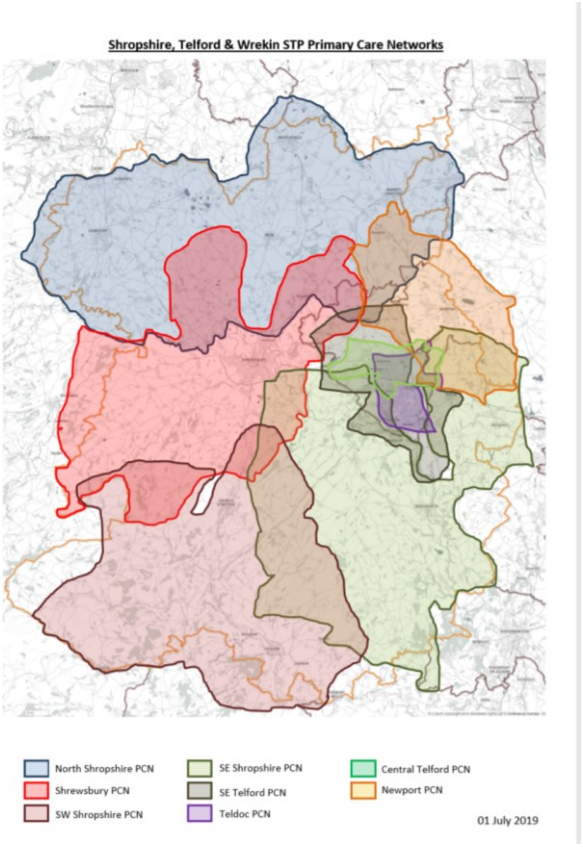


Figure 8: Primary care network coverage

A joint primary care strategy is in place across Shropshire, Telford and Wrekin which includes nine programmes of work:

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

The strategy will be used to further progress development of PCNs and embed them within the wider system.

6 Developing provider networks

Given our geography, relative population size and workforce issues our local providers are beginning to establish relationships to ensure local sustainability of services and access to supplementary services beyond our boundaries where necessary. Providers are developing alliances based around specific service areas working together to develop a clinically led new service model. The NHS Long Term Plan envisages that a formal provider alliance will govern the relationships between providers within the STP.

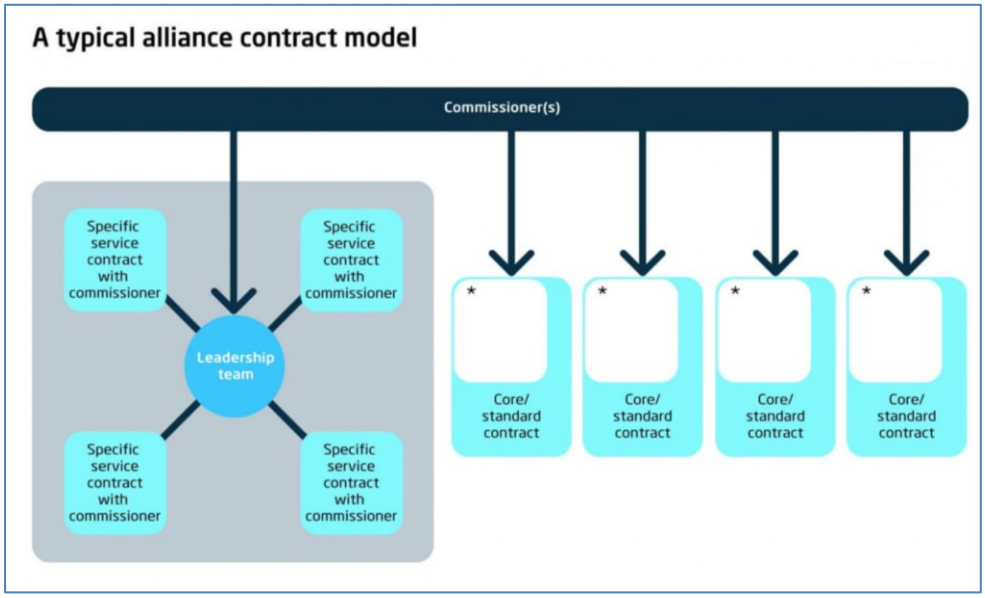


Figure 9: Example of an alliance contractual model

During the next twelve months these alliances will continue to develop and embed within the local system. These local alliances are the first steps towards an Integrated Care Provider (ICP).

8 Place Based Alliances

Figure four illustrates the importance of our place based alliances; one Shropshire based and one Telford and Wrekin based. We already have strong governance in relation to place based programmes of work which provide forums and mechanisms through which partners from health, social care, education, housing, voluntary sector and others meet regularly to review the integrated working. We anticipate that a large proportion of the required transformation and integration work will be undertaken at the Place level.

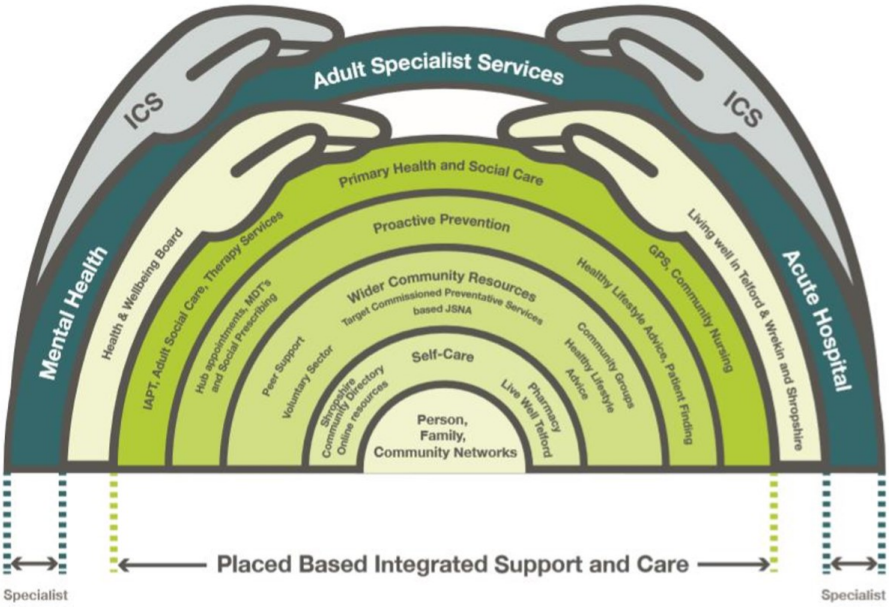


Figure 10: Place based integration

The ICS plans to support people to be as healthy as possible for as long as possible by improving population health, transforming community services and stemming the significant growth in emergency acute hospital admissions. The system will work with communities to reduce health inequalities by improving the health and wellbeing outcomes for the whole population especially those who are vulnerable and those living in more deprived communities. The CCG and ICS plan to utilise the Population Health Management approach to understand the local population needs and what is driving demand to enable more focused work at both Place and System level via the system enablement group relating to population health management. By keeping people well for longer and for managing their care closer to home we will be able to absorb the impact of the growing numbers of older people without increasing the need for hospital beds.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group




Communications and Engagement Strategy 2021- 2022

Document Control Sheet

Title	Communications and Engagement Strategy 2021 - 22
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Version history	
16 Aug 2019	V1 – shared with Executive Lead Governance and Engagement Telford &Wrekin CCG V1a- shared with Executive Lead Governance and Engagement Telford & Wrekin CCG
18 September 2019	V2 - updated and refreshed by AH
20 September 2019	V3 - updated
24 September 2019	V4 - engagement review
10 April 2020	V5 - refresh
28 April 2020	V6 – incorporation of elements from Commissioning Strategy
Jan 2021	V7 – update for final phase of transition period and launch of single CCG
Mar 2021	V8 – update for final phase of transition period and launch of single CCG
April 2021	V9 – updated Logo and Title of new CCG

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1) Background

Who we are

NHS Shropshire, Telford and Wrekin CCG is a newly created single commissioning organisation which will be officially launched in April 2021 following the dissolution of NHS Shropshire CCG and NHS Telford and Wrekin CCG. The intention is that it offers a streamlined and unified approach to the planning, buying, and monitoring of local health services for people across the county.

The CCG is led by a governing body. All general practices in the CCG area are members of the CCG and have elected clinical representatives on the governing body.

The CCG is responsible for commissioning services including:

- Planned hospital care
- Rehabilitative care
- Ambulance services
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services

The CCG also has delegated authority from NHS England/Improvement for commissioning General Practice Primary Care services.

Our mission statement and strategic priorities for the new CCG

We wish to create a genuinely new organisation with a refreshed mission statement, strategy, values and objectives. We recognise that we are on a journey to becoming a strategic commissioner and that this will not be completed in one step. Therefore we have started work to develop a proposed new purpose statement and strategic priorities for the new CCG:

Mission Statement:

To be inserted when approved by NHS STW CCG

Strategic priorities:

To be inserted when approved by NHS STW CCG

As a single strategic commissioning organisation we act in the interests of:

- A population of circa 500,000
- 223 Full time equivalent members of staff
- 53 GP practices

- 7 combined Primary Care Networks
- Shropshire and Telford & Wrekin Sustainability and Transformation Plan

Our role is to commission services that meet the needs of our communities. We strive to improve access and outcomes for all patients in our communities across Shropshire, Telford and Wrekin.

We want to make sure that the way we work when commissioning services on behalf of the local population is effective and that the priorities for the population are identified, listened to, and acted on.

As a strategic commissioning organisation our aim is to develop better integrated health and social care across the county. This means care that joins up hospitals, primary care, health and social care, mental health and physical health for the benefit of the population individually and in communities.

2) About the strategy

This communications and engagement strategy has been developed to support the creation of a new strategic commissioning organisation to serve the population of Shropshire, Telford and Wrekin.

Following the publication of the Whiter Paper setting out a plan for dissolution of CCGs and the creation of statutory Integrated Care Systems (ICS), this strategy is designed to support the CCG through its first year and transition into an Integrated Care System. This is also set against a backdrop of the COVID-19 pandemic, and the significant this has had on healthcare services and communities everywhere.

It is assured and monitored by our lay members for public and patient involvement and approved by our governing body.

The communications and engagement strategy ensures that the CCG meets its legal duty, as set out under Section 14Z2 and 13Q of the NHS Act 2006 (as amended by the Health and Social Care Act 2021 – public involvement and consultation by CCGs) to involve users when making changes to local services and will ensure compliance with the Equality Act: Public Sector Equality Duty. It will also link to the equality impact assessment produced in relation to the creation of the new, single strategic commissioning organisation.

The strategy, although designed for the short term, builds on the meaningful approach to stakeholder communications and engagement developed by the Shropshire, Telford and Wrekin CCGs. It will further enhance the communications and engagement links already in place.

As the needs of the new CCG and developing ICS emerge over the forthcoming months, a new communications and engagement strategy will be developed which will support the newly formed ICS going forward. This will link closely to the commissioning strategy to ensure that all of our stakeholders, including patients and the general public, are fully engaged in the development of our commissioning plans.

In developing the new ICS communications and engagement strategy, we will involve our key stakeholders, including primary care, staff, Healthwatch, partnership forums, the public and patients, as well as the voluntary and community sectors as it develops and evolves.

In addition, the communications and engagement team is being restructured as part of the management of change programme. This will include the introduction of a ICS Director of Communications and Engagement for the Integrated Care System and CCG with effect from 1April 2021. These actions provide a further opportunity to reassess our communications strategy and activities, and to ensure our finite resources are being utilised to best effect.

3) Aims and objectives

The aims and objectives of our communications and engagement are:

Aims:

- To increase awareness and understanding of the new strategic commissioning organisation amongst our stakeholders (see section 6).
- To support the new organisation in delivering its strategic priorities, ensuring a proactive approach to involving all stakeholders, particularly patients and the public, in shaping commissioning priorities and transformation plans for the benefit of the local population.
- To use patient feedback to support effective quality assurance of commissioned services.
- To support system collaboration and development of the emerging ICS and Primary Care Networks.
- Create two way channels to capture views and ideas on our locally commissioned services and the work of the CCG.
- To support staff through the transition from a CCG to a newly formed ICS.

Objectives:

Leadership and governance

- To ensure our executives and governing body members (our leadership team) are supported to be role models for effective communications and engagement aligned to the values of our organisation.

Staff engagement and communications

- To ensure our staff understand the mission statement and values of the organisation and how they relate to their role.
- To ensure staff are regularly updated on appropriate corporate matters.
- To ensure two way dialogue which enables staff to feel engaged.

Public and patient involvement including equalities and health inequalities

- To ensure the organisation adheres to all statutory and legal duties to consult and engage, as well as in making changes to support health and care transformation.
- To ensure there is public and patient representation across the organisation.
- To ensure public and patient feedback is clearly evidenced in influencing decision making.

Primary Care engagement

- To ensure our members feel valued and able to influence our decisions and priorities.
- To support the development of Primary Care Networks (PCNs) and local Integrated Care Partnership (ICP) schemes.
- To share best practice and develop a joined up approach to Primary Care engagement across our footprint.

Stakeholder collaboration

- To work collaboratively in support of public confidence in our organisation.
- To work with partners to reduce duplication of effort, share learning and ensure the dissemination of consistent messages from all ICS partner organisations.

4) Our communications and engagement principles

To reflect our new organisation's constitution, mission statement and values the principles that will underpin all of our communications and engagement activities are:-

- **Timely:** our communications will be delivered at the appropriate time to keep stakeholders informed.
- **Accurate:** all communications will be accurate to the best of our knowledge.
- **Accessible:** communications will be presented in an accessible way, incorporating best practice standards for technical accessibility, using Plain English for written materials.
- **Collaborative:** we will work with other organisations, for example, in the statutory, voluntary and community sectors, to deliver communications and engagement activities to our shared stakeholders.
- **Meaningful:** engaging with our patients, staff, public, and stakeholders will be meaningful and add value by patient experience and insight being fed into the decision making process and the commissioning cycle.
- **Evidence based:** we will deploy tools and methods that are proven to be good practice. We will evaluate our engagement methods and communications channels to ensure they remain fit for purpose. This includes feedback, for example, from the Improvement and Assessment Framework.

5) Methodology

This strategy continues to build on the preparatory work set in the previous transition communications and engagement plan. It will help to facilitate a smooth transition from the planning phase into an implementation stage, whilst providing a foundation to build on for our future development as a strategic commissioner within an ICS.

There are a number of core tools for communications and engagement which have been updated for the new single CCG. These will be further developed over the next 12 months as the new ICS communications and engagement strategy is developed.

Local identity style and CCG logo
A new local identity style has been developed for the new CCG, within the NHS brand guidelines. This will enable the CCG to adopt a unique style which reflects its purpose and the communities it serves, whilst sitting within the highly recognisable NHS brand. It will be used in conjunction with the single NHS Shropshire, Telford and Wrekin CCG logo.

The new style and CCG logo was introduced from 1 April 2020. A range of templates have been created, and the logo has been provided for addition to other materials. Instructions on the correct use of the NHS logo, local identity style and the correct use of the single CCG name have been provided.

Moving forward, a review of all branding documents across the organisation needs to be undertaken, to ensure the consistent and correct use of the CCG style and logo on all documents. This will be conducted between April 2021 and September 2021.

Corporate website
A new website for the single CCG has been commissioned, and went live on 1 April 2021. This has adopted the new CCG logo and brings together core information from across Shropshire, Telford and Wrekin.

The two former websites will remain in place until the end of April 2021, with a redirect to the new website.

To ensure the new website was ready and operational for 1 April 2021, a phased approach was adopted for populating the content. An audit of the content was undertaken to identify the most significant information which must be live on the new site from 1 April 2021. A programme will then be developed to review, update and populate the rest of the site over the next three months. An additional plan will also be developed to ensure the website is kept up to date on an ongoing basis moving forward.

Social media
The social media presence of the two previous CCGs was inconsistent. Both CCGs had a Twitter account, but only Telford and Wrekin CCG was on Facebook. Further work is needed to achieve the full potential of a social media presence to support our communications and engagement activity.

A revised social media presence for the single CCG was established, with new platforms set up. This will focus on Twitter and Facebook initially, with other social media platforms explored in due course. A social media engagement strategy for the ICS will be developed for implementation after April 2021, to develop our network of contacts on social media and to make best use of these platforms as an effective part of our communications and engagement approach.

Staff communications
At present, the following newsletters are issued by email to staff across the CCG:

- Staff newsletter - currently weekly, and essential until a solution is put in place to share information across the single CCG via an intranet or shared filing system.
- Huddle update – a written summary of the weekly CCG huddle is currently shared by email, the same afternoon. This approach will be reviewed in 2021.

Media relations
The communications and engagement team provides a media relations service which includes both pro-active and re-active media engagement.

A programme of press releases to support key NHS messages and local activity is planned throughout the year. This is delivered in conjunction with Shropshire, Telford and Wrekin ICS and also NHSE/I, as well as providing support for local commissioning projects and corporate news.

Urgent news items are also issued as required, subject to the appropriate approval. Media enquiries are managed on an as and when basis, again subject to the

appropriate approval. An Out of Hours media service is currently provided by our CSU and will continue until the end of the current financial year.

The communications and engagement team has a number of contacts in the local media. Media distribution lists for the two CCGs have been combined, however further work is required to update them post April 2021. After this, they will be managed on an ongoing basis.

The communications and engagement team will also ensure appropriate senior team members and the board chair receive appropriate media training. This should include generic media interview skills (refresher sessions where required) and training to support specific subjects.

Engagement forums

Our consultation and engagement work at present is being undertaken virtually, due to COVID-19 safety measures. This is a new challenge for the CCG, however we have successfully used the following techniques:

- Digital surveys (backed up with a postal option for accessibility requirements)
- Virtual events – delivered using MS Teams as a platform and providing a means of remote but direct engagement for a manageable number of stakeholders.

Further work will be required to develop a programme of engagement activity for the new CCG and ICS workstreams, which takes into consideration COVID-19 safety precautions and also plans for future options once safe and permissible.

Our engagement activity has to date focussed around the creation of the single CCG and Covid related engagement. However, the communications and engagement team continues to support commissioners in fulfilling their duties to engage.

GP Practices

CCG communications with practices currently relies on the weekly Practice Bulletin, which helps to collate key information into one format, thereby reducing individual emails. There are also weekly calls with all practices attended by both practice managers and GPs. Practice nurse facilitators work with the quality team to share information through weekly team meetings with all practice nurses. This format will be reviewed in 2021 as the emerging needs of the CCG and the practice members emerge, moving forward in to the new environment.

A programme of communications activity is also undertaken as part of the CCGs commitment to support the Primary Care Commissioning Committee (PCCC). During 2020/21 this included six agreed campaigns across the area.

Partnership working

The CCG currently supports a number of partnership forums, including Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Care Closer to Home.

6) Our stakeholders

A stakeholder is defined as anyone who has an interest in the organisation and can influence or impact on its success. Stakeholder management involves building and maintaining the active support and commitment of these people, groups or organisations to facilitate the timely implementation of change. By understanding our stakeholders and their priorities, it becomes possible to influence, and to minimise or resolve issues which may have become a barrier to success.

As a strategic commissioning organisation, we need to communicate with stakeholders at a number of different levels, including locally, regionally, and nationally. Within our own local footprint, we recognise that we have two distinct places; Shropshire and Telford and Wrekin, which mirror the local authority areas, as well as 8 PCNs, and that stakeholders in these different areas might have different priorities and needs that require a different communications and engagement approach.

We also understand that working closely with our neighbouring commissioning organisations, particularly in Powys, is crucial. All of these factors will be taken into account in our communications and engagement strategy action plan.

Our priority stakeholders are summarised in the high level stakeholder map below and listed in more detail on the following page:

High Level Stakeholder Map		
High Influence	**INFORM** ▪ Elected representatives ▪ Statutory groups and regulators ▪ NHSE/I ▪ ICS partner organisations ▪ Media ▪ Member practices/staff ▪ Other health and care professionals	**PARTNER** ▪ Governing Body members ▪ ICS Leadership Board ▪ Health and Wellbeing Boards ▪ Local Authority Leadership ▪ Provider organisations in the community ▪ Primary care representative organisations ▪ NHS England ▪ STP / ICS ▪ PCNs and ICPs
Low Influence	**MONITOR** ▪ Public Health England ▪ Wider GP and Primary Care Workforce ▪ CQC ▪ Professional Bodies ▪ Strategic commissioners in neighbouring areas	**INVOLVE** ▪ Voluntary and community sector ▪ Patient Groups/Representatives ▪ CCG staff ▪ Patients ▪ General public ▪ Seldom heard groups
	Low Interest	**High Interest**

- **Patients** – people who are registered at one of our 53 local GP practices; Powys patients who are recipients of our commissioned services

- **General public** – the population of Shropshire, Telford and Wrekin and outside our footprint where patients are served by the providers for which we are a lead commissioner

- **Patient groups** – representatives with a remit to seek out and bring forward the views of their fellow patients and wider community. This includes, for example, Healthwatch and patient participation groups.

- **Seldom heard groups** – people whose circumstances mean they have one or more of the protected characteristics as identified in the Equality Act 2010 or who could find it harder than the general population to access services

- **CCG staff** – everyone employed by the organisation, or partners in our delivery such as Commissioning Support Unit (CSU) staff or external consultants

- **GP practice staff**– CCG GP members, staff working in our 53 primary care practices and collaboratively in our 7 Primary Care Networks

- **Other health and care professionals** – including clinicians working at our acute trust, social care professionals and people delivering mental health services

- **Providers in the local community** – including pharmacists, optometrists, care and nursing homes, physiotherapists

- **Primary care representative organisations** – Local Medical Committee, Local Pharmaceutical Committee, Local Optical Committee

- **Politicians / elected representatives** – MPs, County Councillors, Town Councillors, Parish Councillors, local joint committees

- **STP / ICS** – our commissioning partners including our two local authorities and our providers

- **Statutory groups and regulators** – [Joint] Health Overview Scrutiny Committee, Healthwatch Shropshire and Healthwatch Telford and Wrekin, NHS Involvement/NHS England/Improvement, where appropriate

- **Strategic commissioners in neighbouring areas** – including Powys, Staffordshire, Black Country, Herefordshire and Worcestershire, Cheshire

- **Voluntary and community sector** – organisations whose service provision is predominantly delivered by volunteers along with professional support, often bespoke to individual communities

- **Media** – local, regional, and national media (both online and offline) that help us to tell our story and to communicate with the general public.

These stakeholders and others where relevant will be considered in planning all activities aligned to this strategy.

7) Achieving our objectives

Leadership and governance

All members of the Governing Body and executive team have a leadership role to play in the delivery of this strategy as advocates of the new organisation and the decisions made. Governing Body members will have a key role in promoting the work and actions of the organisation, in involving senior stakeholders and showing collaborative leadership within the STP partnership.

Leadership from the top of the organisation will give a clear signal to internal and external stakeholders of the importance of communications and engagement. This will provide the drive, enthusiasm, and support for delivering this strategy.

Governing Body members and executives will be supported to be able to articulate and reinforce the mission statement, strategic direction, and objectives of the organisation. This will include the commitment to involve stakeholders in shaping and informing decision making.

The communications and engagement function of the organisation will support governing body members to:

- Understand, influence, and approve the communications and engagement strategy.
- Create a narrative that Governing Body members are comfortable to articulate in a consistent way that enhances the reputation of the organisation and provides confidence to the public and other stakeholders.
- Take an active role in encouraging staff to involve patients, the public, and other stakeholders in planning processes.
- Establish appropriate governance structures to ensure the organisation meets its statutory duties to involve, comply with equality legislation, and pay due regard to addressing health inequalities.

The Governing Body has created a formal committee which is independently chaired. This is called the Assuring Involvement Committee (AIC), and is a forum to scrutinise how the CCG is engaging and involving patients in the services it commissions and to allow stakeholders to have an input into CCG work.

The AIC will be formed, recruiting 10 members of the public from across the Shropshire, Telford and Wrekin area. This presents an opportunity to better reflect the communities we serve. The process of recruiting for this group will begin in April 2021, aiming to have the new group in place by summer 2021.

This group will assure the delivery of the organisation's communications and engagement strategy, will monitor the quality and effectiveness of communications and engagement activities, and ensure the CCG meets its legal responsibilities under the Equalities Act.

The CCG's lead for communications and engagement is responsible for developing the communications and engagement strategy and for co-ordinating delivery of the

activities.

We are committed to ensuring that we have public and patient involvement at all levels in our organisation. This includes:

- Our constitution which describes how we will involve the public in our organisational governance and more widely in the CCG's work.
- A Lay Member for Public and Patient Involvement (PPI) and Lay Member for PPI – Equality, Diversity and Inclusion sit on our Governing Body and assures the CCG in relation to public involvement.
- The impact of proposed decisions on patients and the public will be highlighted in every report that is presented to the Governing Body.
- Governing Body meetings will be advertised on the CCG website and in the media one week before the meeting takes place to allow questions to be submitted.
- Assuring Involvement Committee which will act as the assurance mechanism for the CCG meeting its statutory duties with regard to patient involvement.
- Reviewing the public and patient involvement work of our providers and taking the appropriate action where this fails to meet the required standards.

Staff engagement and communications

Our staff are our representatives and are fundamental to our success as a new organisation. We want to ensure they feel confident in the new organisation and are clear on what success means and how their role contributes overall. A more engaged and informed workforce supports better performance, employee retention, and wellbeing.

We will communicate regularly and in a timely fashion with our staff to ensure that they are up to date with the organisation's work and are involved in any developments.

Solutions for a digital platform to underpin our internal communications are currently being considered. This includes an intranet or shared filing system, such as SharePoint. Once the preferred solution is in place, our approach to staff communications can be reviewed.

Our current mechanisms include:

- Weekly joint CCG staff huddle (with written update)
- Weekly staff newsletter
- All staff emails (for more urgent and time sensitive announcements)
- Workshops, briefings and focus groups where required (currently delivered virtually)

To demonstrate our commitment to staff engagement, we will work with staff to understand how they would like to be engaged with and we will deliver a range of different engagement opportunities, which could include:

- Staff survey
- Staff communications and engagement champions
- Staff Forum
- Wellbeing and health at work events/schemes
- Utilising team meetings structures to cascade and feedback

information
- Staff support groups, including protected characteristics
- Staff awards
- Chair and Accountable Officer Q&A Drop In Session

Public and patient involvement

The new organisation will have a statutory duty to involve patients in decisions about their care and in commissioning processes and decisions (see Appendix A for legal duties). We recognise that it is essential for us to involve the public and patients in developing new and existing services to ensure they meet the needs of our local population.

In order to deliver this duty in the best way possible, the new organisation will also adopt the 10 good practice guidelines set out by NHSE/I in *Patient and public participation in commissioning health and care: statutory guidance for clinical commissioning groups and NHS England*. These provide a framework for engagement work, covering the areas in the annual Improvement and Assessment Framework and ensure compliance with legislation. In adopting these guidelines, we will ensure they are fully reflective of local circumstances and the communities we serve. The 10 good practice areas are:

1. Involve the public in governance
2. Explain public involvement in commissioning plans/business plans
3. Demonstrate public involvement in annual reports
4. Promote and publicise public involvement
5. Assess, plan, and take action to involve
6. Feedback and evaluate
7. Implement assurance and improvement systems
8. Advance equalities and reduce health inequalities
9. Provide support for effective involvement
10. Hold providers to account.

As an organisation, we are committed to public and patient involvement at all levels, including key decision-making processes. For further details, please see the Leadership and Governance section above.

We will determine the appropriate level of involvement using the following three approaches:

- **Informing** – communicating changes to affected people and the wider public
- **Engaging** – undertaking targeted engagement with affected people and/or their representatives
- **Consulting** – formal consultation with affected people and the wider public

In determining the appropriate approach for engagement we consider the following factors:

- The **scale** of any potential changes to services being proposed
- The likely level of **impact** on patients i.e. changes to the way in which services are delivered or to the range of services available.

- The likely level of **controversy** of any changes.

We also engage with a number of external public and patient groups. This includes, but is not limited to, GP practice patient participation groups, Telford Patient First, Shropshire Patient Group, patient support groups and national and local charity sponsored patient groups.

In all of our communications and involvement work with the public and patients, we will ensure that:

- We provide information about the different ways people can get involved by a range of methods that are easy to access, for example, online, social media, printed materials.
- We will make a particular effort to engage with people who are less likely to give us their views, for example, young people, people with a disability, or people living in a rural and/or deprived area.
- We will work with the community and voluntary sectors to make contact with groups who are seldom heard
- We will write any communications and engagement materials aimed at the public in Plain English and will produce them in different formats.
- We will find out the preferred communications and engagement methods of our different target audiences and will communicate and engage with them in the most appropriate ways to meet these needs wherever possible.
- If we organise events and workshops we will make them as accessible as possible by holding them at different times of the day and in different locations, using venues that are easy to access, that have facilities for people with a disability and by using an interpreter where required.
- We will ensure that it is made clear to people why we are asking for their views, how their feedback will be used and how far they are able to influence our processes and plans.
- We will provide training and engagement tools to our lay members, members of the public, and voluntary and community sector staff who assist us with our engagement work.
- We will write a report on all of our public and patient involvement activity, particularly in relation to public consultations; this will be circulated to stakeholders and will be published on our website. This will include a 'you said, we did' section to demonstrate how public and patient views have influenced our local services and how they are delivered.
- At the end of the financial year, we will collate and summarise all of our public and patient involvement work and this will be included in our CCG annual report. This will be made available at our Annual General Meeting and will be published on our website.

