NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

AGENDA

Meeting Title	Governing Body Part 1 Meeting	**Date**	Wednesday 14 July 2021
Chair	Dr John Pepper	**Time**	1.00pm
Minute Taker	Swarmeet Kapur	**Venue/ Location**	Via Microsoft Teams

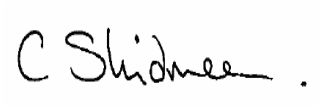
A=Approval R=Ratification S=Assurance D=Discussion I=Information

Reference	Agenda Item	Presenter	Purpose	Paper	Time
GB-21-07.035	Introduction and Apologies	John Pepper	I	Verbal	1.00
GB-21-07.036	Members' Declarations of Interests	John Pepper	I	Enclosure	
GB-21-07.037	Introductory Comments by the Chair	John Pepper	I	Verbal	1.00
GB-21-07.038	Accountable Officer's Report	Claire Skidmore	I	Verbal	1.05
GB-21-07.039	Minutes from previous meetings: • Shropshire, Telford and Wrekin CCG Governing Body Meeting – 12 May 2021 • Shropshire, Telford and Wrekin CCG Extraordinary Meeting – 9 June 2021	John Pepper John Pepper	A A	Enclosure Enclosure	1.10
GB-21-07.040	Action Tracker and Matters Arising from previous meetings	John Pepper	A	Enclosure	1.15
GB-21-07.041	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/	John Pepper	I	Verbal	1.25

Assurance Reports					
	Quality and Performance				
GB-21-07.042	Maternity, including Local Maternity and Neonatal System Update Report	Fiona Ellis		Enclosure	1.35
GB-21-07.043	Restoration and Recovery Update Report	Julie Davies		Enclosure	1.50
GB-21-07.044	Quality and Performance Report	Tracy Slater/ Julie Davies		Enclosures	2.00
	Break				2.10
	Finance				
GB-21-07.045	Finance Report Month 2	Laura Clare		Enclosure	2.20
	Governance				
GB-21-07.046	Proposed amendments to the Governance Handbook	Claire Skidmore		Enclosure	2.30
GB-21-07.047	Board Assurance Framework	Claire Skidmore		Enclosure	2.40
GB-21-07.048	***Item withdrawn***				
Strategic Transformation and other reports					
GB-21-07.049	Integrated Care System Update	Claire Skidmore		Enclosure	2.50
GB-21-07.050	Armed Forced Covenant	Claire Parker/ Tom Brettall		Enclosure	3.00
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)					
GB-21-07.051 (a-g)	Finance Committee – 28 April 2021, 26 May 2021	Geoff Braden	S	Enclosure	3.25
	Quality & Performance Committee – 28 April 2021, 26 May 2021	Meredith Vivian	S	Enclosure	
	Locality Meetings Summary	Claire Parker	S	Enclosure	
	Telford and Wrekin Locality Forum – 16 March 2021, 20 April 2021, 18 May 2021	Dr Ian Chan	S	Enclosures	
	Audit Committee 19 May 2021	Geoff Braden	S	Enclosure	
	Primary Care Commissioning Committee – 2 June 2021	Claire Parker/ Donna MacArthur	S	Enclosure	

	Strategic Commissioning Committee	Ash Ahmed/ Steve Trenchard	S	Enclosure	
GB-21-07.052	Any Other Business	John Pepper		Verbal	3.30
	Date and Time of Next Meeting – Wednesday 8 September 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 - 1 July 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
James	Stephen	Chief Clinical Information Officer (CCIO)	SCC					None declared	20.1.21		

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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
				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

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				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
				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

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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
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		

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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		
						X	Indirect	Wife is Member of University College Shrewsbury - Advisory Board	1.2.21		

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				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, Telford and Wrekin CCG
Governing Body Confidential Part 1 Meeting

Wednesday 12th May 2021 at 15:00pm
Via Microsoft Teams

Present from NHS Shropshire, Telford and Wrekin CCG:

Dr John Pepper	Chair
Mr Meredith Vivian	Deputy Chair and Lay Member for Patient and Public Involvement Governing Body Member
Dr Martin Allen	Secondary Care Doctor Board Member
Mrs Audrey Warren	Registered Nurse Governing Body Member
Dr Michael Matthee	GP/Healthcare Professional Governing Body Member
Dr Adam Pringle	Vice Clinical Chair and 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 Claire Skidmore	Interim Accountable Officer
Mr Steve Trenchard	Interim Executive Director of Transformation
Mrs Zena Young	Executive Director of Nursing and Quality
Mrs Laura Clare	Interim Executive Director of Finance
Mrs Donna MacArthur	Lay Member for Primary Care
Mr Geoff Braden	Lay Member for Governance
Mr Ash Ahmed	Lay Member, Patient, Public Involvement - Equality, Diversity and Involvement

Attendees for both meetings:

Dr Deborah Shepherd	Interim Medical Director
Dr Julie Davies	Director of Performance
Miss Alison Smith	Director of Corporate Affairs
Mrs Sam Tilley	Director of Planning
Mrs Fiona Smith	Joint GP/Healthcare Professional Governing Body Member
Dr Stephen James	Interim Chief Clinical Information Officer
Mrs Claire Parker	Director of Partnerships
Ms Rachel Robinson	Director of Public Health Shropshire Council
Mrs Liz Noakes	Director of Public Health Telford and Wrekin Council
Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Ms Marion Kelly	General Manager, Healthwatch Telford and Wrekin
Mrs Michelle Campbell	Personal Assistant – Transcription of minutes (not in attendance)

1.1 Dr Pepper welcomed Governing Body members and the public to the NHS Shropshire, Telford and Wrekin CCG Governing Bodies meeting 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-21-05.007 – Apologies

2.1 There were no formal apologies to note.

Minute No. GB-21-05.008 – Members' 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.shropshiretelfordandwrekinccg.nhs.uk/about-us/conflicts-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-21-05.009 - Introductory Comments from the Chair

4.1 Dr Pepper noted there was a full agenda which reflects the transition to a new CCG including adoption of strategies and policies. The agenda will focus on quality, performance and finances and an important paper on the Niche Consultancy Report. The focus is also on integrating CCG work with the wider STW system and the ICS. A paper will be presented on the role of a new Committee Assuring Involvement Committee which has been formed to ensure full involvement of the public in our commissioning decisions.

4.2 Dr Pepper marked International Nurses Day and expressed his personal appreciation and gratitude to all nurses across the STW system and more widely within the NHS. Dr Pepper expressed his thanks for the phenomenal work they carried out during the COVID pandemic and the work carried out day to day.

Minute No. GB-21-05.010 – Accountable Officer's Report

Mrs Skidmore provided an overview of current issues which included the following key areas:

5.1 **The ICS Board Meeting held on the 28th April 2021** – Mrs Skidmore reported on the ICS Board Meeting that took place on the 28th April 2021. Regular reports are to be received on the pledges for the system and the work that the Committees will oversee.

5.2 **Financial Recovery** - Mrs Skidmore reported on the financial recovery and highlighted the work around the Big Ticket areas to drive sustainability and the key areas of focus. Teams are intrinsically embedded into the work programme. There is some great work around the development across multi-disciplinary teams in various organisations.

5.3 **Restoration and Recovery Work** – Mrs Skidmore highlighted the restoration and recovery work that is taking place at the moment and the planning around recovering services for patients. We are starting to address the elective lists which will take time to work through.

5.4 **COVID-19 Vaccine Programme** – Mrs Skidmore confirmed that prevalence rates remain low with minimal COVID positive patients in hospital. As the prevalence rates remain low it will allow us to open up the elective activity. We continue with the key message to not be complacent and to observe the rules and encourage the population to receive a vaccination when offered and return for a second dose. The current delivery model is in line with the JCVI Guidance with planning to commence for Phase 3 and a follow up to be outlined in the coming months.

5.5. **Office Move to Ptarmigan House** – Mrs Skidmore reported on the office move from William Farr House to Ptarmigan House. There is slippage in the move schedule due to the delayed delivery of IT equipment. We are preparing for the move and are working toward an agile working policy by taking lessons learnt from the last year with many staff currently working remotely due to the COVID pandemic.

Minute No. GB-21-05.011 – Minutes of the Previous Meetings – 10 March 2021, 24 March 2021 and

14 April 2021

6.1 The minutes of the previous NHS Shropshire Telford and Wrekin CCG Governing Body meetings in common held on 10 March 2021, 24 March 2021 and 14 April 2021 were presented and approved as a true and accurate record of the meeting subject to the following amendments:

6.2 **GB-21-03-034 - Independent Enquiry for Child Exploitation for Telford** - Mrs Young confirmed that it is not a report but a series of engagement meetings with the Chair of the enquiry. Mrs Young and Mr Evans met with the Chair and provided background information. Currently, they are still at the stage for information gathering and this will be an ongoing process. Dr Pepper asked Mrs Young to provide an update on any significant matters to the Board in future should they arise.

6.3 **Meeting Attendees** - Dr Matthee raised a concern on discrepancies in the attendance list to ensure that people are accurately captured in the meeting minutes. The minutes of the meeting held on the 10th March to confirm that the following people did attend the meeting – Dr Michael Matthee, Mrs Rachael Bryceland and Ms Fiona Smith.

6.4 **CNST** Ms Warren raised a query with Mrs Young from the previous minutes on how maternity is progressing. Mrs Young confirmed that this is covered in the quarterly maternity update report and to the local maternity and neonatal system programme Board. It is being attended to and will be covered in the quarterly report.

6.5 **GB-21-01.010 – Performance and Quality Report** – Ms Cawley noted that there was an error on page 4 of the meeting minutes on GB-21-01.010 the hot topic was on neurology and not urology.

6.6 **GB-21-03.038 – Performance and Quality Report –** Mrs Young noted that on point 9.14 and 9.16 the abbreviation is recorded incorrectly and should read Clinical Quality Review Meetings (CQRM) and not Clinical Quality Review

6.7 **GB-21-03.040 – Maternity Update** – Mrs Young noted that there was an error on point 11.18 in the last sentence the policy referred to is the CCG policy but should be the Values Based Commissioning Policy and not Policy for Procedures of Limited Clinical Value.

RESOLVE: Governing Body Members of NHS Shropshire, Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire, Telford and Wrekin CCG held on 10th March 2021 with the amendments outline above.

RESOLVE: Governing Body Members of NHS Shropshire, Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire, Telford and Wrekin CCG held on 24th March 2021 with the amendments outlined above.

RESOLVE: Governing Body Members of NHS Shropshire, Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented as an accurate record of the meeting of NHS Shropshire, Telford and Wrekin CCG held on 14th April 2021with the amendments outlined above.

Minute No. GB-21-05.012 – Matters Arising from the Minutes of the Previous Meetings held on

10 March 2021, 24 March 2021 and 14 April 2021

7.1 Dr Pepper referred to the matters arising from the last meetings on 10th March 2021 and 24th March 2021 and 14th April 2021, noting that some actions were marked as complete, and the following additional verbal updates were given:

GB-21.03.55 – Partnership Board Terms of Reference – Ms Parker gave her apologies that the information on the Partnership Board Terms of reference had not yet been circulated. Ms Parker would arrange for the paper be circulated after the meeting. Action agreed as completed

GB-21-01.004 – Draft ICS Application – Mrs Skidmore confirmed the ICS application had been approved and updated and that there was a new process provided by NHSEI for all systems to move through the ICS application. The process is very similar to the process completed for the CCG merger. Action agreed as completed.

GB-21-01.006 – Matters Arising *[b/f from GB-20-01-010 – Shropshire CCG Strategic Priorities]* –

Dr Davies gave her apologies that the information on the ambulance crew on-scene timings had not yet been circulated. Dr Davies updated on an unexpected illness with a team member and asked the Governing Body to allow time for the paper to be approved by the Quality and Performance Committee in

June. Approval was given by the Governing Body for the paper to be taken to the QPC Committee in June. Action agreed as completed.

GB-21-03.036 *b/f GB-21-01.018* SEND Inspection Report and Written Statement of Action (WSOA)

Dr Pepper asked Ms Parker to confirm if SEND would still be reported to the Governing Body. Ms Parker suggested that the report should go to the Quality & Performance Committee. With exception issues to be reported to the Governing Body. Mr Vivian asked for confirmation on an agreed action to showcase the work under the SEND banner, including people using services and part of the design. It would be an opportunity to showcase the effort made to make things better. Ms Parker confirmed, that it was agreed that this will be presented at the Quality and Performance Committee. Mrs Skidmore confirmed that the first point for the work should be the Quality and Performance Committee with Mr Vivian's support, but then brought to the Governing Body if there were any items of exception to report. Action agreed as completed.

GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report – Performance 14 Day Rule - Dr Davies confirmed that it is David Whiting who is leading the report. David Whiting has not yet made contact with Dr Matthee and Dr Davies agreed to follow this up directly with David Whiting. Action remains open.

GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report – Quality – MPFT – Dr Matthee confirmed that a formal letter from MPFT had not been received. Mr Trenchard to follow up. Action remains open.

GB-21-03.040 – Maternity Update - Caesarean Section - Mrs Young has requested from SaTH a more detailed report to consider caesarean sections in the round which will go to CQRM and QPC. An update at the next meeting to be provided when the report is received. Action remains open.

GB-21-03.045 – Update on the System Improvement Plan - Mr Trenchard updated that the Improvement Plan is superseded by the ICS Development Plan and is now the responsibility of Nicky O'Connor to align a System One Plan. Once completed, it will be brought back to the Board to share. Action agreed as completed.

7.2 Dr Matthee raised the Matters Arising Actions Log. Could we ensure that actions are marked as completed as this would give better clarity. Action completed.

Minute No. GB-21-05.013 – Questions from Members of the Public

8.1 Dr Pepper advised the CCG had received questions from the public for this meeting. Answers are to be submitted and published on the website within 2 weeks.

8.2 Dr Pringle asked if the questions had been circulated to the Board. Mrs Skidmore advised that questions had been circulated to the Executive Team but would be circulated to the Board outside of the meeting.

8.2 Mr Vivian asked about the questions from the public to the Governing Body and raised a concern that responses are not seen by the Governing Body prior to publication and felt that this was not good practice. Mr Vivian asked if this could be addressed. Mrs Skidmore to take the matter outside of the meeting and will arrange to discuss this with Mr Vivian. Action remains open.

ASSURANCE

Minute No. GB-21-05.014 – NHS Shropshire, Telford and Wrekin CCG Quality and Performance Report

Performance Report

9.1 Dr Davies presented the Performance section of the joint Quality and Performance Report, which was taken as read.

9.2 Dr Davies updated Governing Body members on the new Neurology service that is now live. It is a service commissioned from New Cross but will continue to be provided within the County footprint. The

go live has gone well and continues to meet weekly with both SaTH and New Cross on any operational issues. Dr Davies confirmed she planned to provide an update to the Governing Body in July for assurance on the new service.

9.3 Dr Matthee asked for clarity on page 3 cancer waits, it reads 2 minute wait, (breast cancer not suspected). Dr Davies confirmed that there are two 2 week standards, one for overall cancer; we do have a breast symptomatic two week standard which is non cancer. There is a two week pathway that is a non cancer pathway hence why it is worded this way.

9.4 Dr Matthee highlighted the report and the arrows used in the reporting line and suggested a data linear reporting system would be better. Dr Davies to take this action directly with Dr Matthee. In terms of the making data count, a request has been made at Quality Performance Committee to move this incrementally at a programme level to make progress. Dr Davies advised that this is a significant piece of work.

9.5 Mrs MacArthur raised the marked increase in walk in's and under 16's. Mrs MacArthur asked for clarify on how this is being managed and IAPS and the numbers which are still very low. Why are we still not achieving the target? Dr Davies confirmed that the underlying reasons on the under 16's increase walk-in's was an increase as schools reopened. There is currently a piece of preparatory work for discussion to be taken forward to the Urgent and Emergency Operational Group next week for review.

9.6 Dr Davies updated on IAPS. The issue around the capacity is complete but are still not back to previous levels. Dr Davies confirmed that referrals are improving and back to pre COVID levels with a Performance Assurance Manager looking at Mental Health with a pre-meet every month. Dr Davies asked Mr Trenchard to provide background to the point. Mr Trenchard provided an update, there are two different IAP models in the system. We are behind in terms of the investment for Telford and Wrekin and are uncovering some possible internal waits in the IAP Team. As part of our transformation work, we think there is a piece of work to be completed around standardising the IAP approach which should be joined up in our transformation work over the next year. Dr Pepper asked for a timescale for the transformation work to address the immediate concerns. Mr Trenchard to look into the particular issues in relation to performance and provide an interim update at the next meeting.

9.7 Dr Pringle raised the increase in Accident and Emergency activity and the assumption that this is due to Parainfluenza Virus with 50% of children seen at Shropdoc with symptoms of Croup. This is due to children not seeing anybody over the winter period which now have Croup. It raises a question on the need for a public information piece to try and encourage people to stay at home or a scheduled appointment to stop the spread of the virus. If we could look at Accident and Emergency to keep the cross infections rate down. Dr Davies to take this forward to the Urgent and Emergency Operational Group.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG NOTED the content of the NHS, Shropshire, Telford and Wrekin CCG Performance Report and the actions being taken to address the issues identified. The following four points are noted for action:

ACTIONS:

Dr Davies to provide an update on the new Neurology Service at the July meeting.

Dr Davies to discuss the data linear reporting system with Dr Matthee.

IAPS - Mr Trenchard to look into the particular issues in relation to performance and provide an interim update at the next meeting.

Dr Davies to take the increase in Accident and Emergency activity in children with Croup and Parainfluenza Virus to the Urgent and Emergency Operational Group.

Quality Report

10.1 Mrs Young presented this item and taking the paper as read highlighted the following points:

10.2 The Quality Assurance visit to recommence around Shrewsbury and Telford Hospitals and how we can undertake a different approach. As an example, join the Maternity Safety Champion Approach with work underway to engage with all providers.

10.3 Visits to care homes and the quality assurance with the requirements of the Health Protection Board for the system.

10.4 The outbreak position for infection, prevention and control has improved in line with COVID. We continue to have a close line of sight.

10.5 The serious incident framework. The guidance issued last year by NHSEI with improvement was to consider the management of SI within timeframes at local discretion and professional judgement. Work continues on this on a case by case basis.

10.6 The CQC Section 31 for Children's Young Persons Mental Health issued to SaTH Hospitals. This is a system piece of work with a significant number of strands taken forward by Mr Trenchard and Mrs Young on behalf of the CCG.

10.7 Mrs Warren raised the Maternity Dashboard and clarity on when we may have sight of this. Mrs Young confirmed that the CSU have commissioned a piece of work and it is key to have valid data and to have it understood. The Dashboard we are preparing is part of the LMNS work which allows us to understand our population, maternity health and the outcomes. This is on various things that can happen on a maternity journey to allow us to cut the data in various ways. Mrs Young to provide a sample report at the next Maternity Quarterly update.

10.8 Mrs Warren raised the report performance indicators and Children's Triage and Sepsis, which is monitored through CQRM. How does the Governing Board have sight of the improvements? Mrs Young confirmed that the assurance feeds through to Board by engagement meetings with the Trust. The internal governance meetings have sight of their CQC returns and update on action plans. In addition, this is also addressed at the Clinical Quality Review Meeting and the System Oversight Assurance Group. This is then reported through to the Quality and Performance Committee of the CCG.

10.9 Mrs MacArthur raised the CQC report into anaesthetic cover critical care services at PRH. It states that there is a national shortage and the Trust is mitigating for this. Are we assured that the mitigation is appropriate and we have safe services within the organisation. Mrs Young confirmed that the mitigation actions are around medical rotas and cover and are confident that they have sufficient seniority to cover the rota. This continues to be under review.

10.10 Dr Pepper raised MPFT and the continued request for extension for their SI's. Is there a concern on capacity or complexity and are we assured we are receiving all the SI's that we should be? Mrs Young confirmed that this relates to the point on serious incident framework that NHSEI have relaxed on the requirements. Discussions are taking place with MPFT on the application of this principle.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG NOTED the content of the Quality Exception Report. The following four points are noted for action:

ACTIONS:

Maternity Dashboard - Mrs Young to provide a sample report at the next Maternity Quarterly update.

Minute No. GB-21-05.015 – Niche Consultancy Report

11.1 Mrs Young presented this item and taking the paper as read, the following points were highlighted:

11.2 Mrs Young and Dr Shepherd are co-leading the work for the CCG.

11.3 The Niche Report was commissioned by the CCG in 2018, it has taken a while to progress for a variety of reasons. In particular, staff changes at senior level and COVID making it particularly difficult to progress. We should note the achievement of delivering this piece of work under very difficult circumstances.

11.4 Dr Shepherd updated on the Learning from Deaths System Work and Regional work. A system Learning from Deaths Group is to be set up. There is a lot to learn that would not have come from individual organisation learning from deaths reviews. It is formed from what happens at interfaces between the organisations and that has been a valuable process. In addition, there is also a Regional Learning from Death Forum which currently on hold but about to recommence.

11.5 Dr Pepper opened up discussion for questions.

11.6 Ms Noakes highlighted a number of issues raised in the report around the poorer quality of care for those with mental illness. How can we learn from the findings from this review in terms of the interfaces.

11.7 Mr Vivian was troubled by the report, 38% having poor quality of care. It felt that the people that are in receipt of this poor care could be described as valued less than other parts of the population.

11.8 Dr Pringle asked if there is a benchmark and asked for clarify on the 38% poor care. Is it 38% poor care or 38% poor documentation. In addition, the issue raised on the excess of older people being admitted overnight with poor care and with no overnight care services.

11.9 Mrs MacArthur raised the content of the report and how troubled she felt after reading some of the content. In terms of individuals, we appear to be failing the most vulnerable group of patients. For next steps, is there a training and skills issue around care for those particular patients? In addition, it was noted in the report that it was agreed right at the outset that any cases of immediate concern would be raised with individuals.