Equalities and health inequalities

In addition to the duty to involve, the organisation has a legal duty to pay due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not. We are committed to ensuring that we pay due regard to our public sector equality duty in all of our work, as well as the need to reduce inequalities between patients in access to and outcomes from healthcare services, and to ensure services are provided in an integrated way where this might assist in reducing health inequalities.

To achieve these aims, we will:

- Ensure that we understand our local population and will regularly review local demographic and health data to ensure that we continue to meet local needs.
- Identify those who are likely to have poorer health outcomes or whose voices are less likely to be heard.
- Use a range of inclusive approaches and engagement tools to make it easier for different groups to give us their views.
- Work with partner organisations, including the voluntary and community sectors, to enhance our engagement with different groups, particularly those with poorer health outcomes.
- Ensure that all of our public-facing communications are in a variety of accessible formats and are distributed through a variety of channels to meet the needs of different groups.
- Link our public and patient involvement strategy to EDS2
- Consider equality as part of our decision-making processes, including producing an equality impact assessment for any service developments or policy changes.

We will pay particular attention to the differences in our population across Shropshire, Telford and Wrekin, using health population management tools, including rural areas and those with a high level of deprivation. We will build on national campaigns to reinforce consistent messages about the most appropriate health services to use for different illnesses and conditions. We will also deliver local campaigns and engagement activities, often working with the local voluntary and community sectors, to target specific groups living in specific areas if required. We will ensure our communication and engagement activity reflects our focus on place within our overall footprint and is tailored as required.

We will regularly review the effectiveness of our communications and engagement activities with seldom heard groups and people having one or more of the nine protected characteristics and will adapt our methodologies if certain groups are under represented in our work.

Primary care membership engagement

The NHS Long Term Plan firmly places Primary Care at the centre of future healthcare delivery models. As a commissioning organisation we fully appreciate the importance of supporting our Primary Care members to:

- Embrace their insight into local population healthcare, ensuring it informs our priorities and decision making.
- Develop Primary Care Networks (PCNs) that work for the local healthcare and wellbeing needs of patient populations.
- Support knowledge sharing across Primary Care to aid swift development and maturity of networks.

The PCNs and clinical directors are still in their early developmental phases and are working to understand their collective roles in the system. Further work is needed to clarify how the CCG can support two way engagement with the networks and their members. This will be explored together as part of the work to develop a new communications and engagement strategy for the CCG.

It should be remembered that membership of the PCNs is optional, and there are currently five non-member practices across Shropshire, Telford and Wrekin. These practices need to enjoy the same two way dialogue with the CCG and going forward the ICS.

The current Primary Care communications and engagement strategy outlines how public facing communications and engagement support can also be provided to the practices as a network. The strategy is in line with the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP) Primary Care Strategy 2019-2024, covering the same period.

The initial focus has reflected the NHS Long Term Plan's directive of self-care. A combination of area wide and localised campaigns will be explored for the next financial year.

8) Evaluation

We have stated our commitment to ensuring our approach is evidence based. Evidence on whether we are delivering the strategy can be obtained through:

- Ad hoc surveys and feedback relating to particular projects and activities.
- A number of public and patient involvement opportunities.
- Attendance by different groups from different locations at CCG meetings and events.
- Event feedback questionnaires/surveys.
- Improvement and Assessment Framework results.
- Patient participation feedback.
- Staff survey results.
- Media and social media outcomes – media coverage and reach, number of retweets and likes.
- Website statistics e.g. number of visits, number of page views.
- 'You said, we did' outcomes.
- Lessons learnt – learning lessons from our communications and engagement activities and using this to strengthen future work.
- Compliments and complaints.

9) Appendix A: Legal duties

Participation theme/duty	Relevant Act
Involve patients in decisions about their care	• S.14U of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) - Duty to promote involvement of each patient • S.13H of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) - Duty to promote involvement of each patient
Involve patients in commissioning processes and decisions	• S.14Z2 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) - Public involvement and consultation by Clinical Commissioning Groups • S.13Q of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) - Public involvement and consultation by the Board • Chapter 2, Section 242 of the NHS Act 2006 – Duty to involve
Remove or minimise disadvantages suffered by those who share one of the nine protected characteristics	• Equality Act 2010 • Section 149 of the Equality Act 2010 • Section 2 and 3 of the Equality Act (specific duties) regulations 2011 • Human Rights Act 1998 • Sections 14P, 14T, and 14Z1 Health and Social Care Act 2012 - Duties to promote NHS Constitution, reduce inequalities and promote integration
Consult the relevant Local Authority Health Scrutiny Committee around the planning and delivery of service change in certain circumstances	• S.244 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

10) Appendix B: Strategy action plan

Activity	Process	Lead	Progress made	Deadline
Key internal stakeholder communications to be aligned including:				
Staff newsletter	Production schedules now in place for joint newsletter	AH	Staff newsletters now aligned – April 2020	Complete
Staff briefings	Protocol in place for staff briefings		Staff briefings now aligned - April 2020	Complete
Staff announcements	Cascade process in place and joint staff database		Joint briefings now in place with plans cascading and sharing feedback to all staff	Complete
Stakeholder Review to create a new stakeholder database	Merge stakeholder membership of both CCGs where appropriate, mindful of IG	AH	Stakeholder membership merged, however due to IG requirements, a substantial number of member contacts had to be removed.	Complete
	Review requirements for the new CCG and develop a new stakeholder database	CH	Work with key partners, including voluntary and community organisations, to identify the most appropriate groups and methodology.	March 2022
Phase two stakeholder engagement event	Outcomes of phase two event assessed and responded to.	SM/JL	Report written and shared with workstream leads for responses which are then collated as evidence.	Complete

Phase three engagement event	Planning for phase three event. Event organisation Event delivered Event report produced, and responded to.	SM SM SM SM	Plan developed and approved. Provide appointed, facilitators identified and briefed, delegates invited. Report written and shared with workstream leads for responses which are then collated as evidence.	Complete Complete Complete Complete
Corporate identity style and user guide	Develop a local identity style for the new organisation	SM	Proposal to be developed with opportunities for staff involvement (focus group and survey too ascertain preferred option). Final version to be chosen and approved by the Exec Team. User guide developed for preferred version.	Complete Complete Complete
Corporate resources	Work with the corporate team to carry out audit of resources and cross reference required format and quantities with production schedules. This applies to: Corporate letterheads Staff lanyards Corporate signage	SM	Branded materials to be created and shared with for use. -	Complete

Website development	Audit of current web site and confirm information transfer. Develop proposal for new website and appoint provider. Concepts developed, CMS created for population offline. Initial content updated. Website populated for launch. Pre-launch checks.	CH AH/SM SM SM SM SM	Review to be carried out and content mapping with a cleanse on content so no out of date information is carried over. Proposal approved by Exec. Tenders received and under consideration. Concepts approved by exec, website built. Identify phase 1 content and update Web editors trained and given section access. Technical checks	June 2021 Complete Complete Complete Complete Complete
Launch of new website and ongoing management	New site goes live. Links redirected to new site.	SM SM CH	Communications programme to promote new website to stakeholders. Redirections from former site prior to decommissioning and archiving. Plan developed to manage website content on an ongoing basis.	Complete Complete June 2021
Social media	Development of new social media platforms for new CCG/ICS Strategy to build followers. Further expand social media presence and potential	SM CH CH	Initial set up with Twitter and Facebook Development of online campaign. Exploration of further platforms	Complete April 2021 – March 2022 March 2022

Intranet / shared drive - pending outcome discussion on one agreed channel	Review of content current held on both the Intranet at Telford and Wrekin CCG and shared files held on the drive at Shropshire CCG	SM/CH	Review to be carried out and proposal to be prepared	May 2021
Launch of the new single strategic organisation	Staff, stakeholder and media launch of the new CCG	SM	Internal and external announcements, press release and social media updates.	Complete
New CCG communications and engagement strategy	Harmonisation of the two existing CCG communications and engagement strategies into a transition strategy.	SM	Joint CCG transition communications and engagement strategy written.	Complete
	Longer term communications and engagement needs of the CCG/ICS reviewed and agreed in order to develop a new ICS strategy document.	CH	New communications and engagement strategy developed for the new ICS moving forward.	October 2021
	Audit of communications channels and tools.	CH	Stocktake and reassess requirements.	October 2021

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group




Our Organisational Development Strategy and Plan 2019- 2022

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We note that there are two KLOEs for application to create a single CCG that we are required to meet regarding Organisational Development:

- The development of an outline OD plan, and
- Progress in development of an HR/OD Strategy.

This document is intended to cover both of these KLOEs.

In sections 1 and 2 it defines the OD strategy, vision and priorities for the CCGs. These sections do not go into huge detail as this detail is provided elsewhere in the Case for Change and Operating Model paper.

Then in sections 3, 4 and 5, the action plan for the delivery of the vision and three priorities is provided.

1. Introduction

Becoming a single strategic commissioner

The NHS is in a period of significant change. The Ten Year Plan lays down a clear and compelling future vision of Integrated Care Systems within which CCGs take on the role of a strategic commissioner, working with Integrated Care Providers to deliver real change. The NHS Interim People Plan lays the foundations needed to make the ten Year Plan a reality; positive culture, compassionate and engaged leaders and to make the NHS an agile inclusive modern employer.

We know that we must respond flexibly to this new landscape and consider where best to focus clinical and managerial and staff time to transform into commissioning organisations fit for this future.

The Ten Year Plan is clear that NHS England expects there to be one CCG for each Integrated Care System footprint in the future. It indicates that in future CCG roles could consist of:

- Taking on a more strategic role, working in partnership with LA commissioners focusing more on population health need, whole system and patient outcomes

- Retaining statutory responsibilities but some of these responsibilities to be discharged through working alongside system partners e.g. allocation of financial resources, and service reconfiguration;

- Putting in place arrangements to discharge the small number of statutory responsibilities that the CCGs must continue to undertake alone e.g. handling procurement processes;

- Increasingly aligning activities with local authorities at 'place', aiming to integrate commissioning using one of the four models set out in the LTP;

- Working with local authorities and providers at 'place' level to shift some traditional commissioning activities (e.g. pathway redesign) to providers who may be better placed to undertake this work, and

- Directing CCG resources as they consolidate towards delivery of the necessary system-wide (and place) functions.

- The recently published White Paper now sets out a clearer direction for the introduction of statutory Integrated Care System (ICS) and the dissolution of existing CCGs.

This is a huge change in the landscape facing CCGs.

Therefore Shropshire CCG and Telford and Wrekin CCGs have had to consider the most appropriate organisational form for strategic commissioning going forward.

The conclusion of these discussions was that Shropshire CCG and Telford and Wrekin CCG Governing Bodies both agreed to undertake work on an application to NHS England to dissolve the existing two organisations with a view to creating one single strategic commissioner across the Shropshire and Telford and Wrekin footprint.

We feel there are very good reasons for doing this, as outlined in our Case for Change document.

This OD plan

It is critical that this process creates a genuinely new organisation with a refreshed mission statement, strategy and objectives. We know that significant work will need to be undertaken to develop a new culture, way of working and governance arrangements for the new organisation, taking the best of both CCGs to create something that really works.

We recognise the complexities and uncertainties that this process will create, including the requirement for managers and staff to come together into a single staffing structure.

Therefore we commit to ensuring that staff, members and leaders all have the opportunity to input into the design process.

This plan therefore outlines the key actions we wish to take to create the new organisation.

It also covers some areas of more traditional OD that we think will be required alongside the design process of building a new organisation.

Our aim is to undertake a planned whole system effort to build a new organisation with the highest levels of effectiveness and efficiency in meeting the health needs of the Shropshire, Telford and Wrekin population.

We see such an approach as underpinned by the development and growth of individuals, teams, and the organisation as a whole.

Accordingly the OD plan is intended for several key audiences:

- **Staff:** This plan commits to providing support to staff to go through the design and restructuring process that will be required, while developing skills, personal support and environmental factors required for them to do their jobs effectively both now and in the new organisation.

- **GP members:** This plan will outline how GP members will be involved in the design process of building a new organisation, as well as committing to exploring some key issues that will affect GPs such as the development of ICPs and PCNs.

- **Leaders and Governing Body members:** This is a complicated and ambiguous process in some ways and leaders will require support to understand their role, provide support to their staff and GP members, and function as a corporate leadership team throughout the transition process.

- **Partner organisations:** The CCGs cannot deliver transformation by themselves. They need to work with their partners across the Integrated Care System to deliver change. This plan provides ways for the CCGs to embrace and engage with partners in a collaborative way to support delivery in the future.

2. Our Vision for the Future

We wish to create a genuinely new organisation with a refreshed mission statement, strategy, values and objectives.

Therefore we have not provided here any information on the mission, values and objectives of the existing two CCGs. A key part of the OD plan will be to develop this information for the new organisation.

We recognise that we are on a journey to becoming a strategic commissioner and that this will not be completed in one step.

However we have a clear vision for how the new organisation will evolve over time. This is outlined in our Case for Change document and Operating Model appendix to it.

In summary it involves becoming a Strategic Commissioner which will co-develop the system strategy and outcomes with providers, and then commission the strategy with the Integrated Care Provider (ICP). The ICP will have significant autonomy and flexibility to run services and manage delegated budgets.

General practice will play a significant role within the ICP, ensuring that GPs work with their clinical colleagues to deliver the best possible services for the people of Shropshire, Telford and Wrekin.

In essence the strategic commissioner will decide the how, and the ICP will decide the what, with the strategic commissioner holding the ICP to account for delivery.

Accordingly, as it becomes a strategic commissioner over time, the CCG will shrink and become a different kind of organisation, behaving in a very different way, focusing on setting strategy and outcomes, and leaving the ICP to determine how those outcomes are met within the budget envelope.

This is a bold and ambitious vision for the future and accordingly we need a carefully planned programme of OD to support us to get there and identify the key decisions that must be made to design the new organisation.

Our OD priorities

To achieve our vision for the future, we think three things are particularly important. These are our three OD priorities for 2019/22:

a) We want to make sure we have all the building blocks necessary in terms of strategy, structure, process and skills that will allow us to become a strategic commissioner and create a new organisation: **Becoming a Strategic Commissioner**

b) We want to focus on supporting and developing our staff to deliver the transformation we need and become influential in the new ways of working that will be required in the future: **People Development**

c) We want to make sure our new organisation is well led and can unleash the talent within our staff base to deliver our plans: **Leadership Development**

The following section explains the actions we are going to take against each of these three workstreams in order to develop the new organisation, and deliver real transformation.

3. Priority One: Becoming a Strategic Commissioner

Shropshire and Telford and Wrekin CCGs have decided to move towards becoming a single strategic commissioner.

We appreciate that this is a long and complicated journey and that we are at an early stage.

Much work and a number of joint decisions need to be made, with input and agreement from both CCGs as well as external partners.

Work has already been done on the Operating Model and staffing structures.

The CCGs are clear that this process will create a genuinely new organisation with a refreshed vision, strategy and priorities.

The CCGs are also clear that the new organisation will commission services sensitively to meet the needs of the population, with a strategic focus on reducing health inequalities. It will commission services in different ways and at different levels, wherever it makes most sense to do so.

We understand that there is a considerable amount of work to be done. The CCGs need to agree on future ways of working, systems and structures in more detail, in particular with regard to place and what it means for the new organisation.

We will work with our members, our partners (including local authorities, NHS providers and PCNs) and our staff to develop the thinking to ensure that we develop a robust approach for the future.

Key issues to be resolved

We know that developing a new organisation will require a wide range of OD work. Some key areas that will have to be resolved are:

- Setting up the shadow Governing Body with both executive and non-executive teams and providing OD support for the new teams to come together
- Finalising the operating model
- Developing staffing structures
- Developing governance processes
- Developing a vision, strategy and priorities for the new organisation
- Developing values, behaviours and culture for the new organisation
- Developing decision making processes and ways of working for the new organisation: 'this is the way we do things round here'
- Focused OD support for staff teams to come together and build new identities.

These are the basics of forming a new organisation.

In addition there will be OD work required for the CCGs to make the transition into becoming a strategic commissioner at the heart of an Integrated Care System, which represents a significantly different role. This could involve the following activities:

- Ensuring that staff understand the implications of strategic commissioning and are heavily involved in the design process
- Developing a population health management approach for the new organisation and assessing the skills required
- Developing the way in which a strategic commissioner will operate in the future, including developing shadow staffing structures for strategic and tactical commissioning, decision making processes and governance.
- Developing the ICPs: providers may need support from the CCGs in being encouraged to focus on transforming certain pathways

- PCN development and building the links between the PCN and the ICP, establishing the role of general practice within the ICP
- Developing the relationship between the strategic commissioner and the ICP including issues such as contracting, capitated budgets
- Development of the ICS approach: issues such as governance, decision making, finances, and the role of primary care

If such an approach is going to be implemented, there are certain critical steps that must be taken. These are outlined in the action plan below.

Action	Date	Owner	Updated position post Covid
New Chair and Accountable Officer to establish the shadow Governing Body.	By September 2020 Revised 31st March 2021	New Chair and AO	Interim AO initially appointed November 2019/ and then subsequently appointed March 2021 and Chair elected February 2021
Deliver shared Constitution between two CCGs prior to creating a single CCG to recruit and elect shared governing body members to both statutory boards. Also deliver Committees in Common.	August 2020	Director of Corporate Affairs	Approved by NHSE/I 10 August 2020
Focused OD sessions with each of: • Whole shadow Governing Body • Clinical leaders • Lay members • Executive team These sessions will aim to define roles and responsibilities, understand what makes an effective board and team, and start to develop a leadership / board / executive culture. Particular focus will be provided on creating a new culture of system leadership, both individually and for the whole Governing Body.	June – September 2020	Director of Corporate Affairs	Workshops 1 and 2 delivered by Deloitte to cover these areas

Action	Date	Owner	Updated position post Covid
Operating Model Development: • Hold an initial working group session on the operating model with local authority colleagues, developing a proposal • Take the proposal and consult with leaders, staff and partner organisations.	Complete in October / November 2019	Accountable Officer	Completed October and November 2019 with further discussions taking place with local authorities on place model up to August 2020
Creation of one senior management team, undertaking a management of change process for Directors and Executive Leads.	Complete in December 2019	Accountable Officer	Completed December 2019
Recruitment and appointment process for remaining two Director posts	By May 2020	Director of Corporate Affairs / CSU	Completed by May 2020
Following appointment of the new executive team develop an appropriate organisational structure with staffing structures to deliver the CCG's core business. Core to this action will be the mapping of current people to functions in order to inform the future alignment of staff across the CCG. Also key to identify what functions are core and what could be done at place based to help inform development of staffing structures. This is linked into the further development of the Clinical Commissioning Strategy where the finalised operating model will sit.	By end of March 2020 Revised end of March 2021	All Directors	Initial new staff structures developed by March 2020 but postponed due to Covid. Structures were reviewed July and August 2020 for staff. MOC took place Sep – Dec 2020 and completed by 31st March 2021.
Creation of one staff structure, undertaking the management of change process for both CCGs' staff.	By End March 2021	All Directors	Completed by 31st March 2021

Action	Date	Owner	Updated position post Covid
OD session with shadow Governing Body to develop governance arrangements for new organisation and consider new constitution. This will include development discussions on the content of the new Constitution, and a review of committee structure and purpose of committees, terms of reference, membership and frequency of meetings.	By September 2020	Director of Corporate Affairs	Completed by August 2020
OD session with GP members from across Shropshire, Telford and Wrekin to understand what GP members want from the new organisation, the key issues that matter to them, how they want to be involved, and the way in which member engagement should happen in the new organisation. Development discussions on the content of the new Constitution will be held. On the back of this a further work programme will be developed to engage GP members in the design process.	By September 2019	Director of Corporate Affairs	Completed October 2019
OD sessions with staff to develop thinking on vision, values, behaviour and culture of the new organisation. • Initial session taking place with senior managers on 27 September 2019. • Further sessions to take place through October – December 2019. • EMT session in March 2020 to discuss and put together an initial draft. • Further work with staff at OD sessions in June 2020 / July 2020. • Shadow Governing Body receives inputs from staff and finalises and signs off.	By September 2020 Revised – June 2021	Director of Governance / Corporate Affairs	First three bullet points were completed up to March 2020. Staff OD sessions were postponed due to Covid but restarting this OD work with CSU OD partners in April 2021 for completion by June 2021

Action	Date	Owner	Updated position post Covid
Implement an organisation wide OD programme for all staff in the following key areas: • What strategic commissioning means and what the future could mean for them. This will focus on the core skills required in the future, including delivery within a complex environment, matrix and agile working. • Developing the ways in which a strategic commissioner will operate in the future, including processes and roles. • A team working programme for the new teams with a focus on creating a vision, purpose and operating principles, using team working tools. Emphasis will be placed on creating a strong culture of cross directorate working and matrix working. • Establishing the detail of how decision making and operating principles will work in the new organisation, both in the transition period and the final strategic commissioner role.	By May / June 2020 Revised: June 2021	Director of Corporate Affairs	Staff OD sessions were postponed due to Covid but restarting this OD work with CSU OD partners in April 2021 for completion by June 2021
Review CCG business processes and governance structures and ensure they are fit for purpose for a high performing CCG, ensuring that staff are fully supported to deliver our agenda.	By September 2020	Accountable Officer	Completed by September 2020
Continue feeding into the design process for the Integrated Care System.	Ongoing	Accountable Officer	This continues to be ongoing. The STP/ICS has successfully had its application to create a shadow ICS approved..

Action	Date	Owner	Updated position post Covid
Set up task and finish groups to explore the following issues: • Population health – how the new organisation develops its approach • Finance – how the new organisation moves towards developing a new capitated budget and financial approach • Contracting – how the new organisation might contract with the ICP in the future, exploring the mechanisms within the ICP contract • The role of general practice – how will the increasingly blurry commissioner – provider split work for individual GPs, how will PCNs develop, and how will PCNs link into the ICP • Quality – how will the new organisation maintain high quality services and make quality core to all staff roles?	By December 2020 Revised March 2022	Accountable Officer	The CCG and wider system are taking part in the Wave 2 PHM pilots The system has an external consultants to develop a strategic financial model for the system including the CCG which will be an aligned incentive model The ICP's are at very early developmental stage, but the learning from the MSK Alliance will form part of the process for developing new contracting models that move away from PbR and tariff. The CCG as a strategic commissioner is committed to local determination and devolving budgets where possible to ICP/place This is still being worked through but initial thinking is that PCN's (and primary care) have a pivotal role in the development of working on a place based model and as part of ICP's. Tactical commissioning will be carried out at ICP level and in that sense primary care will have the same challenge as any other provider. The Telford and Wrekin Integrated Place Partnership is well established with a Board that includes all providers including primary care and has been operating for approximately 2 years. Shropshire is now following this model with bringing 2 existing forums into the Shropshire Integrated Place Partnership (ShIPP). It is planned that these two boards will form the basis for the development of ICP's. The CCGs are committed (as the system is) to ensuring high quality services for the population we serve. As we move to a an outcome based approach to commissioning there is a key role for quality team in ensuring that the right outcomes from a quality perspective are used for commissioning purposes and that these are then monitored as part of contract delivery. There will continue to be a requirement for Quality meetings with providers but these will be more based on the total pathway rather than on an individual provider basis.

Action	Date	Owner	Updated position post Covid
Arrange a facilitated OD session between the CCG and the ICP, as a board to board exercise with providers.	By May 2021	Accountable Officer	The ICP's have not yet been established by the system so the AO has not been in a position to progress this action.
Arrange an event for PCN Clinical Directors with provider leads to explore the relationships between CCG staff, the PCNs and the ICP.	By December 2020	Director of Partnerships	There is a system wide clinical transformation group which includes all providers including PCNs
Consolidate PMO functions across system to maximise capacity through removal of duplication of effort.	March 2022	Accountable Officer	Will be completed as part of the work to integrate CCG into ICS
Designing and launching a communications and engagement process with the public.	By July 2020	Director of Corporate Affairs/ CSU	The communication and engagement process was three events to originally take place face to face in workshop style. All three engagement events (one face to face and the other virtual) were held in January 2020, December 2020 and in March 2021.
Review of current HR support capacity from CSU	April 2020	Director of Corporate Affairs	This was completed and additional CSU HR Capacity committed.

4. Priority Two: People Development

We know that to deliver our vision our biggest priority has to be supporting and developing our staff, who are our greatest asset. With reference to the NHS Interim People Plan we must make the Single Strategic Commissioner an employer of excellence; valuing, supporting, developing and investing in our people. We also need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.

We aim to create a respected, skilled, supported and engaged team of strategic commissioners. This will require in some cases new skills and ways of thinking for which we will need to provide support and clear development opportunities.

Areas such as resourcing are critical to this process, recruiting and retaining the best people for the job, whilst striving to continually grow the capabilities of those in post to enable them to carry out their roles with excellence.

We know that effective, committed, multidisciplinary teamwork does not happen by chance – it needs conscious and well-designed team development. Effective teams achieve better outcomes for patients.

We need to get the best out of our people by providing effective and clear structures and processes within which they can operate. We will ensure that there are robust and well tested business process in place and that everybody understands how these work, how decision making works, and how to get things done.

Examples of work that can be undertaken in this area include reviewing appraisal policies to ensure staff get timely feedback and their talent needs are being recognised, developing an annual skills gap analysis to identify skills shortages and investing to fill such gaps, promoting opportunities to mentor others and for appropriate secondments for individuals.

We know that the staff from both CCGs will play a critical role in all of this work, and will help us to design new programmes of work and provide feedback on how any new processes are operating. We will involve staff in shaping the values and behaviours that we want to guide the development of our culture as two staff teams move into one.

The following actions have been identified for this workstream:

Action	Date	Owner	Updated position post Covid
Engage staff through staff briefings to understand what support staff would like through the transition process to a new organisation, particularly in dealing with a potential management of change process. Subsequently, develop a work programme for delivering support to staff.	Complete by January 2020	Director of Corporate Affairs	This was completed and a support package commissioned which included Change Ambassadors, Resilience workshops, CV and interview skill training, communication hub
Deliver a resilience programme to support staff during the management of change process, by holding resilience sessions for all staff to provide additional support, tools and techniques to help them positively manage change during the transitional period focusing on instilling positive behaviours, greater wellbeing and increased aspiration.	By March 2020	Director of Corporate Affairs	Initially these had to be delayed due to Covid. These were subsequently held in August, September and October 2020
Provide additional support to staff on CV skills, interview techniques, etc. in preparation for future recruitment and selection activities that will be undertaken by the CCG to create the new organisation.	By March 2020	Director of Corporate Affairs	Initially these had to be delayed due to Covid. These were subsequently held in September 2020
Develop and roll out staff survey, capturing and evaluating staff responses.	By December 2020 Revised: August 2021	Director of Corporate Affairs	This was delayed due to Covid and then the staff management of change process. CCG plans to run its own staff survey in July/August 2021
Consider the development of a “Staff Council” or Staff Engagement Group to support ongoing proactive and meaningful engagement with staff	By December 2020 Revised: May 2021	Director of Corporate Affairs	This will be one area that will be picked up in staff OD discussions in April and May 2021
Hold regular staff briefings and engagement sessions on the formation of the new organisation, and create a plan of topics for staff discussion from the two CCGs throughout the transition.	Ongoing	Director of Corporate Affairs	This is still ongoing with Deloitte briefing sessions initially , now through the Accountable Officer weekly joint staff huddle meetings on a Tuesday

Action	Date	Owner	Updated position post Covid
Review priority organisational HR policies (e.g. Organisational Change) and ensure they are fit for purpose in 2019/2020 and communicated to all staff. Those of lower priority can be reviewed by January 2020.	By December 2019	Director of Corporate Affairs	Priority HR policies have been reviewed.
Diagnostic exercise regarding a coaching and mentoring programme	October 2020	Director of Corporate Affairs/CSU	Has been delayed due to Covid. Diagnostic exercise undertaken in February and March. Outcomes fed back to AO and Exec team in March 2021
Delivery of coaching and mentoring programme	December 2020 Revised: June 2021	Director of Corporate Affairs/CSU	Has been delayed due to Covid. Plan to start delivery April – June 2021
Scoping and planning exercise regarding a talent management process	October 2020 Revised: June 2021	Director of Corporate Affairs/CSU	Has been delayed due to Covid. Plan to start delivery April – June 2021
Implementation of talent management process	December 2020 Revised: June 20	Director of Corporate Affairs/CSU	Has been delayed due to Covid. Plan to start delivery April – June 2021

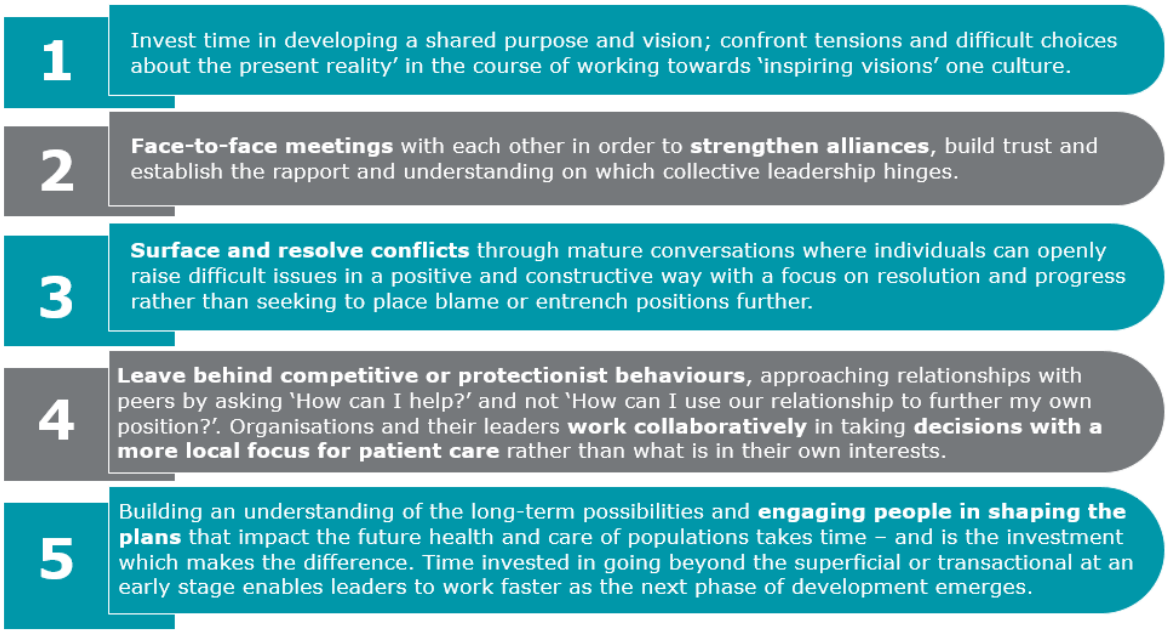
Action	Date	Owner	Updated position post Covid
Review the appraisal process with alignment of individual objectives to new organisational strategic goals, definition of personal development plans and development opportunities for all staff, development of high performer pathways and succession planning, and creation of a coaching culture. This will include consideration of the process by which training budgets should be allocated and decisions should be made. This should be transparent for all staff. Ensure all Directors and line managers are carrying out monthly 1:1s and annual appraisals that define clear objectives linked to organisational priorities. Monitor and analyse number of appraisals and 1:1s.	By September 2020 Revised: June 2021	Director of Corporate Affairs	This has been delayed due to Covid. CSU HR will start this work \April – June 2021
Identify training and secondment opportunities for staff and communicate these directly to staff through the corresponding staff intranets.	June 2021	Directors of Corporate Affairs	This has been delayed due to Covid. CSU HR will start this work April – June 2021

Priority Three: Leadership Development

Leadership development is crucial for the CCGs given the seismic shift in culture and leadership practice that will be needed to create a new organisation operating as a strategic commissioner, combined with the need to lead genuinely local commissioning.

Our aim will be to create leaders with the capability and confidence to find solutions to new challenges, and develop our individuals to thrive. In line with the NHS Interim People Plan we will develop positive, compassionate and improvement focused leadership to create the culture that delivers better care.

The kinds of behaviours that may be required are summarised in the diagram below:



This represents a significant change in thinking and mind-set for the CCG leaders across the board – executives, clinicians and lay members.

Potential initiatives identified include: individual coaching programmes based on 360 degree feedback surveys for all of the senior staff, including clinicians and executive team members, and putting team development programmes in place for the Governing Bodies and management teams coming together as one. Initially this needs to focus on behaviours, methods of operation and building trust.

Both CCGs could further their efforts for leadership initiatives, by equipping leaders and potential leaders with the necessary skills and training, providing key development opportunities to allow leaders to achieve their goals in an environment in which they can thrive and feel supported. More proactive efforts to spot talented future leaders would also benefit both the organisation and individual and further emphasis on this should be instilled.

The following actions have been identified for this workstream:

Action	Date	Owner	Updated position post Covid
Review the clinical leadership arrangements for the new organisation. Ensure clinical leads for each governance / assurance role and priority programme are identified and their roles clarified.	By May 2020	New Clinical Chair	Completed by Clinical Chair and Medical Director – information included in operating model
Development of a diagnostic exercise to determine level of mentoring/coaching support required for Directors.	By May 2020	Accountable Officer	Delayed due to Covid. Completed March 2021
Review of current plan for senior leadership development programme.	By May 2020	Accountable Officer	Delayed due to Covid. Diagnostic completed in March 2021.
Scoping and planning for enhancements to senior leadership development programme.	By May 2020 Revised: April 2021	Accountable Officer	Delayed due to Covid. Plan to start April 2021
Review current senior leadership development programme to ensure that it meets the needs of the new emerging organisation.	By May 2020	Director of Corporate Affairs	Delayed due to Covid. Diagnostic completed in March 2021.
Response to the outcome of the review of the senior leadership development programme.	By July 2020 Revised: April 2021	Director of Corporate Affairs	Delayed due to Covid. Plan to start April 2021
Scoping and planning exercise for Governing Body development programme	By end June 2020	Director of Corporate Affairs	The planning of this was done pre Covid.
Delivery of Governing Body development programme	By end April 2021	Director of Corporate Affairs	Delivery started when new Joint Governing body members were appointed in August 2020 - completed 31st March 2021

Action	Date	Owner	Updated position post Covid
Facilitated team development sessions to be held for new Governing Body, Executive Team, and lay members. These will focus initially on behaviours, methods of operation and building trust.	By September 2020	Director of Corporate Affairs	Delivery started when new Joint Governing body members were appointed in August 2020 – ongoing until March 2021
Facilitated development sessions to be held for the new Governing Body, Executive Team and lay members on the 'technical' aspects of holding a position of office/working on a public board such as governance, conflicts of interest, legal mandate of the Governing Body, etc. to ensure shared understanding of the roles and responsibilities of Governing Body Members.	By December 2020	Director of Corporate Affairs	Delivery started when new Joint Governing body members were appointed in August 2020 – ongoing until March 2021
Development of support for existing managers including: • Undertake Manager training needs analysis. • Delivery of leadership development programme for Managers. • Indicative topic areas could include coaching skills, HR for non-HR managers, difficult conversations, Emotional Intelligence, managing conflict, facilitating and leading team meetings, developing others.	By December 2020 Revised: June 2021	Director of Corporate Affairs	Has been delayed due to Covid. Plan to start delivery April – June 2021
Consider available management and leadership offers from NHS Leadership Academy to support the development of current and future managers and leaders.	By September 2020 Revised: June 2021	Directors of Corporate Affairs	Has been delayed due to Covid. Plan to start delivery April – June 2021

Action	Date	Owner	Updated position post Covid
Delivery of leadership development programme for aspiring managers and leaders. First identify key individuals for potential. Then roll out a focused programme of training and support. Indicative topic areas would include managing change, strategic and operational awareness, team working and collaboration.	By June 2021	Directors of Corporate Affairs	Has been delayed due to Covid. Plan to start delivery April – June 2021

5. Conclusion and Next Steps

This OD Plan contains practical, pragmatic and deliverable actions that will help the CCGs to build a new organisation.

The CCGs will plan with its OD partners; Deloitte and Midlands and Lancashire CSU the more detailed scoping and delivery of the component parts of this plan.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Risk Management Strategy

DRAFT

Document Control Sheet

Title:	Risk Management Strategy		
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Version 1.1 draft	14/04/21	Presentation to Audit Committee
Version 1.2	12/05/21	Presentation to Governing Body

The formally approved version of this document is that held on NHS Shropshire, Telford and Wrekin Clinical Commissioning Group's website at

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Printed copies or those saved electronically must be checked to ensure they match the current on line version.

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1 Introduction

In order to fulfill the CCG's mission statement it is important that we operate as a properly constituted organisation with appropriate governance arrangements. Through these arrangements, we will be able to deliver our statutory functions, strategic oversight, financial control and probity, as well as driving quality, encouraging innovation and managing risk.

There will be elements of risk in all activities we undertake or commission others to undertake on our behalf. These risks will have the potential to undermine, threaten or prevent the CCG achieving its mission statement and objectives. It is therefore essential that there is a clear Risk Management Strategy and processes in place to provide clarity of the risks affecting each area of its activity, how the risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives.

Ensuring risks are properly identified, evaluated, documented and managed effectively, consistently and systematically must continue to be an integral part of everyday practice throughout the CCG. It also requires a culture of transparency and honesty to be promoted and embedded throughout the CCG.

The processes described in this strategy ensure that risk management is integrated into all business decision making, planning, performance reporting and delivery processes, to support rigorous and innovative decision making in all aspects of the CCG's work.

2 Purpose

'Risk' is defined as the threat that an event or action will adversely affect an organisation's ability to achieve its objectives and to execute its strategies successfully. This includes both risk to the organisation and the risk to those individuals to whom the CCG owes a duty of care.

The Risk Management Strategy establishes a framework for the effective and systematic management of risk to the CCG. It will enable the CCG to have a clear view of the risks affecting each area of its activity; it will allow clarity on how the risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives. Implementation of this Strategy is essential to the continuance of the CCG achieving a robust risk management system throughout the organisation on which the quality of care to patients ultimately depends.

The purpose of this Risk Management Strategy is to:

- Define what risk management is about and what drives risk management within the CCG;
- Ensure structures and processes are in place to support the assessment and management of risks throughout the CCG;
- Outline how the strategy will be implemented;

- Identify the relevant roles and responsibilities for risk management within the CCG;
- Formalise the risk management process across the CCG, ensuring it continues to be part of normal business and delivers consistency of approach;
- Promote a culture of honest reporting and transparency which is upheld throughout the CCG to ensure risks are properly identified, documented, evaluated and managed.
- Assure the public, patients, staff, auditors and partner organisations that the CCG is committed to managing risk appropriately.

3 Approach

3.1 The strategy outlines an integrated approach to risk in that the processes in this strategy do not make distinctions in the methodology of approach between differing types of risk, i.e. clinical quality, financial, reputational and health and safety risks are examined using the same methodology.

3.2 By using a single approach to risk management, there is assurance that there is a consistent approach to the identification of risks and opportunities, making information from disparate disciplines comparable, and readily transferable through the hierarchy of monitoring and escalation to the Governing Body where necessary. It also gives the Governing Body assurance that risk is effectively managed and monitored by the Audit Committee.

3.3 The CCG Governing Body has defined its risk appetite, with due regard to the opportunities and risks to the delivery of its objectives and those that may affect day to day activities:

- We expect to fulfil our statutory and regulatory duties to maintain and improve quality and safety in our activities and those of the organisations we commission health care from.
- We will:
    - accept risk graded as very low;
    - avoid expenditure and use of resources on those graded low;
    - manage in a cost effective manner those graded moderate;
    - and robustly seek to reduce those graded high.
- We will not accept risks that have a material adverse impact on quality of healthcare, health inequalities or life expectancy.

4 Accountabilities, Roles and Responsibilities

The Strategy applies to all CCG staff members, contractors, Governing Body and Committee members; it is not just the responsibility of one person or role within the organisation. Ensuring risks are managed effectively, consistently

and systematically must remain an integral part of everyday practice throughout the organisation for everyone.

The following section defines the roles, responsibilities and lines of accountability of committees and key individuals relating to risk management.

4.1 NHS Shropshire, Telford and Wrekin CCG Governing Body:

The Governing Body has ultimate responsibility for approving and monitoring the CCG's risk management processes.

To meet this requirement the Governing Body will:

- Agree the CCG's strategic objectives and review them regularly.
- Approve a Risk Management Strategy
- Establish and maintain a structure as set out in the Strategy for the effective management of risk throughout the CCG.
- Seek assurance from the Audit Committee via regular reporting, on the risks and progress on mitigating actions articulated in the Board Assurance Framework and Directorate Risk Registers.
- Review this Strategy every three years.

4.2 Audit Committee:

The Audit Committee will focus on the effectiveness of the risk management systems and processes created as part of an effective system of internal control that have been approved by the CCG Governing Body. It is responsible for assessing the effectiveness of the risk management framework: Board Assurance Framework, Directorate Risk Register and Primary Care Commissioning Risk Register, and in particular the adequacy of the implementation of this Strategy and of risk management across the CCG.

The Audit Committee will:

- Review the Board Assurance Framework, Directorate Risk Register and Primary Care Commissioning Risk Register on a regular basis (at least twice a year).
- Provide assurance to the CCG Governing Body regularly (at least twice a year) of the effectiveness and adequacy of risk management processes.
- Review and approve the Risk Assessment Code of Practice that sits below the Risk Management Strategy.
- Receive and consider reports from other committees as applicable.
- Review internal and external sources of information to provide adequate assurance that risks are being appropriately mitigated.
- Review this Strategy every three years and submit to the CCG Governing Body for approval.

4.3 All Committees:

All committees of the CCG have a responsibility to actively identify and seek mitigating actions for risks that arise within their area of responsibility as set out in their terms of reference.

All Committees will be responsible for:

- Identifying any risks arising in the course of their deliberations and recording them as appropriate on either the Board Assurance Framework or Directorate Risk Registers.
- Identifying and implementing or overseeing implementation of mitigating actions where the identified risk/s are within the Committee's areas of responsibility.
- Ensuring the appropriate transfer of responsibility for identifying and implementing mitigating actions where the identified risk/s are not within the Committee's areas of responsibility.
- Regularly reviewing identified risks and the impact of mitigating actions where these are within the Committee's area of responsibility and reporting progress/assurance, or by exception limited assurance via Chair's report to the Governing Body or Audit Committee as applicable.

4.4 Accountable Officer

- Ensuring that Directors identify risks, where applicable, and they report them on either Board Assurance Framework (BAF) or appropriate Directorate Risk Registers (DRR).
- Ensuring that Directors provide updated risk information on the BAF and DRR for reporting to the Audit Committee, other Committees and Governing Body in a timely way.

4.5 Managers (including Directors)

- Managers are responsible for the effective management of risks in their related areas and should ensure the implementation of the CCG's Risk Management Strategy and Risk Assessment Code of Practice by:
- Demonstrating personal involvement and support for the promotion of risk management.
- Ensuring that staff accountable to them are aware of and understand risk management in their areas of responsibility.
- Ensuring risks in functions for which they are accountable are identified and managed and mitigating actions implemented.
- Ensuring identified risks, where applicable, are reported on either Board Assurance Framework or appropriate Directorate Risk Registers and updated as applicable.
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis.
- Ensuring risks are escalated where they are of a strategic nature.
- Ensuring that learning from events, incidents, risk assessments is disseminated throughout the organisation.

4.6 CCG Staff:

Risk management is not simply a corporate function; it is the responsibility of all staff to ensure that, to prevent harm, aid innovation and avoid challenge by the Department of Health or by claim or court action, risks to safety and effective working and potential improvements are fully identified and action taken to mitigate wherever possible.

All staff working for the CCG will:

- Be aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others and to comply with appropriate CCG rules, regulations, policies, procedures and guidelines.
- Be familiar with the Risk Management Strategy and Risk Assessment Code of Practice and comply with the requirements stated in each.
- Identify and report risks to their manager or Director.
- Reporting incidents and complaints as applicable in line with established processes.
- Co-operating with others in the management of risks identified within the CCG.
- Taking action to protect themselves and others from risk.

4.6 Commissioning support, Collaborative Commissioners, Contractors, Agency and locum staff

Managers must ensure that where they are outsourcing, employing or contracting agency and locum staff that are made aware of, and adhere to, all relevant policies, procedures and guidance of the CCG, including incident reporting and health and safety.

They should also:

- Take action to protect themselves and others from risk
- Bring to the attention of others the nature of the risks which they are facing in order to ensure that they are taking appropriate mitigating action.

4.7 Staff responsible for Risk Management

Accountable Officer: the Accountable Officer has responsibility for ensuring the CCG has a programme of risk management and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support.
- Ensuring an appropriate committee structure is in place, with regular reports to the CCG Governing Body.
- Ensuring that a senior manager is appointed with managerial responsibility for overseeing the risk management process.
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG.

Director of Corporate Affairs: is the senior manager responsible for risk management, specifically to:

- Ensuring effective risk management systems are in place throughout the CCG
- Ensuring the Board Assurance Framework and Directorate/Primary Care Commissioning Risk Registers are frequently reviewed and updated.
- Ensuring there is appropriate external review of the CCG's risk management systems, and that this is reported to the Audit Committee and CCG Governing Body.
- To provide advice and guidance on the contents of this strategy and the Risk assessment Code of Practice for Managers and members of staff.

5 Risk Management Processes

5.1 Risk Management Framework

The CCG has in place a Board Assurance Framework (BAF), supported by the Directorate Risk Register (DRR) which are the mechanisms used to record high level strategic and operational risks and opportunities across all functions of the CCG, including delegated co-commissioning of primary care

The BAF and DRR are linked to the defined objectives of the CCG, the Primary Care Commissioning Risk Register (PCCRR) is linked to the defined objectives of the Primary Care Strategy and together reflect the risk appetite of the organisation.

5.2 Risk Identification

Identification of risk is the first part of an effective risk management strategy. A strong organisational commitment to risk management will ensure that risks identified at all levels of the CCG are properly managed. The CCG has both a proactive and reactive approach to identifying risk. The proactive approach includes the use of the risk assessment process set out in the CCG's Risk Assessment Code of Practice, and then implementation of mitigating actions arising from the assessment. The reactive approach includes responding to information, which could be internally or externally generated, for example complaints, claims, audit findings, service development or redesign, incident reporting from providers, contract activity information.

All staff, managers and Directors are required to identify risk specific to their own areas of responsibility and report or/and record these and then analyse, evaluate and manage them or accept them.

The strategy outlines a risk management system which requires all risk to be identified using the same methodology, regardless of which function of the CCG the risk sits i.e. financial, human resources, reputational management, quality, commissioning, contract monitoring.

In addition, executive summary reports taken to the Governing Body and committees require authors to identify any risks or opportunities in the content of the report that may need highlighting and or adding to the Board Assurance Framework or Directorate Risk Register.

5.3 Risk Assessment

The same simple process, documented in the Risk Assessment Code of Practice and using a single matrix for measuring impact and likelihood, will be used for identifying and grading risks in the BAF, DRR, PCCRR and for assessing risks and opportunities throughout the CCG (including health and safety risks):

- Identify – sets out to identify the exposure to uncertainty. The identification process can be both proactive and retrospective. Risk assessments will be undertaken (as set out in the Risk Assessment Code of Practice which can be found as a separate document on the CCG's website), both proactively and retrospectively, to explore risks and relating to a specific activity, project or plan. Some of these will be conducted jointly with other stakeholders, e.g. the local authority and patient groups.
- Analyse – once risks have been identified each one will be analysed by assessing both what the consequence/impact and the likelihood would be of it occurring, this is set out in detail in the Risk Matrix in appendix 2.
- Evaluate – using the single grading risk matrix in appendix 1 as a simple approach to quantifying risk. The matrix defines qualitative measures of consequence (severity) and likelihood (frequency or probability) using a simple 1 – 5 rating system. This can then be used as the basis of identifying and analysing risk. The risk score is Consequence x Likelihood.

  In the first instance risks are measured with existing controls in place and then finally what controls need to be in place to reduce the risk to an acceptable level. The subsequent risk ratings using the risk matrix in appendix 1 are recorded in the appropriate document (either the Board Assurance Framework, Directorate Risk Register, Primar Care Commissioning Risk Register, service area Risk Register or project risk register). This process creates a manageable programme of risk management.
- Control – this is the process of selecting and implementing appropriate actions and controls to modify the risk. Mitigation options include:
  - accepting the risk
  - accepting the risk supplemented by contingency plans if deemed necessary,
  - treating the risk in an appropriate way to constrain the risk to an acceptable level - i.e. mitigation
  - actively taking advantage regarding the uncertainty as an opportunity to gain a benefit
  - terminating the activity giving rise to the identified risk where this is possible or appropriate.

  Where the risk needs to be mitigated, the actions taken and who will undertake them and by when, are also recorded on the appropriate document.

  Risks graded very low and low (1 – 6) will be accepted without significant effort to address them and this will be done by the manager

of the service area. If low graded risks can be readily addressed with very limited resources this may be undertaken.

Risks graded moderate and significant (between 8–10) must be notified to the respective Director by the Manager of the Service. These more operational risks should be recorded in the Directorate Risk Register/ or the Board Assurance Framework for strategic risks. Reasonable effort will be put into addressing risks graded moderate, especially where they have the ability to affect significant numbers of patients or staff. Action plans will be drawn up to mitigate, at least to the level of moderate, risks graded high/extreme.

Risks graded high (12 – 15) must be notified to the Director. These risks may be added to the Board Assurance Framework or the Directorate Risk Register.

Risks graded severe (above 20) must be notified to the Director and Accountable Officer. These risks must be added to the Board Assurance Framework.

Action plans will be drawn up to mitigate, at least to the level of moderate, risks graded high/extreme. If the risk poses an imminent danger then the Director and or the Accountable Officer will report to Governing Body members immediately.

Acceptance of risk – the general principle to follow when determining if a risk identified requires ongoing actions and review is that the benefit of taking the risk outweighs the risk itself. If the risk in its current situation outweighs the benefit this implies that either:

- The activity that creates the risk should be ceased or
- Further mitigating controls to reduce the consequence or likelihood are necessary.

Any further mitigating controls will have a burden attached to them, normally financial, but could be a reduction in service or other aspect. The burden must be commensurate with the controls to be introduced, and the risk itself, i.e. a large cost for a small gain in risk reduction would not be acceptable.

Taking risks is part of everyday life and has many benefits. An organisation cannot be innovative without taking risks. The risk management framework provides CCG staff with a tool to manage risks in a controlled way. Accepting risk should not be seen as a failure to manage risk.

- Review - risk score and actions need to be regularly reviewed to ensure they have produced the expected result, and if they have not for further actions to be identified for implementation or consideration of accepting the risk. Review will be undertaken by the manager of the service liaising with their Director. The Director/Accountable Officer individually will review their specific risks on both the Board Assurance Framework and Directorate Risk Register and feed changes to the Director of Corporate Affairs, who will collate, report and highlight changes to the Executive team in the first instance before onward

reporting to Audit Committee and then by exception to CCG Governing Body via the Audit Committee Chair's report.

Individual committees are also expected to review the risks that form part of their responsibility.

Where review highlights the need to accept a risk the Director will provide narrative in the specific document that explains the rationale for the acceptance and this then goes to Executive team and Audit Committee for consideration and agreement.

Risks may be escalated between the Board Assurance Framework and the respective risk registers. The process for this is shown in appendix 3. There are exceptions to this process, where the Board or Committee, Accountable Officer or Director reviewing the risk feel that the risk would be better managed at a different level. This should be documented.

Examples include:

Reduction in level – the risk rating indicates a high residual risk that the CCG does not have the opportunity to control. All risk reduction controls are proven to be effective. Raising the level of risk that may only have a risk rating warranting Directorate Risk Register but it may have an effect on the delivery of key principles so it could be escalated to the Board Assurance Framework so that the Governing Body is assured that the risk will be managed effectively as part of the delivery of objectives.

5.4 Recording risk

Risks above a certain level as specified in appendix 2 will be recorded on either the Board Assurance Framework (BAF) which is used to record high level strategic risks. The BAF is supported by the Directorate Risk Register (DRR) with operational risks recorded here. The CCG has a separate risk register for primary care that sits below the Directorate Risk Register which feeds up into the Directorate Risk Register if risks require escalation, because it undertakes this responsibility under delegated authority from NHS England on its behalf. Therefore it simplifies the reporting and recording of these risks specifically, but still allows cross referencing between the two risk registers if required.

A description of the template for recording risk on the BAF/DRR and an example is shown in appendix 3.

5.5 Process for Review and Monitoring of Risk

Maintenance of the BAF/DRR or any other risk register kept for low or very low risks will be undertaken by ensuring all risks are managed by their review date which will be entered onto the risk register. The risk rating should gradually decrease from the initial score to meet the target score – the current score is the only rating that will change. If the current score is not reducing then the actions that have been put in place to address the risk must be reviewed, as it would appear that the actions are not effective at reducing the risk. Or alternatively the target risk score has been set too low to achieve.

The risk owner for each risk will be accountable for ensuring each risk is reviewed and monitored at least quarterly and this is documented in the risk register. The risk owner will also be responsible for ensuring the controls are in place and any actions necessary are properly recorded and met.

The Director of Corporate Affairs will provide corporate oversight of timely reviews by risk owners and present the BAFF/DRR to the Executive meeting on a regular basis prior to presentation to Audit Committee.

The Board through the Audit Committee is responsible for corporately monitoring the BAF/DRR.

5.6 Closing risks

An active BAF or risk register contains the risks that are relevant to the organisation that are being addressed. Once a risk has reached its target rating (and is at an acceptable level of risk) it may be closed after agreement at the Audit Committee and Governing Body. Once closed the risk should be taken off the active BAF or risk register and added to an archive version. On the active BAF or risk register a line should be left in, giving details of the risk reference and description, when it was closed and which committee/Board agreed to it.

5.7 Other Assurance Activities

There are a number of functions / activities, required by best practice, legislation or regulation, undertaken, unless stated, which form part of the structure of risk management for the CCG, these include:

- Incident management and triangulation
- Claims management
- Recommendation monitoring, including: audit and higher level enquiry recommendations.
- Complaints and PALs management

6 Related Documents

The following documents contain information that relates to this policy:

Risk Assessment Code of Practice

Maternity Risk Assessment Code of Practice

Mental Wellbeing and Resilience Risk Assessment

Display Screen Equipment Policy

Health and Safety Policy

Office Safety Policy

Fire Policy

Serious Incident Policy

Incident Reporting Code of Practice including NHS to NHS Concerns

Business Continuity Plan

Complaints Policy

7 Dissemination

This strategy will be:

- placed on the website and
- distributed to Governing Body members, Directors and staff by the Director of Corporate Affairs, with an explanation of what is expected of them.

8 Advice and Training

Advice/one to one training will be provided via the Director of Corporate Affairs where appropriate.

9 Review, Reporting and Compliance Monitoring

This strategy will be reviewed every three years by the CCG Governing Body on the advice of the Audit Committee.

Risk management reporting will, in the main be received by the Audit Committee, with exception reporting to the Governing Body; consequently the committee will have responsibility for ensuring that effective compliance is maintained.

10 Glossary

Name	Description	Statutory / Regulatory / Best Practice
Assurance		
Assurance:	provides confidence, freedom for doubt, confidence	Acknowledged best practice is to ensure that, as part of governance processes and via an audit committee, the governing body receives sufficient assurance, through principally its risk management mechanisms that risks and legislative or regulatory challenges are adequately controlled.
Risk Management		
Risk:	The chance of something happening that will have a detrimental impact upon objectives, which is measured in terms of consequences and likelihood	
Opportunity:	The chance of something happening that will have a positive impact upon objectives, which is measured in terms of consequences and likelihood	
Risk management processes:	is the identification, assessment, and prioritization of risks (defined in ISO 31000 as the effect of uncertainty on objectives, whether positive or negative) followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities. Risks can come from uncertainty in financial markets, project failures (at any phase in design, development, production, or sustainment life-cycles),	Acknowledged best practice in all businesses, regulatory requirement of the Department of Health, absence of compliance will not stand any organisation in good stead if there is court action, claims or inspection. Requires a competent person / expert to undertake / lead.

	legal liabilities, credit risk, accidents, natural causes and disasters as well as deliberate attack from an adversary, or events of uncertain or unpredictable root-cause.	
Risk management strategy:	describes the mechanisms used to manage risk throughout an organisation.	Regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk appetite / risk culture:	a statement of the degree of residual risk that the governing body feels is acceptable to carry without reduction together with those it feels must be mitigated to the lowest possible level.	Best practice. Requires a competent person / expert to undertake / lead.
Risk register:	mechanism used to evaluate risks and opportunities that are significant enough to affect the delivery of the organisation's objectives.	Regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk assessment:	a single mechanism for identifying risks and opportunities that affect activities throughout an organisation, e.g. a new project in development, commissioning decision making, safety of staff and assets.	Statutory requirement of the Health and Safety at Work Act, regulatory and best practice. Requires a competent person / expert to undertake / lead.
Risk matrix:	a single matrix for grading all risk activity, which can be a matrix based upon best practice or simple RAG rating, which maps consequence against likelihood.	Best practice. Requires a competent person / expert to undertake / lead.

Appendix 1: Risk Matrix

The risk evaluation matrix is a simple approach to quantifying risk by defining qualitative measures of consequence (severity) and likelihood (frequency or probability) using a simple 1 – 5 rating system. This allows the construction of a risk matrix, which can be used as the basis of identifying and analysing risk. The risk score is Consequence x Likelihood.