11.10 Dr Matthee raised the content of the report and the fact that he was not surprised especially with some of the discharges which were all too frequent last year. Overall, it was a very positive report and noted that page 25 and 26 had captured everything accurately.

11.11 Dr Pepper reflected on how we should take the learning forward and the need for tangible changes. In particular, the most vulnerable groups, elderly and those with severe mental illness and dementia. Dr Pepper requested that this be addressed within the Learning from Deaths Group to explore the services for people for admittance avoidance. Dr Pepper asked for clarity on the quality and respect forms and if this has or will be addressed.

11.12 Dr Matthee raised from the report diabetes and discharge. Is there a place for the diabetic nurse service to be expanded and should this include hospitals with some form of better system in place for diabetes.

11.13 Mr Trenchard shared his concern with colleagues on the content of the report and raised the important messages that come out of the report. It is about how we do things earlier and take forward as a system. In addition, it also raises the requirement to have good physical health checks in place by aligning mental and physical health throughout all of our work and pathways.

11.14 Mrs Young thanked everyone for their questions and offered assurance that the recommendations are to be acted upon. The report is presented as is at the moment with the note that there is further work to be carried out. Through the newly established system Learning from Deaths Group the terms of reference will be developed to include coverage on the recommendations of this report. The report does highlight that there are lessons to be learnt that will benefit other patients who have not died. The report is not just about those that have died but how we manage medicines that might require rapid review.

11.15 Dr Pepper reflected on the report and the tangible changes required. However, there is also some excellent treatment outlined. In summary, there is a lot of learning and actions to take away. Dr Pepper asked Mrs Young to provide a list of all the recommendations as they are, against how these are to be individually actioned and progressed. Dr Pepper recommended an interim report to the Governing Body in July to update on the addressed concerns. Mrs Young advised that for the reporting it would be better for an update in September. Dr Matthee felt that this was too long. Dr Pepper requested that the interim report be produced and shared at the next Committee Meeting in July. For clarity, the questions that we

are asking are that the recommendations and the points highlighted in the report are taken to the two groups and also to the System Quality Governance structure to address the recommendations.

11.16 A discussion took place and it is agreed that a report should be assured by the System Quality Group and the Quality and Safety Committee for ICS. Mrs Young confirmed that this is where the Learning from Deaths Group will report into.

11.17 Mr Trenchard raised that the report could be shared through a public communication through an appropriate channel that provides the assurance that this is being taken seriously. Also, to recognise some of the good practice but collectively wanting to use this as a means to make improvements.

11.18 Mrs Cawley shared Mr Trenchard's comments and supported the suggestion for publication. Healthwatch Shropshire in 2020 published a report about end of life and palliative care and the findings supported the key findings from the Niche Report. Mrs Cawley to share the report with Dr Shepherd and the End of Life Group.

11.19 Mrs Cawley raised a matter on people with diabetes discharging themselves from hospitals because they feel that their diabetes is not managed appropriately. Mrs Young to follow up separately and address at the Quality and Performance Committee with the CCG.

RESOLVE: NHS, Shropshire, Telford and Wrekin CCG are asked to note the contents of the Niche Consultancy Report and the next steps for Shropshire, Telford and Wrekin system approach from learning from deaths.

ACTIONS - NICHE CONSULTANCY REPORT:

11.15 Mrs Young to provide an interim report from the recommendations made in the report and provide an update at the July Governing Body meeting
11.18 Mrs Cawley to share a report produced in 2020 from Healthwatch Shropshire about end of life and Palliative findings.
11.19 Mrs Young to share with the Quality and Performance Committee information provided by Mrs Cawley on patients with diabetes not being managed appropriately.

FINANCE

Minute No. GB-21-05.016 – NHS Shropshire, Telford and Wrekin CCG Finance Report Month 12

12.1 Mrs Clare presented the combined Finance and Contracting report for the period up to the end of the Month 12 position, which was taken as read. The following key headlines were focussed upon:

12.2 Mrs Clare reported that the final position for 2020/21 was a £600,000 deficit across the two legacy CCG's against the target of break even from NHS England. It is important to note, that this needs to be taken in the context of last year. We have received significant non recurrent funding because of the COVID pandemic. The underlying position is £71m deficit and this has been taken for the starting point for the longer term financial strategy.

12.3 As part of the audit process and the annual accounts there is a section in the report that outlines that Governing Body members do need to make the declaration regarding knowledge of information relevant to Auditors for the purpose of the Audit Report.

12.4 Mr Braden raised the underlying issue and the £71m deficit. In October, we had a £50m deficit and broke even for Shropshire and a little of an overspend for Telford. Mr Braden wished to highlight the hard work that has been carried out by the Execs, Mrs Skidmore and Mrs Clare to take us from that position in October to achieve £71m of QIPP savings.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG NOTED the information contained in the Financial Report and approved the declarations outlined in paragraph 25 for the annual accounts.

Minute No. GB-21-05.017 – Update on progress against our ICS Pledges

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

13.2 Mrs Skidmore noted previous conversations at Governing Body that had highlighted the need to have more of an update on what is happening within the ICS space. We feel more included and there are a number of us involved in lots of pieces of work. We are trying to find a way to give Governing Body an oversight of all the strands and have started to see an update report coming through to the system and Chief Executives Group. In addition, there is also more reporting coming through to the ICS Board. The report is available and highlights the specific progress made in all of our areas for our pledges. We did note a gap for HR in the report but Mrs Rankin has reported back to Chief Executives Group on the Workstream for HR.

RESOLVE: NHS, Shropshire, Telford and Wrekin CCG noted the report and the work being done in the delivery of the ICS's 10 pledges.

Minute No. GB-21-05.018 – IT Strategy Update and Digital Tactics

14.1 Dr James presented this item and the following points were noted:

14.2 The paper presented describes where we are at the moment with the strategy and the process we are taking in producing the strategy and the initial priorities. The additional note is the tactical projects in giving an update on where we are with the first two.

14.3 The first is on the domains for general practice which is part of infrastructure and security with 24 of the 51 practices and is still on target to complete the remainder by the end of the month.

14.3 The second is the fibre to the premises, we have 5 practices which we hope to have completed by the end of the month.

14.4. Dr Pepper raised a point on the workshops and if many people were indeed attending and people signing up to attend. Dr James confirmed that the next workshop will involve people from other parts of the system in the discussion. The alignment to the system is very important.

14.5 Dr Pepper asked the Governing Body to note the progress and plan around the development of the CCG IT Strategy and the key tactical projects in place for 2021/22. Regular updates will be provided as development progresses.

RESOLVE: NHS, Shropshire, Telford and Wrekin CCG noted the report and the progress and plan around the development of the CCG IT Strategy and the key tactical projects in place for 2021/22.

Minute No. GB-21-05.019 – Assuring Involvement Committee

15.1 Mr Vivian and Ms Smith presented an update on the Assuring Committee. The Committee is setup to assure that patients and the public are involved appropriately and effectively in our commissioning activities and our work more widely. The Committee is to assure, on behalf of the CCG Governing Body that people are being involved and that plans are in place to involve people appropriately and that decisions of the CCG Governing Body have been informed by people.

15.2 Appointments are in progress with 12 members to be appointed to the Committee. Mr Vivian and Mr Ahmed are in place as part of the Committee with the additional 10 appointed members. Miss Smith is also involved and people should receive letters imminently to join the Committee and for it to be up and running.

15.3 Dr Pepper highlighted that this is to be a twofold Committee the first partly meeting the public sector and quality duty as well. A discussion took place and Mr Vivian agreed that this will strengthen the process. The Committee will be there to ask the question, have the people affected by these decisions been involved in them?

15.4 Mrs Cawley raised that she is keen to explore how Shropshire Healthwatch can offer support to the Committee.

15.5 Mrs Young asked how the new Committee fits to the system governance arrangements moving forward and if we are setting something that would end on the 31st March. Mr Vivian confirmed that he would like the Committee to step into the system place.

15.6 Dr Shepherd raised that it was an encouraging development as we often talk about intending to engage with the public for their input and this will be a very useful resource. Dr Shepherd asked for clarity on how we envisage this working and if we should bring projects to the Committee. Mr Vivian confirmed the Committee is there to assure a piece of work. The Committee is not the involvement method itself but to assure the involvement process.

15.7 Mr Trenchard commented that he thought it is a good idea. There is presently, a lot of discussion in the broader system across health and care. We have initial plans to capture and scope the involvement that is already happening. We can learn from across all our transformation schemes and will have a forward rolling programme of plans that can come through to the Assurance Involvement Committee.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG noted the content contained in the verbal Assuring Involvement Report.

DECISION MAKING

Minute No. GB-21-05.020 – CCG Corporate Mission Statement and Strategic Priorities

16.1 Dr Pepper asked the Committee for any questions on the CCG Mission Statement and Strategic Priorities which we have brought back after some amendments.

16.2 Ms Noakes raised a comment on the Health and inequalities phrase. It does feel like where and when services are planned and not the how. Ms Walker would like to recommend the following change in the wording of the mission statement to read:

To reduce health inequalities by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.

16.3 Mr Vivian commented on the language. The paper refers to strategic objectives and then separately strategic priorities.

16.4 Mr Vivian raised that safety did not appear in the language here but wondered if we ought to highlight safety element.

16.5 Mrs Skidmore confirmed that she takes on board the comment made from Ms Noakes on the more rounded description suggested.

16.6 On Mr Vivian's point on strategic priorities or objectives and the need for consistency. These are our strategic priorities which link back to and form the foundation for our foundation for our board assurance framework. The priorities are listed at the top of that assurance framework and will map our risks and mitigations and give our assurances against them.

16.7 In terms of the point on safety Mrs Skidmore would be happy to include the word in the strategic priorities.

16.8 Dr Pepper would like to add a reference to our priorities in the covering report we bring to board to see how the workings over the year align to our priorities. This would allow us to reference the priorities as we bring papers through. Miss Smith to action.

ACTIONS - CORPORATE MISSION STATEMENT AND STRATEGIC PRIORITIES:

16.2 Miss Smith to update the wording of the mission statement to read for Health and Inequalities additional information agreed.

16.4 Miss Smith to include the word safety in the Strategic Priority around quality.
16.8 Miss Smith to provide a reference to our priorities against the papers we bring to Board and Committees in the covering report templates.

RESOLVE: NHS, Shropshire, Telford and Wrekin CCG noted the report and was asked to note the actions and changes in the Corporate Mission Statement and Strategic Priorities.

Minute No. GB-21-05.021 – Operational Plan

17.1 Mrs Tilley presented the verbal update on the Operational Plan to give a statement on where we are and next steps following updates received previously. To reiterate the context, we are in a very unusual planning round this year given different timescales. This is due largely to COVID moving the timescales on and condensing those to a degree as well. We are also for the first time completing the planning round as a system rather than individual organisations. In previous updates that NHS England specify, a timetable and a number of elements of the plan need to be submitted in different forms in different points.

17.2 The first milestone draft narrative plan along with the finance plan and draft activity information is to be submitted on the 6th May. We are pleased to say that this is now completed with the system pulling together collectively to populate quite a difficult template. We have now completed this as a draft and have submitted and are expecting feedback from NHS England at our review meeting tomorrow. We will continue to work towards refining our plan for final submission on the 3rd June.

17.3 In terms of next steps, the initial interim piece has been submitted as we continue to work on the plan as a system. As it is a system plan we are also submitting to the ICS Board on the 26th May for system sign off. Leading up to this we are also looking at how we sign this off as a CCG. Ms Tilley will finalise steps for the CCG sign off with Dr Pepper and Mrs Claire.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG noted the content contained in the verbal update.

Minute No. GB-21-05.022 – 2021/22 Finance Plan

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

18.2 Mrs Clare advised that the financial plan forms part of the overall plan submission to NHSE/I on the 6th May. It is still complicated, in terms of the financial temporary arrangements put in place for the first 6 months of this year. We need to highlight that this is how we are delivering against the Sustainability plan that is being put in place against the system. The H1 plan is simply a 6 month plan within the framework with a separate funding envelope. The most likely scenario is a £6m system deficit. In terms of the overall system sustainability plan, focus needs to be around the efficiencies plans and developing the Big 6. In terms of transformational savings for the system across the future years, we are focussing all our efforts with Mr Trenchard's team leading the process and setting up the internal governance around this.

18.3 Mrs Skidmore offered her support and reiterated Mrs Clare's point on the financial plan and the need to complete this as a system, as well as an organisation. We are asked to deliver a break even plan but are careful to articulate why this is possible in reporting terms to meet requirements. We have set a plan for breakeven with a supporting narrative that describes the £6m risk that we hold for the first half of the year. At the Executive Meeting, a discussion took place around the adjustment for break even within the CCG position. We would like to assure members not agreeing to take on the £6m for CCG that this is a place to park the position. As we complete our system reporting we look at our results which we consider as a Board our CCG results. Mrs Clare's team report the wider context in terms of system position and all

Chief Executives agree that management of that risk for the system is a collective responsibility. This is not just a risk for the CCG which is important to point out to Board members.

18.4 Mr Braden wanted to add to the recommendations for Board to consider referring back to the letter from the 5th March from the NHSEI. It is clear on the expectations on each of the constituent parts of ICS delivering their 3% target in H1 in £6m gap. We are currently at £4.9m and have some work to do. The longer it takes to plan the things that you are going to execute the less impact it will make in a year. Mr Braden noted the work and input from the Finance Committee in providing support for the Executives.

In addition, the urgency against the backdrop of 3% should not be ignored. The issues we are asked to note is to be clearer around what should be done. Mr Braden asked Committee members to read the letter sent from NHSEI.

18.5 Mrs Clare commented on Mr Braden's points and the final recommendation where we note progress and next steps to develop the Sustainable Finance Plan. We should draw out that the key focus is working toward delivering more against the 3% target and really making sure we have the resource against the Big 6 for the future transformational savings.

18.6 Dr Pringle commented on the straight line and top level, looking at £30m QIPP. Larger savings are going to take longer term system redesign and need to happen over years, which in turn will make a more realistic structure over time.

18.7 Mrs Clare commented that the plan is about sustainability and maintaining the level of spend seen in previous years. There is a need this year to work on the Big 6 transformational savings and anything else that comes out. We can then work on delivering from the next financial year and that will take full system commitment and ownership. Mr Trenchard's team are working on each of those schemes individually.

18.8 Mr Trenchard fully supported Dr Pringle's comments. A suggestion is around the way we run our Sustainability Working Group next year or the year after to pull out a plan over the next 5 years. The challenge is getting on board the finance and performance colleagues to understand the activity and the changes and thinking about the impact. This is a year of stabilisation and planning for the longer term view.

RESOLVE: NHS, Telford and Wrekin CCG are asked to note the contents contained in the report and the recommendations noted and approved.

DECISION MAKING

Minute No. GB-21-05.023 – Governing Body Annual Cycle of Business April 2021 – March 2022

Dr Pepper introduced the item on the cycle of business for the Governing Body and asked for any questions.

19.1 Dr Pepper referred to the Flu Plan reference in the document and whether the timing was realistic. Mrs Tilley confirmed that the Flu Plan is to be presented in November and is a realistic timeframe. Mrs Tilley commented this it is an estimate in terms of when the plan will be prepared and when it actually falls in the business cycle. Currently, we are expecting some complex planning in terms of how this will align with COVID. We are still waiting on guidance on how this can be brought forward should we be in a position to do so earlier.

19.2 Mrs Young raised LMNS should feature in the plan as it does not appear at all and would Miss Smith with the details. Miss Smith to include.

ACTIONS - DECISION MAKING:

19.1 Governing Body Cycle of Business - Miss Smith to add LMNS in the Governing Body Annual Cycle of Business and Mrs Young to confirm timing.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG RECEIVED and NOTED for information the Governing Body Annual Cycle of Business and approved adoption the Governing Body Cycle of business as included in the report.

Minute No. GB-21-05.024 – Transition to new CCG – Adoption of Key Strategies and Policies

20.1 Ms Smith presented this item for approval and noted that the report is split into three sections. The first part representing a number of strategies of which 3 were developed through the application process to transition to a single CCG. For some of these, the narrative reflects a point in time and due to delays created by COVID the Communications and Engagement Strategy has defaulted to a one year strategy. The second section was around the adoption of key policies for the new CCG. The following detail was provided:

- Commissioning Strategy (App 1) – developed over the last 8 months as part of the application process
- Communications and Engagement Strategy (App 2) – developed over the last 8 months
- OD Strategy and Plan (App 3) – used during the process of application with some work still ongoing post April 2021
- Risk Management Strategy (App 4) – took to Audit Committee last month approved for support and recommendation to the Governing Body for approval
- Conflicts of Interest Policy (App 5) – requires approval by the Governing Body
- Health and Safety Policy (App 6) – requires approval by the end of May by the Governing Body

Finally the third section was around the adoption of legacy NHS Shropshire CCG and NHS Telford and Wrekin CCG Policies outlined in the following documents appended to the report:

- CCG Policies for Adoption by STWCCG (App 7)
- Medicines Management Policies for Adoption by STWCCG (App 8)

20.2 Mr Vivian suggested that updated strategies had the new mission and strategic objectives included. Mrs MacArthur also reiterated Mr Vivian's point and commented on a gap around some of the things happening with the ICS for Primary Care Commissioning and the delegated functions and that they are not represented in any of the diagrams or structure sections. Miss Smith commented that this is an area that has not been clarified. It is delegated so that the statutory responsibility remains within NHS England so the ability to vary is severely limited. Guidance from NHS England must be followed in terms of policies and strategies with Primary Care there is less room for manoeuvre and we await the legislation.

20.3 Dr Shepherd raised Medicines Management Policies and the fact that there is no consistency between those that are published on the website and those that are not. Dr Shepherd asked that if the publishing section on the new website could be reviewed by Medicines Management and in most cases published as a reference. Mrs Young to action.

20.4 Mrs Skidmore raised the Finance Strategy which had also been through the application process but did not appear in this paper. A judgement was made to not to include the Finance Strategy, it was submitted as part of the suite of documents in the merger process. There is a plan to take this through the system work and bring back in the coming months.

20.5 Ms Noakes commented on the Children's Best Start in Life and felt that it was not strongly represented in the Commissioning Strategy document. A recommendation was made for Children's Physical Health to be placed under Community and Place Based Care. There is reference made to all age mental health in the mental health section which does not appear to be strong enough in terms of how the document is written and children's health.

LMS – Maternity System is also not included in the Commissioning Strategy and the best start in life not adequately reflected. Mrs Tilley to take this action to the Exec team.

20.6 Ms Cawley raised the Communication Strategy. Ms Lawley would like to see a more explicit reference to Health Watch in the document. A question was raised on the role of Healthwatch and the support provided to the CCG on assurance. In terms of the reports produced it differentiates Healthwatch from other patient groups that are listed. In addition, frequently the word 'co-production' is used across the system in strategies but is not included in the strategy. A discussion took place and Ms Smith agreed on the points raised by Ms Cawley to make reference to Healthwatch more explicit. In addition, the use of the word 'co-production' would be included in the strategy.

20.7 Dr Matthee commented on the Commissioning Strategy and felt it was a good piece of work but still required work. Dr Matthee raised that Placed Based Care and Primary Care does require adjustments.

20.8 Dr Pepper thanked Ms Smith for the tremendous work in bringing together the policy documents.

RESOLVE: NHS Shropshire, Telford and Wrekin CCG RECEIVED and NOTED for information the Committee Chairs' reports as presented in the Key Strategies and Policies. There are four recommendations for action with suggestions of amendments to be made with no objections to the suggested amendments and action.

ACTIONS:

Medicines management policies - Dr Shepherd asked that if the publishing section on the new website could be reviewed by Medicines Management and in most cases published as a reference. Mrs Young to action.

Commissioning Strategy - Mrs Tilley to review the Commissioning Strategy with a recommendation for Children's Physical Health to be placed under Community and Place Based Care.

Commissioning Strategy - LMS – Maternity System is also not included in the document. Mrs Tilley to review with the Exec Team.

Communications and Engagement Strategy - Miss Smith to have a more detailed reference to Healthwatch in the Communication and Engagement Strategy.

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:

Minute Nos. GB-21-05.025 to GB-21-05.029 NHS Shropshire, Telford and Wrekin CCG:

Audit Committee – 17 March 2021
Strategic Commissioning Committee – 17 March 2021
Finance Committee – 24 March 2021
Quality & Performance Committee – 24 March 2021
Primary Care Commissioning Committee – 3 February 2021

Minute Nos. GB-21-05.030 to GB-21-05.032 Previous NHS Shropshire CCG Reports Only

South Shropshire Locality Forum – 4 February 2021, 3 March 2021
Shrewsbury and Atcham Locality Forum – 18 February 2021, 18 March 2021
North Shropshire Locality Forum – 22 February 2021, 22 April 2021

Minute No. GB-21-05.033 Previous NHS Telford and Wrekin CCG Report Only

Telford and Wrekin CCG Practice Forum – 16 February 2021

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

Minute No. GB-21-05.034 – Any Other Business

22.1 There were no further matters to report.

Date and Time of Next Meeting

It was confirmed that the date of the next scheduled Governing Body Part 1 meeting is: Wednesday 14 July 2021 – time, venue and modality of the meeting to be confirmed nearer the time.

Dr Pepper officially closed the meeting at 15:24 pm.

SIGNED …….. DATE ……

MINUTES

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

Wednesday 9th June 2021 – 10.00-11.00
Using Microsoft Teams

Attendees:

Dr John Pepper	Chair
Mrs Audrey Warren	Registered Nurse Governing Body Member
Dr Michael Matthee	GP/Healthcare Professional Governing Body Member
Dr Adam Pringle	Vice Clinical Chair and 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 Claire Skidmore	Interim Accountable Officer
Mr Steve Trenchard	Interim Executive Director of Transformation
Mrs Zena Young (part)	Executive Director of Nursing and Quality
Mrs Laura Clare	Interim Executive Director of Finance
Mr Geoff Braden	Lay Member for Governance
Mr Ash Ahmed	Lay Member, Patient, Public Involvement - Equality, Diversity and Involvement
Miss Alison Smith	Director of Corporate Affairs
Dr Deborah Shepherd	Interim Medical Director
Mrs Sam Tilley	Director of Planning
Mrs Claire Parker	Director of Partnership
Dr Julie Davies	Director of Performance
Mrs Trudy Attfield	Minute taker

Minute No. GB-21-06.035 - Apologies

1.1 The Chair welcomed everyone to Extraordinary Board meeting held in public and apologies were noted:

Mr Meredith Vivian	Deputy Chair and Lay Member for Patient and Public Involvement Governing Body Member
Dr Martin Allen	Secondary Care Doctor Board Member
Mrs Donna MacArthur	Lay Member for Primary Care
Dr Steve James	Chief Clinical Information Officer

Minute No. GB-21-06.036 - Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the CCG's Governing Body Register of Interests and was available to view on the CCG's website at:

https://www.shropshiretelfordandwrekinccg.nhs.uk/about-us/conflicts-of-interest/register-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-21-06.037 – NHS Shropshire CCG Annual Report and Accounts 2021 Auditors Findings Report: To receive assurance from Chair of Audit Committee

Minute No. GB-21-06.038 – NHS Shropshire CCG Annual Report and Annual Governance Statement including: Annual Accounts 2020/21 and Letter of Representation 2020/2021

Minute No. GB-21-06.039 – NHS Telford & Wrekin CCG Annual Report and Accounts 20/2021 Auditors Findings Report: To receive assurance from Chair of Audit Committee

Minute No. GB-21-06.040 – NHS Telford & Wrekin CCG Annual Report and Annual Governance Statement including: Annual Accounts 2020/21 and Letter of Representation 2020/2021

3.1 Mr Geoff Braden advised that the above reports for both CCGs had been presented to an extraordinary Audit Committee held on Wednesday 9 June and highlighted the following key themes:

3.2 The National Audit Office had given instructions to the Auditors to be stronger in questioning certain areas because of the perspective that the NHS have a strong cash position so it was a requirement to obtain more detail to ensure expendables were appropriate. Work continued with external auditors and the finance team have a deadline date of Friday 11th June to provide additional evidence to some areas. Mr Braden assured members that the issues outstanding were not material and assurance had been received from the internal auditor that this would not affect the decision and would not prevent the signing of the accounts. It will be an unqualified opinion and the only qualification will be the Section 30 letter which is a standard letter when targets had not been hit.

3.3 Mr Braden outlined that part of the internal audit was to look through significant risks and said that one positive was that Shropshire had received a positive outcome in terms of the draft external accounts with regard to the approach to CHC. The on-going financial risk was around sustainability for this year, the 3% challenge in 2022/23 and the need to focus on this to prevent this becoming a deficit in future years

3.4 Positive feedback had been received with regard to the work carried out in the merging of the two CCGs and the Hospital transformation programme.

3.5 In relation to improving efficiency in the economy i.e. relationships with Providers – this was challenged because of the lack of improvement but stated that they were positive in terms of the efforts taken to address the shortfall especially in patient care. A suggestion had been made to Mrs Claire Skidmore to take the opportunity, when the external auditor had completed the findings, to invite the external audit lead back to talk to the Executive Team around the findings and perspectives they may have.

3.6 It was noted that Telford CCG had a similar outcome with the only difference being that there was a £800,000 variance on prescribing within the adjustment, so again work was currently being carried out to identify any anomalies that needed to be submitted by the Friday deadline.

3.7 Miss Alison Smith advised that the full annual reports for both previous CCGs had also been presented to the extra-ordinary Audit Committee and that a draft version had also been taken to the Audit Committee and external Auditors in April so they had received significant scrutiny. No issues were raised with regard to the content of the reports and the Audit Committee had recommended approval by the Governing Body that both reports were accurate and that they sufficiently described the positions of both CCGs when they were dissolved on the 31st March.

3.8 Miss Smith also advised that, together with the annual report, the governance statement including the annual accounts 2020/21 and the letter of representation needed to be approved today by the Governing Body. Mrs Clare clarified that this had been presented in draft format and that the only changes made to these had been very minor presentational issues. Accounts would stay exactly as they are and delegation was to accept the final audit findings report.

3.9 Mrs Warren asked a question with regard to the external auditors findings on patient safety (page 16) and highlighted that a lot of the findings were positive which described the engagement and sharing of information with the Trust saying that this had improved over the last year, but that this had also stated that despite these actions, SaTH's patient care performance had not significantly approved and asked Governing Body if anything could be carried out to support helping to change this. Mrs Skidmore advised that this had been discussed at Audit Committee as it had been acknowledged that the CCG were carrying out all the correct actions and that the wording that the audit partner had made around improvement in SaTH was not that they were not improving as they were in certain areas but maybe not as fast as would like. The Board had previously seen improvement in an area but then felt when the focus moved to another area then historically have then seen slippage in the original improved area. It was agreed that there was a need to ensure that where improvement happened then need to ensure that it was maintained and did not slip so would ensure commitment to this and constantly monitor and provide any encouragement and support.

3.10 Dr Pepper said that there was a requirement to obtain delegated authority to conclude the audit findings report on Monday which would fall under the urgent decisions delegation within the constitution 6.3.16. It was agreed that delegation would fall with Miss Smith, Mrs Skidmore, Mrs Clare, Dr Pepper and Mr Braden. Governing Body members agreed to the delegation.

ACTION: It was agreed that delegated authority to conclude all the audit findings would be given to: CS/LC/JP/GB/AS

Members ratified the annual report 20/21, including the annual governance statement and annual accounts 20/21 and the letter of representation 20/21 for both NHS Shropshire CCG and NHS Telford & Wrekin CCG and GB final approval to the above group. - Agreed

Minute No. GB-21-06.041 – Learning Disability Mortality Review Programme (LeDeR) Report for NHS Shropshire CCG and NHS Telford and Wrekin CCG

4.1 Mrs Zena Young discussed the Learning Disability Mortality Review Programme Report previously shared and explained that this was an mandatory annual requirement and that the completed report would be published onto the CCG's website. The report had been unable to be presented to the last Quality and Performance Committee and she asked the Board to note that following discussions today that this would be presented back to the Quality and Performance Committee at the end of June for any amends and ratification, before being placed onto the website. Mrs Young advised that the CCG remained high performing, both nationally and regionally, and was fully compliant with all the requirements of the LeDeR Programme. The Steering Group which ran across the system, with contribution from system partners took forward the learning and recommendations from LeDeR reviews and mapped out any progress.

4.2 Mrs Rachael Bryceland commented that the review was doing very well and asked if this was based on a 75% target? In preparation for the closure of the current LeDeR platform in March 2021 each CCG was tasked with completing any outstanding reviews, Mrs Young informed that the CCGs had achieved 100% of reviews by December 2020 and was fully compliant with only 3 reviews outstanding due to CDOP (these were agreed with NHSE) and that would transfer to the new LeDeR platform in June 2021.

4.3 Mrs Bryceland commented that GP practices were being asked to work to a criteria which also involved assessing the IQ of the patient and said that this was not a Primary Care criteria and that she felt that there should be more joint working with education to help identify the population that may not have been captured on the current registers? Mrs Young advised that herself and Mrs Parker would find out more detail around how the CCG was supporting this through the system work to identify categorisation and coding and obtain a response back for the meeting.

ACTION: Mrs Young agreed to liaise with Mrs Parker to obtain detail around how the CCG was supporting criteria requested by GPs and obtain a response back for the next meeting

4.4 Dr Shepherd asked for clarification around the detail outlining the number of people outlined who have had a DNA CPR completed and said that a DNA CPR was not appropriate for everyone with a Learning Disability and asked whether a 'respect form' would be a more appropriate measure for those people? Mrs Young endorsed that this needed to be assessed on an individual case by case basis for clinical reasons and needed to include service users and families. Mrs Young agreed to take this question back through the Steering Group and ask them to follow up and link in with the system end of life care group.

ACTION: Mrs Young to feedback to Steering Group concerns raised with regard to the use of DNA CPR not being appropriate for everyone with a Learning Disability and the suggestion of the use of a 'respect form'

4.5 Dr Pringle acknowledged the good result achieved but said that looking back on the LeDaR project that it had taken a length of time to achieve the good outcomes and asked if there was anything from the process that the CCG could transfer across to other areas of concern to help improve those areas. Mrs Young explained that this was an NHSE resourced piece of work and the methodology for LeDeR reviews was very intensive and required case reviews, some which are very complex so the approach would be difficult but explained that the CCG was currently looking at a system learning review approach as this part of patient safety strategy and work had already started to carry out some joined learning reviews of specific cases.

4.6 Dr Matthee expressed concern around the clarity of Primary Care Involvement in supporting the transition from child into adult services and said that he felt that the report was not clear as to what this meant and felt that there was a gap? Dr Pepper commented that this was how children transition into adult services and talked about GPs supporting the transition. Dr Pepper asked if this was in the report because of specific findings from the reviews, and asked if there was a difficulty or area of improvement for the transition from Children's services into Adults services that required addressing? Mrs Young advised that this was a high level report and that the steering group would take this forward and informed that the group was represented with wide membership from the system. Mrs Parker highlighted that the transition was often an issue of Learning Disability and Autism and that this was one of the themes that the Learning Disability & Autism Board picked up and advised members that Dr Priya George was a member on the group and that she would ensure that the comments and learning from the annual review went to this system board. She advised that, from a Primary Care perspective, not every LD&A individual was necessary in receipt of acute or mental health services and some were around physical health checks and how to look at obtaining information for the next piece of work which would be carried out around learning from annual health checks and to identify what impact this had on individuals and what Primary Care support would be required.

4.7 Dr Matthee said that within the NICHE report it talked about deaths in hospital and asked if there was a dedicated team involved to help staff in hospital with regards to looking after some people with Learning Disabilities. Mrs Young clarified that all Providers had specialist nursing services for Learning Disabilities and that they had a range of services to help support individuals both for planned electives and for the unplanned and unscheduled care episodes, which included support to families.

4.8 Mrs Bryceland asked how many of the additional deaths reported in the last year were affected by the 'no visitor rule' due to Covid whereby carers couldn't accompany the patient and whether any recognition had been given to understanding the patient's needs and asked if Learning Disability Homes were being trained in the early detection tools i.e. Stop and Watch. Mrs Young advised that visiting was impacted through Covid but explained that each Provider had exceptions to a blanket ban to visitors and these were assessed on a case by case basis so individuals with particular needs would have been considered. Mrs Parker agreed to pick up the question with regard to the training around the detection tools at the LD&A Board and report back.

ACTION: Mrs Parker to relay question with regard to training in LD Homes of the early detection tools at the LD&A Board and report back to Board

4.9 Mrs Young advised members of an inconsistency within the report and that this should be asking for Board to receive and note the report only as there was still a requirement for this to go through the Quality and Performance Committee. Miss Smith suggested that the Governing Body would agree the report in principal but would delegate any minor changes to the Quality and Performance Committee.

Members agreed and noted all recommendations.

Minute No. GB-21-06.042 – Any Other Business

5.1 There were no further items raised.

DATE OF NEXT MEETING

Wednesday 14 July – Time to be confirmed

SIGNED …….. DATE ……

NHS Shropshire, Telford and Wrekin CCG

ACTIONS FROM THE GOVERNING BODY MEETINGS HELD IN PUBLIC

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
10th March 2021 GB-21-03.038 – NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report – performance 14 Day rule	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 foreward. 12/05/21 update - Dr Davies confirmed that it is David Whiting who is leading the report. David Whiting has not yet made contact with Dr Matthee and Dr Davies agreed to follow this up directly with David Whiting.	Julie Davies	July Meeting	.
10th March 2021 GB-21-03.038 NHS Shropshire CCG and NHS Telford and Wrekin CCG Quality and Performance Report – Performance 14 Day Rule	Mr Trenchard to liaise with MPFT regarding Dr Matthee receiving feedback and responses. 12/05/21 update - Dr Matthee is still awaiting a formal letter from MPFT. Mr Trenchard to follow up.	Steve Trenchard	July Meeting	
10th March 2021 GB-21-03.040 Maternity Update Caesarean Section	Mrs Young agreed to look at MPV 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 agree to look at these figures and clarify the data 12/05/21 update : Mrs Young has requested from SaTH a more detailed report to consider caesarean sections in the round which will go to CQRM and QPC. An update at the next meeting to be provided when the report is received.	Zena Young	July Meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
12th May 2021 GB-21-05.014 – NHS Shropshire, Telford and Wrekin CCG Quality and Performance Report <u>Performance Report</u>	Dr Davies updated Governing Body members on the new Neurology service that is now live. Dr Davies confirmed she planned to provide an update to the Governing Body in July for assurance on the new service. Dr Matthee highlighted the report and the arrows used in the reporting line and suggested a data linear reporting system would be better. Dr Davies to discuss the data linear reporting system directly with Dr Matthee. IAPS – Mr Trenchard to look into the particular issues in relation to performance and provide an interim update at the next meeting. Dr Davies to take the increase in Accident and Emergency activity in children with croup and parainfluenza virus to the Urgent and Emergency Operational Group.	Julie Davies Julie Davies Steve Trenchard Julie Davies	July Meeting July Meeting July Meeting July Meeting	
12th May 2021 GB-21-05.014 – NHS Shropshire, Telford and Wrekin CCG Quality and Performance Report <u>Quality Report</u>	Maternity dashboard – Mrs Young to provide a sample report at the next Maternity Quarterly update.	Zena Young	July Meeting	
12th May 2021 Minute No. GB-21-05.015 Niche Consultancy Report	Mrs Young to provide an interim report from the recommendations made in the Niche Report and provide an update at the July Governing body meeting. Mrs Cawley to share a report produced in 2020 with Dr Shepherd and End of Life Group from the Healthwatch Shropshire End of Life and Palliative Findings Report. Mrs Young to share with the Quality and Performance Committee information provided by Mrs Cawley on patients and diabetes not being managed appropriately in hospital settings.	Zena Young Lynn Cawley Zena Young	July Meeting July Meeting July Meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
12th May 2021 Minute No. GB-21-05.020 CCG Corporate Mission Statement and Strategic Priorities	Miss Smith to update the wording of the mission statement to read: *To reduce health inequalities by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.* Miss Smith to include the word "safety" in the Strategic priority around quality. Miss Smith to incorporate a reference to strategic priorities in the covering paper template brought to the Governing Body.	Alison Smith Alison Smith Alison Smith	July Meeting July Meeting July Meeting	This has been updated and is now published on the CCG's website – recommend action is closed The word safety has been incorporated into the Strategic Priority around quality – Recommend action is closed Covering sheet template for Board papers has been amended to include a reference to CCG priorities and has been disseminated to Staff and PAs for use Recommend action is closed
12th May 2021 GB-21-05.023 Governing Body Annual Cycle of Business April 2021 – March 2022	Miss Smith to add LMNS in the Governing Body Annual Cycle of Business and Mrs Young to confirm timing.	Alison Smith Zena Young	July Meeting	LMNS has now been added into cycle of business – recommend action is closed
12th May 2021 GB-21-05.024 Transition to new CCG – Adoption of Key Strategies and Policies	Dr Shepherd raised Medicines Management Policies and the fact that there is no consistency between those that are published on the website and those that are not. Dr Shepherd asked that if the publishing section on the new website could be reviewed by Medicines Management and in most cases published as a reference.	Zena Young	July Meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
	Commissioning Strategy – Mrs Tilley to review the Commissioning Strategy with a recommendation for Children's physical health to be placed under Community and Place Based Care.	Sam Tilley	July Meeting	
	Commissioning Strategy - LMS – Maternity System is not included in the Commissioning Strategy and the best start in life not adequately reflected. Mrs Tilley to review with the Exec team.	Sam Tilley	July Meeting	
	Communications and Engagement Strategy – Miss Smith to add a more detailed reference to the role of Healthwatch and co-production	Alison Smith	July Meeting	References to Healthwatch and co-production have been added – recommend action closed
GB-21-06.040 – NHS Telford & Wrekin CCG Annual Report and Annual Governance Statement including: Annual Accounts 2020/21 and Letter of Representation 2020/2021	It was agreed that delegated authority to conclude all the audit findings would be given to: CS/LC/JP/GB/AS	Claire Skidmore Laura Clare John Pepper Geoff Braden Alison Smith		
GB-21-06.041 – Learning Disability Mortality Review Programme (LeDeR) Report for NHS Shropshire CCG and NHS Telford and Wrekin CCG	Mrs Young agreed to liaise with Mrs Parker to obtain detail around how the CCG was supporting criteria requested by GPs and obtain a response back for the next meeting	Zena Young	July Meeting	
	Mrs Young to feedback to Steering Group concerns raised with regard to the use of DNA CPR not being appropriate for everyone with a Learning Disability and the suggestion of the use of a 'respect form'	Zena Young		
	Mrs Parker to relay question with regard to training in LD Homes of the early detection tools at the LD&A Board and report back to Board	Claire Parker		

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held in Public on 14 July 2021

Item Number:	Agenda Item:
GB-21.07.042	Maternity Services Update

Executive Lead (s):	Author(s):
Zena Young – Executive Director of Nursing & Quality Zena.young@nhs.net	Zena Young – Executive Director of Nursing & Quality Fiona Ellis – Programme Manager, LMNS

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)**
Various elements of this report have been reported to QPC/LMNS meetings in previous months		S, D, I

Executive Summary:

This report provides an overview of the scope of information routinely monitored by the CCG and LMNS. It covers updates on the main quality and safety areas, both in terms of performance and achievements, and also the transformation schemes, identifying actions being taken and where further improvements are needed.

Perinatal Quality Surveillance:
Data quality generally remains a concern, with manual processes in place for audit and recording. There has been a delay in the planned implementation and roll out of the Badgernet Maternity Record. Work continues between the CCG and the Trust to finalise the parameters, tolerances and related assurance indicators for each of the data lines in the dashboard.

Detail of SaTH maternity dashboard exceptions are provided in the report. There are no particular areas of concern, however a rise in Post Partum Haemorrhage (PPH) rate was noted in month and the data quality of this reporting is being checked and each case reviewed for any avoidable factors.

Midwifery Staffing: There remains significant gaps and instability in substantive midwifery leadership at SaTH with some mitigation, but are impacting on the ability to achieve a more rapid pace of change. The Midwifery Led Unit at Shrewsbury remains closed due to estates works and the CCG have requested assurances on the thresholds for safe staffing in anticipation of this facility being refurbished and ready for reopening.

A breakdown of Serious Incidents for February – May 2021 is provided in the report; there were no discernible themes identified from a review of the initial information which covered a range of different service elements and settings.

Ockenden Report Compliance:
Of the 52 actions in total required to be implemented by SaTH/system, 4 of these are currently off-track, with detail provided in the report. The LMNS is closely involved in review of evidence submitted.

CNST Compliance:
As of 06/07/21, SaTH are reporting compliance on 3 of the 10 standards, with a further 3 standards possibly ready to be declared as compliant by the submission date (22 July) with 4 standards not confident of being achieved by that date. SaTH expect to be fully compliant with all 10 Safety Actions by September 2021, and have confirmed that the elements of non-compliance do not pose a risk to the quality of care provided to women, babies and their families.

Maternity Transformation:
Progress against many of the transformation schemes is challenged, due to additional staffing pressures within SaTH. The new service being implemented to support Smoke Free Pregnancy Pathways is in line with good practice, but a long term funding solution is required to enable its continuation. Continuity of Carer is off-track, but not out of line with the scale of implementation in other areas across the country. An assurance statement confirming the current level of attainment in relation to the Saving Babies Lives Care Bundle has been received from Sherwood Forest Hospital. Two elements remain not fully in place and there are action plans in place for both. The Midlands Maternity and Perinatal Mental Health Clinical Network continue to support SaTH in auditing progress against the requirements. The Maternity Voices Partnership continues to increase the breadth and depth of co-production across the system.

Perinatal Quality Surveillance/ICS Quality Governance
The reports provides a synopsis and assurance that the new requirements of the LMNS to take on full and on-going oversight of quality; LMNS Terms of Reference have been revised accordingly and there is detail on the STW system approach to implementing perinatal oversight and quality governance in the report.

Transforming Midwifery Care (the reconfiguration of midwife-led services):
The position remains that the CCG/LMNS is awaiting approval from NHSEI at national level in order to go out to public consultation on the proposals for Midwifery Hubs. The CCG awaits the informal review of plans by Sherwood Forest Hospital before next steps.

Recommendations/Actions Required:

Governing Board are invited to receive this update report and:

- Note and discuss the contents of the report and progress being made
- Note areas of concern and actions being taken to address
- Note that a funding model for smoking cessation, which could encompass wider health education needs to be developed and agreed.

Report Monitoring Form

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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).* The report outlines how perinatal health inequalities are being reduced through a number of schemes including continuity of carer, the response to addressing perinatal inequalities related to COVID-19, smoking in pregnancy, saving babies lives care bundle, continuous glucose monitoring and specifically the development of the Perinatal Equity Strategy.	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* Reduced Stillbirth, Neonatal Death and Brain Injury Improved health in pregnancy and beyond, including in relation to smoking Improved outcomes for pregnant people with Type 1 diabetes Improved perinatal mental health	Yes

3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).* *The Perinatal Quality Surveillance in place, including feedback from service users ensures that a range of partners are involved in understanding the data in order to improve the quality and safety of service through sustainable changes.*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).* The Local Maternity System already provides a system-wide vehicle for driving forward transformation, quality and safety improvement. Through the new structure, embedded within the ICS, this will be formalised.	Yes
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

Maternity Services Update

1.0 Introduction

This report serves to provide an update to Governing Board on Maternity Services. The previous report was received to Board in March 2021.