Consequence (severity)

	Consequence score (severity levels) and examples of descriptors				
Domains	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Extreme**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of petients
Quality/ complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint Local resolution Single failure to meet standards Minor implications for patient safety unresolved Reduced performance	Treatment or service has significantly reduced effectiveness Formal Complaint Local Resolution (with potential to go to independent review) Repeated failure to meet internal	Non compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment /services Gross failure of patient safety if findings not acted upon Inquest/ombudsman inquiry Gross failure to meet national standards

		rating if unresolved	standards Major patient safety implications if findings are not acted upon		
Human resources/ organisational/ development/ staffing/ competence	Short term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack fo staff Unsafe staffing level or competence (>5 days) Loss fo key staff Very low staff morale No staff ateending mandatory/key training	Non-delivery of key objective/ services due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty/ Inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendation/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severity critical report
Adverse publicity	Rumours Potential for public concern	Local media coverage Short term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions raised in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10-25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
Service/ business interruption/ Environmental impact	Loss/Interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/ interruption of >1 day Moderate impact on environment	Loss/ interruption of > 1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood (frequency or probability)

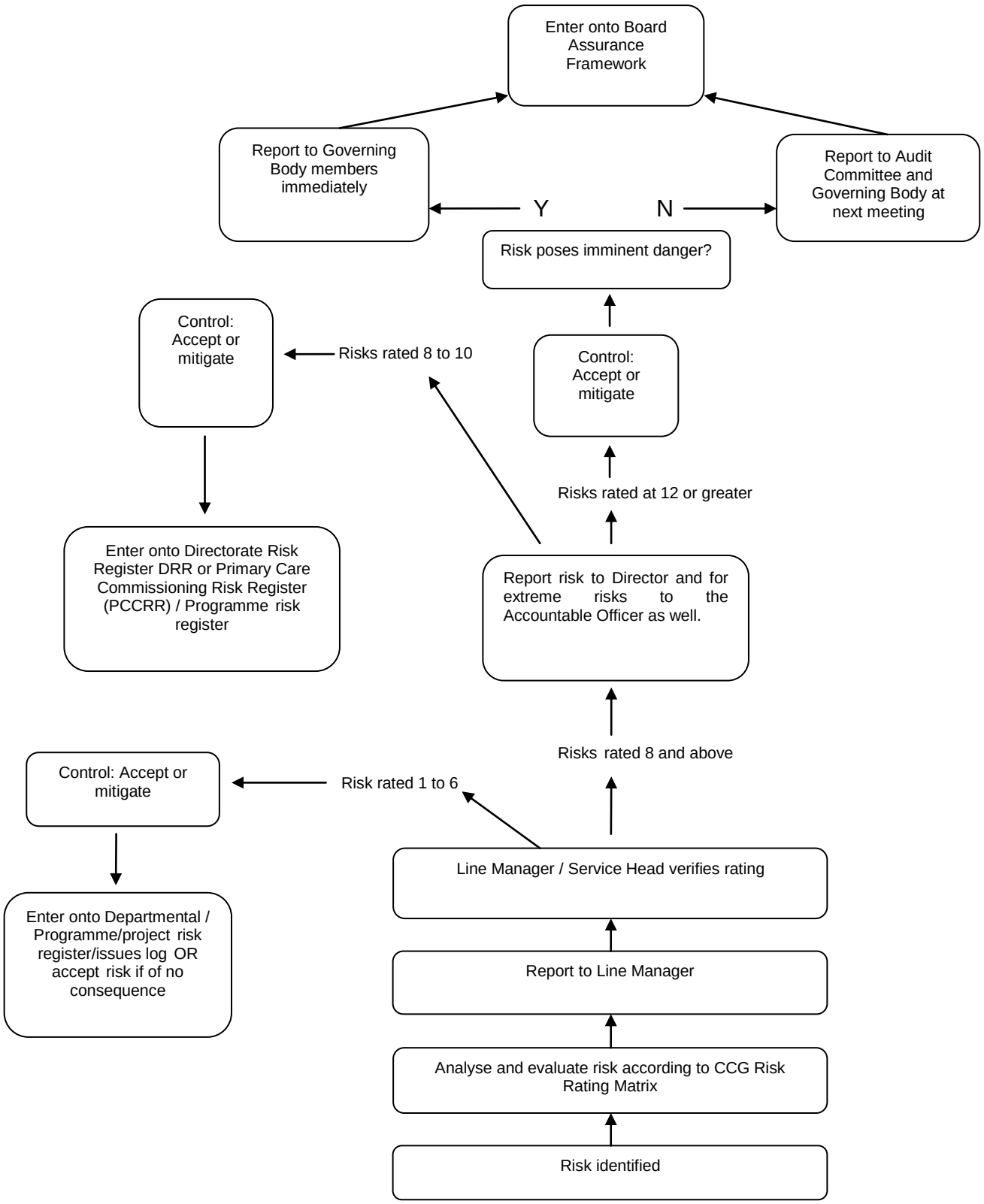
Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it happen/does it happen?	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1 per cent	0.1 – 1 per cent	1 – 10 per cent	10 – 50 per cent	>50 per cent

Risk Score (Consequence x Likelihood)

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

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

Appendix 2: Risk Escalation Process Map



Appendix 3: BAF/DRR Template

BAF/DRR template showing content structure:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Risk ID	Objective	Opened/added by/ ref to provider BAF	Risk title and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls/ assurances	Risk Score (consequence x likelihood)	Risk Score Trend	Action plan/cost/action lead/review date/sufficient mitigation	Target risk score for end of financial year	Director or risk owner	Risk Owner	Committee/ GB oversight	Amendments: name and date
	Objective 1: To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes, based upon best available evidence														

Column 1 – unique number reference given sequentially

Column 2 – Cross reference risk to the objective it would prevent the CCG achieving

Column 3 – Who/What added the risk and when, and what external risk registers it maps to

Column 4 – Summary title of risk and then fuller description of risk

Column 5 – Summary of the opportunity the risk may present

Column 6 – Summary of the controls already in place when the risk was identified and subsequently updated on review.

Column 7 – Summary of the assurances already in place when the risk was identified and subsequently updated on review.

Column 8 – Summary of the gaps in appropriate controls/assurances at the time the risk is identified and subsequently updated on review.

Column 9 – Using the risk matrix an evaluation of the consequence and likelihood of the current risk taking into account the existing controls and assurances.

Column 10 – Add in a trend arrow to show if risk rating has stayed the same, increased or reduced from last reporting review.

Column 11 – Using the gaps in controls and assurances in column 7 identify actions required to fill those gaps and also to achieve the target rag rating in column 10 which reflects the point that the risk will be accepted. This should also document the review date.

Column 12 – Evaluate the target risk score at which point the risk will become acceptable.

Column 13 - Director identified – this is the person who will be accountable for coordinating strategic delivery of the mitigating actions

Column 14 - Risk Owner identified – this is the person who will be accountable for coordinating operational delivery of the mitigating actions (applicable to ERR only)

Column 15 – Identify here which Committee or if GB will maintain regular oversight and receive regular reporting on risk.

- GB – Governing Body
- QS – Quality and Safety Committee
- F – Finance Committee
- PC – Primary Care Commissioning Committee
- AC – Audit Committee
- SCC – Strategic Commissioning Committee
- AIC – Assuring

Column 16 - Audit trail of amendments to the risk record.

EQUALITY IMPACT ASSESSMENT

Stage 1 Initial screening

Name of the proposed policy/service/function: Risk Management Strategy 2021-23

Author(s) of the policy/service/function: Alison Smith, Director of Corporate Affairs

Directorate: Corporate Affairs **Date created:** April 2021 **Date for review:** April 2023

The main aims of the policy or proposed policy/service/function:

The strategy documents the CCG's approach to risk management for 2021-23

The intended objectives and outcomes of the policy/service/function:

The strategy documents the CCG's approach to risk management for 2021-23

Does the policy/service/function affect any of the following groups of people? (Y or N)

Group	Positive impact	Negative impact	Why? (Please explain your reasons. This section must be completed)
Race	X		Risk management is a mechanism that provides the opportunity for identification of areas in the organisation commissioning processes or internal business processes where equality issues may be hidden to be exposed and actions to mitigate them undertaken.
Gender	X		See above.
Disability	X		See above.
Sexual orientation	X		See above.
Age	X		See above.
Religion or belief	X		See above.
Gender reassignment	X		See above.
Marriage and Civil Partnership	X		See above.
Pregnancy and Maternity	X		See above.

NOTE:

Positive impact – there may be a positive impact on any of the groups above in relation to promoting equal opportunities and equality. For example, a targeted programme for black and minority ethnic women would have a positive effect on that group compared to white women and all men. It is not, however, necessarily an adverse impact on white women and men.

Negative impact – there may be a negative impact on any of the groups (i.e. disadvantage them in any way). An example of this would be that if an event were to be held in a building with no loop facilities a negative and adverse impact would affect attendees with a hearing impairment

What evidence has been used to screen the policy? (e.g. monitoring data, consultation, focus groups, local population data): Risk assurance activity is all inclusive; all matters will be treated equally.
What monitoring arrangements are in place for the future? This report supports the Audit Committee in providing assurance of compliance with the Risk Management Strategy and related codes of practice.

If no negative or adverse impact has been identified please sign off and the process ends here.

Signature: Alison Smith	**Date: 08/04/2021**

If a negative or adverse impact has been identified please proceed to Stage 2

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held on 12 May 2021

Item Number:	Agenda Item:
GB-21.05-024	Conflicts of Interest Policy

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Tracy Eggby-Jones Corporate Affairs Manager tracy.eggby-jones@nhs.net

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Shropshire CCG and Telford & Wrekin CCG Audit Committees	November 2019	D
Shropshire, Telford and Wrekin CCG Audit Committee	April 2021	D

Executive Summary (key points in the report):

In November 2019, and in response to an internal audit review and publication of new NHS England guidance, both Shropshire CCG and Telford & Wrekin CCG reviewed their existing Conflicts of Interest policies. Although each CCG retained their own individual policy, there were aligned to be a mirror image of each other in preparation for the establishment of the new single strategic commissioning organisation. The policies were presented and approved by the relevant CCG's Audit Committee at the time.

The policies have now been fully aligned as one policy for adoption by the new CCG, NHS Shropshire, Telford and Wrekin CCG. There have been some minor changes to include:

- the CCG's new logo/branding
- details of the CCG's Fraud Champion, Laura Clare, Section 5, page 33
- contact details in Section 9, Page 35, have been updated.
- the wording in the declarations Appendix 2 for employees and Appendix 9 for contractors has been strengthened, to include *'The information detailed on this signed declaration can be used by the CCG's Counter Fraud Team for the purposes of investigation, sanction and redress.'*

The policy has been reviewed by the STW CCG Audit Committee in April 2021 and also by Mr Paul Westwood, Counter Fraud Specialist, to ensure it meets the counter fraud, bribery and corruption measures outlined by the NHS Counter Fraud Authority.

The Governing Body is asked to approve the Conflicts of Interest Policy as per scheme of reservation and delegation.

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

Recommendations/Actions Required:

NHS Shropshire, Telford and Wrekin CCG Governing Body is asked to approve the Conflicts of Interest Policy as per scheme of reservation and delegation.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

CONFLICTS OF INTEREST POLICY

Document Title:	Conflicts of Interest Policy
CCG document ref:	
Author/originator:	Alison Smith, Director of Corporate Affairs
Date of approval:	21 April 2021
Approving Committee:	Audit Committee
Responsible Director:	Director of Corporate Affairs
Category:	General
Sub Category:	Corporate
Date policy due for review:	April 2023
Target audience:	Members of the CCG's Governing Body (clinical, executive and lay), committee and sub-committee members, localities and their members and all decision making staff involved in commissioning, contracting and procurement processes and decision-making

VERSION CONTROL

Document location

This document is only valid on the day it was printed.

The current version of this document will be found at www.shropshiretelfordandwrekinccg.nhs.uk/

Revision History

Date of this revision: 21 April 2021

Date of next revision: April 2023 (or as required)

Version	Date	Author	Change Description
1	21/04/21	Tracy Eggby-Jones	

Approvals

This document requires the following approvals:

Name/Committee	Title (if individual)
Audit Committee	

Distribution

This document has been distributed to:

Name and job title/Staff newsletter	Date of Issue	Version
All GP Member practices, Governing Body members, committee and sub committee members, all CCG staff, CSU staff, HR		1.0
CCG website, staff newsletter		1.0

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1 Introduction

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (STWCCG) and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

Managing conflicts of interest appropriately is essential for protecting the integrity of NHS Shropshire, Telford and Wrekin CCG from perceptions of wrongdoing. The CCG must meet the highest level of transparency to demonstrate that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the CCG.

It will not be possible to avoid conflicts of interest. They are inevitable in many aspects of public life, including the NHS. However, by recognising where and how they arise and dealing with them appropriately, commissioners will be able to ensure proper governance, robust decision-making, and appropriate decisions about the use of public money.

Section 14O of the National Health Service Act 2006, inserted by the Health and Social care Act 2012, sets out that each CCG must:

- maintain one or more registers of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees;
- publish, or make arrangements to ensure that members of the public have access to these registers on request;
- make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group, and record them in the registers as soon as they become aware of it, and within 28 days; and
- make arrangements, set out in their constitution, for managing conflicts of interest, and potential conflicts of interest in such a way as to ensure that they do not and do not appear to, affect the integrity of the group's decision-making processes.

NHS England has published guidance for CCGs on the discharge of their functions under this section and each CCG must have regard to this guidance. This policy has been based upon this guidance.

In addition, the NHS (Procurement, Patient Choice and Competition) Regulations 2013 set out that commissioners:

- must manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been or appears to have been affected by a conflict;
- must keep appropriate records of how they have managed any conflicts in individual cases.

The CCG has set out in its constitution under Section 6, and specifically sections 6.1 and 6.2, how the CCG will comply with these requirements.

2 Purpose

The aim of this policy is to protect both the organisation and individuals involved from impropriety or any appearance of impropriety by setting out how the CCG will manage conflicts of interest to ensure there can be confidence in the probity of commissioning decisions and the integrity of the clinicians involved with the work of the CCG. The policy will help to foster an open and transparent culture which provides an environment where everyone working on behalf of the CCG is able to identify and help manage conflicts of interest where they may arise. It is important to emphasise that by managing conflicts or perceived conflicts of interest, this is not a judgement on the integrity of the individual concerned, but the mechanism by which both the individual and organisation can be protected from criticism of impropriety.

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

Conflicts of interest may arise where an individual's personal interests or loyalties or those of a connected person (a relative or close friend) conflict with those of the CCG, or might be perceived to conflict with those of the CCG. Such conflicts may create problems such as inhibiting or being seen to inhibit free discussion which could result in decisions or actions that are not in the interests of the CCG, and risk giving the impression that the CCG has acted improperly.

The CCG Governing Body's responsibility includes the stewardship of significant public resources and the commissioning of health and social care services to the population of Shropshire, Telford and Wrekin. The CCG Governing Body is therefore determined to ensure the organisation inspires confidence and trust amongst its staff, partners, funders, suppliers and the public by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the CCG.

The CCG requires all serving members of the CCG Governing Body, committees/sub-committees and staff who take decisions where they are

acting on behalf of the public or spending public money should observe the principles of good governance:

- The Nolan Principles
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA)
- The seven principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code
- Standards for members of NHS Boards and CCG Governing bodies in England.

Appendix 1: First report of the Committee on Standards in Public Life (1995) The Nolan Principles

This policy should be considered alongside the CCG's other organisational policies:

- NHS Shropshire, Telford and Wrekin CCG Constitution
- NHS Shropshire, Telford and Wrekin CCG Governance Handbook
- NHS Shropshire, Telford and Wrekin CCG Standing Orders, Scheme of Reservation and Delegation of Powers and Prime Financial Polices
- Declaration of Gifts, Hospitality and Sponsorship – Anti-Bribery Policy and Procedure
- Policy and Guidance for Joint Working with the Pharmaceutical Industry (including rebate schemes) & Commercial Sponsorship of Meetings/Training Events
- Raising Concerns at Work Policy
- Other relevant HR policies

2.1 Fraud Bribery and Corruption

As set out in this policy, all employees, members of the CCG (the GP practices in Shropshire, Telford and Wrekin), members of the CCG Governing Body and its committees and sub committees and contractors and providers of services will at all times comply with this policy and declare any Conflicts of Interest both on appointment and as personal circumstances change during the course of their working with the CCG. Failure to declare such interests or alternative employment, may result in disciplinary action and/or criminal investigation by the CCG.

All employees, members of the CCG, members of the CCG Governing Body and its committees and sub committees and contractors and providers of services have a duty to ensure that public funds are safeguarded.

If there are any suspicions that there has been a potential act of fraud, bribery or corruption, or there has been any suspicious acts or events witnessed, these concerns must report the matter to the CCG's Counter Fraud Team (contact details can be found in Section 5, page 33 of the policy or on the CCG's website www.shropshiretelfordandwrekin.nhs.uk) or alternatively the concerns can be reported to the NHS Fraud and Corruption Reporting Line on 0800 028 4060. Alternatively reports can be made through the online reporting tool at https://cfa.nhs.uk/reportfraud

3 Responsibilities

3.1 Employees, members of the CCG (the 52 GP practices in Shropshire, Telford and Wrekin), members of the CCG Governing Body and its committees and sub committees and contractors and providers of services will at all times comply with this policy.

3.2 It is the responsibility of all Shropshire, Telford and Wrekin CCG members, employees, Governing Body members and members of its committees and sub committees, contractors and provider of services to familiarise themselves with this policy and comply with its provisions.

3.3 The CCG Governing Body will ensure that all employees, members of the CCG, the Governing Body itself and its committees and sub committees, contractors and providers of services are aware of the existence of, and responsibilities resulting from, the policy.

3.4 The Accountable Officer has overall accountability for the CCG's management of conflicts of interest.

3.5 The Director of Corporate Affairs is responsible for:

- The day to day management of conflicts of interest matters and queries;
- Maintaining the CCG's register(s) of interest and the other registers referred to in this policy;
- Supporting the Conflicts of Interest Guardian to enable them to carry out the role effectively;
- Providing advice, support and guidance on how conflicts of interest should be managed; and
- Ensuring that appropriate administrative processes are put in place.

3.6 The Conflicts of Interest Guardian role will be undertaken by the Chair of Audit Committee, providing they have no provider interests. They should, in collaboration with the Director of Corporate Affairs:

- 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;

- Be a safe point of contact for employees, contractors Board and committee members of the CCG to raise any concerns in relation to this policy;
- Support the rigorous application of conflict of interest principles and policies;
- Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- Provide advice on minimising the risks of conflicts of interest.

3.7 The CCG Chair and Conflicts of Interest Guardian are responsible for making decisions on arrangements for mitigating conflicts or potential conflicts of interest once declared, based upon the decision making framework set out in section 4.8 of this policy. The CCG Chair and the Conflicts of Interest Guardian are also responsible for reviewing the operation of this policy and for proposing changes to this policy for consideration by Audit Committee as part of its assurance review.

3.8 Executive members of the CCG's Governing Body have an ongoing responsibility for ensuring the robust management of conflicts of interest. All CCG employees, Governing Body and committee members and member practice staff will continue to have individual responsibility in declaring their interests when required at meetings or other situations, keeping their declarations up to date and following the mitigating actions set out in the register of interests if a conflict arises.

3.9 Line Managers of NHS Shropshire, Telford and Wrekin CCG must ensure members of staff are aware of the policy and the process to be followed for declaring interests. Line managers must consider any declarations of interest made by their staff and put in place mitigating arrangements where appropriate. Where this is not clear, they should consult the Director of Corporate Affairs, the Chair of the CCG or the Conflicts of Interest Guardian for advice and guidance.

3.10 Heads of Commissioning and the procurement function in the CSU must ensure that bidders, contractors and direct service providers adhere to this policy, and that the service re-design and procurement processes used by the CCG reflect the procedures set out in this policy.

4 Procedures/Processes

4.1 Definition of a conflict of Interest

A 'conflict of interest' is:

> "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

A conflict of interest occurs where an individual's ability to exercise judgement or act in a role is, could be, or is seen to be impaired or otherwise influenced by, his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement, or undue influence can also be a conflict of interest.

Conflicts can arise in a number of different ways; an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. kudos or reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or has an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions, or could be perceived to do so. These are all conflicts of interest.

The important things to remember are that:

- a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;
- if in doubt, it is better to assume a conflict of interest and manage it appropriately, rather than ignore it;
- for a conflict to exist, financial gain is not necessary.

4.2 Identifying conflicts of interest

Interests can be captured in four different categories:

- a financial interest: this is where an individual may get a direct financial benefit from the consequences of a commissioning decision they are involved in making. This could, for example, include being:
  - A director, including a non-executive director or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
  - A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business,

partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.

- A management consultant for a provider.

This could also include an individual being:

- In secondary employment – with another NHS body, another organisation which might be in a position to supply goods/services to the CCG, Directorship of a GP Federation and self employment, including private practice, in a capacity which might conflict with the work of the CCG or which might be in a position to supply goods/services to the CCG.
- In receipt of secondary income from a provider;
- In receipt of a grant from a provider;
- In receipt of any payments (for example Honoraria, one-off payments, day allowances or travel or subsidence) from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

- Non-financial interest: This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. This may, for example include situations where the individual is:
  - An advocate for a particular group of patients;
  - A GP with special interests e.g. in dermatology, acupuncture etc.
  - A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
  - An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
  - A medical researcher.

  GPs and practice managers, who are members of the CCG Governing Body or committees of the CCG, should declare details of their roles and responsibilities held within their GP practices.

- Non-financial personal interest: This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:
    - A voluntary sector champion for a provider;
    - A volunteer for a provider;
    - A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
    - Suffering from a particular condition requiring individually funded treatment;
    - A member of a lobby or pressure group with an interest in health.
- Indirect Interests: This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a commissioning decision they are involved in making (as those categories are described above) for example:
    - A spouse/partner (someone who is married to, a civil partner of, or someone with whom the member of staff lives);
    - A close relative to the individual or partner e.g. parent or parent in law, grandparent, child, grandchild or sibling;
    - A close friend;
    - Business Partner.

A declaration of interest for a "business Partner" in a GP partnership would include all relevant collective interests of the partnership, and all interests of their fellow GP partners by cross referring to the separate declarations made by those GP partners on their declarations.

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between the person and the individual, and the role of the individual with the CCG.

The above categories and examples are not exhaustive and discretion will be exercised on a case by case basis, having regard to the principles set out in section 2 of this policy in deciding whether any other role, relationship or interest which would impair or otherwise influence the individual's judgement or actions in their role with the CCG.

Where individuals are unsure whether a situation falling outside of the above categories may give potential for a conflict of interest, this should be discussed initially with the Director of Corporate Affairs, who will co-ordinate advice from the Conflicts of Interest Guardian of NHS Shropshire, Telford and Wrekin CCG, if necessary, who will provide an independent view. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

When considering if an interest is relevant and material, the Financial Reporting Standard No. 8 (issued by the accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

The CCG requires individuals employed by or contracted to provide services to the CCG, to obtain prior permission to engage in secondary employment, and reserves the right to refuse permission where it believes a conflict will arise which cannot be effectively managed.

4.3 Declaring and registering interests

NHS Shropshire, Telford and Wrekin CCG use the skills of many different people, all of whom are vital to its work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this policy these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and non executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

In line with the points set out above, examples of the categories of staff this may apply to includes:

- CCG Employees – all full and part time staff, permanent staff, staff on sessional or short term contracts, students, trainees and apprentices, agency staff and seconded staff;

- Members of the CCG - all GP Practice Partners or where the practice is a company each Director, all Practice Managers and any other practice individual (clinical or non clinical) directly involved with business or decision making of the CCG;
- Members of the CCG Governing Body (and its committees and sub committees) – including co-opted members, appointed deputies and any members from other organisations.
- and anyone else required to declare interests under a contract for their services – all self employed consultants, CSU embedded staff.

All these categories must complete the declaration of Interest form (Appendix 2) and ensure that declarations of interest are made and regularly confirmed or updated in the following circumstances:

- On appointment: applicants for any appointment to the CCG should be asked to declare any relevant interests as part of the election/recruitment process. When an appointment is made, a formal declaration of interests should be made and recorded.
- Annually: all interests should be confirmed annually to ensure that the register is accurate and up to date. Where interests have changed a newly completed and signed form will be required. Where interests have not changed a "nil return" sent via email will be accepted and recorded.
- At meetings: all attendees should be asked under a standing item on the agenda of the meeting by the Chair, to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if the interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest made should be recorded in the minutes of the meeting.
- On changing role or responsibility: where an individual changes role or responsibility within the CCG or its Governing Body, any change to the individual's interests should be declared.
- On any other change of circumstances: wherever an individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.
- At the beginning of a new project/piece of work

In keeping with the Health and Social Care Act Regulations, individuals who have a conflict should declare this as soon as they become aware of it, and in any event no later than 28 days after becoming aware. The declaration of interest form should be completed and returned for all interests (restating existing interests and with new interests added) to the Director of Corporate Affairs.

Where an individual is unable to provide a declaration in writing, e.g. if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter, but no later than 28 days. If the individual, for any reason, has difficulty making a declaration in writing, then they should contact the Director of Corporate Affairs for assistance and support.

If an individual fails to declare an interest or the full details of the interest this may result in disciplinary action resulting in the individual being dismissed or removed from their role.

Appendix 2: Declaration of Interest Form

4.4 What should be declared

Outside Employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- The nature of the outside employment (eg who it is with, a description of duties, time commitment) and relevant dates.

Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation. Including the nature of the shareholdings/other ownership interest and relevant dates.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a

commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Where loyality interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.5 Maintaining a Register of Interests

The declaration of interest forms will be used to create registers of interest. The Director of Corporate Affairs will maintain the following registers of the declared relevant and material interests of:

- Members of the CCG
- Members of the CCG Governing Body
- Members of the committees and sub committees of the Governing Body
- Employees of the CCG and other NHS bodies acting for them and Contractors of the CCG

The registers will be published on the CCG's website at www.shropshiretelfordandwrekinccg.nhs.uk and will be made available on request for inspection at the CCG's headquarters. The registers will also be reported to Audit Committee twice a year, and included in the CCG's Annual Report. By signing and declaring interests, the individual is deemed to give permission for this information to be shared publicly. If there is any reason that the individual believes that their interest should not be included on the public register, then they should contact the Director of Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

The CCG will send annual reminders to all its members, Board and committee members and employees to check for accuracy of the register.

An interest should remain on the public register for a minimum of 6 months after the interest has expired. In addition the CCG will retain a private record of historic interests for a minimum of 6 years after the date on which it expired. This record of historic interests may be viewed by members of the public following application to the Director of Corporate Affairs.

The register of interests will also record the planned mitigating action if the actual or potential conflict arises. Individuals declaring interests should make themselves aware of these proposed actions, so they can comply if the conflict arises.

Appendix 3: Declarations of Interest Register

4.6 Managing conflicts of interest

Within a week of any relevant interest being declared for the first time in line with section 4.3 above, the arrangements for managing any actual or potential conflicts of interest arising from the declared interest will be set out in the register of interests against the specific declared interest for the individual by the Director of Corporate Affairs.

All individuals covered by this policy must comply with the arrangements communicated to them in the register of interests. Where an interest has been declared, the individual will ensure that before participating in any activity connected with commissioning, he or she has received confirmation of the arrangements to manage the conflict of interest via the register of interests.

In relation to the procedure for declaring interest at meetings, the chair will ask at the beginning of each meeting under the "Declarations of Interest" agenda item if anyone has:

1) Any interest already declared on the register that conflicts with any item on that specific agenda; and/or

2) Any new interest that has not already been declared on the register, that may or may not conflict with any item on that specific agenda.

In response, where an individual, employee or person providing services to the CCG is attending a meeting and is aware of an interest that has previously been declared on the register, the individual will bring this interest and the agenda item it conflicts with, to the attention of the chair of the meeting, together with details of arrangements which have been confirmed in the register of interests for the management of the conflict of interest or potential conflict of interest.

The Chair will then make a decision about what action needs to be taken in the meeting based upon the arrangements already stated in the register.

Alternatively, where an individual, employee or person providing services to the CCG attending a meeting is aware of any new interest which has not been declared in the register (whether this conflicts with an agenda item or not), he or she will declare this under the “Declaration of Interest” agenda item. If the declaration of the interest is simply because it is a new interest and does not conflict with any item on the agenda, this will be noted by the Chair and added to the minutes and the Director of Corporate Affairs will be informed to add to the register of interests.

If this new interest conflicts with an item on the agenda, the individual will also outline what the conflict is. As no arrangements will have been confirmed in the register for managing this new conflict, the Chair of the meeting will decide how the conflict will be managed in the meeting. If the Chair feels the conflict is sufficiently material, they may require the individual to withdraw from the meeting or part of it until the arrangements for managing the conflict in the future are added to the register. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting. The Chair will then communicate this to the Director of Corporate Affairs.

The Chair of the CCG Governing Body or any of its committees or sub committees has ultimate responsibility for determining how any conflict should be managed, and will inform the individual of the decision. This may mean that the management arrangements in the register are overridden, if the Chair feels the circumstances warrant it. In making such decisions, the Chair (or vice chair or remaining non-conflicted members) may wish to consult with the Conflicts of Interest Guardian or another member of the CCG Governing Body if this is possible.

It is the responsibility of each individual member of the meeting to declare any relevant interest which they may have. However, should the Chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict, but which the individual themselves have not declared, then they should bring this to the attention of the Chair. This may happen particularly if the individual has not realised that an agenda item has an indirect link with the declared interest, yet another member of the meeting has.