2.0 Perinatal Quality Surveillance

2.1 SaTH Maternity Dashboard

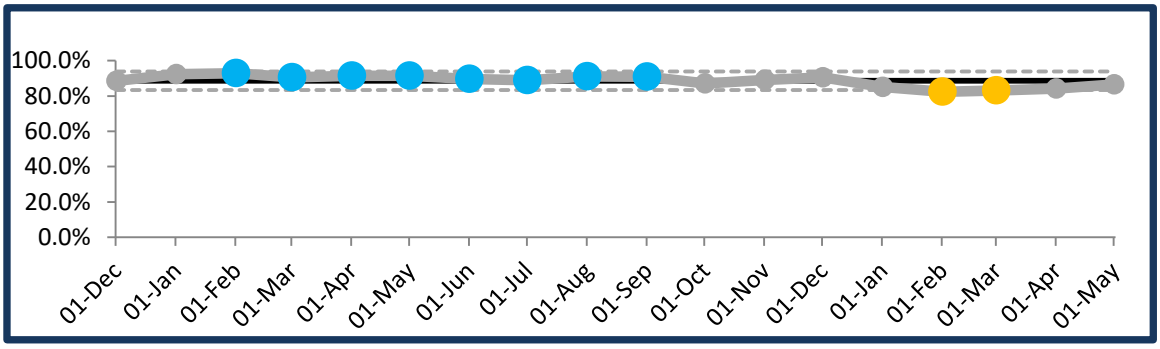
Detailed oversight of the SaTH Maternity Dashboard is maintained via the monthly Clinical Quality Review Meetings (CQRM). In recent months work has been undertaken to upgrade the content and presentation of the SaTH level Maternity Dashboard and the new format and content was presented to CQRM at the June meeting. This requires further work between the CCG and Trust to formally agree the parameters, tolerances and related assurance indicators for each measure and this work should be completed during the next reporting period. SaTH remain responsible as owners of the data to input information accurately and there remains a risk to data quality because of the process of manual data entry and the delay in implementation and roll out of the Badgernet IT maternity record system.

2.2 Dashboard exceptions

The main areas for noting relating to the May data presented to June CQRM are:

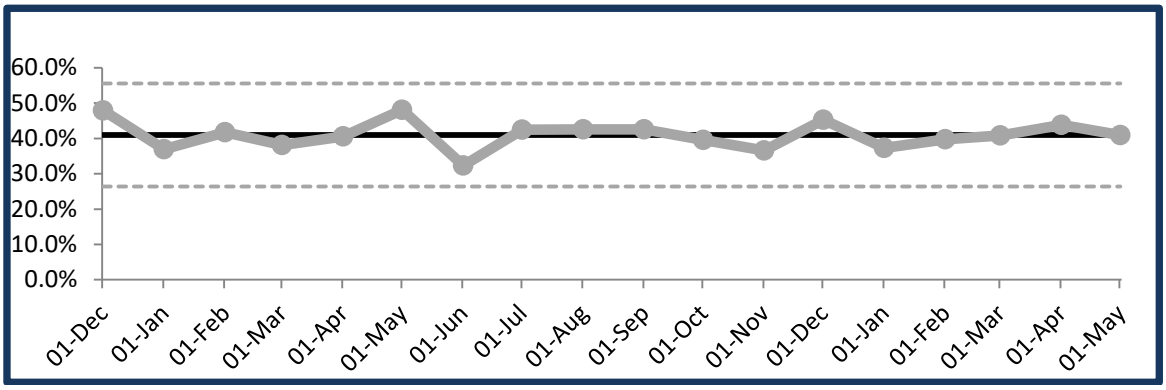
- **Bookings less than 13 week gestation** – 86.5% (target >90%) Changes to booking processes have been introduced and, importantly, there is no impact noted with antenatal or newborn screening rates. The Trust have investigated the lower than required performance level and found data quality issues which should resolve with the introduction of the Badgernet.

Table 1: % of bookings with a gestation of less than 13 weeks - SaTH



- **The induction of labour (IOL) rate** continues to be high at 40.9%, against a benchmark of 28.5% based on 2015 NMPA data. The National Maternity and Perinatal Audit (NMPA) is a large scale audit of the NHS maternity services across England, Scotland and Wales. Using high quality data, the audit aims to evaluate a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies. Nationally there is a trend of increases in IOL rates, due in part to policy changes seen through introduction of measures such the Saving Babies Lives Care Bundle version 2.

Table 2: Overall Induction of labour rate - SaTH

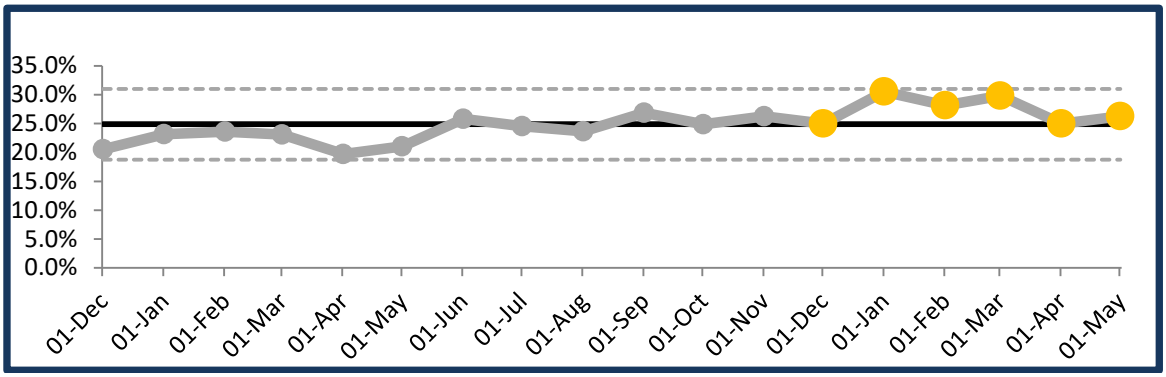


A report by SaTH into the reasons for the higher IOL rate was received to the CCG in December 2020. This report identified the inclusion criteria for surveying IOL rates at SaTH was broader than for other units. SaTH data included termination of pregnancy and pregnancy at all gestations whereas NMPA published data was for term pregnancies only and therefore is not directly comparable with the SaTH data. Data quality was a significant concern with information stored in different locations in patient care records and no universal electronic capture methodology. Again, the Badgernet maternity record when implemented will help considerably with this audit.

- **Smoking at delivery** – 11.9% (national target <6% by end of 2022). Public Health face to face contacts stopped during the height of Covid and Carbon Monoxide monitoring as a way of validating smoking status also ceased, although women continued to self-report their smoking status. Face to face measures are now being reintroduced. The LMNS has invested in resource to SaTH to support achievement of this target and the trust is recruiting to a specialist midwife position to support this work. See further below section 5.3.

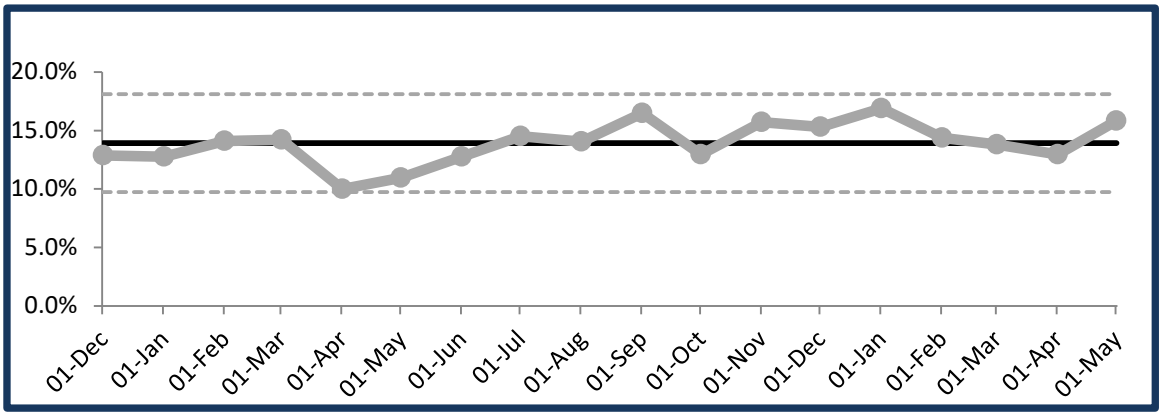
- **Cesarean-Section (C-section) rate** - overall at 26.3%, this rate is close to the NMPA (2015) expected rate of 25%,

Table 3: Caesarean Section rate % - SaTH



Emergency C-Section rates were 15.8% for May 2021 which is higher than the local target of below 10%.

Table 4: % of Deliveries - Emergency C/Section (category 1,2 & 3) - SaTH

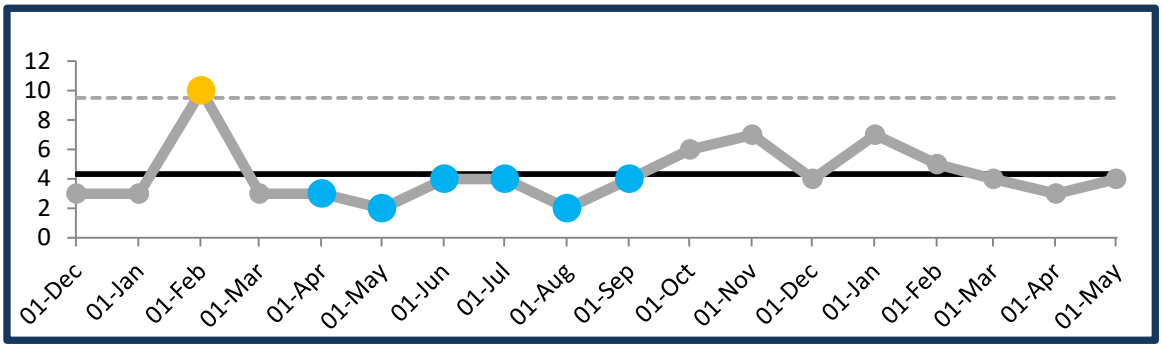


The University Hospital Birmingham Obstetric advisor to SaTH, Mr Richard Kennedy, has advised that there is no cause for concern in the rates of C-sections being undertaken at SaTH. A further themed review has been requested and will be provided once the trust has received their annual GIRFT data set. Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

Through CQRM, SaTH and the CCG are working together to ensure that the parameters and assurances around performance indicators are relevant, including in relation to Induction of Labour and C-Section rates. There is agreement that including targets based on national/regional performance is not always the most appropriate way of ensuring the quality and performance of the service is as it should be, particularly given that many of the national benchmarking data sources available are several years out of date. Moving forward the focus will be on outcomes and auditing a range of indicators to establish whether women and their babies have an appropriate pathway of care that is in line with their clinical needs and preferences, rather than focusing on a published target for a single indicator.

- **Born Before Arrival (BBA)** – Birth that happens away from a hospital or birth centre setting, prior to the arrival of a midwife is referred to as born before arrival (BBA). There were 4 BBA cases reported for May 2021. All cases are reviewed by the obstetric risk meeting to ascertain any learning points. No harms to mother or baby were identified from these case reviews.

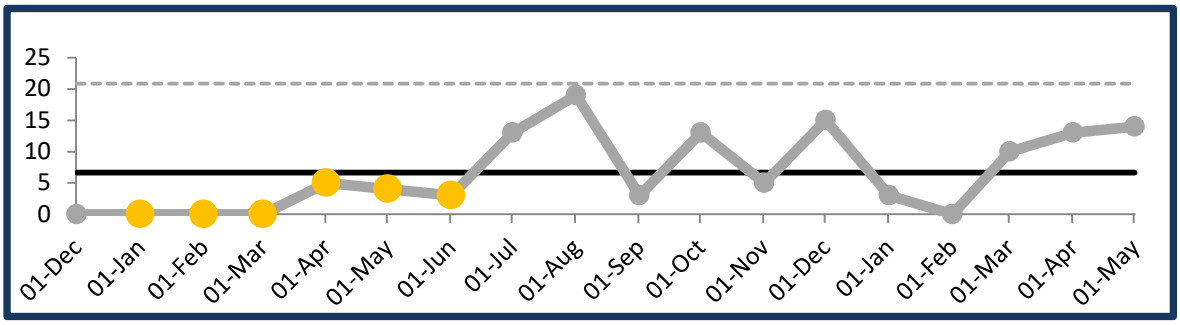
Table 5: BBA (Born Before Arrival) - SaTH



- **Post Partum Haemorrhage (PPH – heavy bleeding experienced by the birthing person after the birth of a baby)** – There were a higher than usual number of PPH's reported for May at 4.5% (N=17), the usual level being around 2%. The data quality of this reporting is being checked and each case is reviewed to identify and address any avoidable factors.

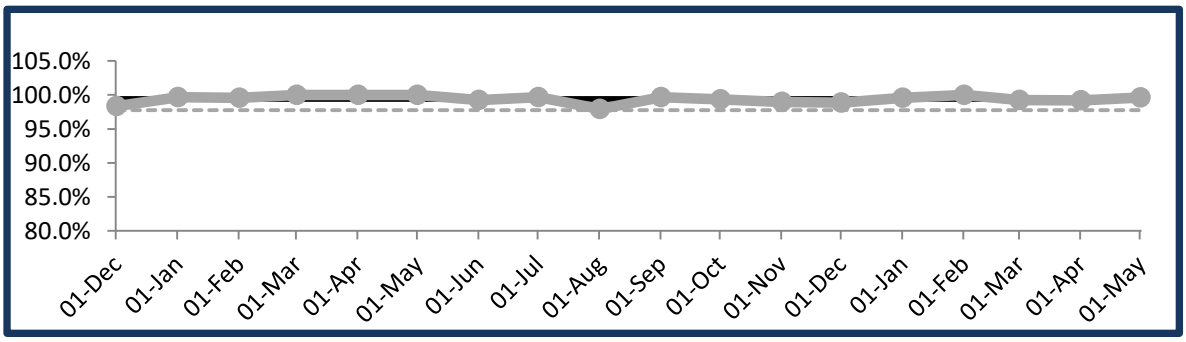
- **Delivery Suite red flags** – this measure relates to insufficient staffing levels on the delivery suite according to the clinical needs of patients. This happened on 14 occasions during May and the staffing escalation process was appropriately instigated, along with their process for prioritising and monitoring women during this time.

Table 6: Delivery Suite Red Flags - SaTH



There were no adverse incidents reported as a result of the staff shortages which in the main impacted on the ability to commence planned IOL's, and the rate of 1:1 care in established labour was maintained for all deliveries.

Table 7: Rate of 1 to 1 care in established labour - SaTH



2.3 Midwifery Staffing

There remains significant gaps and instability in substantive midwifery leadership at SaTH which are in large part being addressed with a variety of temporary support solutions, including from external partners such as Sherwood Forest Hospital and the NHSEI Maternity Improvement support remains in place. Both of these initiatives, plus other senior temporary staff are providing additional support and assurance of quality and safety. This, coupled with a shortfall in substantive midwife numbers, remains an impact on the ability to achieve a more rapid and sustained pace of change.

The key areas of focus of the Sherwood Forest Hospital (SFH) Maternity Improvement Alliance include:

- Maternity safeguarding review
- Improving governance by learning from SFH
- Embedding clinical staff from SFH within SaTH maternity services
- A peer review of SaTH's response to Ockenden
- Benchmarking of leadership structure and mentorship for senior SaTH colleagues

The Midwife Led Unit at Shrewsbury remains closed due to estates works and because of the substantive staffing shortfall, the CCG have requested assurances on the thresholds for safe staffing in anticipation of this facility being ready for reopening.

2.4 Serious Incidents

All Maternity related Serious Incident (SI) notifications are reviewed by the CCG Maternity advisor for identification of any immediate concerns that require urgent action by the trust and for final Root Cause Analysis (RCA) sign-off. Fuller details of each case are shared to the CCG Quality and Performance Committee each month and there were no discernible themes identified from a review of the initial information, however we await the full reports.

Table 8: Perinatal SI's by month of incident

Month	Feb 21	Mar 21	Apr 21	May 21
Number reported	3	2 (reported 06/21)	1	1
Non-maternity related maternal deaths		2		
Externally reported SI	1			

February 2021:

1 x incident raised concerns about the interpretation of CTGs and a potential missed opportunity to deliver the baby earlier. Cardiotocography (CTG) is a way of recording the fetal heartbeat and the uterine contractions during pregnancy on a machine called a cardiotocograph.

1 x incident related to a misunderstanding between the use of 'implantation date' and 'conception date'.

1 x incident raised as a potential missed opportunity to diagnose a threatened miscarriage.

The final SI reported in February related to the transfer of a patient from SaTH to an out of area Mother and Baby Unit and opportunity for earlier identification of sepsis.

March 2021:
There were no SaTH reported maternity incidents during the month of March 2021. However, two SI's were reported in June pertaining to incidents that occurred in March 2021, the later reporting due to the Trust following due process of internal investigation and review.
1 x case related a suspected sepsis.
1 x case related to a baby born in poor condition and met the criteria for cooling. Controlled cooling can be used to treat newborn babies with brain injury caused by a shortage of oxygen during birth.

Sadly two maternal deaths not related to the provision of maternity services were recorded in March. These are not SI's but will be will be reported to MBRRACE-UK as they fall within the criteria of a death within 12 months of pregnancy.

1 x case due to natural causes
1 x case was oncology (cancer) -related.

'MBRRACE-UK' is a collaboration in place to run the national Maternal, Newborn and Infant clinical Outcome Review Programme which conducts the surveillance and investigation of causes of maternal deaths, stillbirths and infant deaths.

April 2021:
1 x incident relating to a water-birth, meets the criteria for HSIB for investigation.

HSIB - Healthcare Safety Investigation Branch conducts independent investigations of patient safety concerns in NHS-funded care across England.

May 2021:
1 x incident related to a baby sustaining significant head trauma following attempted instrumental delivery. There is external input to the investigation of the incident.

In each of these cases, duty of candour was carried out with the families affected and immediate learning points identified have been enacted.

3.0 Ockenden Report Compliance

3.1 The first Ockenden report published December 2020 identified:
- Twenty-seven Local Actions for Learning (LAFL), which are specific 'Must Do' actions for SaTH;
- Seven Immediate and Essential Actions (IEA) for all NHS providers of maternity care, which apply to this Trust, also. These seven themes comprise 25 related actions.
- In total, there are 52 specific actions for SaTH to implement.

3.2 The Trust are taking a cautious approach to declaring any improvements are fully delivered, until there is clear evidence that change has taken place and is embedded over time. The Ockenden report does not set timelines for recommendations to be achieved and regional NHSEI have confirmed that this is to be an iterative process with increasing evidence-base over the cycle of reports. CCG, LMNS and Maternity Voices Partnership representatives are reviewing the evidence being submitted and are working closely with the trust to provide additional information as part of this process

Table 9: Ockenden progress status as of 31 May 2021

	Total Number of Actions	Not Started	Off Track (see exception report)		At Risk (see exception report)		On Track		Completed
			March	April/ May	March	April/ May	March	April/ May	
LAFL	27	0	0	2	0	0	27	25	0
IEA	25	3	0	2	0	0	22	20	0
Total	**52**	**3****	**0**	**4**	**0**	**0**	**49**	**45**	**0**

3.3 Of the actions not yet delivered, 4 are off track for the following reasons:

LAFL 4.65 – '*The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.'*

There is the need for additional posts to be in place before this action can be met fully. These form part of the overall maternity business case that is under consideration within the system. Interim arrangements are in place in the meantime.

LAFL 4.98 – '*There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.'*

There is an apparent contradiction between the requirement as expressed in the Ockenden Report, and current national and network guidance (from BAPM - the British Association of Perinatal Medicine), with which the Trust is compliant. The Trust is in discussion with the Ockenden office to clarify this recommendation.

IEA 1.6 – '*All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time the LMS for scrutiny, oversight and transparency. This must be done every 3 months.'*

All Serious Incidents are reported to SaTH Board of Directors in private session. There is a plan to start to provide a summary of all maternity serious incidents and key related issues to the Board of Directors' meeting in public from August 2021.

IEA 7.2 – 'W*omen must be enabled to participate equally in all decision making processes and to make informed choices about their care.'*

This action requires greater consultation with service users, the Maternity Voices Partnership, and Workstream 5 of the Trust's Maternity Transformation Plan – Communications and Engagement. The Trust are re-invigorating this work, with Dr Mei-See Hon, Clinical Director, taking over as lead for this workstream.

3.4 Areas of Positive Improvement

- Meeting the CNST standards for the Saving Babies Lives Care Bundle (v2) (see further below section 4.0 and 5.3)
- Improved consultant presence on the Delivery Suite, along with (minimum) twice daily ward and board rounds, comprising: consultant, registrar, delivery suite co-ordinator and anaesthetists
- Consultants working 7 days per week. Working to achieve 24/7 Delivery Suite consultant cover this year (subject to recruiting a further 6 consultants). Some nights covered already.
- Improved multi-disciplinary team (MDT) training, e.g. PROMPT Training (Practical Obstetric Multi-Professional Training) taking place monthly.
- Weekly MDT simulation exercises taking place on delivery suite, with ad-hoc sessions on midwife led unit (MLU).

- Twice weekly Cardiotocograph (CTG) learning and feedback sessions on Delivery Suite – led by CTG midwife +/- Consultant.

- Non-executive Director leadership as Maternity Safety Champion.

4.0 CNST Compliance

4.1 NHS Resolution (NHSR) is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. This Scheme incentivises safer care by achievement of 10 maternity safety actions. Safety actions 1, 2 and 10 are subject to external review by NHSR. **For the remaining safety standards, Sherwood Forest Hospital have been asked to provide external validation of the self-assessment.**

4.2 The reporting period of the CNST Maternity Incentive Scheme action was deferred nationally during 2020 and the scheme restarted on 1st October 2020. The submission date planned for May 2021 was moved by NHS Resolution to 15 July 2021; this change in date introduced a requirement for auditing to take place to ensure compliance over the additional time period and this has proved a challenge to carry out.