It is good practice for the Chair, with support of the Director of Corporate Affairs, and if required the Conflicts of Interest Guardian, to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers

for particular agenda items of private meetings are not sent to conflicted individuals in advance of the meeting where relevant.

Where the Chair him/herself has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, he or she must make a declaration and the deputy Chair will act as Chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interest or potential conflict of interest in relation to the Chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the Deputy Chair may require the Chair to withdraw from the meeting or part of it. Where there is no Deputy Chair, the members of the meeting will agree between themselves who will chair the meeting. In making such decisions, the chair (or vice chair or remaining non-conflicted members) may wish to consult with the Conflicts of Interest Guardian if this is possible.

Declarations of interests, and the arrangements agreed to manage them, will be recorded in the minutes of the meeting.
To support chairs in their role, they should refer to the declaration of interest checklist attached as Appendix 4.

Appendix 4: Declarations of Interest Checklist for Chairs

4.7 Declarations of Interests on Application for Appointment or Election/appointment to the CCG

Individuals applying for appointment for any position in the CCG will be required, as part of the appointments process, to declare any relevant interests. This includes:

- Lay member appointments to the Governing Body;
- Other appointments of external individuals to the Governing Body, its committees, sub committees and other working or project groups;
- Professional medical practitioners or practice employees standing for election to the Governing Body; and
- All employees and individuals contracted to work for the CCG, particularly those operating at senior or Governing Body level.

The purpose of such declarations will be to enable the Conflicts of Interest Guardian (for Governing Body/Committee roles) or line manager (for staff) to assess, on a case to case basis, whether any of the declared interests are such that they could not be managed under this policy, and would prevent the individual from making a full and proper contribution to the CCG, thus excluding the individual from appointment or election to the CCG.

In so doing the Conflicts of Interest Guardian or line manager will take into consideration the materiality of the declared interest and the extent to which the individual could benefit from any decision of the CCG. For example, any individual who has a material interest in an organisation that undertakes, or is likely to undertake, substantial business with the CCG as a healthcare provider or a commissioning support service should not be a member of the Governing Body, if the nature of their interest is such that they are likely to need to exclude themselves from decision making on so regular basis that it significantly limits their ability to effectively operate as a Governing Body member.

4.8 Mitigating conflicts of interest

Where a conflict of interest exists, there are various ways in which the conflict may be managed, depending on its impact. The level of mitigating action will be determined by the Chair of the meeting based upon previously prescribed mitigating actions stated in the register of interests, in consultation with the Conflicts of Interest Guardian or another non-conflicted Governing Body member, and in the case of an employee, by the line manager. This decision will be recorded in the relevant minutes based upon what is stated in the register of interests and communicated to the individual making the declaration in writing as per section 4.5 above.

The appropriate course of action will depend on the particular circumstances, but could include:

- Requiring the individual who has a conflict of interest not to attend the meeting;
- Ensuring the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter where these are not already available in the public domain;
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when decisions are being taken in relation to those matters. When this happens in a public meeting the individual would still need to leave the room and not sit in the public gallery, as they may be perceived to influence any decision taken by remaining in the room.
- Allowing the individual to participate in some or all of the discussion when the relevant matter is being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matters. This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared;
- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest, but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter under discussion.

NHS England has published a range of conflicts of interest case studies which may be helpful in determining the conflict and how to mitigate it: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/coi-case-studies-jun16.pdf

The following framework[1] will be used to determine what level of mitigation can be put in place to limit the conflict of interest.
Application of the different levels is cumulative, so each interest will be judged against level 1 in the first instance, and if not suitable then level 2 and so on.

Where mitigation arises from any level of management strategy above level 1, the Chair and Conflicts of Interest Guardian would be expected to conduct informal discussions with the individual concerned to ensure they fully understand the action requested of them, and they have an opportunity to seek clarity or raise concerns.

It is imperative that to ensure complete transparency, if any conflicts of interests are declared or otherwise arise in a meeting the Chair must ensure the following information is recorded in the minutes:

- Who has the interest
- The nature of the interest and why it gives rise to a conflict
- The items on the agenda to which the interest relates
- How the conflict was agreed to be managed
- Evidence that the conflict was managed as intended i.e. by recording when individuals left or returned to the meeting.

A template is appended as Appendix 5

Appendix 5: Template for recording minutes

[1] Based upon the publication from ICAC and CMC: "Managing Conflicts of Interest in the Public Sector" – Toolkit November 2004, Tool 9.2 management options ready reckoner Page 60.

Mitigation	When most suitable	When least suitable	Strategies
Level 1 - Register Where details of the existence of a possible or potential conflict of interest are formally registered **All interests must be registered in full**	• For very low-risk conflicts of interest and potential conflicts of interest • Where the act of transparency through recording the conflict of interest is sufficient	• The conflict of interest is more significant or of higher risk • The potential or perceived effects of a conflict of interest on the proper performance of the individual acting for the CCG requires more pro-active management	• Ensure that the interest is widely known by including in the publicly available register of interests • Ensure register of interests is included with the Board agenda so Board members are aware of the conflict. • Ensure register of interests is shared and accessible to all managers so they are aware of staff declarations of interest • **If an individual fails to declare an interest or the full details of the interest, this may result in the individual being dismissed or removed from their role.**
Level 2 - Restrict Where restrictions are placed on the individual's involvement in the matter	• The individual can be effectively separated from parts of the activity or process • The conflict is not likely to arise frequently	• The conflict is likely to arise more frequently • The individual is constantly unable to perform a number of their regular duties/role because of the conflict of interest issues.	• Non-involvement in any critical criteria setting or decision-making role in the process concerned • Refrain from taking part in any debate about the issue • Abstaining from voting on decision proposal • Withdrawing from discussion of affected proposals and plans whether in part 1 or part 2 or a meeting. • Having restricted access to information relating to the conflict of interest • Being denied access to sensitive documents

			or confidential information relating to the conflict of interest
<u>Level 3 - Recruit</u> Where a disinterested third party is used to oversee part or all of the process that deals with the matter.	• It is not feasible or desirable for the individual to remove themselves from the decision making process • Where the expertise of the individual is necessary and not genuinely not easily replaced	• The conflict is serious and ongoing, rendering ad hoc recruitment of others unworkable • Recruitment of a third party is not appropriate for the proper handling of the matter • A suitable third party is unable to be sourced	• Arranging for the affected decision to be made by an independent third party • Engaging a third party or auditor to oversee or review the integrity of the decision making process. • Increase the number of people sitting on the decision-making body to balance the influence of a single member who may have a conflict of interest but who has a defendable reason for remaining on the decision making body • Seeking the views of those likely to be concerned about a potential, actual or reasonably perceived conflict of interest, about whether they object to the individual having any, or any further, involvement in the matter
<u>Level 4 - Remove</u> Where the individual is removed from the matter	• For ongoing serious conflicts of interest where ad hoc restriction or recruitment of others is not appropriate	• The conflict of interest and its perceived or potential effects are of low risk or low significance • The individual is prepared to relinquish the relevant private interest rather than radically change their work responsibilities or environment	• Removing the individual from any involvement in the matter • Abstaining from any formal or informal discussion about the matter • Removing the individual from the situation where they may still exert or be perceived to exert a covert influence on decisions or actions in the matter. • Rearranging the individual's duties and responsibilities to a non-conflicting function

			• Transferring the individual to another project • Transferring the individual to another area of the CCG • Ensuring that the duties/role in which the conflict of interest has arisen are not reallocated to another officer who is supervised by the individual concerned.
<u>Level 5 - Relinquish</u> Where the individual relinquishes the private interest that is creating the conflict	• The individual's commitment to public duty outweighs their attachment to their private interest	• The individual is unable or willing for various reasons to relinquish the relevant private interest	• Individual liquidates their private interest • Individual divests themselves of or withdraws their support for the private interest (this would not be appropriate if the interest is an essential part of the individual's qualification for the position, such as membership of a professional body.)
<u>Level 6 - Resign</u> Where the individual resigns from their position with the CCG	• No other options are workable • The individual cannot or will not relinquish their conflicting private interest and changes to their work responsibilities or environment are not feasible • The individual prefers this course as a matter of personal principle	• The conflict of interest and its potential or perceived effects are of low risk or low significance • Other options exist that are workable for the individual and CCG	• Resignation from the position with the CCG

4.9 Quorum

If members of a 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 and the number of unconflicted members left is below the quorum stipulated for the meeting, the Chair (or Deputy Chair) will determine whether or not the discussion can proceed.

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 and the Director of Corporate Affairs what action should be taken.

Mitigating action to be considered may include:

- requiring the Governing Body or another committee or sub-committee to progress the item of business, or if this is not possible,

- inviting, on a temporary basis one or more individuals to make up the quorum (where these are permitted members of the governing body or committee / sub-committee in question) so that the group can progress the item of business, and this is set out in the CCG's Constitution.

These arrangements must be recorded in the minutes.

4.10 Declarations of Interest in relation to Procurement

In order for the CCG to recognise and manage any conflicts or potential conflicts, declarations of interest, including nil returns where appropriate, will be required from CCG members and CCG/CSU staff in relation to every procurement exercise, including the use of single tender actions (waivers), on which they are engaged. The CCG Commissioning Lead overseeing a procurement process should ensure that the CSU Procurement team seeks declarations of interest at the outset from those individuals involved, and at key points in the procurement process, including at the beginning of project meetings, upon receipt of tenders and during the moderation process. The original signed declaration of interest will be held by the CSU Procurement team and a copy sent to the Director of Corporate Affairs for inclusion in the Register of Interests, and for notification to the Audit Committee and Governing Body. A copy of the declaration of interest form for procurement is attached as Appendix 6.

Particular consideration needs to be given to the role of GP members in procurement exercises where:

- the CCG is proposing to commission through competitive tender and GP practices are likely to bid
- the CCG is proposing to commission through an Any Qualified Provider process, where GP practices are likely to be among the qualified providers offering to provide the service
- the CCG is proposing to commission through single tender from GP practices
- the CCG is proposing to continue to commission by contract extension from GP practices

Where a declaration states an interest that has not already had mitigating action considered and communicated to the individual concerned, then the Director of Corporate Affairs will liaise with the Chair and Conflicts of Interest Guardian to consider whether the conflicts of interest declared specifically for a procurement process would preclude the individual from continuing, or whether mitigating actions can be taken to allow the individual to continue to take a part in the procurement process.

Appendix 6: Procurement declaration of Interest (Project Team)

4.11 Register of Procurement Decisions

In order for the CCG to maintain transparency of decision making and to demonstrate conflicts of interest are managed effectively, the CCG will maintain and publish a register of procurement decisions. A copy of the register of procurement decisions is attached as Appendix 7 and will be made public on the CCG's website.

The register should be updated whenever a procurement decision is taken, which includes procurement of a new service, any extension of a current contract or material variation to a current contract.

In the interests of transparency, the register of Procurement decisions, like the register of interests, will be published on the CCG's website at www.shropshiretelfordandwrekinccg.nhs.uk and will be made available on request for inspection at the CCG's headquarters. The registers will also be reported to Audit Committee three times a year, reported twice yearly to the Governing Body and included in the CCG's Annual Report.

Appendix 7: Register of Procurement Decisions

4.12 Designing services and conflicts of interest

The CCG recognises the benefits to be gained from engagement with relevant providers, especially clinicians, in confirming the design of service specifications. However, Monitor's procurement regulations highlights that conflicts of interest can occur if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid for in a competitive process.

The same difficulty could arise in developing a specification for a service that is to be commissioned using the 'Any Qualified Provider' process, such as where there is not a competitive procurement but patients can instead

choose from any qualified provider that wishes to provide the service and can meet NHS standards and prices.

The CCG will seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the way in which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services.

The CCG will seek to follow the principles set out in the Office of Government Commerce guidance on pre-procurement engagement with potential bidders, in engaging with potential providers when designing service specifications. Such engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination, and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent.

The CCG will consider the following points when engaging with potential service providers:

- Use engagement to help shape the requirement but take care not to gear the requirement in favour of any particular provider(s).
- Ensure at all stages that potential providers are aware of how the service will be commissioned, e.g. through competitive procurement or through the 'Any qualified provider' process.
- Work with participants on an equal basis, e.g. ensure openness of access to staff and information.
- Be transparent about procedures.
- Maintain commercial confidentiality of information received from providers.

Engagement with potential providers should be used to:

- frame the requirement;
- focus on desired outcomes rather than specific solutions; and
- consider a range of options for how a service is specified.

Other practical steps the CCG may also consider adopting are:

- Advertise the fact that a service design/re-design exercise is taking place widely (e.g. on NHS Supply2Health) and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions) – i.e. do not be selective in who works on the service specifications unless it is clear conflicts will not occur;
- As the service design develops, engage with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the commissioner's website or workshops with interested parties;

- Use engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s);
- If appropriate, engage the advice of an independent clinical adviser on the design of the service;
- Be transparent about procedures;
- Ensure at all stages that potential providers are aware of how the service will be commissioned;
- Maintain commercial confidentiality of information received from providers; and
- When specifying the service, specify desired (clinical and other) outcomes instead of specific inputs.

Where an individual has declared a relevant and material interest or position in the context of the specification for, or award of, a contract the individual concerned will be expected to act in accordance with the arrangements for the management of conflicts of interest outlined with this policy and may be excluded from the decision making process in relation to the specification or award.

Monitor has issued guidance on the use of provider boards in service design:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284832/ManchesterCaseClosure.pdf

4.13 Commissioning New Care Models

This section addresses the management of conflicts of interest in the changing landscape of the NHS. As this landscape changes and providers/ commissioners develop new models of care consideration of the Conflicts of Interest that may result will be needed. New care models refer to any multi-speciality community provider (MCP), Primary and Acute Care Systems (PACS) or other arrangements of a similar scale or scope that (directly or indirectly) includes primary medical services.

Where the CCG is commissioning new care models, particularly those that include primary medical services, it is likely that there will be some individuals with roles in the CCG (whether clinical or non clinical) that also have roles within a potential provider, or may be affected by decisions relating to new care models. Any conflicts of interest must be identified and appropriately managed, in accordance with statutory guidance and this policy. The position should also be reviewed whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests.

There may be occasions where the conflict of interest is profound and acute, to an extent where the CCG will want to consider whether, practically, such an interest is manageable at all. If an interest is not manageable, the appropriate course of action may be to refuse to allow the circumstances which gave rise to the conflict to persist. This may require an individual to step down from a particular role and/or move to another role

within the CCG and may require the CCG to take action to terminate an appointment if the individual refuses to step down as set out in the table on page 23, level 7 - terminate.

Where a member of CCG staff participating in a meeting has dual roles, for example a role with the CCG and a role with a new care model provider organisation, but it is not considered necessary to exclude them from the whole or any part of a CCG meeting, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes, but where it is appropriate for them to participate in decisions they must only do so if they are acting in their CCG role.

The CCG should identify as soon as possible where staff might be affected by the outcome of a procurement exercise, e.g., they may transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest, and CCGs should ensure they manage the potential conflict. This conflict of interest arises as soon as individuals are able to identify that their role may be personally affected.

Similarly, the CCG should identify and manage potential conflicts of interest where staff are involved in both the contract management of existing contracts, and involved in procurement of related new contracts.

Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed appropriately, in accordance with this statutory guidance, without compromising the CCG's ability to make robust commissioning decisions.

The CCG should consider whether it is appropriate for the Governing Body to take decisions on new care models or (if there are too many conflicted members to make this possible) whether it would be appropriate to refer decisions to a CCG committee. There are a number of options the CCG could consider:

1) The CCG could consider delegating the commissioning and contract management of the entire new care model to its Primary Care Commissioning Committee. This Committee is constituted with a lay and executive majority, and includes a requirement to invite a Local Authority and Healthwatch representative to attend.
2) The establishment of a NCM Commissioning Committee as a sub committee of the Governing Body could help to provide an alternative forum for decisions where it is not possible/appropriate for decisions to be made by the Governing Body due to the existence of multiple conflicts of interest amongst members of the Governing Body.

4.14 Contract Monitoring

The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.

Any contract monitoring meeting needs to consider conflicts of interest as part of the process by the Chair of the contract meeting inviting declarations of interest, record and declared interests in the minutes of the meeting (see Appendix 5); and manager any conflicts appropriately and in line with this guidance. This applies equally where a contract is held jointly with another organisation such as the Local Authority or with other CCGs under co-ordinating commissioner arrangements.

The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

Commissioning Leads should be mindful of any potential conflicts of interest when they disseminate any contract or performance information/reports on providers, and manage the risk appropriately.

4.15 Specific safeguards for managing conflicts of interest for General Practices that are potential providers of CCG-commissioned services

The CCG may commission primary care services, including incentive schemes, from General Practices. If a General Practice, or group of practices, provides a service, the CCG will need to demonstrate to the Audit Committee (and to the external and internal auditors) that the service:

a) clearly meets local health needs, and has been planned appropriately;

b) goes beyond the scope of the GMS / PMS contract;

c) offers best value for money; and

d) has been commissioned via the appropriate procurement process.

A General Practice or group of practices may belong to a provider consortium in which GPs have a financial interest.

Where General Practices are potential providers of CCG-commissioned services, the NHS Commissioning Board's Code of Conduct for managing conflicts of interest should be followed (Appendix 8) and the procurement should be approved by the Audit Committee.

Appendix 8: Code of Conduct template

4.16 Specific safeguards for managing conflicts of interest for contractors and people who provide services directly to the CCG

Anyone participating in the procurement, or otherwise engaging with CCG, in relation to the provision of services or facilities, will be required to make a declaration of any conflict or potential conflict of interest.

The Commissioning Lead overseeing a procurement process should ensure that the CSU Procurement team seeks declarations of interest from potential bidders/contractors in the procurement process (Appendix 9), with the original signed declaration of interest held by the CSU Procurement team.

Anyone contracted to provide services or facilities directly to the CCG will be subject to the same provisions of the Constitution in relation to managing conflicts of interests. This will include services provided by external organisations like Commissioning Support Services, private businesses, and third sector/non profit organisations. This requirement will be set out in the contract for services. Contractors will be required to make a declaration on form included as Appendix 9, which will need to be returned to the CSU Procurement Team.

Appendix 9: Declaration of conflicts of interest for bidders/contractors template

5 Raising Concerns and Reporting Breaches

Failure to comply with the CCG's policy on conflicts of interest could result in the CCG facing civil challenges to decisions they make which could delay development of better services for patients. In extreme cases staff and other individuals could face personal civil liability e.g. a claim of misfeasance in public office. Failure to manage conflicts of interest could also lead to criminal proceedings including for offences such as fraud, bribery and corruption. The Conflicts of Interest Policy should be read in conjunction with the CCG's Declaration of Gifts, Hospitality and Sponsorship – Anti Bribery Policy and Procedure and Counter Fraud and Corruption response Policy.

It is therefore the duty of every CCG employee, Governing Body member, committee or sub-committee member and GP practice member to speak up about genuine concerns in relation to the administration of the CCG's policy on conflicts of interest management and to report these concerns to the Conflicts of Interest Guardian or the Director of Corporate Affairs who will investigate.

However, where an individual wishes to have their concern dealt with in confidence, non compliance or suspected non-compliance with the Conflicts of Interest Policy should be reported in the first instance to the Director of Corporate Affairs, following the CCG's Raising Concerns at Work Policy. If anyone wishes to report non compliance who is not an employee of the CCG and they wish it to be treated confidentially then they should ensure that they follow their own organisation's Whistleblowing Policy. The procedure for investigation and reporting back is set out in the CCG's Raising Concerns at Work Policy which can be found on the CCG's website.

Following investigation, an anonymous report would be presented to the CCG's Audit Committee, together with an action plan and/or areas for lessons learnt to be disseminated.

In those cases where the breach is of such a material nature that it requires an HR investigation, the Director of Corporate Affairs will liaise with HR on evoking processes under the CCG's Disciplinary Policy. In these

circumstances the Accountable Officer will inform The Area Director at NHS England Midlands and East.

In addition to the reporting mechanisms described above, patients and other third parties can make a complaint to NHS Improvement in relation to a commissioner's conduct under the Procurement Patient Choice and Competition Regulations. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

Any suspicions or concerns of acts of fraud, bribery or corruption should be reported to the CCG's nominated Counter Fraud Specialist:

- Mr Paul Westwood, Counter Fraud Specialist
- Telephone 07545 502400
- Email paul.westwood@cwaudit.org.uk
  or secure email pwestwood@nhs.net

Or CCG's Fraud Champion:

- Mrs Laura Clare, Deputy Director of Finance
- Telephone 07808 159217
- Email laura.clare@nhs.net

Alternatively any suspicions or concerns of acts of fraud, bribery and/or corruption can be reported online via https://cfa.nhs.uk/reportfraud or via the NHS Fraud and Corruption reporting line on 0800 028 4060.
Anonymised details of breaches will be published on the CCG's website for the purpose of learning and development.

6 Breaches of the Policy

6.1 If any individual fails to declare an interest or the full details of the interest, this may result in disciplinary action resulting in the individual being dismissed or removed from their role.

6.2 Any unwitting failure to declare a relevant and material interest or position of influence, and/or to record a relevant or material interest or position of influence that has been declared, will not necessarily render void any decision made by the CCG or its properly constituted committees and sub-committees, although the CCG will reserve the right to declare such a contract void.

7 Related Documents

The following documents contain information that relates to this policy:

- NHS Shropshire, Telford and Wrekin CCG Constitution
- NHS Shropshire, Telford and Wrekin CCG Standing Orders, Scheme of Reservation and Delegation of Powers and Prime Financial Polices
- Declarations of Gifts, Hospitality and Sponsorship - Anti-Bribery Policy and Procedure

- Counter Fraud and Corruption Response Policy
- Raising Concerns at Work Policy
- NHS England's Managing Conflicts of Interest: Revised Statutory Guidance for CCGs gateway reference 06768 16/06/17

8 Dissemination

This policy will be disseminated by the following methods:

- Publication on the CCG website and intranet site

Staff:

- Staff bulletin with declaration of interest form attached for completion.
- Directors/line managers to raise awareness of the policy via staff briefings.

Governing Body members:

- Email circulated by the Director of Corporate Affairs to highlight the new policy and ask for any amended interests to be declared.

CCG members:

- Awareness raising at Locality Boards by the Chair of the CCG.
- Letter from Chair to Locality Board's GP/Practice Manager representatives, asking them to read the policy and make the necessary declarations of interest.

9 Training and Advice

Training will be provided on an annual basis via an online training package provided by NHS England.

Advice on declaration of interests can be sought from the following people:

Alison Smith
Director of Corporate Affairs
NHS Shropshire, Telford and Wrekin CCG
Halesfield 6
Telford
TF7 4BF
Tel: 01952 580464
Email: alison.smith112@nhs.net

Geoff Braden
Lay Member - Audit
Conflicts of Interest Guardian
NHS Shropshire, Telford and Wrekin CCG
Halesfield 6
Telford TF7 4BF
Tel: 01952 580464
Email: g.braden@nhs.net

10 Review and Compliance Monitoring

10.1 Review

An annual review of the policy will be undertaken by Internal Audit as part of their audit plan. The outcomes will be reported in the CCG's Annual Governance Statement which forms part of the CCG's Annual Report.

10.2 Compliance Monitoring

The Audit Committee will require assurance annually on compliance with the policy as part of its assurance programme.

Appendix 1

First report of the Committee on Standards in Public Life (1995) The Nolan Principles:

Selflessness – holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness – holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – holders of public office should promote and support these principles by leadership and example.

Appendix 2

Declaration of Interest Form for Employees and Members

Name:	
Relevant CCG(s):	
Position within, or relationship with, the CCG (or NHS England in the event of joint committees):	

Detail of interests held (complete all that are applicable). If there are no interests please indicate a 'nil' response:

Type of Interest* *See reverse of form for details	Description of Interest (including, for Indirect Interests, details of the relationship with the person who has the interest)	Date interest Relates from and to:		Actions to be taken to mitigate risk (to be agreed with line manager)
		From	To	

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisations' policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and, in the case of decision making staff' (as defined in the statutory guidance on managing conflicts of interest for CCGs) may be published in registers that the CCG hold.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.. The information detailed on this signed declaration can be used by the CCG's Counter Fraud Team for the purposes of investigation, sanction and redress.

Decision making staff should be aware that the information provided in this form will be added to the CCG's register which are held in hardcopy for inspection by the public and published on the CCG's website. Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will held in hardcopy for inspection by the public and published on the CCG's website and must inform the third party that the CCGs' privacy policy is available on the CCGs' website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

This paragraph applies to decision making staff only (if not applicable please indicate in box below)
I **do / do not [*delete as applicable*]** give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons in the box below:

Employee/Member Signature:

Signature:_____ **Position**:_____ **Date**:_____

Line Manager or Senior CCG Manager

Signature:_____ **Position**:_____ **Date**:_____

Please return to Tracy Eggby-Jones, Corporate Affairs Manager, NHS Shropshire, Telford and Wrekin CCG, Halesfield 6, Telford, TF7 4BF or via e-mail tracy.eggby-jones@nhs.net

Types of interest

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment (see paragraph 56 to 57); • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Appendix 3

Register of Interests for CCG Members and Employees

Name	Current position (s) held in the CCG i.e. Governing Body member; Committee member; Member practice; CCG employee or other	Declared Interest (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	

Appendix 4

Declaration of interests Checklist for Chairs

Timing	Checklist
In advance of the meeting	• Check agenda has standing item for declarations of Interest and states a definition of a conflict of interest • Check the register of interests to establish any actual or potential conflicts of interest that may occur in the meeting from the public register held on the CCG website
During the meeting	• Check and declare the meeting is quorate • Chair requests members to (1) declare any interests in specific agenda items – stating what conflict has arisen and (2) any new interests that may not have been declared previously, and if they conflict with a specific agenda item. • Chair makes decision as to how to manage each interest which has been declared, either (1) following the prescribed mitigating action outlined in the register of interests for interests already declared on the register or (2) determining for interests newly declared in the meeting, whether /to what extent the individual member should continue to participate in the meeting and that this decision is recorded and actioned.
Following the meeting	• Check that all new interests declared in the meeting are promptly updated onto a declaration form and transferred onto the register of interests by the Director of Corporate Affairs. • Report what action was taken in relation to a conflicts of interest arising at the meeting or where a conflict of interest has affected quoracy in the Chair's report to the Governing Body or to the meeting's parent Committee.

Appendix 5

Template for recording minutes

***XXXX* Clinical Commissioning Group**
Primary Care Commissioning Committee Meeting

Date: ***XXXXXXX***
Time: ***XXXXXXX***
Location: ***XXXXXXX***

Attendees:

Name	Initials	Role
XXXXXX	XX	XXX CCG Governing Body Lay Member (Chair)
XXXXXX	XX	XXX CCG Audit Chair Lay Member
XXXXXX	XX	XXX CCG PPI Lay Member
XXXXXX	XX	Assistant Head of Finance
XXXXXX	XX	Interim Head of Localities
XXXXXX	XX	Secondary Care Doctor
XXXXXX	XX	Chief Clinical Officer
XXXXXX	XX	Chief Executive – Local Healthwatch

In attendance from 2.35pm

XXXXXX	XX	Primary Care Development Director

Item No	Agenda Item	Actions
1	**Chairs welcome**	
2	**Apologies for absence** <apologies to be noted>	
3	**Declarations of interest** *XX reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of XXX clinical commissioning group.* *Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link: http://xxxccg.nhs.uk/about-xxx-ccg/who-we-are/our -governing-body/* **Declarations of interest from sub committees.** *None declared*	

	Declarations of interest from today's meeting *The following update was received at the meeting:* • *With reference to business to be discussed at this meeting, XX declared that he is a shareholder in XXX Care Ltd.* *XX declared that the meeting is quorate and that XX would not be included in any discussions on agenda item X due to a direct conflict of interest which could potentially lead to financial gain for XX.* *XX and XX discussed the conflict of interest, which is recorded on the register of interest, before the meeting and XX agreed to remove himself from the table and not be involved in the discussion around agenda item X.*	
4	**Minutes of the last meeting** *<date to be inserted>* ***and matters arising***	
5	**Agenda Item** *<Note the agenda item>* *XX left the meeting, excluding himself from the discussion regarding xx.* ***<conclude decision has been made>*** ***<Note the agenda item xx>*** *XX was brought back into the meeting.*	
6	**Any other business**	
7	**Date and time of the next meeting**	

Appendix 6

Procurement declaration of Interest (Project Team)
NHS Shropshire, Telford and Wrekin Clinical Commissioning Group

[INSERT PROJECT TITLE AND CCG NAME]
TENDER REF: [INSERT REF]

PART 1 – CONFLICT OF INTEREST DECLARATION

Name & Organisation:

Name:-	
Title:-	
Organisation:-	
Date:-	

Project Role:

Nature of Conflict (please state "none" if no conflict exists):

Signed:	

Summary Assessment / Recommendation (to be completed by Project Manager)

This person's involvement in the project [should cease/can continue]:-

Signed:-	
Name:-	
Date:-	

[INSERT PROJECT TITLE AND CCG NAME]
TENDER REF: [INSERT REF]

PART 2 – CONFIDENTIALTY UNDERTAKING

Name & Organisation:

Name:-	
Title:-	
Organisation:-	
Date:-	

Project Role:

I understand that I may be invited to participate either directly or indirectly in the procurement process and hereby undertake:

- To treat all information and documents under conditions of strict confidentiality.
- Not to disclose, make any copies of, or discuss any received information with any person who is not directly involved in the procurement process.
- Not to use (or authorise any other person to use) information and documents other than for the purpose of my work in connection with the procurement process.
- To dispose of, or return to the project manager, documents as confidential material as soon as I have no further use of them.

This undertaking applies until the time when the tendering process is complete and a contract signed with the chosen supplier. This undertaking shall not apply to any document or information that becomes public knowledge otherwise than as a result of a breach of any of the above undertakings.

Signed:	
Date:-	

Notes and Guidance

The commissioner is required to ensure that any procurement exercise is undertaken in such a way that ensures:

- Transparency – procurement activities must be fair and open.
- Objectivity – decisions must be based on objective data and criteria.
- Non-discrimination – the procurement process must not discriminate amongst providers.

In support of the above, the commissioner requires that any individual involved in procurement exercise signs up to a conflict of interest and confidentiality undertaking.

Both parts should be completed. All pages should be dated and signed. If the document is completed by hand please ensure that the information required is presented clearly.

1. Notes - Conflict of Interest Declaration

Examples of conflicts of interest include:

- Having a financial interest (e.g. holding shares or options) in a Potential Bidder or any entity involved in any bidding consortium including where such entity is a provider of primary care services or any employee or officer thereof (Bidder Party);
- Having a financial or any other personal interest in the outcome of the Evaluation Process;
- Being employed by or providing services to any Bidder Party;
- Receiving any kind of monetary or non-monetary payment or incentive (including hospitality) from any Bidder Party or its representatives;
- Canvassing, or negotiating with, any person with a view to entering into any of the arrangements outlined above;
- Having a close member of your family who falls into any of the categories outlined above; and
- Having any other close relationship (current or historical) with any Bidder Party.

The above is a non-exhaustive list of examples, and it is the participant's responsibility to ensure that any and all potential conflicts – whether or not of the type listed above – are disclosed in the declaration prior to participation in the procurement process.

Any disclosure will be assessed by the commissioner on a case-by-case basis. Individuals will be excluded from the procurement process where the identified conflict is in the commissioner's opinion material and cannot be mitigated or be reasonably dealt with in another way.

2. Notes – Confidentiality Undertaking

The procurement process encompasses any formal and informal meetings, associated discussions, meeting preparation and follow up or any other related activity.

Information means all information, facts, data and other matters of which knowledge is acquired, either directly or indirectly, as a result of participating in the procurement process.

Documents means all draft, preparatory information, documents and any other material, together with any information contained therein, to which the participant has access, either directly or indirectly, as a result of participation in the procurement process. Furthermore, any records or notes made by the participant relating to information or documents shall be treated as confidential documents.

Staffordshire and Lancashire CSU
Anglesey House
Towers Business Park
Rugeley
Staffordshire
WS15 1UL

Appendix 7

Template: Procurement decisions and contracts awarded

Ref No	Contract/ Service title	Procurement description	Existing contract or new procurement (if existing include details)	Procurement type – CCG procurement, collaborative procurement with partners	CCG clinical lead (Name)	CCG contract manger (Name)	Decision making process and name of decision making committee	Summary of conflicts of interest noted	Actions to mitigate conflicts of interest	Justification for actions to mitigate conflicts of interest	Contract awarded (supplier name & registered address)	Contract value (£) (Total) and value to CCG	Comments to note

Appendix 8

Code of Conduct Template

Service:	
Question	**Comment/ Evidence**
1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations?	
2. How have you involved the public in the decision to commission this service?	
3. What range of health professionals have been involved in designing the proposed service?	
4. What range of potential providers have been involved in considering the proposals?	
5. How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
6. What are the proposals for monitoring the quality of the service?	
7. What systems will there be to monitor and publish data on referral patterns?	
8. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?	
9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?	
10. Why have you chosen this procurement route e.g., single action tender?[2]	

[2]Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).

11. What additional external involvement will there be in scrutinising the proposed decisions?	
12. How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
13. How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	
Additional questions for proposed direct awards to GP providers	
15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
16. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
17. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

Appendix 9

Template Declaration of conflict of interests for bidders/contractors

Name of Organisation:	
Details of interests held:	
Type of Interest	**Details**
Provision of services or other work for the CCG or NHS England	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person	[*complete for all Relevant Persons*]	
Details of interests held:		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Provision of services or other work for the CCG or NHS England		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		

Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions		

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

The information detailed on this signed declaration can be used by the CCG's Counter Fraud Team for the purposes of investigation, sanction and redress.

Signed: …….

On behalf of: …….

Date: …….

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Health and Safety Policy

Author(s) (name and post):	Sarah Hunter – Health, Safety, Fire & Security Officer
Version No.:	Version 1.0
Approval Date:	May 2021
Review Date:	May 2023

Document Control Sheet

Title:	Health and Safety Policy		
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Equality Impact Assessment:			
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Document Amendment History

Version No.	Date	Brief Description

The formally approved version of this document is that held on the NHS Shropshire, Telford and Wrekin CCG website: www.shropshiretelfordandwrekinccg.nhs.uk

Printed copies or those saved electronically must be checked to ensure they match the current online version.

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1 Introduction

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (STW CCG) attaches great importance to the health and safety, welfare and security of its entire staff, and recognises its legal obligations under the Health and Safety at Work Act 1974 and other relevant legislation, to ensure the health, safety and welfare of its staff, so far as is reasonably practicable. STW CCG also accepts such responsibility for other persons who may be affected by its activities whilst on any of its sites or conducting activities on its behalf.

Work can make a positive or negative contribution to an individual's health. Organisations that successfully manage health and safety recognise the relationship between the control of risks and the core business objectives plus the important contribution which employees and their representatives can make to improve health and safety.

STW CCG, in adopting a positive pro-active stance on health and safety aims to promote an accountable culture which is just and fair to its employees and enables the CCG to learn from incident reports and risk assessments in order to continuously improve its health and safety management and where necessary, change policy/procedure to enable this to happen.

This policy will set out the CCG's arrangements for health and safety and follow the recognised standard of HSG65 for all health and safety related policies, this safety model includes Plan, Do, Check and Act.

2 Purpose/Scope

This policy applies to all employees of STW CCG including agency, contracted, and sub-contracted staff. Managers at all levels are expected to take an active lead to ensure that health and safety and systems of internal controls are of the highest standard and integral to the operation of the organisation.

STW CCG will ensure that adequate resources are provided to meet legal health and safety standards and provide sufficient information, instruction and training to enable employees, independent contractors, bank and agency staff to carry out their work safely.

STW CCG's Health and Safety objectives are to:

- Comply with all relevant Health and Safety Legislation, Approved Codes of Practices (ACOP), Guidance Notes and other relevant standards.
- Integrate Health and Safety principles into service delivery, management and decision making processes.
- Consult and Communicate with employees and trade union representatives to ensure they are all aware of their health and safety responsibilities.
- Strive for continuous improvement in health and safety standards.
- Recognise the different demands that the CCG faces and work to deliver a consistent approach to managing health and safety.

To achieve these objectives the CCG will:

- Develop and maintain a documented and consistently applied health and safety management system including clear roles, responsibilities, and clear reporting lines.
- So far as is reasonably practicable, provide and maintain healthy and safe workplaces, equipment and methods of working.
- Provide sufficient resources to meet our commitment to health and safety.
- Appoint competent persons to support us in meeting our statutory duties.
- Provide employees at all levels with suitable and sufficient information, instruction, training and supervision to enable them to work safely and avoid any actions that may adversely affect the health and safety of themselves or others.
- Work with partners, stakeholders, external contractors and other agencies to develop awareness, a common understanding and promote good standards of health and safety.
- Undertake continuous monitoring of our health and safety performance.

3 Responsibilities

In order to ensure that health and safety is successfully managed within the CCG, clear lines of responsibility and accountability to ensure a positive health and safety culture is fostered by the visible and active leadership of senior management.

3.1 The Accountable Officer

The Accountable Officer has overall accountability and responsibility for all matters involving health, safety, welfare and fire appertaining to STW CCG; it is also the responsibility of all Heads of Service and Managers to manage health and safety issues within their functional area.

The Accountable Officer in turn, nominates the Director of Corporate Affairs as the nominated Officer with delegated authority to ensure the implementation of the Health and Safety Policy.

A signed statement of intent can be found at Appendix 1 and all staff are required to read and understand this policy.

3.2 Executive Directors, Community Health Services Managing Director and Deputy Directors

Executive Directors and Deputy Directors will support the Accountable Officer and carry direct responsibility for the implementation of Health and Safety related policies within their areas of control. They will do all that is reasonably practicable to establish and maintain high standards of health, safety and welfare in their areas of control.

3.3 Specialist Staff

The Director of Corporate Affairs will act as the 'competent person' as defined in the Management of Health and Safety at Work Regulations 1999, in all matters of health and safety that directly affects STW CCG and its employees.

Has the responsibilities to:

- Identify and assess health and safety risk arising from the CCG's organisational, commercial and service delivery policies, strategies, its operations and supply chains.
- Identify health and safety risks arising from corporate policy and strategy.
- Ensure that health and safety risks arising from the CCG's activities are assessed and reviewed.
- Prioritise health and safety risks according to how they affect the CCG.
- Make sure a range of options to control identified health and safety risks are considered and decision criteria are suitable.
- Specify health and safety controls and maintain the HSMS.
- Promote best practices in the application of the CCG's Health and Safety Policy, Procedures and Health & Safety projects and support the development of relevant knowledge and skills.
- Monitor and evaluate health and safety performance to ensure it is consistent with STW CCG's Health & Safety Policy, Procedures and Health & Safety projects and that the organisation learns from experience.

Health and Safety (Fire) and Security Officer (MLCSU)

The MLCSU Health Safety (Fire) & Security Officer will support as a 'competent person' as defined in the Management of Health and Safety at Work Regulations 1999, in all matters of health and safety that directly affects STW CCG and its employees.

The Health and Safety Officer will;

- Provide professional advice and information to the CCG on health and safety responsibilities, legislation, and good practice.
- Review all new health and safety legislation and guidance and advise senior management on their responsibilities, the impact of any changes and additional measures that need to be taken.
- Advise the Leadership Team and managers on the health and safety implications of any unsatisfactory working conditions for CCG employees.
- Assist in the continuous development of a proactive approach to all health and safety matters that affect the CCG and its undertakings.
- Advise and assist the Managing Director, Directors, Function Leads, Managers and Staff to establish Corporate Health and Safety policies/procedures/guidance and priorities.
- Develop and actively maintain a close working relationship with CCG management and employees on all matters pertaining to health and safety at work.
- Assist with any required Health and Safety related training.

- Promote and advise on the process of systematic hazard identification and risk assessment throughout the CCG and advise managers on the undertaking of risk assessments in relation to their work activities.
- Notify the Health & Safety Executive as required by Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- Assist managers in the investigation of serious incidents, accidents and monitor and report information on incident trends;
- Develop and implement suitable health and safety monitoring systems, including auditing and sample inspections, to monitor health and safety standards and compliance with CCG health and safety policies.
- Liaise with the appropriate enforcing authorities (such as the HSE, Fire Authority, CQC etc.) on all matters concerning the health and safety of CCG employees and CCG premises.
- In conjunction with Managers monitor the health and safety standards of contractors working on behalf of the CCG.

3.4 Line Managers

All managers are responsible for ensuring that health and safety is an integral part of the
management process within their areas of responsibility.

All managers have the responsibility to:

- Ensure that the CCG's Health & Safety Policy, and its requirements are understood and met by all employees.
- Ensure all employees have induction and instruction emphasising health, safety, security and welfare aspects of all operations.
- Promote a positive and proactive approach to Health and Safety.
- Ensure risk assessments are undertaken for work activities they control, in consultation with their employees. This includes identifying the hazards, those at risk and how they could be harmed.
- Develop, implement and review safe working practices to satisfy themselves that appropriate and sufficient control measures are in place to remove or reduce any identified risks to as low as is reasonably practicable.
- Ensure that they and their employees have adequate levels of training, instruction and supervision to work safely with minimal risk to themselves or others.
- Ensure that emergency and evacuation procedures, especially means of escape in the event of fire, are known to all staff, contractors, volunteers, visitors and customers and that escape routes are kept free from obstructions.
- Ensure employees report all accidents and incidents and that methods to prevent a recurrence are implemented through investigation.

3.5 All Staff

All staff employed and contracted by STW CCG have the following responsibilities:

- To read and understand the CCG's Health and Safety Policy, Procedures and Guidance documents that are relevant to their activities and perform their work in accordance with the requirement of these.

- Comply with all relevant legislation, CCG policies and procedures, complete mandatory and statutory training, and report untoward incidents or unsafe occurrences.
- Work in a safe manner at all times, follow procedures that are in place and take reasonable care of their own safety and the safety of others who may be affected by their acts or omissions.
- Know all the emergency procedures which may apply to the premises and familiarise themselves with fire alarm activation systems and escape routes;

All staff also have a responsibility for bringing to the immediate attention of their manager any failings that could be detrimental to themselves and others, including visitors/service users.

3.6 The Governing Body

Overall and final responsibility for health and safety performance, and legal compliance lies with the Governing Body who has given delegated authority to the Audit Committee to make decisions on its behalf as set out in the Scheme of Reservation and Delegation. The Audit Committee will receive and review regular reports on progress.

3.7 Committees and Groups

Health and safety performance will be measured by the MLSCU Health & Safety Officer and reported back to the Audit Committee on a quarterly basis by:

- Monitoring corporate performance standards.
- Regular auditing and undertaking inspections.
- Accident/incident reporting and investigation.

4 Procedures / Processes

4.1 Risk Assessments

The Management of Health and Safety at Work Regulations 1999 make more explicit the general duties placed on the CCG under the Health and Safety at Work Act 1974. In order to meet with the regulatory requirements, the CCG will ensure:

- Risk assessments are carried out in order to evaluate and adequately control hazards, so to ensure the health, safety and welfare of employees, and others who may be affected by work activities of the CCG.
- Risk assessments are recorded in writing, on the appropriate form (available from CCG Staff Intranet)
- Arrangements will be made for putting into practice the preventative and protective measures that follow from the risk assessment.
- Risk assessments will be regularly monitored and reviewed to ensure they remain ‘live’ documents. They will be updated in accordance with legislative requirements, Standards, Codes of Practice etc.
- The outcomes of risk assessments will be readily available and communicated to staff. Staff will receive instructions and/or training associated with the level of risk identified and the control measures taken to prevent or control risks.

4.2 Accident and Incident Reporting

In the event of an accident/incident staff will ensure that a detailed entry of the event is recorded on an accident form (available from CCG Staff Intranet) and sent to the Corporate Affairs Manager and will also notify their line manager who will subsequently determine, in conjunction with the MLCSU Health & Safety Officer, if notification is required under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

Where an accident/incident has occurred, it is necessary to carry out a review of the risk assessment of the task being undertaken at the time (where applicable), to ascertain if additional precautions, an alteration of the method of work or additional control measures are necessary. This must be written down and the conclusions clearly defined and acted upon. As a learning organisation we will use the information to prevent re-occurrences, where reasonably practicable, to the same events.

4.3 Health and Safety Representatives and Consultation

Mangers should strive to have in place arrangements to consult with staff on matters of health and safety. Where Health & Safety representatives are in place, whether they are Trade Union or non-Trade Union appointments, full co-operation should be given to the requirements of their role in the workplace.

The duties of Health and Safety representatives are, to a degree, job, and work area specific with a common theme of ensuring the environment is as safe as is reasonably possible and protecting their colleagues from harm.

Any member of staff may make representation to Safety Representatives or Staff Representatives on any matter relating to their Health, Safety or Welfare.

5 Related Documents

The overall corporate Health and Safety Policy is supported by a number of other operational policies/procedures that provide more detailed guidance on certain aspects of health and safety. These documents do not supersede this policy but should be read in conjunction with it. These documents are all available on the CCG Staff intranet.

A list of supporting policies/procedures are:

- Fire Safety Policy
- Display Screen Equipment Policy
- First Aid Policy
- Health and Wellbeing Management Policy
- Incident Reporting Procedure
- Lone Working Policy
- Managing Challenging Behaviour Policy
- Office Safety Procedure
- Safe Driving at Work Policy
- Security Policy

6 Dissemination

For health and safety management to be effective within the organisation, this strategy must become a living document and a natural "part of everyday working practice".

A structured and supportive approach for the implementation of this strategy will demonstrate STW CCG's commitment that all staff are taking positive steps and working in partnership with each other and stakeholders to provide a positive health and safety culture within the organisation.

To achieve this, the Health and Safety Policy will be;

- Approved by STW CCG's Audit Committee and reviewed every 2 years unless there is a change in legislation or guidance or through lessons learnt.
- Circulated to all Managers, with specific responsibilities detailed in the document.
- Available electronically on the CCG's shared drive and via the CCG's staff intranet.
- Available to all stakeholders on request (in an appropriate format).

It is a legal requirement that a Health and Safety poster (Health and Safety Law "*What You Need to Know*" HSE (2008)) is displayed in every workplace area that employees have access to that outlines British Health and Safety law.

7 Advice and Training

7.1 Advice

Any employee who has concerns about any aspect of health and safety management within the CCG or the services it provides, should raise the issue, firstly, with their line manager or failing that with the CCG's Health and Safety Support.

Contact details

Mark Jump Health & Safety (Fire) and Security Manager – 07771996217
Sarah Hunter – Health and Safety (Fire) and Security Officer – 07919303749

7.2 Training

Health and Safety training is a statutory requirement of legislation and therefore mandatory for all staff of STW CCG. Provision will be made to ensure staff receive adequate information, instruction and training with respect to Health and Safety where appropriate. All new permanent employees must receive an Induction to include Health, Safety, Welfare, Fire and Security procedures and arrangements.

8 Review and Compliance Monitoring

8.1 Review

The Audit Committee has responsibility for ensuring that health and safety performance is reviewed and will ensure that regular progress reports are presented to the Governing Body.

8.2 Compliance Monitoring

The Audit Committee has responsibility for monitoring the effectiveness of the Health and Safety Policy and will ensure that regular progress reports are presented to the Governing Body.

9 References

- The Health and Safety at Work Act 1974;
- The Management of Health and Safety at Work Regulations 1999;
- The Workplace (Health, Safety & Welfare) Regulations 1992;
- The Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- The Health and Safety Information for Employees Regulations 1989;
- The Safety Representatives and Safety Committees Regulations 1977 (as amended);
- The Health and Safety (Consultation with Employees) Regulations 1996 (as amended);
- Equality Act 2010;
- HSE Successful Health and Safety Management (HSG 65).

Appendix 1

GENERAL STATEMENT OF HEALTH AND SAFETY POLICY

Philosophy

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (STW CCG) is committed to providing a safe and healthy working environment for all its employees and regards health and safety as a matter of the utmost importance. An effective policy enhances business performance, reduces injuries and ill health, protects the environment and reduces unnecessary losses and liability. It follows that minimising risk to employees, visitors, and property is inseparable from all other business objectives.

General Statement of Policy

The CCG, as an employer, is committed to ensuring the health, safety and welfare of its employees, so far as is reasonably practicable. We also fully accept our responsibility for other persons who may be affected by our activities and we will take steps to ensure that our statutory duties are met at all times. The Executive Team expects all staff, visitors, contractors and other employers who work at the CCG to share this commitment by complying with the CCG policies and procedures, and to understand that they too have legal and moral obligations to themselves and to one another.

We intend to ensure the health and safety of all persons who may be affected by our activities are maintained by ensuring that, in so far as is reasonably practicable:

- A safe working environment is provided, along with adequate welfare arrangements and facilities;
- Identifying hazards and conducting formal risk assessments when appropriate in order to minimise the risk for all activities undertaken by the CCG;
- All systems of work are safe and without unnecessary risks to health and safety;
- Providing, managing and maintaining plant and equipment so that it is, so far as reasonably practicable, safe and that risks to health are controlled;
- Ensuring that control measures and emergency procedures are: in place; effective ; properly used; monitored and maintained;
- Provide suitable and sufficient information, instruction, training and supervision at all levels necessary to ensure that staff are competent to undertake their work activities;
- Consulting with and involving our staff in matters relating to their own health and safety;
- Keeping up to date with best practice in relation to health and safety and complying with all relevant legislation and authoritative guidance.
- Contractors & Providers undertaking work on behalf of the CCG, are competent to do so;

The CCG will undertake to continually review and develop our safety management systems, with the overarching aim of conducting our activities in a manner which does not affect the health and safety of any staff, contractors, visitors or members of the public.

I and the other members of the Executive Team are committed to this Policy and to the implementation and maintenance of the highest standards of health, safety and welfare within the CCG. We expect every member of the CCG to share this commitment and to work together to achieve it.

Signature of Managing Director: _____

Printed Name: _____ **Date:** _____

Appendix 2

CCG Health & Safety Risk Assessment

(See Guidance Document on Staff Portal for assistance in completing this risk assessment)

Location / Site		**Date**		**Completed By**	
Activity		**RA. Number**		**Reviewed By**	
Persons at Risk		**Review Date**			

Hazard	Existing Control Measures	Initial Risk* (see matrix box below for explanation of L,C,R)			What further actions need to be done to reduce the risk?	Who needs to do it and by when?	New Risk Rating	Date Completed
		L	C	R				

Incident and Risk Assessment Matrix

L= Likelihood Score (How likely is it that the Hazard will Occur?)

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occcur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<1%	1 – 5%	6 – 20%	21 – 50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	Will almost certainly occur

C= Consequence Score (What would be the consequence if the Hazard did occur?)

Consequence Scoring	1 - Insignificant	2 - Minor	3 – Moderate	4 - Major	5 - Catastrophic
Staff , Visitors	Minimal injury requiring no/minimal intervention. No time off work.	Minor injury or illness; Time off work>3 days;	Injury requiring professional intervention; RIDDOR Reportable Time off work 1 – 4 days.	Major Injury leading to long term disability; Time of work >14 days	Incident leading to death; Permanent injuries or irreversible health effects.

R= Risk Rating Matrix(Multiply L score by C score to get risk rating e.g 2x2=4)

Likelihood	Consequence				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 – Rare	1	2	3	4	5
2 – Unlikely	2	4	6	8	10
3 – Possible	3	6	9	12	15
4 – Likely	4	8	12	16	20
5 – Almost Certain	5	10	15	20	25

Very Low Risk — **Unlikely to cause problems**

Low Risk — **Needs to be resolved or accepted at Departmental level***

Medium Risk — **Needs to be resolved or accepted at Directorate level***

High Risk — **To be resolved or accepted at Trust level**

***If the Risk is not acceptable or cannot be resolved at the appropriate level, it needs to be fed to the next level.**

Appendix 3

Manual Handling Procedure

1 Introduction

Manual handling injuries can occur wherever people are at work, including office and agile environments. Heavy manual labour, awkward postures, equipment handling and previous or existing injury are all risk factors implicated in the development of musculoskeletal disorders.

Statistics show that manual handling of hazardous loads is one of the most common causes of absence due to injury in the workplace. This procedure outlines the measures that must be taken by both managers and employees to reduce the risk of injuries being incurred and sets out guidance for the moving and handling of loads.

2 Definitions

Manual Handling is defined as “any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving) by hand or bodily force”. Regulation 2(1) Manual Handling Operations Regulations 1992 (as amended) 2002.

3 Roles & Responsibilities

Responsibilities of all staff:

Where hazardous handling tasks cannot be avoided a suitable and sufficient risk assessment should be made taking into account:

- The nature of the task
- The nature of the load
- The capabilities of the individuals involved in the task
- The working environment
- Provision, maintenance and suitability of equipment

A risk assessment should be used to implement control measures that eliminate or, where this is not possible, to reduce the risk of injury to the lowest level reasonably practicable. Accidents and incidents must be reported immediately in compliance with Incident Reporting procedures and treatment/advice sought in the case of injury.

Any employee aware of a health problem or condition, whether or not due to injury which may affect their required manual handling capabilities must report this directly to their manager or refer to the Occupational Health provider if further advice or support is required. Employees who do not carry out safe manual handling techniques, as identified within the LMS training programmes, but carry out unsafe techniques which increases the risk of injury to themselves and others, may be subject to disciplinary action in line with the CCG's Disciplinary Policy.

Managers responsibilities:

Managers must ensure that all manual handling incidents are reported immediately in compliance with the CCG's Incident Reporting System and that appropriate investigations are undertaken.

Managers must ensure that staff carry out their manual handling training via the Learning Management System eLearning tool. If required, further training must be given to staff whose roles require instruction in the use and maintenance of specialised manual handling equipment where provided in the workplace.

Managers are responsible for ensuring that risk assessments are conducted where staff are asked to conduct moving and lifting tasks as part of their job role.

4 Training

Initial mandatory manual handling training will be provided through Learning Management e-learning System.

All new employees must receive training at the first opportunity following appointment if they are unable to provide a record and details of previous training which satisfy the requirements of the CCG. Staff will receive refresher training as necessary. Staff may also be asked to attend further training if new risks are identified or if there are significant changes to the manual handling requirements of their specific role.

All managers must ensure that any staff whose roles require moving or lifting tasks on a daily basis must provide these staff with further face to face manual handling training. A risk assessment will determine the requirement of this training. M&LCSU Health & Safety Department can assist in this training.

5 Monitoring

Manual handling instruction is regarded by the CCG as mandatory training and considers it to be an integral part of the risk management process and all staff must complete on-line training (or attend a course if applicable) when required to do so. Compliance will therefore be monitored through the electronic staff records.