4.3 As of 06/07/21, SaTH are reporting compliance on 3 of the 10 CNST standards, with a further 3 standards possibly ready to be declared as compliant by the submission date (22 July) with 4 standards not confident of being achieved by that date. SaTH expect to be fully compliant with all 10 Safety Actions by September 2021, and have confirmed that the elements of non-compliance do not pose a risk to the quality of care provided to women, babies and their families.

4.4 Some detail of the gaps is provided in the table below.

Table 11: SaTH self-assessed compliance with SBLCB v2, position at 06 July 2021and CCG narrative.

Safety Action	Compliance Level	CCG Response
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Compliant** Compliant on 8/8 indicators	Evidence not reviewed by CCG. CCG are requesting a paper to CQRM (PNQSG) providing detail of the approach to PMRT and themed findings from these reviews.
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	**Not yet compliant** Compliant on 1/2 indicators	LMNS SRO and Programme Manager approved SaTH Safety Action plan for full compliance 07.07.2021, which relies on commencement of Badgernet implementation. Safety Action plan needs to be presented to LMNS Programme Board for formal ratification (05.08.2021) Also requested is the Badgernet implementation and roll-out plan.
3. Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	**Compliant** Compliant on 6/6 indicators	Evidence not reviewed by CCG. CCG are requesting an assurance statement from SFH to confirm their review process of this Safety Action.

4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	**Not compliant** Compliant on 3/4indicators	Evidence not reviewed by CCG. CCG are requesting an update on assurance from SaTH to CQRM (PNQSG).
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	**Not compliant** Compliant on 0/8 indicators	CCG are requesting an update on assurance from SaTH to LMNS Programme Board which delivers the workforce requirements for 51% Continuity of Carer by 2022.
6. Can you demonstrate compliance with all five elements of the SBL care bundle?	**Not yet compliant** Compliant on 31/33 indicators.	The CCG has received an assurance statement from SFH explaining their process of review of these indicators. Report from Clinical Network re SBL compliance due to be received by LMNS Programme Board on 5th August 2021.
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Compliant** Compliant on 5/5 indicators.	Assured against minimum evidence requirements. Note further work taking place to move to 'gold standard'. Increasing number of coproduction activities, but not yet business as usual.
8. Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of CNST Maternity Incentive Scheme year three in December 2019?	**Not yet compliant** Compliant on 12/13 indicators	Evidence not reviewed by CCG. An update will be received via SaTH MTAC meeting.
9. Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	**Not compliant** Compliant on 17/19 indicators	Evidence not reviewed by CCG. An update will be received via SaTH MTAC meeting.
10. Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	**Not compliant**	Evidence not reviewed by CCG. An update will be received via SaTH MTAC meeting.

n.b. MTAC = Maternity Transformation Assurance Committee – A SaTH internal governance meeting that the CCG is a member of.

5.0 Maternity Transformation Schemes

The Local Maternity and Neonatal System (LMNS) is responsible for driving forward maternity transformation in line with national priorities. Progress against the national deliverables set for 2020/21 is provided below.

5.1 Pandemic Recovery

NHSEI have asked LMNS to focus on the following areas in service recovery following the impact of the COVID-19 pandemic.

- *Re-open suspended services*
  SaTH were able to continue with the vast majority of services within the maternity pathway throughout the COVID-19 pandemic. Some elements of the service have been delivered in a different way but are now being re-introduced where safe to do so, for example carbon monoxide testing. Whilst pregnant people continue to be able to access antenatal appointments in a range of settings, antenatal clinics within GP practices are not currently taking place. The maternity voices partnership will be undertaking a piece of work to better understand where pregnant people would like to be able to access their antenatal appointments in order to improve access to appointments in the community. Birthing people continued to have a choice of birth setting throughout.

- *Restrictions on Access*
  There have been restrictions in place in relation to when partners can accompany the pregnant/birthing person. However, a 'partner passport' was co-produced with the Maternity Voices Partnership to enable those with additional needs to be accompanied during appointments throughout the restrictions. Access for partners has now been re-introduced where safe to do so.

- *Maternity staffing recovery*
  The stability of the workforce continues to be a challenge. The CCG and LMNS continue to work closely with the Trust to ensure this is addressed as a priority.

- *Deliver 4 equity actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women*
  Communications have been co-produced with the Maternity Voices Partnership to raise awareness of the specific risks for Black, Asian and Minority Ethnic women and work continues to further improve this. The Maternity Voices Partnership have been involved in the development of an operational policy to address the additional risks and continue to be involved in this work. SaTH are routinely discussing vitamins, supplements and nutrition in pregnancy with all women including those most at risk and are recording information as required on to the maternity information system.

5.2 Personalised Care Plans

All those accessing maternity services have a personalised care and support plan that was co-produced through the Maternity Voices Partnership (MVP). The implementation of Badgernet will enable people accessing maternity services to have an electronic personalised care and support plan.

The personalisation agenda is being strengthened through the work of the MVP including through the development of a suite of co-produced 'choice' leaflets, which include evidence based information to support informed decision making. The first leaflet to be launched was the Birth Place Choices leaflet, with the Labour and Birth choices leaflet in development. Other co-produced information to be published in this suite of leaflets will include Antenatal Choices and Postnatal Choices.

5.3 Saving Babies Lives Care Bundle version 2

The national ambition is to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2025. The Saving Babies Lives Care Bundle version 2 (SBLCB

v2) brings together five elements of care that are widely recognised as evidence-based and/or best practice with the aim of reducing perinatal mortality across England. The second version of the Care Bundle was introduced in March 2019 and extended its scope to include preterm birth. Unless all 5 elements of the SBLCB are fully implemented the Trust will not meet CNST compliance for this Safety Action.

Sherwood Forest Hospital (SFH) are providing support to SaTH in reviewing the evidence against implementation of SBLCB v2 and have provided a statement accepted by the CCG confirming their process of external assurance and SaTH achievement as follows. Two elements remain not fully in place and there are action plans in place for both.

Table 10: SFH assurance of SaTH compliance with SBLCB v2, 17 June 2021

Element 1: Smoking in Pregnancy	***This element has been met.***
Element 2: Fetal Growth Restriction (FGR)	***This element has been met.***
Element 3: Reduced Fetal Movement (RFM)	***This element has been met.***
Element 4: Intrapartum Fetal Monitoring	***This element is partially met.*** There remains on-going training requirements which have been impacted by the availability of training during covid pandemic.
Element 5: Antenatal corticosteroids, within seven days of birth	***This element is partially met.*** The 85% target was not met. 4 women received one dose of Dexamethasone and gave birth before the second dose to complete the course was due for administration. 1 woman had received full course of Dexamethasone more than 7 days previously and was not offered a second course. An action plan will been submitted to address the reduced compliance.

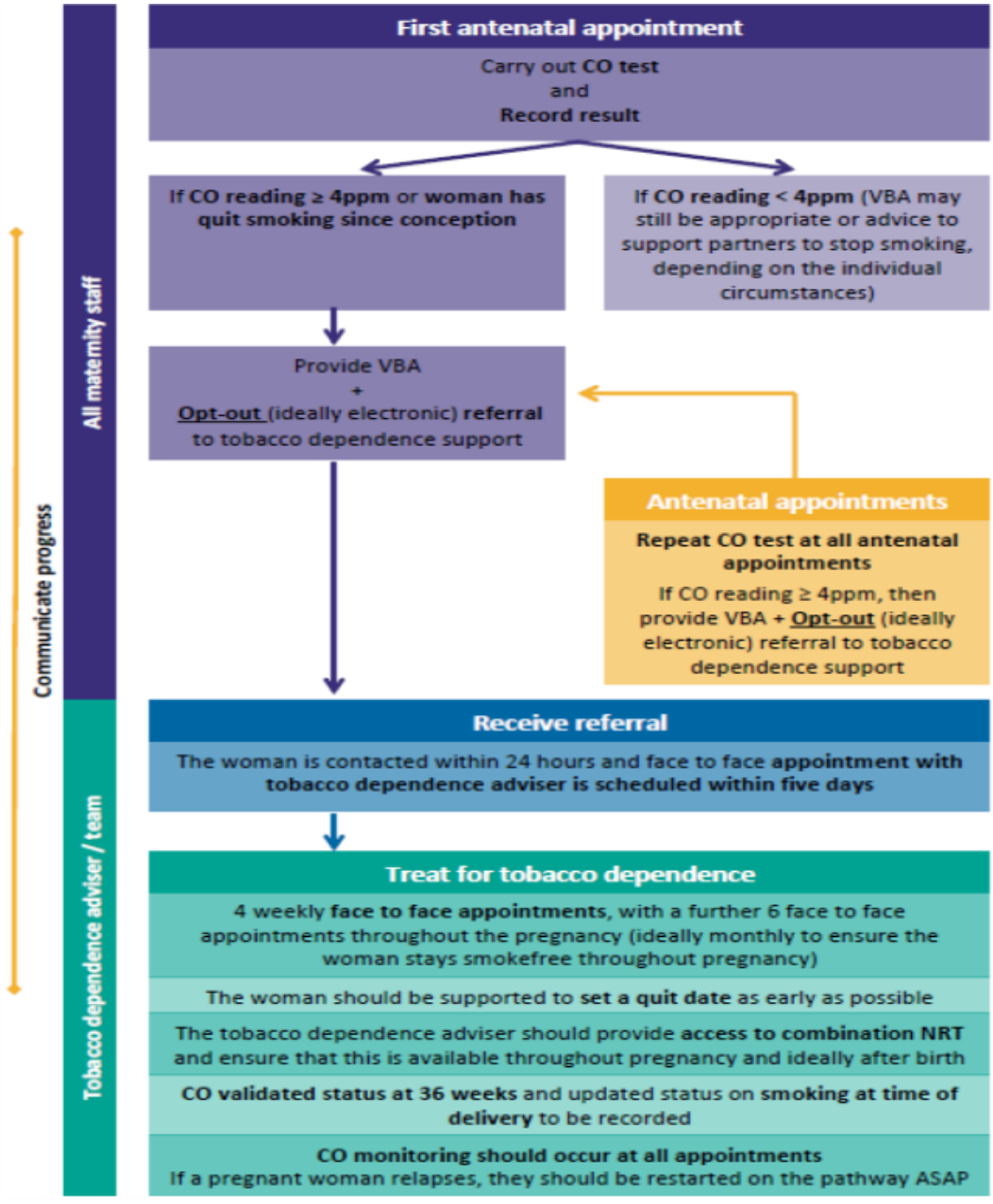
In addition, the LMNS commissioned the Midlands Maternity and Perinatal Mental Health Clinical Network to support SaTH in auditing compliance against Saving Babies Lives Care Bundle Version 2. The Clinical Network reports progress to LMNS Programme Board regularly. The latest report was presented to LMNS Programme Board on 1st April 2021 which noted good progress with a number of recommendations outlined. The next report will be presented to LMNS Programme Board on 5th August.

5.4 Smoke Free Pregnancy

Smoking in pregnancy is the main modifiable risk factor for a range of negative outcomes for both mother and baby. Nationally, a smoking at time of delivery (SATOD) target is set as 4% by 2026 with the aim of achieving a smoke-free start for all children from 2030. The LMNS has a nationally set target to make new NHS smoke free pregnancy pathways available for up to 40% of maternal smokers by March 2022. The Shropshire, Telford and Wrekin LMNS has SATOD rates above the national average and more than double the 2022 target with a SATOD rate in 2020/21 for Telford and Wrekin CCG at 14.3% and 10.8% for Shropshire CCG.

Through one off funding from across the system, a new Healthy Pregnancy Support Service is being implemented which will provide an enhanced level of support for women to stop smoking during pregnancy. The Long Term Plan allocations to systems for implementation of the smoke free pregnant pathways have been announced and the notional allocation for maternity for Shropshire, Telford and Wrekin is significantly less than amount required for the delivery of the new Healthy Pregnancy Support Service. The new service model being implemented across Telford and Wrekin is in line with good practice. However, there is a significant risk to the sustainability of the service if substantive funding is not identified within the system.

The recommended pathway for maternity is illustrated below and is in line with the service that will be delivered through the Healthy Pregnancy Support Service.



5.5 Maternal Medicine Networks

Maternal Medicine Networks are being established across the country to further ensure women with acute and chronic medical problems such as heart disease and neurological conditions have timely access to specialist advice and care at all stages of pregnancy. The development of these formal networks is still in development with the Maternal Medicine Hubs yet to be confirmed. Once the hubs are confirmed SaTH can continue to engage in the formal development of pathways to ensure women

from Shropshire, Telford and Wrekin with acute and chronic medical problems have access to the specialist advice and care they need throughout pregnancy.

5.6 Perinatal Mental Health

Specialist Perinatal Mental Health Service

Around one in four women experience mental health problems in pregnancy during the 24 months after giving birth. The NHS Long Term Plan includes specific areas for improvement in relation to Perinatal Mental Health including in relation to increasing access to specialist services, expanding access to psychological therapies and offering specialist services to partners/fathers experiencing perinatal mental health issues.

In Shropshire, Telford and Wrekin Perinatal Mental Health services are provided by Midlands Partnership NHS Foundation Trust. In relation to the Specialist Perinatal Mental Health service, the NHS Long Term Plan access target rates for 20/21 of 7.1% have been achieved for Telford & Wrekin at 7.5% and Shropshire was lower than the target rate at 5.9%. The Long Term Plan ambitions include an access target of 8.6% for 2021/22.

'The Lighthouse' Maternal Mental Health Service

Shropshire, Telford and Wrekin LMNS were successful in securing Early Implementer status for a Maternal Mental Health service. This service provides trauma informed psychological intervention for mothers and partners who experience mental health difficulties arising from birth and maternity experience and whose needs are not met by specialist perinatal mental health services, IAPT or secondary mental health care.

The service aims to meet the needs of mothers and partners who may experience PTSD following birth trauma or PTSD following perinatal loss from early miscarriage, recurrent miscarriage, stillbirth, neonatal death, termination of pregnancy for any reason and after a pre-birth assessment leading to removal for safeguarding by Children's Services and / or experience tokophobia i.e. extreme anxiety of childbirth.

This is a multiagency service with midwives, health visitors, GPs, psychologist and psychological therapist and obstetricians working alongside each other. Referrals are discussed weekly at the multiagency MDT. The service has been seeing women and families since February in a slow launch and working towards a wider launch.

Maternity Review Psychological Service

The Maternity Review Psychological Service was commissioned by NHSEI and has been developed specifically in Shropshire, Telford and Wrekin to support women and families who are part of the Ockenden Review into cases of serious and potentially serious harm at SaTH. The families who have come forward to the Review have experiences spanning a 40 year period so this includes older adults, couples, intergenerational groupings, children, and also adolescents and adults with birth-related disabilities. The trauma informed clinical model is a strength-based, consultation and intervention approach which aims to assist families in enhancing their ways of coping. This service is up and running and is staffed by psychologists and led by a Consultant Psychologist.

5.7 Continuous Glucose Monitoring

The NHS Long Term Plan set an ambition for all pregnant women with type 1 diabetes to be offered continuous glucose monitoring by March 2021, to help improve neonatal outcomes. SaTH were able to establish this offer before the March 2021 deadline and the latest performance data shows that 100% women with type 1 diabetes are being offered Continuous Glucose Monitoring, with 98% women taking up the offer.

5.8 Neonatal Critical Care Review

This programme is based on aligning capacity, developing an expert neonatal workforce and enhancing the experience for the parents.

In terms of aligning capacity and service specification, SaTH meet the terms of requirement for this action and no further action is needed. There is a demand for an increase in transitional care where the mother and baby stay together. The projected need is for 8 cots and this could be reduced to 6 cots with the Transforming Midwifery Care proposal for Maternity Hubs where care such as jaundice and antibiotic treatment could be carried out along with assistance with feeding difficulties. If maternity hubs are open for 12 hours a day it would potentially enable antibiotics to be delivered, jaundice treatment and help with feeding difficulties where mother and babies currently admitted to the consultant ward at Princess Royal Hospital. The proposed change could mean that they could be cared for at home with the involvement of the hub.

The workforce elements of the recommendations are presenting the most challenge. Developing an expert neonatal nursing workforce is an issue locally and has been a bottle neck across the country. SaTH currently have 80% QIS (Qualified in Speciality) nurses and are confident that the remaining 20% of nurses will have completed the required training by the end of this year. The trust has approved the recruitment of an additional Neonatal Consultant to enable 7 day working and placements with the Neonatal Intensive Care Unit to keep skills and practice up to date. The recruitment and training of Allied Health Professionals is an area that requires major investment and is a national issue. The only resource SaTH neonatal services currently have access to is adhoc support and goodwill of dieticians and speech and language therapists.

Through LMNS funding, progress has been made for Family Integrated Care where the families are not just visitors but involved in the delivery of the care including improvements in the facilities and equipment available for families to use and in training for all staff.

5.9 Continuity of Carer (CofC)

The ambition for CofC is that by March 2022, most women booked for maternity care are placed on to continuity of carer pathways and that this is offered to all women by 2023. In implementing CofC, greater focus needs to be on providing this for people from Black, Asian and Minority Ethnic communities and those living in deprived areas, as there is a proportionately greater impact for these women. Continuity of Carer means that those accessing maternity services receive all of their care from the same small team of midwives. As previously noted, SaTH have introduced two CoC teams; one in Telford and one in Shrewsbury and the Trust are seeking to expand out and launch two more teams, however the additional pressures of Covid and staffing availability have made it challenging to achieve this and there is a risk that this ambition will not be achieved locally.

The table below summarises the position to date.

TRUST % on CofC Pathway (of all bookers) 2021	All Patients	BAME	Deprivation
Jan 21 data	11.5%	11.4%	4.9%
Feb 21 data	11.6%	12.3%	5.6%
March 21 data	11.8%	12.1%	5.3%
April 21 data	10.5%	17.4%	2.4%
May 21 data	11.3%	21.9%	4.5%
June 21 Data	11.3%	21.9%	4.5%

A further 5 continuity of carer teams are needed in order to achieve CofC for most women, with 11 teams required to achieve continuity of carer for all women.

The LMNS has provided funding for an additional 5.6WTE midwives in order to release midwives from their existing roles into continuity of carer teams. A continuity of carer lead midwife is also being recruited to drive progress forward in line with national targets.

Despite not yet being on track to deliver the national targets, our local performance in relation to continuity of carer is similar to other LMNS, as this presents a key challenge to many services particularly in light of the additional staffing pressures faced due to the impact of COVID-19.

5.10 Perinatal Equity Strategy

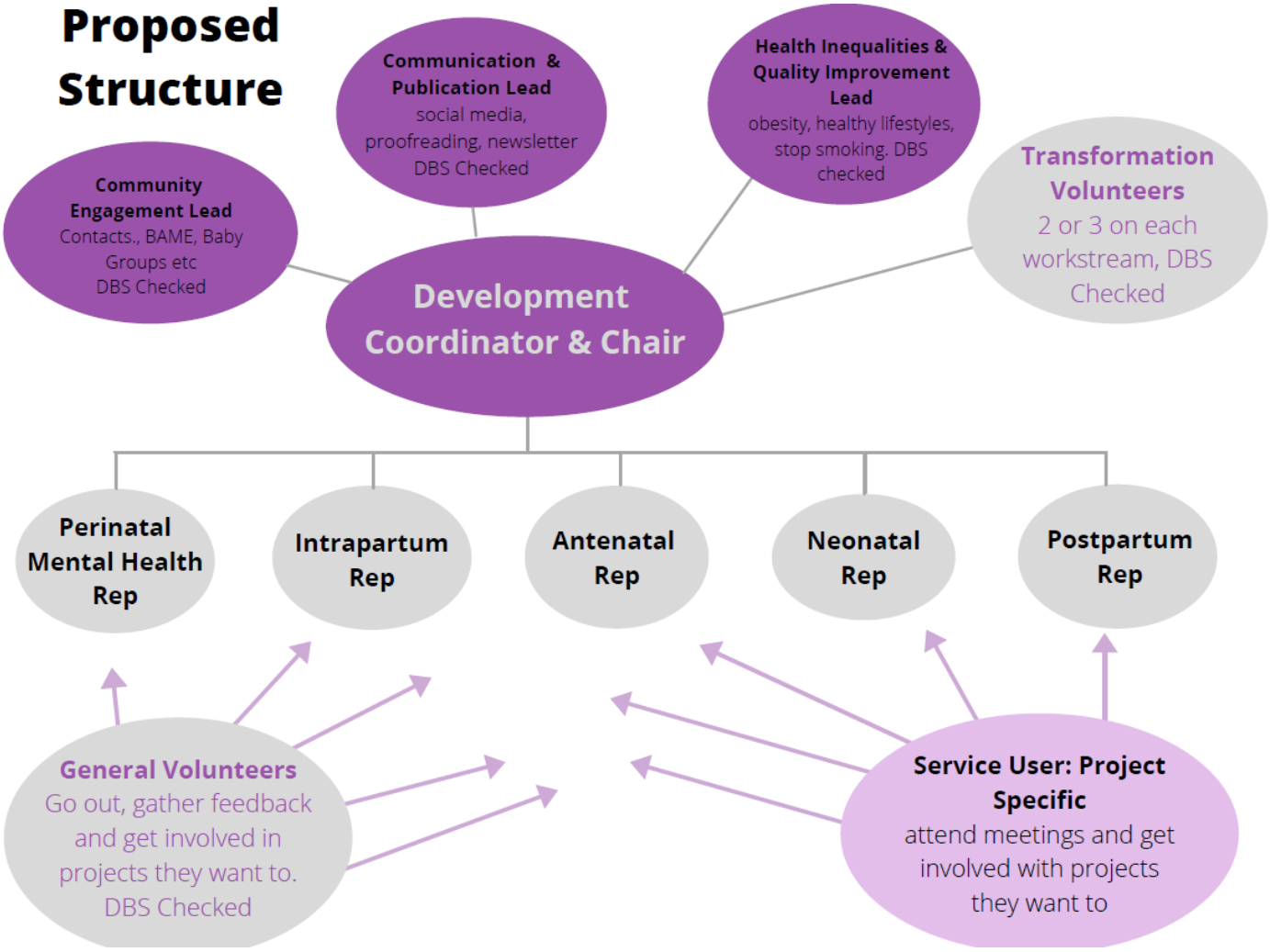
Following the publication of a national equity strategy for maternity and neonatal care, the LMNS will be required to develop a local equity strategy in co-production in order to ensure that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes.