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There is further information available from the Health & Safety Executive website https://www.hse.gov.uk/msd/manual-handling/index.htm

or you can contact your Health & Safety Representative

NEW POLICY					DEVELOPMENT	RISK RATING (Low, Medium, High)	PROCESS			COMPLETION PHASE	COMMENTS
Historic CCG *(if applicable)*	Policy Area	Policy Name	Policy description	Responsible Director	Development Status (RAG Rated) Complete (Any issues identified recorded in Column Z) In Progress Not yet commenced	Overall Risk Rating	Date Approved	Where Approved	Where Ratified	Phase 1 - Policy no longer required or duplicate Phase 2 - New policy to be adopted in April/May Phase 3 - Adopt existing policy(ies) - with timeframe for review Q1 Phase 4 - Adopt existing policy(ies) - with timeframe for review Q2 Phase 5 - Adopt existing policy(ies) - with timeframe for review Q3 Phase 6 - Adopt existing policy(ies) - with timeframe for review Q4	
	Health & Safety	Accident and Incident Reporting Procedure	To ensure the accurate and timely reporting of accidents, incidents and near misses within the CCG, and to enable lessons to be learnt and changes to be implemented, where identified.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Annual Leave and bank holiday policy	Policy sets out the CCG process for taking annual leave and bank holidays	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Corporate	Gifts, Hospitality and Sponsorship - Anti-Bribery Policy and Procedure	The purpose of this strategy and policy is to detail the CCG's aims and responsibility for the effective management of security in relation to staff, patients, visitors and property. The CCG is committed to the provision of safeguards against crime and the loss or damage to its property and/or equipment.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Appraisal Policy and Procedure	This policy is designed to provide a framework across the CCG for a wellplanned and effective staff appraisal system.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Apprenticeship Policy	Policy sets out the CCG process apprenticeships	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Attendance Management Policy	Policy sets out the CCG process for short and long term sickness	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Bullying and Harassment Policy	Policy sets out the CCG process dealing with incidents of bullying and harassment	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
Shropshire	Corporate	Business Continuity Plan	TBC	Sam Tilley	In progress	Medium	Jul-21	Audit Committee	Audit Committee	Phase 3	Currently being reviewed by Sam Tilley in line with the office relocation in June.
	Corporate	Conflicts of Interest Policy	Sets out how the CCG will manage conflicts of interest arising from the operation of the organisation. The policy applies to members of the CCG's Governing Body (clinical, executive and lay), committee and sub-committee members, localities and their members, and all those involved in commissioning, contracting and procurement processes and decision-making.	Alison Smith	Complete	Low	May-21	Audit Committee	Governing Body	Phase 2	
Shropshire	Commissioning	Consultant to Consultant Referrals Policy	The purpose of this policy is to ensure that patients are referred to appropriate services within secondary care.	Sam Tilley / Steve Trenchard	In progress	Medium	TBC	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 4	To be updated
	Commissioning	Decommissioning and Disinvestment Policy	The aim of the policy is to provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest.	Sam Tilley	Complete	Low	Apr-21	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 2	
Telford & Wrekin	Commissioning	Defining the Boundaries between NHS and Private Healthcare	This policy defines the boundaries between privately funded treatment and entitlement to NHS funding, under a range of circumstances.	Sam Tilley / Steve Trenchard	In progress	Medium	TBC	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 3	To be updated

Historic CCG *(if applicable)*	Policy Area	Policy Name	Policy description	Responsible Director	Development Status (RAG Rated) Complete (Any issues identified recorded in Column Z) In Progress Not yet commenced	Overall Risk Rating	Date Approved	Where Approved	Where Ratified	Phase 1 - Policy no longer required or duplicate Phase 2 - New policy to be adopted in April/May Phase 3 - Adopt existing policy(ies) - with timeframe for review Q1 Phase 4 - Adopt existing policy(ies) - with timeframe for review Q2 Phase 5 - Adopt existing policy(ies) - with timeframe for review Q3 Phase 6 - Adopt existing policy(ies) - with timeframe for review Q4	COMMENTS
	Finance	Detailed Financial Policies	Control environment for managing financial affairs. They identify the financial responsibilities which apply to everyone working for the CCG and its constituent organisations.	Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Disciplinary Policy	Policy sets out the CCG process dealing with incidents of misconduct	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Health & Safety	Display Screen Equipment Policy	The aim of this policy is to ensure that staff are not subjected to unacceptable levels of risk to their health or safety when using display screen equipment (DSE).	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Information Governance	Employee Privacy Notice	As part of its employment activities, Shropshire, Telford & Wrekin CCG collects, stores and processes personal information about prospective, current and former staff. This Privacy Notice includes applicants, employees (and former employees), workers (including agency, casual and contracted staff), volunteers, trainees and those carrying out work experience. We recognise the need to treat staff personal and sensitive data in a fair and lawful manner. No personal information held by us will be processed unless the requirements for fair and lawful processing can be met.	Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Equality and Diversity Policy	Policy sets out the CCG process for Eqaulity and Diversity	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
Joint Shropshire and Telford & Wrekin CCG	Commissioning	Ethical framework for priority setting and resource allocation	The purpose of setting out the principles and considerations to guide priority setting is to provide a coherent framework for decision making, promote fairness and consistency in decision making, ensure that the reasons behind decisions that have been taken are clear and comprehensive.	Sam Tilley / Steve Trenchard	In progress	Low	TBC	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 5 (subject to new guidance being published following the consultation)	Became joint policy in May 2019. Will require rebranding (ie new logo and new organisational name)
Telford & Wrekin	Commissioning	Experimental and Unproven Treatments	The policy sets out the circumstances where a commissioner may wish to fund an experimental treatment, interventions which are judged to be experimental or not of proven effectiveness will not be routinely funded.	Steve Trenchard	In Progress	Low	TBC	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 3	To be updated
	Safeguarding	Failed Contract Protocol; for all staff working with children and young people	Protocol	Zena Young	Complete	Low	May-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
	Human Resources	Family Leave Policy	Policy sets out the process for applying for different types of family leave	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Health & Safety	Fire Safety Policy	The fire safety policy is available to all employees in order to help them become aware of potential fire risks and hazards. The fire safety policy also informs employees of what to do in the outbreak of a fire and how best to ensure the safety of employees and others.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	

Historic CCG *(if applicable)*	Policy Area	Policy Name	Policy description	Responsible Director	Development Status (RAG Rated) Complete (Any issues identified recorded in Column Z) In Progress Not yet commenced	Overall Risk Rating	Date Approved	Where Approved	Where Ratified	Phase 1 - Policy no longer required or duplicate Phase 2 - New policy to be adopted in April/May Phase 3 - Adopt existing policy(ies) - with timeframe for review Q1 Phase 4 - Adopt existing policy(ies) - with timeframe for review Q2 Phase 5 - Adopt existing policy(ies) - with timeframe for review Q3 Phase 6 - Adopt existing policy(ies) - with timeframe for review Q4	COMMENTS
	Human Resources	Flexible working and Special Leave Policy	Policy sets out the process for applying for lexible working and special leave	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Grievance and Disputes Policy	Policy sets out the process for raising concerns	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Health & Safety	Health & Safety Policy	This policy outlines T&W CCG's mechanism for ensuring the safety of all people affected by its work including staff, contractors working on its behalf and visitors to its premises.	Alison Smith	Complete	Low	May-21	Governing Body	Governing Body	Phase 2	
	Health & Safety	Health and Wellbeing Management Policy	The purpose of this policy is to create a working environment where the good mental health and well-being of its employees is paramount and where colleagues feel valued and protected.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Infection Prevention and Control	Standard Infection Control Precautions Policy	This policy sets out the responsibilites for ensuring the appropriate systems and processes are in place within the organisation to protect staff, minimise the risk of infection and reduce the risk of cross infection.	Zena Young	Complete	Low	Feb-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
	Information Governance	Information Governance & Data Security and Protection Policies	This overarching Data Security and Protection or Information Governance policy provides an overview of the organisation's approach to information governance and includes data protection and other related information governance policies, and details about the roles and management responsible for data security and protection in the organisation.	Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Information Governance	Information Governance Handbook	To outline the standards and expectation of staffs' compliance and expected code of conduct of all staff working for Shropshire, Telford and Wrekin CCG.	Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Information Governance	Staff Code of Conduct	All staff are required to read and sign the declaration at the back of the Staff Code of Conduct. Signing the declaration does not confirm that you are aware of everything but confirms that you have read it and know where to refer back to in the future if required.	Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Health & Safety	Lone Working Policy	The purpose of this policy and the guidelines it contains is to reduce and prevent risks to members of staff undertaking lone working as part of their daily work routine for the CCG.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Safeguarding	Modern Slavery and Human Trafficking	Statement	Zena Young	Complete	Low	Feb-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
	Quality	NHS to NHS (N2N) Standard Operating Process	Policy requires revision to include Shropshire. Needs rebranding.	Zena Young	Complete	Low	May-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
	Health & Safety	Office Safety Policy	The CCG wishes to ensure that all office environments within its operations are both managed and used in a manner that is conducive to the safety of all CCG employees and other parties who may have cause to work in the offices, for whatever reason.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	

Historic CCG *(if applicable)*	Policy Area	Policy Name	Policy description	Responsible Director	Development Status (RAG Rated) Complete (Any issues identified recorded in Column Z) In Progress Not yet commenced	Overall Risk Rating	Date Approved	Where Approved	Where Ratified	Phase 1 - Policy no longer required or duplicate Phase 2 - New policy to be adopted in April/May Phase 3 - Adopt existing policy(ies) - with timeframe for review Q1 Phase 4 - Adopt existing policy(ies) - with timeframe for review Q2 Phase 5 - Adopt existing policy(ies) - with timeframe for review Q3 Phase 6 - Adopt existing policy(ies) - with timeframe for review Q4	COMMENTS
	Corporate	On Call Executive/Director Policy	TBC	Sam Tilley	Complete	Low	May-21	Executive Team	Executive Team	Phase 2	
	Human Resources	Organisational Change Policy	Sets out the approach and process for management of change	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
Telford & Wrekin	Commissioning	Patients changing responsible commissioner	The terms of this policy outline the circumstances where the CCG will and will not honour existing funding commitments.	Steve Trenchard	In progress	Medium	TBC	Strategic Commissioning Committee	Strategic Commissioning Committee	Phase 3	To be updated
	Human Resources	Pay Protection Policy	Sets out the approach and process for paying pay protection	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Performance Management Policy	Sets out the process for managing performance	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Safeguarding	Policy and Procedures for Managing Allegations against staff and persons in a position of trust in respect of children, young people, and adults (with care and support needs)	This policy relates to circumstances when an allegation is made that a child/young person or adult with care and support needs is suffering or likely to suffer harm caused by an employee/worker from Shropshire Clinical Commissioning Group (CCG) or that an employee's behaviour indicates they are unsuitable to work with children or vulnerable adults.	Zena Young	Complete	Low	May-21	Exec Lead sign off as only contact / title change	Exec Lead sign off as only contact / title changes	Phase 2	
Shropshire	Safeguarding	Prevent Duty Guidance Policy.	This Policy is based upon the draft Prevent Policy guidance issued by NHS England. It explains the purpose of the government's Counter Terrorism strategy and the specific Prevent duties of all NHS organisations in the Counter Terrorism and Security Act. It explains the CCG's obligations as a commissioner, the requirements to train staff and the process to be followed when colleagues identify patients and other individuals for whom there are concerns that they may be subject to exploitation through radicalisation.	Zena Young	In progress	Medium	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	To be updated
	Information Governance	Privacy Notice		Claire Skidmore	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Probation Period Review Policy	Sets out the process for probation periods	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Professional Registration Policy	Sets out the process for professional registration	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Corporate	Raising Concerns at Work Poicy	This policy sets out the process for dealing with Whistleblowing concerns raised. It also contains the procedure to be followed when employees or members of the public wish to raise concerns in relation to Shropshire Clinical Commissioning	Alison Smith	Complete	Low	Apr-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Recruitment and Selection policy	Sets out the process for recruitng staff	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Human Resources	Retirement Policy	Sets out the process for retirement	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	

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Shropshire	Risk Management	Risk Stratification Policy	TBC	Claire Skidmore	In progress	Low	TBC	Audit Committee	Audit Committee	Phase 3	Currently being reviewed as a joint policy - with new branding and logo.
Shropshire	Safeguarding	Safeguarding Adults Policy – further to the Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands.	This Safeguarding Adult Policy specifically addresses issues for the CCG in terms of the particular role it plays in ensuring adult safeguarding is everyone's business. Shropshire CCG along with its partners in the Keeping Adults Safe in Shropshire Board has adopted the West Midlands wide adult Safeguarding policy and procedure. This CCG policy should therefore be read in conjunction with the Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands. The West Midland procedure is also available on this website.	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress
	Safeguarding	Safeguarding Children and Young People Statement	Statement	Zena Young	Complete	Low	Feb-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
Telford & Wrekin	Safeguarding	Safeguarding Children and Adults Commissioning Policy	How the CCGs will discharge its corporate accountability to safeguarding children and adults	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress
	Safeguarding	Safeguarding Declaration	Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG) is committed to the protection of vulnerable children and adults. The CCG will execute its statutory duties under the Children Act 2004 and the Care Act 2014 by	Zena Young	Complete	Low	Feb-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
Shropshire	Safeguarding	Safeguarding Supervision policy (Child and Adult)	This policy demonstrates and explains how Shropshire CCG provide safeguarding adults/children supervision and how staff can access safeguarding supervision. This recognises the CCG role in supporting staff with safeguarding concerns.	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress
	Human Resources	Secondment Policy	Sets out the process for secondment	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Corporate	Security Management Policy and Strategy	The purpose of this strategy and policy is to detail T&W CCG's aims and responsibility for the effective management of security in relation to staff, patients, visitors and property. The CCG is committed to the provision of safeguards against crime and the loss or damage to its property and/or equipment.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
	Quality	Incident Reporting and Management Policy	This policy sets out the responsibilites for ensuring the appropriate systems and processes are in place within the organisation to manage incident reporting and investigation, including Serious Incidents	Zena Young	Complete	Low	Mar-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	
	Corporate	STW Complaints and Compliments Policy and Procedure	The aim of this policy is to ensure that all contacts from service users are listened to, that concerns and complaints are resolved quickly and simply and that information gained from them is used to improve the services commissioned.	Alison Smith	Complete	Low	May-21	Quality & Performance Committee	Quality & Performance Committee	Phase 2	

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Shropshire	Safeguarding	Shropshire, Telford and Wrekin CCG Multi-Agency Mental Capacity Act (MCA) Guidance Policy	This policy is the product of a multi-agency piece of work undertaken by the Shropshire and Telford Mental Capacity Act operational group. It included local authority, independent sector and NHS representation. It provides an update for all those within the health and social care economy regarding their duties to help empower those who may lack capacity and uphold lawful procedures to ensure actions are taken to support decision making, assess capacity and when necessary act in ways that are the least restrictive possible and in the best interests of the person. It also includes practical information about assessing capacity and making best interest decisions.	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress
	Information Governance	Standard Operating Procedure for the Management of Subject Access Requests	This Standing Operating Procedure (SOP) sets out what staff should do when receiving a request for personal information, such as medical information or staff information, and applies to NHS Shropshire, Telford and Wrekin CCG for records for which they are the Data Controller (or Data Processor as required). The CCG are required to provide a procedure in place to respond to requests made under the Data Protection Act 2018/GDPR. In addition, requests can be made under the Access to Health Records Act 1990.	Alison Smith	Complete	Low	May-21	Audit Committee	Audit Committee	Phase 2	
Shropshire	Safeguarding	The Court of Protection - Section 45 of the Mental Capacity Act 2005 and process to follow for CCG Staff when action is contemplated	This policy is intended to be a practical guide for staff, explaining the main purposes of the Court of Protection and its functions, as well as advising CCG staff on the steps it should take to alert the wider CCG at the very earliest opportunity when action is contemplated. This is to ensure that the proper process of escalation and permissions are in place (see flow chart) as well as affording an opportunity to scrutinise proposals and were applicable agree preventative measures to reduce the need for court interventions in accordance with MCA Code of Practice guidance.	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress
Shropshire	Safeguarding	Training strategy for safeguarding	This strategy aims to ensure that the CCG's employees and staff working in those services commissioned and contracted by the CCG understand their role and responsibilities regarding safeguarding children, young people and adults and the training that must be carried out.	Zena Young	In progress	Low	TBC	Quality & Performance Committee	Quality & Performance Committee	Phase 3	Update in progress

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	Human Resources	Uniform & Dress Code Policy	1.1 This policy sets out the expectations of the CCGs in relation to all its staff: • The wearing of uniforms for clinical staff • The dress code for staff attending visits to clinical areas • CCG staff in office environment • CCG staff representing the CCGs to external agencies • Individuals employed by agencies and other contractors will be expected to adhere to the standards contained in this policy when attending visits to clinical areas for the CCGs • Students undertaking clinical or other placements are expected to adhere to the policies agreed between the CCGs and the relevant education provider.	Zena Young	**Complete**	**Low**	**Feb-21**	**Quality & Performance Committee**	**Quality & Performance Committee**	**Phase 2**	
	Human Resources	Volunteer Policy	Sets out the process for engaging volunteers	Alison Smith	**Complete**	**Low**	**May-21**	**Audit Committee**	**Audit Committee**	**Phase 2**	
	Information Governance	Corporate & Health Records Retention and Disposal Schedule	A guide to management of corporate and health and care records held by Shropshire, Telford & Wrekin CCG	Alison Smith	**Complete**	**Low**	**May-21**	**Audit Committee**	**Audit Committee**	**Phase 2**	
	Information Governance	Information Governance Management Framework		CLaire Skidmore	**Complete**	**Low**	**May-21**	**Audit Committee**	**Audit Committee**	**Phase 2**	
	Information Governance	Standard Operating Procedure for Information Governance Breach Reporting	This Standing Operating Procedure (SOP) sets out what staff should do when they become aware of a data security and protection breach/breach. It is important that information remains safe, secure, and confidential at all times. All staff are encouraged to report all breaches via the Breach Reporting Form as soon as is possible following the identification of the breach.	Claire Skidmore	**Complete**	**Low**	**May-21**	**Audit Committee**	**Audit Committee**	**Phase 2**	

Medicines Managment Policies **Appenxdix 2**

CCG	Policy Area	Priority for updating Document	Which Quarter will the document be updated in	Policy Name	What type of document?	Which committee will approve?	Required on New website?
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Medium**	Q3	Covert Administration of Medicines Policy	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin Clinical Commissioning Group Joint Commissioning Policy: Continuous Glucose Monitoring (CGM) for Type 1 diabetes	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin Clinical Commissioning Group Joint Commissioning Policy: Continuous Glucose Monitoring (CGM) for Type 1 diabetes in Adults and Pregnant women with Type 1 or Type 2 diabetes on insulin therapy	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin Clinical Commissioning Group Joint Commissioning Policy: Continuous subcutaneous insulin infusion (CSII) (without continuous glucose monitoring (CGM)) in adults and children with Type 1 diabetes	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin Clinical Commissioning Group Joint Commissioning Policy: Insulin degludec (Tresiba®▼) for Type 1 and restricted use in Type 2 diabetes	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin Clinical Commissioning Group Joint Commissioning Policy: The use of Flash Glucose Monitoring systems in eligible diabetic patients	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Prescribing Information for Brivaracetam1 as adjunct therapy in the treatment of partial-onset seizures	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Chronic Obstructive Pulmonary Disease (COPD) Rescue Pack Guidance for Shropshire, Telford and Wrekin Clinical Commissioning Groups	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG & Shropshire Community health	Medicines Management	**Medium**	**Q3**	Guideline for prescribing weight-adjusted oral paracetamol in adults	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Grazax in grass pollen induced rhinitis and conjunctivitis.	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	'Think Food' at End of Life Guidance for patients or carers to support nutrition at End of Life	Guidance		NO
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Guide to ordering oxygen for patients in their own home or in care homes	Resource		YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Self-Care Medicines and Homely Remedies A Guide for Care Homes	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Guidance to Support - Novel coronavirus (COVID-19) standard operating procedure Running a medicines re-use scheme in a care home or hospice settingi	Guidance		YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	2020 15 07 Letter to accompany Meds Re use Quick Guide	Template Doc		YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	THE INDIVIDUAL FUNDING REQUEST POLICY JULY 2019	Policy	SOLICITORS + SCC	YES

Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Individual Funding Request (IFR) Application Form	Template Doc	SOLICITORS + SCC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	INDIVIDUAL FUNDING REQUEST OPERATIONAL POLICY & Terms of Reference	Policy	SOLICITORS + SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	pdf EOL DIAMORPHINE PRN medication PSD May 2020	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	pdf EOL syringe driver medication DIAMORPHINE PSD May 2020	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	pdf EOL syringe driver medication MORPHINE PSD May 2020	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	pdf EOL MORPHINE PRN medication PSD May 2020	Template Doc	EOL +APC	YES
Joint Telford & Wrekin CCG and Telford Council Document	Medicines Management	**High**	**Q2**	Protocol for the use of emergency salbutamol inhalers in schools	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Gabapentinoid Prescribing In Chronic Pain	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	20200618 Shropshire and Telford and Wrekin CCG Opioid use and reduction in Primary Care for Non Cancer Pain	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Adult Guidance for the supply of blood glucose and ketone meters, test strips and lancets in Primary care May 2020	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Bariatric Surgery Guideline on vitamins, minerals and medication	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Administration of intravenous treatment - for the management of Cellulitis in the community	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Guidance on Folic Acid Dosing (Preconception and during pregnancy)	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Management of Hypomagnesaemia in adults in primary care	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Treatment of overactive bladder symptoms and urgency urinary incontinence in women in Primary Care (in line with NICE NG123)	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Chronic Obstructive Pulmonary Disease (COPD) Rescue Pack Information Leaflet	Resource	APC	yes
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	On-going access to treatment following a 'trial of treatment' which has not been sanctioned by NHS Shropshire or NHS Telford and Wrekin Clinical Commissioning Group for a treatment which is not routinely funded or has not been formally assessed and prioritised	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	On-going access to treatment following the completion of industry sponsored clinical trials or funding	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	On-going access to treatment following the completion of a trial explicitly funded by NHS Shropshire or NHS Telford and Wrekin Clinical Commissioning Group	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	On-going access to treatment following the completion of non-commercially funded clinical trials	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Ethical framework for priority setting and resource allocation	Policy	SCC	YES
Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Patients changing responsible commissioner	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Asthma Management Plan	Template Doc		YES

Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	MART ASTHMA PLAN	Template Doc		YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Chronic Obstructive Pulmonary Disease (COPD) Treatment Guidelines	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Palliative Care (EOL) Morphine as Required Prescription Form (review date May 2023)	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Palliative Care (EOL) Diamorphine as Required Prescription Form (review date May 2023)	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Palliative Care (EOL) Morphine Syringe Driver Prescription Form (review date May 2023)	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Palliative Care (EOL) Diamorphine Syringe Driver Prescription Form (review date May 2023)	Template Doc	EOL +APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	NHS Shropshire Clinical Commissioning Group and NHS Telford and Wrekin Clinical Commissioning Group Joint Commissioning Policy: Bath and Shower preparations for dry and pruritic skin conditions	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Shropshire and Telford Local Health Economy Biosimilar Implementation Policy	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Shropshire and Telford Local Health Economy High Cost Drug Management Policy	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	NHS Telford and Wrekin and NHS Shropshire Clinical Commissioning Groups Joint Commissioning Policy: Low intensity Pulsed Ultrasound (e.g. Exogen®) healing system for long bone fractures with non-union.	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Homecare	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Initiating or changing injectable GLP-1 analogue treatment	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Influenza Process Flow	Guidance	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Influenza Transfer Form	Template Doc	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Influenza Transfer Record (spreadsheet)	Template Doc	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Medicines Safety Alert Process	Guidelines	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Decline to prescribe form	Templates	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Shropshire, Telford & Wrekin CCG care home influenza outbreak protocol	Guideline	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	NMP Policy	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Ankylosing spondylitis pathway - Biologics	Guideline	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Psoriatic arthritis pathway - Biologics	Guideline	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Rheumatoid arthritis pathway - Biologics	Guideline	APC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Low-dose naltrexone for the treatment of multiple sclerosis	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Gluten free policy	Policy	SCC	NO

Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Botulinum policy	Policy	SCC	NO
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Low dose Naltrexone for the treatment of multiple schlerosis	Policy	SCC	YES
Joint Shropshire and Telford & Wrekin CCG	Medicines Management	**Low**	**Q4**	Sodium Oxybate for the treatment of cataplexy in adult patients with narcolepsy	Policy	SCC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Safety pen needles and safety lancet devices - Commissioning statement	Guidance		YES
Shropshire CCG	Medicines Management	**High**	**Q2**	Liraglutide (Saxenda® or Victoza®) for the management of obesity.	Policy	SCC	YES
Shropshire CCG	Medicines Management	**High**	**Q2**	NHS Shropshire Clinical Commissioning Group Commissioning Policy: Prescribing of liothyronine (tri-iodothyronine) either alone or in combination with levothyroxine (e.g. Armour® thyroid) for the treatment of hypothyroidism.	Policy	SCC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Local Agreement and Process for Initiating eRD	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Delivery Driver Communication Sheet eRD	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Process for Initiating eRD	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Setting up eRD on EMIS Web eRD	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Explaining eRD to a Patient	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Conversation Crib Sheet	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	NHS Shropshire CCG Repeat Dispensing Patient Leaflet	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	NHS Shropshire CCG Repeat Dispensing Patient Information	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Just In Case Drug Lists	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**High**	**Q2**	Palliative Care Just in Case (JIC) Service Guidance	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Just in Case Pack Brief Guide for GP's	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Pharmacies taking part in the Just in case (JIC) Pack provision in Shropshire	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Patient information leaflet for JIC Packs	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Pharmacy flow chart for JIC packs	Guidance	EOL +APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Sponsorship and Joint Working with the Pharmaceutical Industry	Policy	Audit committee	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	VACCINE MANAGEMENT AND COLD CHAIN STANDARDS	Policy	SCC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Commissioning Statement for Stop Smoking Pharmacological Therapies	Guidance	APC	NO
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Commissioning Policy: Use of Nicotine Replacement Therapy	Guidance	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q2**	Changes to prescribing legislation – Drugs used in the treatment of erectile dysfunction (ED)	Guidance	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Managing Adult Malnutrition in the Community	Policy	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Implementing bulk prescribing for care home patients	Guidance	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Bulk prescribing implementation guidance for: Care Home Staff	Guidance	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Bulk prescribing implementation guidance for: The GP Practice	Guidance	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Bulk prescribing implementation guidance for: Community Pharmacy	Guidance	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Care homes audit for bulk prescribed medication	Template	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Template bulk prescribing order form	Template	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Agreed list of bulk prescribed medication	Template	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Care homes sign in sheet for bulk prescribed medication	Template	APC	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	SHROPSHIRE AND TELFORD LOCAL HEALTH ECONOMY NEW PHARMACY PRODUCT & NEW INDICATION PROPOSAL FORM FOR FULL FORMULARY INCLUSION & INDIVIDUAL PATIENT TREATMENT	Template	APC	YES
Shropshire CCG	Medicines Management	**Low**	**Q4**	Prescribing non-prescription (over the counter) medicines for children attending nurseries and schools	Guidance	APC	YES

Telford & Wrekin CCG	Medicines Management	**Medium**	**Q4**	Protocol for the use of emergency adrenaline auto injectors in schools V1 Jan 2020 JEXT- Joint Telford and Telford Council doc	Resource	APC	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Amiodarone for the treatment of severe rhythm disorders Effective Shared Care Agreement	ESCA	APC	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q2**	Dronedarone (Multaq®) for Atrial Fibrillation Effective Shared Care Agreement	ESCA	APC	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q3**	Prescribing Information Document for melatonin in children, adolescents and adults with learning disabilities	ESCA	APC	YES
Telford & Wrekin CCG	Medicines Management	**High**	**Q3**	Patient Group Direction for supply of levonorgestrel 1500mcg (Emergency Hormonal Contraception) by Pharmacists-Joint doc with Telford Council	PGD	APC	NO
Telford & Wrekin CCG	Medicines Management	**High**	**Q3**	Patient Group Direction for supply of ulipristal acetate 30 mg (Emergency Hormonal Contraception) by Pharmacists-Joint Doc with Telford Council	PGD	APC	NO
Telford & Wrekin CCG	Medicines Management	**High**	**Q3**	Community Pharmacies in Telford and Wrekin Participating in the Emergency Supply Service	PGD	APC	NO
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Reducing Medicines Waste in Care Homes	Guidance	APC	YES
Shropshire CCG	Medicines Management	**High**	**Q2**	Medicine review of Care Home Resident	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	First Dressing Scheme for skin tears In residential nursing homes	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	First Dressing Scheme for Skin Tears Apendix A	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	First Dressing Scheme for Skin Tears Audit sheet	Template	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q4**	First Dressing for Skin Tears Scheme Application Record	Template	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q1**	Reducing medicine waste in care homes	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q2**	A Guide to processing care home prescriptions	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Topical Preparation Record Chart	Template	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Think Food Pathway	Pathway	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Think food at the end of Life	Guidance	APC	YES
Shropshire CCG	Medicines Management	**Medium**	**Q3**	TREATING ADULT MALNUTRITION IN PRIMARY CARE	Pathway	APC	YES
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Pharmaceutical Industry Rebate Schemes V2	Policy	Audit committee	NO
Telford & Wrekin CCG	Medicines Management	**Medium**	**Q3**	Sponsorship and Joint Working with the Pharmaceutical Industry	Policy	Audit committee	NO
Shropshire CCG	Medicines Management	**High**	**Q2**	Shared Care Agreement Apomorphine For use in Parkinson's Disease	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q3**	AZATHIOPRINE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q4**	ORAL CICLOSPORIN RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q1**	Shared Care Agreement Denosumab (Prolia®▼) For the treatment of osteoporosis in adults	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q2**	D-PENICILLAMINE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q3**	Shared Care Agreement – DISEASE MODIFYING ANTI–RHEUMATOID DRUGS (DMARDs	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q4**	HYDROXYCHLOROQUINE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q1**	LEFLUNOMIDE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q2**	ORAL AND PARENTERAL METHOTREXATE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q3**	MYCOPHENOLATE MOFETIL RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q4**	SODIUM AUROTHIOMALATE (GOLD THERAPY) RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO

Shropshire CCG	Medicines Management	**High**	**Q1**	Effective Shared Care Agreement for Somatropin (recombinant Human Growth Hormone) treatment in adults	ESCA	APC	NO
Shropshire CCG	Medicines Management	**High**	**Q2**	SULFASALAZINE RHEUMATOLOGY LOCAL SAFETY MONITORING SCHEDULE	ESCA	APC	NO
Shropshire CCG	Medicines Management	**Medium**	**Q3**	Protocol for weaning COPD patients on Inhaled Corticosteroids	Guidance	APC	NO
Shropshire CCG	Medicines Management	**Low**	**Q4**	Sildenifil and iloprost for the treatment of digital ulceration in systemic schlerosis	policy	APC	NO
Shropshire CCG	Medicines Management	Medium	**Q3**	NHS Shropshire Clinical Commissioning Group (NHS SCCG) Statement on Seven Day Prescriptions a	Policy	APC	NO
Shropshire CCG	Medicines Management	High	**Q2**	Prescribing subcutaneous methotrexate	Guidance	APC	yes
Shropshire CCG	Medicines Management	Medium	**Q3**	Sacubitril valsartan	Policy	APC	YES
Shropshire CCG	Medicines Management	High	**Q2**	Sativex® Oromucosal Spray for spasticity in multiple sclerosis	Guidance	APC	YES
Shropshire CCG	Medicines Management	High	**Q2**	Policy on Iloprost infusion for the Management of Severe Symptomatic Peripheral Ischaemia in Patients with Secondary Raynaud's Disease or Systemic Scleroderma to Prevent Limb Amputation	Policy	APC	NO
Shropshire CCG	Medicines Management	Low	Q4	Trimipramine Review Advice	Guidance	APC	NO
Shropshire CCG	Medicines Management	Low	Q1	Dosulepin Review Advice	Guidance	APC	NO
Shropshire CCG	Medicines Management	Low	Q2	Repeat Prescribing Guidelines	Guidance	APC	NO
Shropshire CCG	Medicines Management	Low	Q3	Medication Review Guidance	Guidance	APC	NO

KEY:

APC	Area Prescribing Committee
EOL	End of Life
ESCA	Essential Shared Care Agreement
PGD	Patient Group Directive
SCC	Strategic Commissioning Committee

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 12 May 2021**

Item Number:	Agenda Item:
GB-21-05.025	Audit Committee Chair's Summary Report

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Geoff Braden Lay Member - Governance

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

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

Executive Summary (key points in the report):

- We reviewed the Board Assurance Framework. Members noted areas that needed updating, although they accepted the difficulties of keeping this up to date while dealing with covid issues. Risk 11 was removed regarding the European Union Exit.
- The Draft Annual Governance Statement was reviewed, which is part of the Annual report for both CCG's. This year it has been consolidated into a single document. The committee was assured on the content which was comprehensive and reliable.
- An Assurance update was received on the Single Strategic Commissioning with a positive and on-track position with updates on action areas from previous scrutiny. The committee felt that there was sufficient actions and planning in place to make the transition to a single CCG in April 20021.
- The committee received a Register of Procurement Decisions which is required to be published on the CGG's website. These include procurement decisions that include both those that are made through normal governance processes and also those using the waiver process.
- The Information Governance Annual report is normally due to be reported at the end of the financial year but now has the deadline of 3oth June 2021. The CCG is on track for the 95% staff trained and the committee was assured that the Date Security and Protection Toolkit (DSPT) would be in place.
- Internal audit reported the current open audit recommendations and confirmation of the ownership and follow up received. The legacy recommendations were reviewed and assigned with a full audit trail agreed.
- Conflicts of interest management report was received with the opportunity for a higher profile of mandatory training to receive higher profile. An update was requested for the July meeting.
- A separate report from Internal Audit was received on the BAF with the need to reinforce the assignment and update of ownership of mitigating actions. As COVID activities are now seeing redployed staff returning to roles an expectation is that this will be corrected.
- It was noted that the CCG received a high level report on Governance Arrangements During COVID-19 in support of Head of Internal Audit opinion. Primary care Internal Audit report was also favourably received.