6.0 Service user feedback and Co-production

6.1 SaTH have reintroduced the monthly Friends and Family Feedback Test (FFT) survey and have a high response and satisfaction rate pertaining to the antenatal care period; they are working to increase the number of responses from the post natal period of care. A more detailed update is due in the next reporting period.

6.2 *Maternity Voices Partnership (MVP)*

The Maternity Voices Partnership continues to develop the breadth and depth of work being undertaken in co-production. In order to ensure appropriate representation in a wider range of work, the MVP is changing the way it is structured and is moving to a more comprehensive structure, as illustrated below.



The Maternity Voices Partnership provides a way for people including service users, providers, commissioners and others to design and improve maternity care together. All these different people working together to share ideas and identify solutions for the design and improvement of maternity care is called co-production. The function of the MVP is more than simply to listen; it is a way of discussing challenges and ways of overcoming them. The group aims to constantly support the development and improvement maternity care for everyone, regardless of who they are or where they live, so everyone has access to the same quality of care.

MVP 5 Key Principles;

1. Coproduce as equals, promoting and valuing participation
2. Seek out and listen to service user experiences
3. Champion the user of service user experience when reviewing services
4. Understand the interdependency of staff experience and positive outcomes.
5. Pursue continuous improvement in maternity services

Key to the work of the MVP is gathering service user experiences. The MVP has this year launched an online Feedback Survey which is designed to be able to be analysed in a number of different ways in order to inform change to services and pathways. The feedback questionnaire can be found here:

https://www.healthwatchtelfordandwrekin.co.uk/shropshire-and-telford-wrekin-maternity-voices-feedback-form

The MVP have driven the Coproduction of services, improvement plans and service user information including Lighthouse (Maternal Mental Health service), Personalised Care and Support Plans, Saving Babies Lives Care Bundle, Birth Place Choices Leaflet, Neonatal service improvements and Healthy Pregnancy projects as well as supporting service developments with project specific focus groups.

The MVP are currently working on an innovative co-production project with the Maternity Transformation Workstreams which invites User Experience via UX Cards (user experience cards) on a certain theme and uses the feedback to directly inform change.

Social Media activity is key in raising the profile of the MVP and there are active Facebook, Twitter and Instagram accounts:

- Facebook: @MaternityVoicesShropTW
- Twitter: @MVP_Shrop_TW
- Instagram: @shrop_telford_wrekin_mvp

7.0 Perinatal Quality Governance

7.1 Alongside the continuation of Transformation and Improvement activity, LMNSs (hosted by STW CCG) are now required to also take on full and on-going oversight of quality, ensuring that an understanding of the quality of maternity and neonatal services informs transformation. This requirement has been set out in NHS Planning Guidance and is in response to the findings of the Ockenden Review into cases of harm and potential harm and includes a requirement stating:

> *"LMS must be given greater accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them."*

7.2 In accordance with requirements, the LMNS terms of reference and work programme have been reviewed to ensure that the LMNS purpose specifically includes all of the following:

- To oversee quality in line with the published NHS guidance 'Implementing a revised perinatal quality surveillance model'[1].
- To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.
- To oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.
- To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care.
- To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships.
- To implement shared solutions wherever possible through shared clinical and operational governance.

7.3 Integrated Care Systems (ICS) are asked to take on formal, structured and systematic oversight of how their LMNS delivers its functions and for there to be clear routes of accountability to the ICS. The revised governance arrangements for this are set out in the ICS Quality and Safety Strategy, approved by ICS Board in June 2021, and the below diagram illustrates the reporting routes:

[11] https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

7.4 The Perinatal Mortality and Safety element of oversight will be undertaken by the new Perinatal Quality Surveillance Group (PNQSG), the successor to the CCG's Maternity CQRM, with refreshed Terms of Reference and maintaining the CCG's statutory oversight role until the ICS is duly authorised.

7.5 Implementing a revised quality and surveillance model includes certain principles to be in place and as part of meeting this requirement the senior responsible officer for the Shropshire, Telford and Wrekin LMNS has engaged with neighbouring LMNS's at an early stage (ahead of the publication of the Ockenden first report) and more recently sought support from the Regional Chief Nursing Officer (RCNO) and Regional Chief Midwife (RCMW) to progress plans to strengthen alliances. The RCMW has advised that:

> *'there is no requirement or ability to formally merge LMNS. Prior to the formation of ICS and the responsibility changes of the LMNS this would not have been possible due to the funding allocation process. Following the publication of the LTP where it confirmed that the LMNS will now take on the role of quality oversight of maternity services on behalf of the ICS it would be impossible for you to have a formal merger because the ICS is the regulatory authority and will hold the governance for that system. What is required is an acknowledged working relationship between the LMNS who are single Trust LMNS and another LMNS. It is particularly important that this arrangement allows peer review, supportive challenge and shared learning.'*

As a result of this confirmation, further discussions are planned within our system, particularly with SaTH clinicians, to agree the form of relationship we wish to pursue and further information on arrangements will be shared to the LMNS for approval in due course.

8.0 Transforming Midwifery Care (the reconfiguration of midwife-led services)

The position remains that the CCG/LMNS is awaiting approval from NHSEI at national level in order to go out to public consultation on the proposals to transform midwifery care that were drafted during 2019. The CCG has been actively engaging with NHSEI on this and has asked Sherwood Forest Hospital to

informally review the assumptions made in the business case, in light of the Ockenden recommendations, to see if these remain valid.

9.0 Conclusion

9.1 The above report provides an overview of the scope of information routinely monitored by the CCG and LMNS. It covers updates on the main quality and safety areas, both in terms of performance and achievements, and also the transformation schemes, identifying actions being taken and where further improvements are needed.

The STW funding model for smoking prevention work requires confirming and will require system partners to work together to find a solution.

9.2 At SaTH there has been progress made across a number of improvement areas in the preceding few months, however there remains some key areas where further progress needs to be made, such as achieving the next stage in implementing additional Continuity of Carer teams which is reliant upon workforce plans and good leadership.

SaTH's internal maternity governance is still reliant upon external support and subject to recruitment to some key governance positions and there remains continued instability in midwifery leadership at this critical time period. The reliability of data quality remains an on-going concern, and the delayed implementation of the Badgernet maternity record is an added frustration.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 14th July 2021**

Item Number:	**Agenda Item:**
GB-21.07.043	Elective Recovery Report – for April & May 2021

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

Executive Summary (key points in the report):

Elective recovery is now underway as Covid demand continues to be at low levels. The STW final recovery plans for the first half of 21/22 (referred to as H1) have been submitted to NHSEI and initial feedback has been positive as it achieves all the national requirements. There are some minor concerns re volume of cancer activity and our rate of use of advice and guidance but the system is working to further improve these via the System Recovery Group and the OP transformation project.

The national Elective Recovery Framework is comprised of two main elements. One is the activity vs a baseline value of all elective activity in 2019/20 allowing for funding, workforce recovery and negative productivity impacts of the ongoing pandemic through 21/22. The monthly thresholds being 70% for April, 75% for May, 80% for June and 85% for July, August and September. The second element is delivery of 5 gateway criteria which are:-

1. Clinical validation, waiting list and long waits
2. Addressing health inequalities
3. Transforming outpatients
4. System-led recovery
5. People recovery

For this month only the activity vs plan vs national target is reported as the criteria for measuring progress against the 5 gateway criteria has only just been released by NHSEI and the system is now developing its reporting processes for this. Performance against these will be included in future performance reports to the Quality & Performance Committee from July and will evolve as the deliverables are more clearly defined by NSHEI.

NHSEI regional team have confirmed they have recommended to the national team that STW has met the full requirements for April. Recommendations for May are due to be given by the regional

team on the 9th July. The CCG and wider system are compiling additional evidence to ensure the full requirements for May are met too.

The system is currently completing a full risk analysis of expected delivery against the key lines of enquiry for the five gateways recently released by the region. This will be reviewed by the system elective /cancer recovery group at July's meeting to enable appropriate mitigating actions to be taking for the reminder of H1 to ensure continues delivery.

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 we fail to deliver the activity thresholds in the Elective Recovery Framework and the associated Gateways requirements the system may not receive the full ERF funding it could/should have done.*	Yes
3.	Is there a risk to financial and clinical sustainability? *The system has made commitments against 75% of the value of the ERF funding that the system expects to receive based on its H1 plan. If the system does not deliver its plans then this income is at risk.. A monthly elective/cancer recovery group is in place to oversee delivery of the plan and seek mitigations to any risks to delivery from system partners.*	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 is asked to note the content of the report and at this early stage receive partial assurance regarding the STW system's delivery of its H1 elective recovery plan.		

Shropshire, Telford and Wrekin
Clinical Commissioning Group

1 Elective Recovery Framework Performance

This month is the first month for reporting the STW system delivery against the H1 elective activity plan and recovery framework. The framework is comprised of two main elements, one being activity and the other is a list of 5 gateway criteria which are:-

1. Clinical validation, waiting list and long waits
2. Addressing health inequalities
3. Transforming outpatients
4. System-led recovery
5. People recovery

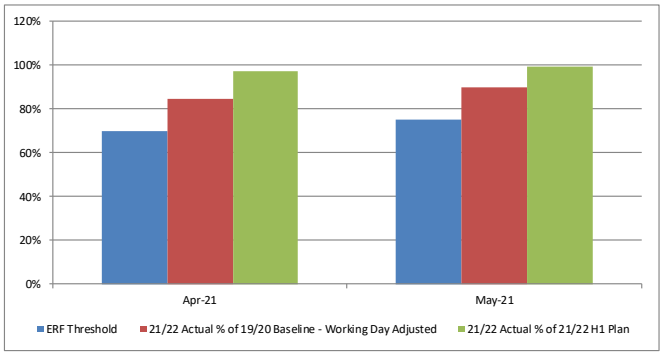
For this month only the activity vs plan vs national target is reported as the criteria for measuring progress against the 5 gateway criteria has only just been released by NHSEI and the system is now developing its reporting processes for this. Performance against these will be included in future performance reports to the Quality & Performance Committee from July and will evolve as the deliverables are more clearly defined by NSHEI.

SATH and RJAH Elective Activity Recovery against H1 Plan and 19/20 Working Day Adjusted Baseline

April is validated data and May is unvalidated data and may be subject to change. Diagnostics are based on DM01 – English Commissioners only and total Provider catchment. May activity especially endoscopy may be understated while awaiting coding completeness.

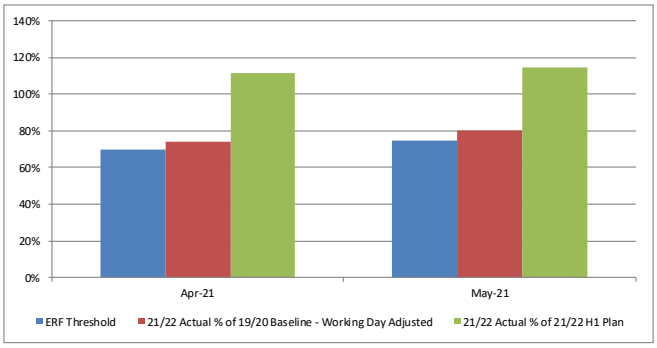
Daycase

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	5914	5138	4991	70%	84%	97%
May-21	5811	5251	5216	75%	90%	99%



Elective

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	868	576	642	70%	74%	111%
May-21	907	636	729	75%	80%	115%



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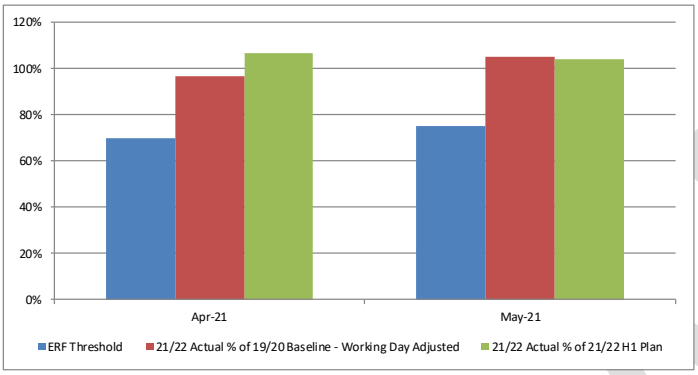
Clinical Commissioning Group

Both daycase and elective have achieved the national thresholds of 70% in April and 75% in May, but our system day case position was slightly below plan for both months.

Both 1st and follow up OP have achieved the national thresholds of 70% in April and 75% in May, but our system follow up position was slightly below plan for both months.

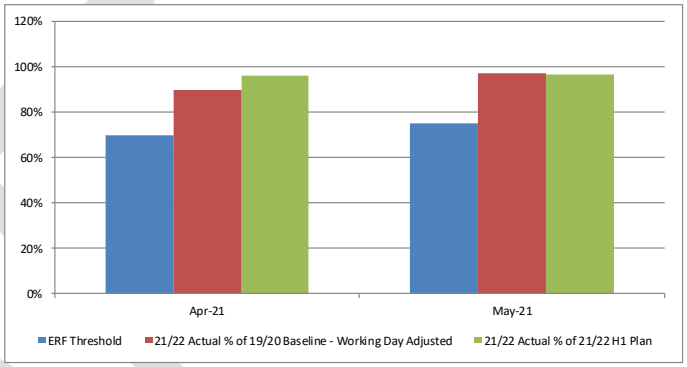
1st Outpatients

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	15215	13813	14724	70%	97%	107%
May-21	14760	14935	15543	75%	105%	104%



Follow Up Outpatients

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	30351	28485	27319	70%	90%	96%
May-21	27755	28004	27041	75%	97%	97%



There is further work to do on this reporting during the next few weeks and in addition there is expectation that the Welsh system will introduce a similar framework based on the English model – this would attract additional income for our local system which is over and above that planned at present. The financial consequences of this and the use of the ERF funding are being monitored at the CCG Finance Committee.

NHSEI regional team have confirmed they have recommended to the national team that STW has met the full requirements for April. Recommendations for May are due to be given by the regional team on the 9th July. The CCG and wider system are compiling additional evidence to ensure the full requirements for May are met too.

The system is currently completing a full risk analysis of expected delivery against the key lines of enquiry for the five gateways recently released by the region. This will be reviewed by the system elective /cancer recovery group at July's meeting to enable appropriate mitigating actions to be taking for the reminder of H1 to ensure continues delivery.

Recommendation

The Governing Body is asked to note the content of the report and receive partial assurance regarding the STW system's delivery of its H1 elective recovery plan.

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REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body meeting on 14th July 2021**

Item Number:	Agenda Item:
GB-21-07.044	Quality & Performance Report

Executive Lead (s):	Author(s):
Julie Davies Director of Performance julie.davies47@nhs.net Zena Young Executive Director of Nursing & Quality Zena.young@nhs.net	Julie Davies Director of Performance julie.davies47@nhs.net Tracey Slater Assistant Director of Quality Tracey.slater4@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	23rd June 2021	SDI

Executive Summary (key points in the report):

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 as overall numbers of A&E attendances and emergency admissions are now greater than historic average for the time of year.
- Ambulance handover delays in excess of 1 hour remain a challenge
- Elective recovery is now well underway but still below pre COVID levels especially in IP and the detail of this for the first two months of the year is subject of a separate report to governing body this month.
- Consequently, waiting times for Elective care continue to show high numbers of long waiters, but the numbers waiting for diagnostics are continuing to reduce.

- In general cancer performance has held up reasonably well up to present but the current Covid surge is likely to present problems in maintaining this position.

- Dementia diagnosis remains below target as patients seem reluctant to come forward for diagnosis – patients referred are being booked in by MPFT so there is no wait for assessment/diagnosis

- IAPT activity has increased but the CCG will not achieve the yearend target due to current levels of funding- the projected level of delivery is being modelled by the commissioning leads and MPFT and will be taken to a future Quality & Performance Committee.

Quality

SaTH

- An update on quality impacts of commissioned services is provided. SaTH remain the most challenged provider and cause for concern within the health system.
- A HM Coroner's Regulation 28 report has been received by SaTH identifying concerns regarding Tele-tracking (the automated portering notification system), whereby insufficient information was recorded, and the level of assistance provided to patients.

RJAH

- There have been 2 wrong site surgery Never Events reported by RJAH during April 2021, both relating to a regional block. CCG has received assurance of immediate changes in WHO process

MPFT

- CCG raised concerns regarding increase in numbers of patients self-harming, MPFT have been asked via CQRM to provide a response.
- The CCG have raised concerns around the interpretation of data and conclusions drawn within the MPFT's suicide report, MPFT have acknowledged receipt of these concerns and will discuss within their collective leadership and provide a response via CQRM (due September 2021). A meeting between CCG and MPFT has been arranged to further discuss.
- STWCCG and partners are continuing work to improve the offer of, uptake and quality of Annual Health Checks for people with a Learning Disability

Safeguarding

- Numbers of children that are coming into care continues to rise. Recent data for Quarter 4 submitted to CQRM demonstrated that the completion of review health assessments is above trajectory which is a positive achievement for Quarter 4.

IPC

- The IPC restoration plan continues to 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.

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 contents of this report

1 Key Performance Challenges

At month 1 of 20201/22, unless otherwise indicated. This month urgent care is reported with the making data count methodology for the first time to the Governing Body. Additional programmes will follow in this format with Cancer being reported in this way from September onwards.
The usual Appendix 1 showing further detail on the indicators has not been reported this month due to the change to the single CCG and the lack of formal historic comparators. The performance analyst is working on proxy comparators for the time being for this summary and they will be included for September's report.

1.1 Urgent Care

A&E Waits at Shrewsbury and Telford Hospitals (month 2, 2021/22)

KPI	Latest month	Measure	Target	Performance	Assurance	Mean	2019/20 YTD	2021/22 YTD	Apr-21	Variance Previous Month	YTD Variance	Variance with Mean
4hr ED Breach Performance Including MIU	May 21	77.0%	85.0%			75.8%	75.7%	78.2%	79.5%	-2.53%	2.49%	1.18%
12 Hour DTA Number	May 21	1	0			60	15	13	12	-91.67%	-13.33%	-98.34%
Ambulance Handover - 60mins Number	May 21	348	0			209	481	594	246	41.46%	23.49%	66.84%
Ambulance Handover - 60mins Rate	May 21	9.2%	0.0%			5.5%	6.2%	7.8%	6%	2.80%	1.58%	3.70%

4 hr ED Breach Performance including MIU (Target 95%)

- Performance has deteriorated when compared to the previous month however remains above the mean. With attendances returning to pre-Covid levels in May and increases in ambulance conveyance, major presentations and conversion rates for admission performance remains challenged. Whilst work has commenced on the RSH ED estate and mitigations such as the two medical SDEC (Same Day Emergency Care) units and recently opened surgical SDEC at RSH are in place, the flow through EDs and into the wards remains a challenge at times. The focus on recovery remains through the Getting SaTH to good Programme which aim to maximising capacity created by SDEC models and supporting flow through from the departments by improving ward management processes

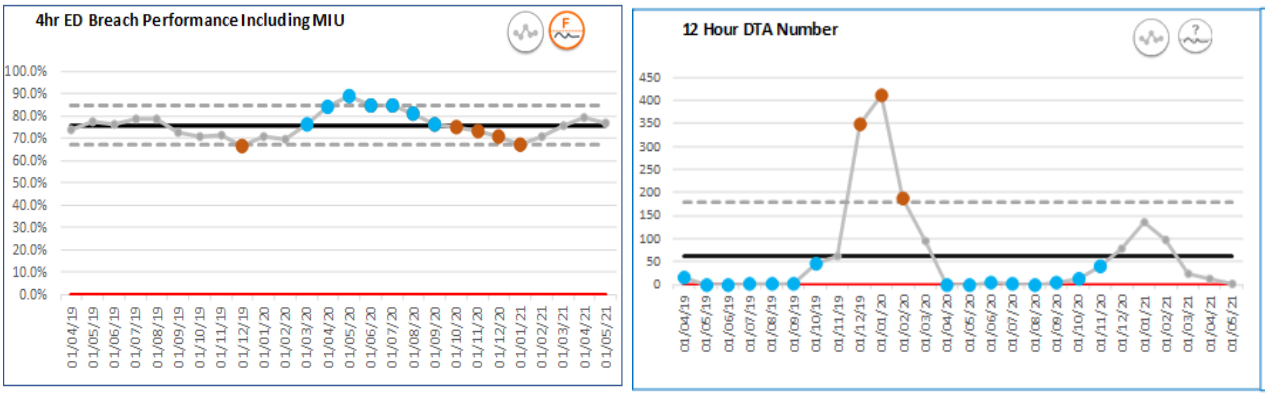
12 Hour DTA Hour Number

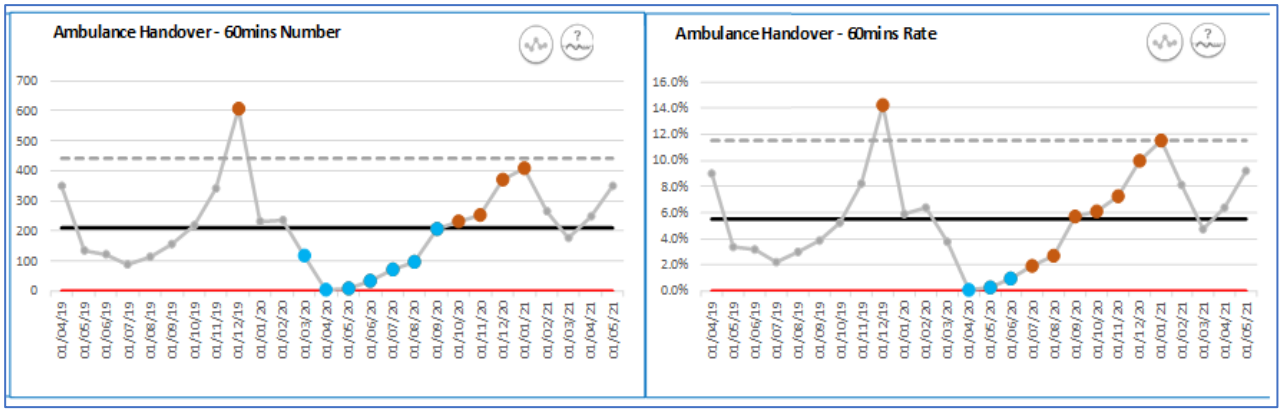
- Performance has improved compared to the previous month and is returning towards the delivery of the target of 0. There is continued focus on the delivery of ward process improvement plan (Getting SaTH to good Programme) to facilitate earlier discharge and allow flow from ED's. To note- As activity starts to increase coupled with the closure of discharge lounge and the reduction in number of medical beds to facilitate the surgical recovery plan the delivery of this target remains fragile.

Ambulance Handover – 60 Mins

- Performance has deteriorated when compared to the previous month due to insufficient physical capacity for offload. This is mainly down to increased acuity noted (increased Majors in May -21) and poor flow from ED into the wards. The project on flow continues, with pre-1200 discharge and process improvements on wards set as a priority. In addition, the Ambulance navigator role remains in place with plan to increase initial assessment to SDEC & UTC where

appropriate. There is an Ambulance arrival standard operating policy in place and a harm review process established.





To Note: On review of the metrics above (except 4 hr performance) none of the SPC rules are triggered to warrant either an orange or blue improving or failing icon to be generated. They are performing in normal variation and assurance of delivery of the target is hit and miss.

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

1.2 Elective Care

Key Performance Indicator	Target	Latest Position	Change from previous	Last achieved
Referral to Treatment within 18 weeks	**>92%**	**59.3%**	↓	Nov '18
Referral to Treatment > 52 weeks	**0**	**4633**	↑	
Diagnostic test waits > 6 weeks	**<1%**	**24.2%**	↓	Jun '19

- Elective activity at local providers is now recovering steadily across the system. The delivery of activity against the new system recovery plan is monitored at the monthly System Elective/Cancer Recovery meeting and a high level summary included in a separate report for the Governing Body.
- Outpatient activity is now improving with April levels mainly on or slightly exceeding plan, with more activity being delivered virtually which is helping the rate of recovery. Routine referrals from Primary Care remain around 30% lower than pre-Covid levels, although there is evidence of recent increases back to 2019-20 levels.
- Overall numbers of waiters have not increased as rapidly as first feared, but an increasing proportion of longer waits will continue to be a feature. Priority continues to be given to those in the highest clinical urgency categories, including cancer.
- Diagnostic waits has been severely impacted by capacity restrictions resulting from Covid 19 but its rate of recovery is much greater due to imaging capacity being enhanced through extending working hours and provision of additional modular facilities which has meant activity above pre-COVID levels has been possible. There is some risk as the additional modular CT at SaTH as now gone as part of national contracting arrangements. Funding has now been agreed to staff the CT/MRI POD which is due to arrive at SaTH in August but won't be operational until October. Focus continues on Endoscopy within SaTH and the detailed demand and capacity model for endoscopy including actions required to increase capacity for recovery e.g. TNE. Latest plans from SaTH do show improvement in the rates of recovery for colonoscopy and gastroscopy, getting closer to expected levels. Based on current projections by September there should be no endoscopy patients waiting over 6wks but this is subject to additional capacity being found to deliver the surveillance activity.

1.3 Cancer Care

Key Performance Indicator	Target	Latest Position	Change from previous	Last achieved
2WW Urgent referral	**>93%**	**85.3%**	↑	Aug '20
2WW Breast (cancer not suspected)	**>93%**	**5.4%**	↓ ↑	Aug '20

31-day wait for subsequent treatment (surgery)	**>94%**	**85.0%**		Jul '20
62-day wait from GP referral to cancer treatment	**>85%**	**79.1%**		n/a
62-day wait for treatment after referral from cancer screening	**>90%**	**45.5%**		Nov '20

- 2ww cancer (and 2 week symptomatic breast) performance deteriorated due to capacity issues in the breast cancer service as a result of IPC requirements. Estates work was completed to address this and a recovery trajectory agreed to deliver this for both the suspected cancer and symptomatic pathways by the beginning of July. This was on track with the team booking at 15 days at the 22nd June. However the scanner at PRH has gone down. The trust are working hard to maximise the unit at RSH and getting mutual aid out of area until the new unit is operational. The breast team are recalculating the recovery trajectory as a result of this recent setback. The system is currently completing a bid for regional funding to support the delivery of the model using community settings for non-suspected cancer cases, manned by a secondary care nurse team. This would take out 33% of activity out of the acute and significantly improve access and delivery of the 2wk cancer target.
- SaTH are currently doing a deep dive on the issues driving the lower performance in 31days surgery metric, the outcome of which will be reported to September's GB meeting.
- SaTH was responsible for 5 waits of at least 104 days for English patients at the end of April. A number of the longest delays are due to complex cases which the various teams are working proactively to address. SaTH have achieved the NHS requirement of reducing the 104 day waits back down to levels seen pre COVID.
- 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. Referral levels continue to be of concern in lung: the CCG and SaTH are working together to try and understand what more can be done to encourage referrals for lung. Lack of walk-in chest x-ray remains due to social distancing and the need to control footfall and flow and this is impacting on capacity. Until Public Health England guidance changes this will remain the case. Significant capacity issues in diagnostics have impacted routine performance but cancer and other urgent cases are being given priority.

1.4 Mental Health & LD Care

Key Performance Indicator	Target	Latest Position	Change from previous	Last achieved
Dementia Diagnosed, as a proportion of estimated prevalence in over-65s	**>66.7%**	**62.4%**		n/a
IAPT: access to psychological therapies, YTD	**100%***	97.6%*	New measure	n/a
Recovery rate from IAPT	**50%**	54.4%		n/a
Early Intervention in Psychosis (package of care within 2 weeks)	**60%**	60%		Q4 20/22

CYP Eating Disorders seen within 4 weeks of routine referral	**95%**	100%		Q420/21

- For some of the metrics we are unable to calculate an accurate historic joint CCG position hence N/A for some measures in the table above. The performance analyst is working on proxy comparators for these going forwards.
- Dementia diagnosis remains below the national target this month there is continued improvement in recent months despite many challenges within Primary Care around capacity and the reticence of patients to come forward for both virtual assessments as well as some re-instated face to face appointments. Referrals to the dementia team have increased from Shropshire GPs around 20% from 2019/20, but have reduced from Telford GPs by 9% same period – so there is still work to do to promote this in Telford through locality leads. Performance of 65.2% for April is better than national performance of 61.7%. Confirmation that MPFT have all patients who are waiting for assessments booked in so no long waits are in the service.
- IAPT access - referrals received, as well as the number of people entering psychological therapies has increased in April and work is underway to re-design the whole service to bring Shropshire and Telford & Wrekin services together with some dedicated senior clinical leadership being put in place. *The measure is now in absolute numbers but performance against this is being shown as percentage for ease of reporting. The CCG will not achieve this target overall in 21/22 as the numbers during the year increase due to limitations in funding available. The expected gap to target for the full year is currently being modelled with MPFT and aim to have a first view for July's Quality & Performance meeting.
- IAPT recovery - Recovery rates remain above the 50% target, April performance has improved on previous months (March was 50.8%). This is indicative performance from MPFT only, until the official quarterly figures are published
- EIP- There are small numbers of patients entering this service; a total of 5 entered the service in April of which 3 waiting less than two weeks (indicative performance from MPFT)
- CYP eating disorders- The number of referrals received is very small, and are all seen within 4 weeks, with just one exception to this in March. Again, this is from local MPFT reporting.

2 Quality

2.1 Shrewsbury and Telford Hospitals NHS Trust:

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

- A recent 29A Warning Notice and actions being undertaken in relation to CQC Section 31 conditions imposed relating to Children with mental health needs and children's safeguarding, was responded to by the trust on Friday 5th March 2021, and completed on 12th March 2021 in line with the CQC's deadlines.
- An update in relation to the CQC Section 31 conditions and Section 29A warning notices already in place outlines that evidence in relation to several conditions relating to the Emergency Department has been collated, and signed off by SaTH Executive Team. This was submitted to CQC on the 9th April 2021 for their review and consideration of the lifting of these conditions.

- Twelve conditions relate specifically to the Emergency Departments, 10 relate to the inpatient wards or across the Trust and 2 relate to the requirement for the Trust to report weekly or monthly on these conditions. In relation to the 6 new conditions, 1 condition was acted upon immediately with no further action required; another condition was acted upon immediately but requires further system wide working to ensure a suitable model of care for CYP with mental health issues is put in place. A further 2 conditions relate to safeguarding and 1 condition relates to training for CYP with mental health and learning disabilities. The remaining condition also requires system wide work in relation to the model of mental health provision for CYP in the Trust to ensure continuous oversight of these needs whilst the young person is in hospital.
- An update on performance against the CQC Section 31 conditions imposed following the CQC inspections shows continued challenge for SaTH to meet all requirements particularly regarding sepsis actions and paediatric triage. Performance remains inconsistent for those two metrics. Achievement of all quality standards across in-patient clinical areas remains work on-going.
- CCG receive from SaTH Section 31 weekly safeguarding activity and monthly action plan which details progress against conditions.

- The number of falls in March was above the monthly trajectory; however both falls per 1000 bed days and falls with harm performance were better than the national and local standards set. Falls action plan is shared via CQRM and shows progress against actions however there is further work being undertaken by the trust that are linked in with the national team to support mitigating actions.
- Following a patient fall and subsequent death SaTH received a HM Coroner's Regulation 28 report has been received identifying concerns regarding Tele- tracking (the automated portering notification system), whereby insufficient information was recorded, and the level of assistance provided to patients.

Maternity:

- A separate report will be submitted to Governing Body

2.2 Robert Jones and Agnes Hunt Orthopaedic Hospital

- There were 2 wrong site surgery Never Events reported during April 2021, both relating to a regional block. One incident involved a SaTH member of staff working at RJAH however following fact finding this Never Event has been attributed to RJAH with support from SaTH to complete the report. Both incidents are undergoing investigation and reports are due in July. Assurance has been sought from the trust who have taken immediate remedial actions. Further to this members of the CCG Quality team have undertaken a Quality assurance visit to the trust and gained assurance of implementation of changes and compliance with the WHO process. This also included a discussion around human factors training.
  There has been a slight increase above their tolerance of Category 2 pressure ulcers and found to be equipment related. There had been increased work around pressure ulcers prevention, which is one of RJAH quality priorities, with a new Tissue Viability Specialist Nurse now in post and increasing training and awareness in the organisation is reported to be driving the increase in reporting of incidents.

2.3 Midlands Partnership FT

- MPFT continue to support SaTH section 31 CYP and work continues across the system to find solutions and future options. This has involved several quality impact assessments exploring viable options to provision of a Place of Safety facility for initial assessment and short term in-patient facilities; work continues to progress at a pace.
- STW GP survey will be bought back in line with governance processes and agree reporting and way forward and align with transformation work.
- CCG raised concerns regarding increase in numbers of patients self-harming, MPFT have been asked via CQRM to provide a response.
- The CCG have raised concerns around the interpretation of data and conclusions drawn within the MPFT's suicide report, MPFT have acknowledged receipt of these concerns and will discuss within their collective leadership and provide a response via CQRM (due September 2021). A meeting between CCG and MPFT has been arranged to further discuss.

2.4 Shropshire Community Healthcare NHS Trust

- At the April CQRM SCHT presented their Strategy for Nursing (Strategy for AHPs currently being written). This provided an overview of the diverse nursing roles within SCHT. Trust gave details of the 3 strategic areas for their vision. These are;
  - Growing our future – attracting, recruiting and keeping nursing staff
  - Learning and developing throughout nursing career
  - Caring with confidence
- Senior Quality Lead undertook a Quality Assurance visit to Whitchurch Community Hospital in-patient ward on 30th April 2021. Reports currently being written but no immediate concerns were raised with SCHT following the visit. Senior Quality Lead noted a positive improvement to the ward environment since previous visit in July 2019.

2.5 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.

2.6 Primary Care

- Additional training on the Ulysses incident and concerns reporting system is being rolled out.
- STWCCG and partners are continuing work to improve the offer of, uptake and quality of Annual Health Checks for people with a Learning Disability. A system wide approach is being developed to ensure buy-in to improve this area of work and to expand its reach. The National team are expecting 70% achievement of completed LDAHCs during 2021/22, with a target of 75% by the end of 2024. The CCG are committed to the aspiration of offering 100% of people with a learning disability an annual health check with clear reasons recorded and reviewed if an

individual chooses not to attend or DNA's. The weekly data collection continues and allows close monitoring against our STW targets. High performing practices are encouraged to share good practices across their PCN.

- For 2021/22 the focus is on the 14-18 year age group, working jointly with SEND Teams, specialist schools, The Local Authority and Parent & Carer groups to ensure LDAHC's are embedded within services i.e. EHCP's and that Young People (YP) are captured on the GP LD register and offered a LDAHC. Joint work to identify YP eligible for Covid vaccination has helped to move this work forward.

2.7 West Midlands Ambulance Service (WMAS)

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

2.8 Care Homes

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

2.9 Independent Providers

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

3.0 Safeguarding

Looked After Children (LAC)

- Numbers of children that are coming into care continues to rise. There are currently 972 LAC; pan-Shropshire; in addition the hosted LAC population is 752. Recent data for Quarter 4 submitted to CQRM demonstrated that the completion of review health assessments is above trajectory which is a positive achievement for Quarter 4.
- A backlog of completion of health assessments in Staffordshire is starting to resolve; the DNLACs are starting to see some assessments coming through for quality assurance purposes; this will continue to be monitored.

Safeguarding children

- Challenges have existed due to continuing children in need and child protection cases in COVID 19 lockdown due to decreased face to face professional frontline family contacts: with a greater than before number of rapid reviews across both Local Authority areas. Additionally, a small number of Serious Adult Reviews/ Domestic Homicide Reviews being jointly reviewed with children learning review cases to 'Think Family' service improvements.
- The Designated Safeguarding staff continue to engage in system planning in relation to the CQC section 31 notice issued to SATH; the weekly meeting which was taking place over 12 weeks is receiving a review to ensure a strengthened process is in place to continue system oversight.

- On 19th May 2021 a planned Quality Assurance visit to the children's ward at SaTH was undertaken by the Designated Nurse Safeguarding Children. One of the S.31 conditions was that SaTH must implement an effective safeguarding oversight system to monitor staff compliance with safeguarding procedures. The visit purpose was to gain assurance following the safeguarding improvements which have been reported to the SaTH Safeguarding Operational group and the regular monitoring meetings with the CQC.
- The safeguarding knowledge and skills of staff alongside processes appeared satisfactory; both staff and parents spoke about the challenges of combining inpatient care for teenagers most of whom have an underlying mental health illness with young children admitted for routine procedures.
- Level 3 safeguarding training is to be rolled out to staff on adult wards where children and young people are placed in line with SaTH Safeguarding policy. Action target is 90% of staff on adult wards will have received child safeguarding training by September 2021 and the CCG are monitoring achievement of this target. A new internal safeguarding referral form with additional safeguarding questions which has been completed.
- The CCG conducted a dip sample of 6 cases to confirm Shropshire Community NHS Health Trust (SCHT) partnership contribution to children and young people (CYP) who are identified as being Child in Need at weekly resolution meetings (CIN Sec17). The findings concluded some children had not been identified; this will receive ongoing review.

Safeguarding Adults

- Liberty Protection Safeguards implementation has been impacted as the Code of Practice and other essential documents appear to have been delayed again. The latest DHSC target was for Spring 2021. This will be covered in the July Adult Safeguarding Report to QP Committee

3.1 Infection prevention and control

- The 2021/22 infection targets for CCGs and NHS Trusts have yet to be published. It is anticipated that they will be announced in July. The CCG IPC service continues to monitor rates of these infections together with infection outbreaks/incidents and subsequent monitoring/ implementation of actions.
- The CCG IPC service continue to support the local health & social care response to the Covid-19 pandemic with a number of specific work streams including the facilitating the IPC work stream and the provision of advice & support to primary care and the care sector, including care homes with suspected/confirmed cases of Covid-19. The IPC restoration plan continues to 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.
- The CCG will continue to support the IPC nurse position for the next 12 months, jointly funded by Shropshire and Telford & Wrekin Local Authorities, to support the ongoing IPC proactive and reactive work streams within adult and children's social care and specialist schools.
- Work is underway within the STW ICS to develop more integrated working for IPC across our system and progress will be reported to the ICS System Quality Group and onward to the ICS Quality and Performance Committee.

3.2 Patient Experience

- In recognising that the invitation and capturing of experience feedback should be fundamental within any organisation, it is the difference which this has been made to the quality of service that is really important and when reviewing the Shrewsbury & Telford Hospital NHS Trust Feedback Hub via their website, it is encouraging to note the following key outcomes:

➢ *Patients shared their concern about the lack of food choice during inpatient stays.*

➢ In response SaTH launched a revitalised food service on the wards, with a new menu and hostess service offering four main course options for lunch and dinner, with patients able to select portion size. Patients are also now able to make their selections on the same day, rather than the day before, which ensures food, is more palatable and tailored to how the patient is feeling on that particular day.

➢ *Another theme which emerged from patient experience feedback was around poor communication and culture within the A&E Department.*

➢ In response SaTH shared a Patient story with staff working within the Emergency Department to raise awareness and encourage reflection. SaTH have subsequently increased the number of ways patients, carers and others can provide feedback on their experience in the Emergency Department, including Matrons seeking real time feedback from 20 patients per week. In addition, volunteers now telephone patients who have received treatment in the Emergency Department seeking their review to inform future approaches.

➢ A patient experience working group within the Emergency Department has been established to act upon the feedback received and to continue to make improvements

3.3 Harm Review report

- A report on harm reviews was presented to QPC in May meeting.
- The report provided a summary of the harm reviews that had been submitted to STWCCG by our four main local providers; over the course of Q4 (2020/21) with specific focus on 104 day Cancer breaches and 12hr ED breaches.
- During Q4, a total of 44 x 12 hour trolley breaches were reported by SaTH. The CCG have agreed a process whereby the first 10 patients plus 10% of any other patients breaching within a 24hr period are reviewed for harms.
- Harm pro formas received (as at 01/02/2021) found that no apparent harm was caused to the patients at the time as a result of the wait.
- Jane Povey (Medical Director Shropshire Community Health NHS Trust) is leading on system STW ICS Clinical/Care Prioritisation Group (CPG) The purpose of the Group is to agree, implement and oversee system approaches to clinical/care prioritisation.

3.4 Serious Incident Report

- A report on serious incidents was presented to QPC in June meeting.

- The CCG has a 20 working day turnaround for review of the completed reports. These are not necessarily closed down within 20 days as some additional work may be required by providers.
- The CCG Quality team can give assurance to Governing Body that all SIs submitted are tracked and monitored to completion and currently there are no overdue SIs awaiting CCG action.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting**
Meeting held on 14th July 2021

Item Number:	Agenda Item:
GB-21.07.045	2021/22 Month 2 Financial Position

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Finance Committee	23.06.21	S, I

Executive Summary (key points in the report):

The financial performance reported in this paper is for month 2 of 2021/22. The Month 2 reporting compares actual performance to a slightly amended plan to that previously approved. The original plan submitted was amended and resubmitted w/c 14th June in line with the guidance. The amendments included category realignment and agreed redistribution of allocations across the system. The revised submission took the CCG only control total from a deficit of £4.936m to a deficit of £4.751m and when including system adjustments it took the CCG control total from a surplus of £1.714m to a surplus of £1.251m. The detail of this has been discussed at the Finance Committee.

Planned H1 position for the CCG:
CCG planned deficit : £4.751m
System adjustment held by the CCG to balance overall plan (highlighted as risk and likely position to NHSEI): (£6,000k)
TOTAL CCG (inc system adjustment) planned surplus : £1.251m.

H1 Year to Date- M2:
The CCG year to date position overall is currently showing a £1.767m adverse variance to the planned surplus of £0.416m, i.e. a £1.351m deficit. This includes a £2m adverse position against the system adjustment and £0.233m improved position on the CCG.
The year to date improvement for the CCG is due to acute spend being slightly less than planned due to an unfortunate delay (starting in May instead of April) in the new neurology service transferring from SATH to Royal Wolverhampton and a small reduction on the Betsi Cadwaladr contract value.
In year efficiency plans are currently delivering slightly above the identified YTD plan with savings so far of

£0.5m.

H1 Forecast- M6:
The CCG forecast position at M6/H1 overall is currently showing a £5.989m adverse variance to the planned surplus of £1.251m, i.e. a deficit of £4.739m. This includes a £6m deficit position against the system adjustment and a very slight improved position on the CCG.

The forecast position for the CCG incorporates the following current forecast variances:
£1.1m overall adverse variance on Individual Commissioning (including Mental Health)
£0.6m improvement on acute expenditure due to the reasons outlined in the year to date position.
£0.2m improvement on the patient transport contract due to reduced activity levels.
£0.3m improvement on other, this is mostly due to programme pay reductions due to vacancies

The forecast position includes forecast delivery of efficiency plans in H1 of £2.5m.

The CCG is currently working with system partners and NHSEI on the development of the system sustainability plan. Although the system as a whole is currently forecasting a £6m deficit against the H1 envelope this position remains in line with the system sustainability plan projected expenditure. Internal and system reporting will focus on the underlying position of the CCG and system and performance against the system sustainability expenditure control totals.

The current CCG recurrent expenditure control total in the system sustainability plan is expenditure on non system providers of £453.368m. Based on the information that we currently have on recurrent expenditure the CCG is currently £7.2m away from delivering that control total. This is mainly due to the unidentified full year efficiency of £7.3m against the £13.5m 3% target set.