- Both CCG's received the Interim Head of Audit Opinion and the respective Annual report with significant assurance given. Two areas of moderate assurance included accounts payable and CHC, both of which had robust mitigating actions against them.
- External audit were positive regarding the upcoming annual accounts and discussion took place again against the changing Value For Money considerations. The respective action plans were considered along with discussions on the overall £71m underlying deficit. Secondary healthcare was highlighted as a significant risk as it has through the year.
- Counter Fraud work continues, both for awareness-raising exercises and investigations. There are no risk issues to raise with the Governing Body at present.
- The Committee also received papers on: losses, special payments and waivers; briefing paper on new government counter fraud functional standard; Provider Self Review tool.

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

Recommendations/Actions Required:
The Governing Body is asked to note this report.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.026	Strategic Commissioning Committee Chair's Report

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
First presentation at Governing Body	12/05/2021	S

Executive Summary (key points in the report):

Covid Phase 3 Recovery

The committee received a report on the Covid recovery position within the system. Main points included: challenges in A&E but work is being undertaken at a system level to improve the position; radiology is above planned recovery levels but endoscopy is a concern as it was impacted by the escalation into theatre areas; the improvement in cancer waits has continued; the overall position on long waits still reflects the impact of suspension of services last year. The committee asked for reassurance around workforce availability and whether this would impact on the system's ability to cope with an increase in referrals but were advised that the position is being tracked and staff sickness levels have been decreasing in recent weeks.

Breast Cancer Improvement Plan

The committee received a report requesting approval of a number of actions to support the recovery of breast referral pathways and address the backlog of patients, asked to note the planned trajectory of recovery of the 14 day target by July 2021, consider whether priority should be given to patients referred on the suspected cancer pathway and note that recovery will be monitored by the fortnightly SaTH Cancer Performance & Assurance.

Clinicians on the committee had a number of questions around the proposed actions and requested further input and clarification from the breast team before agreeing to them. The committee agreed to defer approval of the paper until the required assurance had been provided.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	
2.	Is there a financial or additional staffing resource implication?	
3.	Is there a risk to financial and clinical sustainability?	
4.	Is there a legal impact to the organisation?	
5.	Are there human rights, equality and diversity requirements?	
6.	Is there a clinical engagement requirement?	
7.	Is there a patient and public engagement requirement?	

Recommendations/Actions Required:
Governing Body Members are asked to note the contents of the report.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **Shropshire, Telford and Wrekin CCG Governing Body Meetings held in Public on 12 May 2021**

Item Number:	Agenda Item:
GB-21-05.027	Finance Committee Chair's Summary Report

Executive Lead (s):	Author(s):
Claire Skidmore Executive Director of Finance claire.skidmore@nhs.net	Geoff Braden Lay Member - Governance

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

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

Executive Summary (key points in the report):

- Executive Director of Finance gave an update on the month 11 position giving an overspend of £1m for the combined CCG's, which is significantly better than that previously forecasted. Shropshire were on target for a small underspend and Telford an overspend of around £1.5m.
- The annual accounts were on track for completion to the agreed timescales in May.
- Discussions took place on the underlying deficit position of £71m which still requires updating to the Governing Body.
- The 2021/22 position was presented to the committee which demonstrated the underlying position of the CCG vs the 3% task. This roughly equates to just over £13m for the CCG alone.
- The overall system financial position was discussed and understood with focus returning to the CCG plan and achieving the 3% task through QIPP and other programmes of change.
- Greater scrutiny of the plans with a monthly update requested.
- A letter from NHSEI was received and discussed with the implications of needing to achieve the finance position and the consequences including hold on investment and capital noted.
- There was a significant gap that still requires work to identify activities towards the 3% and Finance committee requested that this was addressed with urgency.
- At this time, the Finance committee were unable to assure the board on achieving the £13m task with the detail currently received.
-

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

Recommendations/Actions Required:
The Governing Body is asked to note this report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12th May 2021**

Item Number:	Agenda Item:
GB-21-05.028	Summary Report of Shropshire CCG and Telford and Wrekin CCG Quality and Performance Committees in Common meeting on 24th March 2021

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Full minutes approved at the Shropshire, Telford and Wrekin CCG Quality and Performance Committee meeting.	27th April 2021	

Executive Summary (key points in the report):

Purpose

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

To provide a summary of the main items reviewed at the 24th March 2021 meeting.

Performance

- Performance measures related to the Urgent and Emergency Care environment locally remain challenging in particular in relation to the 4 hour treatment standard for A&E though overall numbers of A&E attendances and emergency admissions are lower than last winter. Reductions in lower acuity walk-in patients means that in relative terms, the case mix is more weighted towards the more acutely ill patients.
- Improvements to processes are being worked through with input from ECIST but need to be layered on to the requirement to manage potential Covid patients and the adjustment to procedures this entails
- Ambulance handover delays in excess of 1 hour remain a challenge. This is connected to peaks in the rates of ambulance arrivals both on a day to day basis and within individual days.
- The NHS111 First Initiative is showing positive indications of achieving objectives even though true measurement of impact is difficult in the current circumstances.
- Elective activity at local providers has been impacted in January and February by the post

Christmas Covid surge. Consequently, waiting times for Elective care and Diagnostics continue to show high numbers of long waiters. As the demands of Covid reduce some restoration of elective capacity has been possible in recent weeks and this is expected to gather pace.

- In general, cancer performance held up reasonably well. The specific issues around 14 day targets for breast cancer are subject of a separate report but are now resolved and performance is showing signs of improvement. As elective capacity re-emerges priority is being given to dealing with urgent cases including cancer. Some cancer work continues to be directed toward the Nuffield Hospital but only a small amount of that will be available in April and May which is currently the subject of local contractual arrangements to maximise the system capacity available for recovery. Diagnostic performance and capacity remains significantly dependent on external modular provision and the funding necessary to support this. Progress has been made in reducing diagnostic backlogs, particularly for Imaging but the position for Endoscopy remains challenged.
- IAPT activity remains well below targeted levels due to lower levels of presentation and the CCGs will not achieve the year end cumulative target given the accumulated shortfall in performance to date.
- Initiatives have been put in place at SaTH to return the breast cancer appointment assessment times back to the fourteen day target. As a result of new arrangements being put in place the trajectory for recovery shows that the backlog should be cleared by the end of June 2021 and performance on target from July 2021.

Quality

- **CQC visit February 2021** (unannounced): Mental health services for Children and Young People were inspected; the trust has been served with a further Section 31 relating to CYP.
- **Stroke Sentinel National Audit Programme** – February 2021 reported best level results since August-November 2016.
- **Maternity:** 4 SI's have been reported this month, with no discernible themes; however the CCG has requested further assurance on the management of suspected sepsis in pregnancy. The CCG has also requested the trust to include review of the full term of pregnancy within all RCA investigations, rather than commencing at the point of birth / delivery.

MPFT:

- Concerns raised at CQRM regarding the number of SI extension requests.
- SaTH have raised concerns re service provision of MPFT LD nurses in SaTH.
- Following a recent unexpected death; the CCG have raised concerns regarding initial triage of individuals expressing suicidal thoughts.

Primary Care:

- **Annual Health Checks**: The CCG and partners are continuing work to improve the uptake and quality of Annual Health Checks for people with Learning Disabilities. The significant variation in uptake of AHCs across the system continues. A multi-agency approach is being developed to ensure system buy-in to improve this area of work.

IPC:

- A reducing number of Covid-19 outbreaks have been reported in NHS providers managed in accordance with Incident Management Processes. IPC team are undertaking proactive training refresh within Care Home and Domiciliary settings.

Quality Assurance:

- Visits across most providers remain postponed. Assurance from internal QA processes is being sought via CQRM's and the CCG are looking at resuming attendance at inspections beyond April 21.

All providers:

- Guidance has been received from NHSE/I with regard to retrospective SI reporting of Covid 19 related harm/death (probable hospital acquired cases). Providers need discussion on their approach to these reviews. There is requirement to retrospectively report all eligible cases as an SI.

Quarterly review of Serious Incidents

During Q3 there were a total of 54 SIs and 1 Never Event reported by the 4 main providers for Shropshire and Telford and Wrekin patients. This is a slight increase in SI's from Q2 and Q1 where there were 41 and 38 reported respectively. The Committee noted:
MPFT - Common themes include clinical care, communication, FACE (Functional Analysis of Care Environments) risk assessments and poor documentation. These common themes continue to be raised with the trust at the SI review meetings and have also been identified within their own SI annual report for 2019/2020.
SaTH – There has been an increase in Urology related SIs being reported. The trust is currently undertaking a thematic review of the cases and has recently requested an extension so that they can include a further incident in the RCA.
SCHT – Pressure ulcers continue to be the main themes amongst SCHT's SIs. The trust have introduced an updated RCA report for Pressure Ulcers which provides a framework for staff to use to ensure all relevant information is recorded for a review of causes to be made. Once this has been embedded the plan is to adapt the Falls RCA report in a similar manner.

Continuing Healthcare Update

- CHC assessment process and business as usual activity recommenced on 01/09/2020
- The number of outstanding deferred assessments (COVID-19 referrals) requiring assessment and decision as at 14/03/2021 is 192 (Shropshire = 142, Telford and Wrekin = 50) a reduction from 697 (Shropshire = 493, Telford and Wrekin = 204) at 31/08/2020.
- Overall CHC eligibility conversion rate = 21.97% (Shropshire = 22.56%, Telford and Wrekin = 21.11%)
- The number of CHC referrals requiring assessment and decision outstanding more than 28 days as at 28/02/2021 is 228 (Shropshire = 197, Telford and Wrekin = 31).

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

Recommendations/Actions Required:
The Governing Body is asked to note for assurance and information.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 12 May 2021**

Item Number:	Agenda Item:
GB-21-05.029	Primary Care Commissioning Committee (PCCC) Summary Report (Meeting date: 3 February 2021)

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

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

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

Executive Summary (key points in the report):

Please note this report relates to a Primary Care Commissioning Committee held in Common for NHS Telford and Wrekin CCG and NHS Shropshire CCG

The detail below provides a short summary of the items, discussion and actions.

a) Financial position

The Interim Director of Finance advised that the primary care budgets are forecast to be overspent across both former organisations by £1.2m. The main reason for the overspend was due to the Covid Expansion Fund. The original NHSE/I letter identified an allocation to practices across both former CCG's, the allocation was then reduced significantly.

The finance team are currently reviewing the national guidance to make the Primary Care Delegated function allocations.

Savings in Primary Care are normally realised through the prescribing budget, but this is currently a risk as the medicines management team are involved in the Covid Vaccination programme. Any investments the CCG wish to make must go through the NHSE investment process and it is unclear what the process will be for ring-fenced allocations.

b) Primary Care Report

- Estates
  Of the 2019/20 capital projects 7 schemes were approved. 4 have been completed and 3 will be completed late Spring 2021. Whitchurch is utilising Estates and Transformation funding to support the change of administration space to clinical space.

For 2020/21 9 projects had been identified for which funding would need to be identified.

The main projects that are underway currently are the Shawbirch new build, the Shifnal new build, the Whitchurch Pauls Moss new build and the Cavell Centre project. The Cavell Centre project has submitted a Project Initiation document to NHSE, awaiting approval before moving to a full business case.

The former CCG's estates strategies are currently being aligned into one strategy.

- Primary Care Networks (PCN)
  From April1st 2021 a new PCN has formed called South East Telford PCN.

c) Practice Visits
A proposal for re-commencing practice visits is being undertaken to bring together the previous CCG's ways of working and to make a proposal that meets the objectives for the CCG and is supportive of the practices, who find the visits to be a mainly positive experience but must have clear outcomes, including meeting the delegated functions of the CCG.

d) Learning Disability Annual Health checks Quality Visit
A proposal to audit the quality of the Learning Disability Health Checks was discussed. Both former CCG's had achieved the outstanding figure of delivering 77% of LDAHC against a national target of 67%. It was agreed that quality outcomes are important and that the review process needed to outline its key outcomes of the audit to inform the health check process has an impact on the individual receiving the check, including their feedback.

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

Recommendations/Actions Required:
Board representatives from NHS Shropshire, and Telford and Wrekin CCG are asked to receive this paper.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT AND MONITORING

Agenda item	GB-21-05.030
Committee:	Governing Body Part 1 Meeting
Date:	12 May 2021

Title of report:	South Shropshire Locality Forum
Responsible Director:	Claire Parker, Director of Partnerships
Author of report:	Dr Matthew Bird
Presenter:	N/A

Purpose of the report:

To update the CCG Governing Body about the topics discussed at the meetings and any actions arising they need to be aware of.

Key issues or points to note:

Key areas of discussion at the following meetings:

4th February 2021

- CCG Chair, Locality Chair and Director of Partnerships Updates.
- Update from the SaTH Pathology Team.
- Dr Stephen James provided an update about the implementation of the Integrated Care Record.

3rd March 2021

- CCG Chair, Locality Chair and Director of Partnerships Updates.
- Discussion about the proposed proforma for 2 week wait colorectal referrals.
- Mental Health update.
- Overview and live demonstration of the online Kooth service and resources available.
- Phlebotomy update – this included information about the ongoing review and how patients and Primary Care can give feedback.
- Respiratory Update from Dr Katy Lewis.

Actions required:
No actions required – report provided for information only.

Monitoring Form
Agenda item: GB-21-05.030

Does this report and its recommendations have implications and impact with regards to the following:

1	Additional staffing or financial resources implications	No
2	Health inequalities	No
3	Human Rights, equality and diversity requirements	No
4	Clinical engagement	No
5	Patient and public engagement	No
6	Risk to financial and clinical sustainability	No

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT AND MONITORING

Agenda item	GB-21-05.031
Committee:	Governing Body Part 1 Meeting
Date:	12 May 2021

Title of report:	Shrewsbury and Atcham Locality Forum
Responsible Director:	Claire Parker, Director of Partnerships
Author of report:	Dr Ella Baines
Presenter:	N/A

Purpose of the report:

To update the CCG Governing Body about the topics discussed at the meetings and any actions arising they need to be aware of.

Key issues or points to note:

Key areas of discussion at the following meetings:

18th February 2021

- CCG Chair and Director of Partnerships Updates.
- Overview and live demonstration of the online Kooth service and resources available.
- Mental Health update – Members raised issues re long waiting lists and rejected referrals.
- Phlebotomy update – this included information about the ongoing review and how patients can give feedback.

18th March 2021

- CCG Chair and Director of Partnerships Updates.
- Discussion about the proposed proforma for 2 week wait colorectal referrals.
- Update from the Public Health Nursing Service.
- Mental Health update.
- Update about the new Maternity IT System – BadgerNet.

Actions required:
No actions required – report provided for information only.

Monitoring Form
Agenda item: GB-21-05.031

Does this report and its recommendations have implications and impact with regards to the following:

1	Additional staffing or financial resources implications	No
2	Health inequalities	No
3	Human Rights, equality and diversity requirements	No
4	Clinical engagement	No
5	Patient and public engagement	No
6	Risk to financial and clinical sustainability	No

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT AND MONITORING

Agenda item	GB-21-05.032
Committee:	Governing Body Part 1 Meeting
Date:	12 May 2021

Title of report:	North Shropshire Locality Forum
Responsible Director:	Claire Parker, Director of Partnerships
Author of report:	Dr Katy Lewis
Presenter:	N/A

Purpose of the report:

To update the CCG Governing Body about the topics discussed at the North Locality meetings that took place in February and April and any actions arising they need to be aware of.

Key issues or points to note:

Key areas of discussion at the following meetings:

25th February 2021

- CCG Chair, Dr Julian Povey, CCG Chair, gave an update on the following:
  - Dr John Pepper's appointment as Chair of the new CCG from 1st April 2021.
  - Election process of a new GP member (Shropshire) to the Governing Body.
  - The vote on the new CCG Constitution had been carried.
  - Covid-19 rates in the county - rates declining in Shropshire and Telford & Wrekin. Update on number of positive cases in SaTH, continues to be busy but numbers falling.
  - Covid vaccination programme - going really well locally, the numbers of vaccinations that had been administered were shared, the different sites and target cohorts. Detailed breakdowns of uptake so far and planned activity were shared. Acknowledgement of the hard work by practices and PCNs. Discussion regarding the identification of carers.
- Locality Chair update – Respiratory discussion – Team to be invited to the next meeting.
- Director of Partnerships Updates.
- Discussion about Maternity prescribing issues.
- Discussion about the proposed proforma for 2 week wait colorectal referrals. Practices reported that they are getting requests to do FIT testing.
- Mental Health update from Cathy Davis. Highlights included that formal NHS England approval had been received of the Community Mental Health Transformation programme work and development of place-based hubs, which is now moving to the development phase and will be piloted with North Shropshire PCN and Wrekin PCN. This will develop over the implementation period to cover all PCNs. The Perinatal Mental Health service is now open for referrals and additional support available for patients linked to the Ockenden Review. An action plan is being developed from the

Mental Health Survey undertaken by Dr Priya George last Autumn and will be brought to future meetings. There have been a number of crisis support service expansions - the 24/7 helpline now has options for under 18s and over 18s as part of the general access route into services. A Children and Young People's crisis service is now up and running and operating 24/7, this is already having an impact on avoiding admissions into SaTH of children and young people. Additional resource in the third sector (Mind) put in place from winter monies. An overview was also given of the available winter discharge schemes. There was discussion around issues with Autistic Spectrum Disorder (ASD) referral and assessment, with referrals from the GP being bounced back and requested from the school. Issue also raised of letters being received back following a referral into MPFT with a request for the GP to monitor the patient while they were waiting to be seen by the service.
It was noted that the mental health survey results had not yet been shared with localities.

- Jennifer Shergill, Kooth Engagement Lead attended the meeting to discuss and demonstrate the resources offered via Kooth. This included a demonstration of Swivle, a new online promotional portal where professionals can view and download a full suite of digital resources; a Kooth demo site to show the extent of information and resources available to young people, and campaign information.

22nd April 2021

- CCG Chair Update – Dr John Pepper attended his first meeting as STWCCG Chair.
- Locality Chair and Director of Partnerships Updates.
- Mental Health update from Cathy Davis. Frustration that the mental health survey results had still not been shared with localities.
- Phlebotomy update – this included information about the ongoing review and how patients and Primary Care can give feedback.
- Respiratory Update from Sarah Pezzaioli, Shropshire Community Health NHS Trust. Updated guidance materials were shared on referral pathways.
- Practices raised concern about increasing numbers of requests from secondary care to undertake 'secondary care work'. Plus continual issues with patients on waiting lists being told to talk to their GP to expedite the referral.

Actions required:
No actions required – report provided for information only.

Monitoring Form
Agenda item: GB-21-05.032

Does this report and its recommendations have implications and impact with regards to the following:

1	Additional staffing or financial resources implications	No
2	Health inequalities	No
3	Human Rights, equality and diversity requirements	No
4	Clinical engagement	No
5	Patient and public engagement	No
6	Risk to financial and clinical sustainability	No

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 12 May 2021**

Item Number:	Agenda Item:
GB-21-05.033	TWCCG CCG Practice Forum – 16 February 2021

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Ian Chan T&W CCG Forum Chair Ian.chan@nhs.net

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

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

Executive Summary (key points in the report):

CCG Update

Unfortunately as Mr Evans or any of the directors were unable to attend the meeting there was no update provided.

GP Practice Forum Chair's Update

Dr Chan reminded members that the vote for the new CCG Constitution closed at 8pm on 16th February.

Clinical Commissioning Developments / Proposals

Neurology Update

Dr Julie Davies attended the meeting for this agenda item. The arrangements with New Cross Hospital, Wolverhampton are being finalised. A paper outlining the arrangements will be presented to the Joint Strategic Commissioning Committee (JSCC) at their meeting, which is taking place on 17th February.
The service run by New Cross Hospital is on schedule to begin on 1st April 2021.
The outpatient clinics and capacity would be maintained at both the Royal Shrewsbury and Princess Royal Hospitals.
Discussions are on-going with a GP Practice within Telford and Wrekin to provide additional clinic space.

The Neurology staff who currently work for SaTH would be TUPE'd over to New Cross Hospital on 1st April 2021. There will then be a period of consolidation.

Following the COVID period there would be a second phase of work looking at pathways and future models of care; including for options to deliver this care closer to home for patients. There will be full patient and public engagement on this and it will then be taken through the Joint Health and Scrutiny Committee (JHOSC) later in the year.

Dr Coventry asked if there would be any neurology inpatient provision and in relation to liaison with neurosurgery, which neurosurgery teams would be involved with the New Cross Hospital model.
Dr Davies responded that inpatient provision is covered as part of the agreement with New Cross Hospital and by having the scale of New Cross Hospital behind the service, there would be a greater nucleus of a service and New Cross Hospital had been successful in recruiting additional Consultant Neurologists. With regards to neurosurgery, currently this is being worked through; SaTH will link to University Hospitals of North Midlands and New Cross have been linked to University Hospitals Birmingham. There is also some day case capacity, which needed to be sourced and this would be discussed at the next meeting with New Cross Hospital.

Integrated Care Record

Dr Stephen James, Chief Clinical Information Officer, attended for this item for both CCGs along with Mrs Gill Richards, Information Governance Manager at Shropshire Community Health Trust (SCHT) who is also one of the IG Leads for the Integrated Care Record. The chosen solution is CareCentric, which is provided by Graphnet. The specific area of CareCentric is called One Health and Care and was already up and running in Staffordshire. CareCentric already covers 20m of the English population and is the biggest supplier of integrated care records at the present time. The project team is being led by SCHT. The integrated care record itself provides real time access to a single secure shared care record, which allows care professionals to communicate and collaborate safely and effectively across disciplines and organisations. Patient information will be stored in a cloud based data store. Organisations that will be able to add patient information will be GP Practices, SaTH, RJAH, the CCG, the two local authorities, WMAS, SCHT and MPFT. There is a patient portal where individuals will be able to access their own records, which will not be available immediately but will become available later in the process. The benefits of the system include that it will reduce how often patients need to repeat their health and social care history. It allows for patient information to be available to all staff who are directly involved in their care. It will improve patient safety, clinical decision making and clinical and operational efficiency, and there will also be time savings. It will reduce the amount of time GP Practice staff deal with telephone calls and emails from secondary and social care as the information will be available to them on CareCentric. The areas that it will impact on general practice are the data sharing agreement, the legal basis that is being used under GTPR is direct care, therefore there are no issues regarding consent either implied or explicit.

Dr James said that in relation to the data sharing agreements he was in the process of approaching the LMC to ask them to endorse the process that would be followed. Dr Chan asked what benefits were being seen within the organisations who had already implemented CareCentric.
Dr James responded that various case studies had been released but it depended on how it was being used and there were other components of CareCentric including MDT working and the patient portal. It also included population health management. The benefits seen included a reduction in attendance at A&E, reduced admissions and it had a positive impact on primary care.
Dr Chan asked, in relation to how data was shared, would data from other organisations be fed directly into the primary care data system. Dr James responded that he believed that data could be copied across but would not automatically transfer into EMIS. Mrs Richards said that it was a central platform and so the regular feeds from the data controllers would go into the one healthcare platform, which is a viewing platform for all of the organisations. Although direct care would be the main focus there will be a phase to introduce secondary use for example planning and research purposes and this should come into place in the autumn.

Mental Health Service Update

Mrs Sutherland attended the meeting for this agenda item. The following key points were highlighted.
The main piece of work underway is the three year transformation project. Ms Cathy Davies is leading this work in Shropshire and elford and Wrekin.
Looking to pilot two PCNs in the first year; North Shropshire with an element in Wrekin.
The specialist perinatal service is now in place and will see women who have moderate to severe mental health problems in relation to the perinatal period. This service will only see women who have had a baby. They will shortly be opening a maternal mental health service. This service will see people who no longer have a baby, whether the baby has died or has been taken into care; and also women with Tokophobia.

A service is in place that supports families who are going through the Ockenden Review and are referred directly by the Ockenden Review service. Over the past year crisis support for mental health had been increased and there is an urgent mental health helpline, which is available 24/7. Support is available to both patients and carers. The children's and young people's crisis service is now 24/7. Mrs Sutherland noted that it is early days; however an impact is being seen in relation to admission avoidance. Additional resource has been made available to increase the resource in the third sector; which had enabled the implementation of calm cafes run by Mind. Extra funding from the winter monies has been made available up until Easter, to support elderly inpatients within SaTH to enable their discharge. Funding has also been made available for the Autism Hub so that they can offer safe and well checks and activities in lockdown. There are also some mental health discharge admission avoidance schemes being put in place to reduce the demand on beds in emergency services. Shropshire, Telford and Wrekin still struggle to recruit consultant psychiatrists in particular. The Midlands Partnership NHS Foundation Trust (MPFT) is therefore looking at different ways to recruit staff.

Dr Chan acknowledged the amount of investment into mental health services and asked how the quality of the commissioned services was being monitored. Mrs Sutherland responded that quality meetings take place monthly with MPFT who provided information on what they are doing and how issues are being investigated. In relation to the survey, this had shown that there were issues around responsiveness both to patients and primary care and also the communication with primary care. Mrs Sutherland said that the budget for the local STP in relation to mental health services was less than all STPs in the country apart from one. There is also a

mental health investment standard, which is a percentage of the CCG's income and mental health services have to be increased by that amount. However, as very little is invested into mental health services, very little is invested into the mental health investment standard, which in turn results in an increase in health inequalities. Discussions are taking place with NHSE/I to endeavour to even this out and NHSE/I acknowledge that the CCGs need to put more into that baseline. Mrs Sutherland said that she was hopeful that more funding would be provided, more than fair share, by NHSE/I.

Mrs Sutherland said that there was an extra £500m available nationally for mental health and if Shropshire received its fair share this would equate to £5m. Dr Chan said that it would be useful for GP Practice Forum to receive updates around quality indicators to see that improvements are being made. Mrs Sutherland responded that the action plan from the GP Survey would be brought to the GP Practice Forum. There are also assurance documents that are produced for NHSE/I that highlight specific targets such as IAPT and EIP, which can be shared with members. Currently NHSE/I had stopped the assurance process so they have not been updated. Mrs Sutherland would like to present a mental health update to Forum as frequently as possible. Mrs Sutherland would also like to talk to GP Practice Forum members about learning disabilities. Mrs Sutherland will bring an update to each meeting.

GP Practice Forum Meetings Structure

Mrs Craddock will be chairing the Provider Forum until this arrangement is reviewed when the new CCG structures are in place. The Provider Forum will take place between 12.30pm to 1pm. There were no objections to this by the members.

Any Other Business

Dr Coventry said that as a Practice they had found it quite hard to work out how to vote on the new CCG's Constitution. There was some uneasiness around the Constitution, which may lead them to abstain from voting, which was around how the best interests of the patients and healthcare system in Telford would be supported in the new CCG. The Practice was unsure whether other GP Practices felt the same.

Dr Chan said that the Practice was correct to consider that possibility and felt it was important that the voice of the GP Forum was heard and it was also important that the Provider Forum should be maintained. Dr Chan said that at this point in time the work that had been undertaken ensures that Telford has a voice in the new CCG. A lot of work will come to the PCNs, however Practice based interests needed to be maintained and the Forum is the place to do this.

Dr Thompson said that a PLT event was planned for March 2021and it had been raised with Mr Evans as to whether the time could be used for COVID vaccinations as under the current situation it was difficult to plan an external PLT event. Shropdoc cover had already been arranged. Ms Parker had confirmed that she was happy with this suggestion. Dr Thompson noted that this would be around the 12 week mark for second vaccinations. GP Practices would receive further information via email.

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

Recommendations/Actions Required:

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