Recommendations/Actions Required:
The governing body is asked to: **Note** the information contained in this report and the need to focus all efforts on delivery of the 3% recurrent efficiency target in order to meet the requirements of the sustainability plan.

Report Monitoring Form

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).* *Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework. Sufficient staff resources to identify and deliver the required efficiency plan is crucial to the achievement of the required financial position.*	Yes
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* *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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored. Key variances and risks to the System position are highlighted.*	Yes

Tables included in this report:

Graphs included in this report:

2021/22 Month 2 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 2, and reports against a revised plan for H1 submitted week commencing 14th June.

2. The Month 2 reporting compares actual performance to a slightly amended plan to that previously approved. The amendments in the revised plan included category realignment and an agreed redistribution of allocations across the system. This was agreed within the System and cleared all of the unresolved elements to be allocated across the System organisations.

3. The adjustment reflected in the revised submission had a favourable impact on the CCG only position of £185k but the £648k of system reserves has now been allocated out to all organisations and therefore this had an adverse impact overall on the CCG control total (including system adjustments) of £463k. The revised submission took the CCG only control total from a deficit of £4.936m to a deficit of £4.751m and when including system adjustments it took the CCG control total from a surplus of £1.714m to a surplus of £1.251m.

Table 1: CCG H1 Control Total

	£m
CCG Planned H1 Deficit	4.751
System adjustment held by the CCG to balance overall plan (highlighted as system risk to NHSEI)	(6.002)
TOTAL CCG (including system adjustment) planned H1 surplus	**1.251**

Summary Financial Performance

Financial Performance Dashboard

4. The CCG financial performance dashboard against its key targets is shown in Table 2.

Table 2: Financial Performance Dashboard - Key Indicators

Target/Duty	Target	RAG
H1		
Statutory duty to break-even	Break-Even	
Control Total (exc System adjs)	£4.751m deficit	
Control Total (inc System adjs)	£1.251m surplus	
Sustainability Plan		
Statutory duty to break-even	Break-Even	
Control Total (non-system expenditure total)	£453,369k	
Cash	1.25% monthly drawdown	G
Better Payment Practice within 30 days (Number of invoices)	>=95%	G

5. The CCG is on track to deliver its element of the H1 plan but this does breach our statutory duty to break even and when the system adjustment element is added in, we do not meet the plan requirement. This predicted £6m deficit for the system in H1 was flagged to NHSEI in the plan submission and it was agreed by the system to be held by the CCG in terms of reporting.

6. 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 the CCG in Month 2.

7. The Better Payment Practice targets were also met in Month 2 as over 95% of invoices were paid within 30 days.

H1 Year to Date Position

Table 3: M2 YTD H1 position

	YTD		
Category	**M2 Budget**	**M2 Actual**	**M2 variance**
	£'000	**£'000**	**£'000**
Allocation:			
Programme	140,295	140,295	0
Running Costs	1,530	1,530	0
Co commissioning	12,753	12,753	0
Planned surplus	(416)	(416)	0
Retrospective HDP expected	1,742	1,742	0
	155,904	**155,904**	**0**
Expenditure:			
In system:			
SaTH	58,908	58,908	0
RJAH	8,224	8,224	0
Shropcomm	12,384	12,384	0
In system total	**79,517**	**79,517**	**0**
Out of system:			
Acute	11,681	11,393	288
Community	2,101	2,179	(78)
Individual Commissioning	11,656	11,953	(297)
Mental Health	14,250	14,154	96
Primary Care	17,681	17,381	299
Co Commissioning	12,753	13,033	(280)
Other	6,736	6,376	360
Running Costs	1,530	1,686	(156)
Out of system total	**78,387**	**78,154**	**233**
System Affordability Gap	(2,000)	0	(2,000)
TOTAL	**155,904**	**157,671**	**-1,767**

8. Year to date (YTD) financial performance is an overspend of £1.767m against total budget. However, this reflects a YTD system affordability gap of £2m meaning that CCG performance reflects an improved position against plan of £0.233m.

9. The overall reason for the current favourable year to date variance is the underspend on the acute line. This is due to an unfortunate delay in the start date (from April to May) of the new neurology service transferring from SATH to Royal Wolverhampton, and a small reduction on the Betsi Cadwaladr contract value.

10. There is a small adverse variance in Community expenditure due to an increase in spend in the community ophthalmology service.

11. The Individual Commissioning overspend shown above is offset with Mental Health underspends and the use of the COVID reserve shown in other.

12. The overspend on the Primary care co commissioning allocation is offset with the underspend on primary care as this was budgeted for as part of the plan submission. As previously highlighted this overspend against a ring fenced budget needs to be resolved as part of the efficiency plan going forward.

13. The running costs overspend relates to additional staff costs and unbudgeted agency usage, the majority of which is non recurrent.

14. In year efficiency plans are currently delivering above the YTD identified plan with recurrent savings so far of £0.561m.

15. The year to date position assumes that we will receive £1.742m of hospital discharge programme (HDP) funding in line with the recent guidance. £0.566m relates to HDP expenditure within individual commissioning and £1.176m relates to HDP expenditure incurred by the Local Authorities. If this funding is not approved this will deteriorate the financial position.

H1 Forecast Position

16. NHSEI are currently asking for a forecast at H1/Month 6 rather than full year as funding has only currently been agreed and provided for H1.

Table 4: H1/M6 Forecast

	H1 FOT		
Category	**M6 Budget**	**M6 Actual**	**M6 variance**
	£'000	**£'000**	**£'000**
Allocation:			
Programme	420,885	420,885	0
Running Costs	4,590	4,590	0
Co commissioning	38,260	38,260	0
Planned surplus	(1,251)	(1,251)	0
Retrospective HDP expected	3,560	3,560	0
	466,044	**466,044**	**0**
Expenditure:			
In system:			
SaTH	176,725	176,724	1
RJAH	24,671	24,671	0
Shropcomm	37,153	37,153	(0)
In system total	**238,549**	**238,549**	**1**
Out of system:			
Acute	35,041	34,564	477
Community	6,303	6,370	(67)
Individual Commissioning	34,271	36,046	(1,775)
Mental Health	42,750	42,320	430
Primary Care	53,560	52,723	837
Co Commissioning	38,260	39,100	(840)
Other	18,722	17,772	950
Running Costs	4,590	4,591	(1)
Out of system total	**233,497**	**233,487**	**10**
System Affordability Gap	(6,000)	0	(6,000)
TOTAL	**466,046**	**472,035**	**-5,989**

17. H1 financial performance is a forecast overspend of £6.0m against total budget. However, this reflects a YTD system affordability gap of £6m meaning that CCG performance is currently forecast to be in line with the submitted plan. The £6m adverse variance is in line with the plan submission reported to NHSEI and the risk level flagged.

18. Acute spend is forecast to be slightly favourable as already referenced in the year to date commentary.

19. Adverse performance in Community relates to the overspend in the ophthalmology service. The H1 forecast is currently expected to improve slightly from the M2 position due to a phasing issue. The position will be monitored as further information becomes available.

20. The £1.775m adverse variance on the Individual Commissioning line is partially offset with the underspend shown on Mental Health Individual Commissioning of £0.453m and COVID funding shown in other of £0.194m. The total forecast overspend in H1 for Individual Commissioning is currently therefore £1.128m. The full level of risk flagged around Individual Commissioning in the original plan submission equated to £3.2m due to phasing of spend, at the moment this forecast is an improvement on that level of risk but at m2 we have limited information so this will be monitored carefully and is flagged in the risk section of this report. The majority of the overspend relates to the fact that the CCG is behind in the reviews of patients including those patients funded on Scheme 1 of the Hospital Discharge Programme for which there is no longer any central funding available. Based on current information around recurrent costs, we believe that the Individual Comissioning forecast recurrent spend for the year is in line with the system sustainability plan. This is covered later in this report.

21. As outlined in the year to date section the co commissioning and primary care forecast variances broadly offset each other as the overspend on the co commissioning ring fenced allocation has been planned for in H1.

22. The variance on other expenditure includes the COVID spend factored into Individual Commissioning, a small underspend on Patient Transport and pay underspends due to current vacancies.

23. Running costs is currently forecast to be within budget by Month 6 due to non recurrent benefits from a reduced expected redundancy cost offsetting the current non recurrent cost pressures.

24. Forecast efficiency plans for H1 are slightly above plan with forecast achievement of £2.5m.

25. The forecast position at Month 6 assumes that we will receive £3.560m of hospital discharge programme (HDP) funding in line with the recent guidance. £0.875m relates to HDP expenditure within individual commissioning and £2.685m relates to HDP expenditure incurred by the Local Authorities. If this funding is not approved this will deteriorate the financial position.

Sustainability and Underlying Position

26. The CCG is currently working with system partners and NHSEI on the development of the system sustainability plan. Although the system as a whole is currently forecasting a £6m deficit against the H1 envelope this position remains in line with the system sustainability plan projected expenditure for 2021/22.

27. Internal and system reporting will focus on the underlying position of the CCG and system and performance against the system sustainability expenditure control totals.

28. The current CCG recurrent expenditure control total in the system sustainability plan is expenditure on non system providers of £453.368m, based on the information that we currently have on recurrent expenditure the CCG is currently £7.2m away from delivering that control total. This is mainly due to the unidentified full year efficiency of £7.3m against the £13.5m 3% target.

Table 5: Forecast performance against sustainability non system expenditure control total

	Sustainability		
Category	**M12 Budget**	**M12 Recurrrent Actual**	**M12 variance**
	£'000	**£'000**	**£'000**
Out of system:			
Acute	82,401	81,767	634
Community	11,334	12,472	(1,138)
Individual Commissioning	73,203	73,203	(0)
Mental Health	81,661	81,661	0
Primary Care	97,828	98,267	(440)
Co Commissioning	76,682	76,500	182
Other	21,174	27,569	(6,395)
Running Costs	9,085	9,178	(93)
Out of system total	**453,368**	**460,617**	**-7,249**

29. The M12 Budget shown in table 5 agrees to the CCG non system element of the sustainability plan which has been developed in line with system partners. We have excluded intra system payments from the above as they are still being agreed as part of the Intelligent Fixed Payment system and will be net neutral for the system overall.

30. The M12 recurrent actual columns show the full year underlying forecast position including full year effect of any efficiency plans that have been agreed and developed.

31. The favourable variance within Acute is offset by a comparable adverse variance within Community relating to Children's services. This is purely due to movement between categories since the plan was developed. There is also an additional £500k overspend in the Community programme which is currently siting in other in the sustainability plan.

32. The overspend within Primary Care is attributable to a higher percentage growth assumption for Prescribing costs within the recurrent forecast. This will be reviewed as information is received.

33. Within Other the full year sustainability plan incorporates a 3% full year efficiency target for the CCG of £13.5m. The full year effect of plans that have currently been identified and assessed as deliverable shows a recurrent forecast efficiency delivery of £6.2m. Additional full year efficiency schemes of £7.3m are therefore required in order to achieve the sustainability plan. The transformation team and the programme management office are currently working up further schemes and a detailed report is provided to finance committee on a monthly basis. Table 6 demonstrates how the existing plans are expected to deliver across each of the key themes.

Table 6: 2021/22 Efficiency Forecast £m

Theme	**2021/22 Recurrent full year effect savings (net of investment) forecast £m**
Medicines Management	2.02
Individual Commissioning	3.10
Estates	0.31
Contracts	0.45
Running Costs	0.33
TOTAL	**6.21**

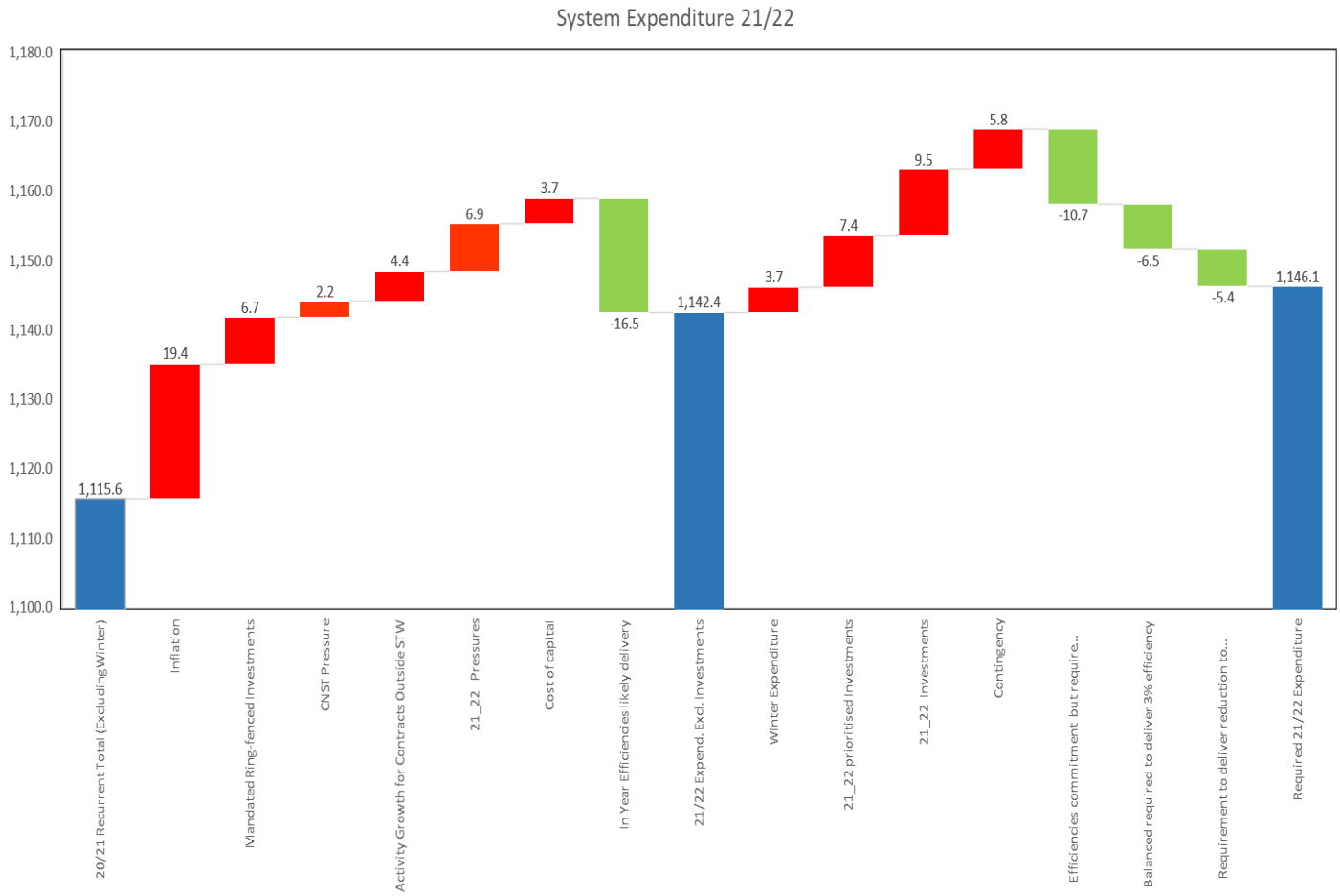
34. Financial review meetings are taking place across each department of the CCG which provide an opportunity to review spend across all budget areas. There are a number of saving opportunities that have emerged and these now need to be developed at pace in order to release efficiencies in year.

35. A deep dive exercise into all areas of opportunity is planned at the next Finance committee meeting which will help to provide clarity and agree milestones for action plans. In addition, the transformation team are reviewing all contracts to ensure these align with agreed outcomes and system priorities.

36. The sustainability working group have generated a key set of actions in which to move efficiency plans forward and teams across the organisation continue to pursue further opportunities through benchmarking.

37. The CCG is committed to working to deliver the 3% full year effect efficiency programme by the end of the year. Until the efficiencies are identified and assessed as deliverable, system investments will not be approved so that the sustainability plan remains at the midpoint of the system bridge shown in Figure 1 below rather than the endpoint. The lack of investment will of course have implications for quality and safety and therefore it is really important that the CCG and the system overall is able to find the required efficiencies to enable investments to be approved.

Figure 1: System sustainability bridge



Risk and Mitigation

38. The forecasts in this report are based on the most up to date information available but at this stage in the year the data is limited. There is therefore inherent risk around the position until we have further monthly data to review. The £7.3m gap in the efficiency plan is included in the current forecast and it is hoped that this will reduce as plans develop.

39. Specific risks in expenditure areas are highlighted below. The CCG now has very little mitigation to offset these risks if they materialise as the decision was made to remove all contingency from the plan as it was unaffordable. If the risks below materialised the CCG only position would be a £1.8m adverse variance to the H1 plan and a £4.2m adverse variance to the sustainability plan. A risk management framework is currently in discussion across the system so that risks can be addressed and system solutions developed.

Table 7: Risk and Mitigation

H1 Risk (£m)		H1 Mitigation (£m)		Full year/underlying Risk (£m)	Full year/underlying mitigation (£m)
Individual Commissioning – risk around volatile forecast and efficiency delivery	1.5		-	3.5	-
Running costs – ability to freeze permanent vacancies given resource issues to deliver plans	0.3			0.7	-
	1.8		**-**	**4.2**	**-**

Long Term Financial Plan

40. Work to date on the system sustainability plan has focused predominantly on stabilising expenditure in 2021/22. The development of the plan now moves rapidly to the future years of the plan and delivering financial balance as a system by 2025/26. Financial modelling is currently underway to map system assumptions to give a 'do nothing' financial position and value of the system financial gap against the recovery trajectory. Projected transformational savings from the 'big 6' will then be factored in as they are developed and the remaining gap will need to be addressed with further system transformational solutions. An initial view of the future years position should be available by July for consideration across the system.

Conclusion

41. In H1 the CCG is currently projecting to deliver within the H1 plan with the exception of the system wide adjustment of £6m which was a risk flagged at a system level when the plan was submitted. For the underlying sustainability plan the CCG expenditure is currently in line with the recurrent plan with the exception of the delivery of the 3% efficiency target which is £7.2m away from where it needs to be. Delivery of the 3% target on a recurrent full year basis remains the priority of all CCG teams.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 14th July 2021**

Item Number:	Agenda Item:
GB-21.07.046	Proposed Amendment to the CCG Governance Handbook

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

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

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

Executive Summary (key points in the report):

The CCG Governing Body adopted the new CCG Constitution and Governance Handbook at its extraordinary meeting held on 14th April 2021.

Following a recent need by the CCG to vary an NHS health contract, it has been identified that some amendments should be made to the content of the Scheme of Reservation and Delegation (SoRD) contained in the Governance Handbook to clarify the decision making in these circumstances for the future.

The proposed amendments are contained in section 9 on page 13 and the terms of reference for the Strategic Commissioning Committee on page 47 of the Governance Handbook draft version 1.4 which is attached as appendix A with amendments shown as tracked changes for ease and can be summarised as:

- Section 9, page 13 – 9.1 adding in approval of contract variations by the AO and Executive Director of Finance
- Section 9, page 13 – new section 9.6 – approve extension contracts by the Strategic Commissioning Committee where the existing contract has a provision for extension.
- Terms of reference of the Strategic Commissioning Committee page 47 – adding in the delegated approval of contract extensions where the existing contract has a provision for extension to reflect 9.6 in the scheme of reservation and delegation.

In section 5.1.4 of the Constitution the Accountable Officer may periodically propose amendments to the Scheme of Reservation and Delegation which can be considered and approved by the Governing Body unless, the changes are to the reserved powers of the membership or at least

half (50%) of all Governing Body members formally request that the amendments are put to the CCG membership for approval.

Therefore in order to ensure the CCG maintains effective and efficient decision making through its Scheme of Reservation and Delegation the Accountable Officer, on the advice of the Director of Corporate Affairs, is proposing that the Governing Body considers approving the changes to the Governance Handbook which it has delegated authority to amend, to reflect the changes shown in appendix A attached without the need to seek ratification by the CCG membership.

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 recommended to APPROVE the Governance Handbook with the highlighted amendments as outlined in the report and appendix A attached.

APPENDIX A

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

GOVERNANCE HANDBOOK

NHS Shropshire, Telford and Wrekin CCG Governance Handbook

Version	Approved by CCG Governing Body	Approved by the Membership where applicable
Version 1.2	n/a	16/02/2021
Version 1.3	14/04/21	n/a
Version 1.4		

Contents

Introduction

NHS Shropshire, Telford and Wrekin CCG's Governance Handbook brings together a range of documents which support the Constitution and good governance. It particularly outlines the Scheme of Reservation and Delegation and Prime Financial Policies that the CCG adheres to.

Amendments to the documents that make up the Governance Handbook are approved by the CCG Governing Body with some exceptions set out in the Scheme of Reservation and Delegation which would require approval by the CCG Membership.

Approved changes then need to be shared with NHS England/Improvement within 14 days of approval for review.

Scheme of Reservation and Delegation (SoRD)

1. Schedule of Matters Reserved to the Clinical Commissioning Group and Scheme of Delegation

2. The clinical commissioning Group remains accountable for all of its functions, including those that it has delegated.

Policy Area	**Decision**	**Reserved to the membership**	**Reserved or delegated to the Clinical Commissioning Group Governing Body**	**Accountable Officer**	**Executive Director of Finance**	**Other**
1.Regulation and Control	1.1 Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.	Yes				
	1.2 Consideration and approval of applications to NHS England/Improvement on any matter concerning changes to the Group's constitution, arrangements for taking urgent decisions, SFIs, and standing orders and statutory and mandated Committee terms of reference and, where that change: • Will have a material impact; or • Is to reserved powers of members; or • Has had at least 50% of all Governing Body Members formally request that amendments be put before the membership for approval.	Yes				
	1.3 Consideration and approval of changes to the Group's constitution, SFIs, arrangements for taking urgent decisions, standing orders and statutory and mandated Committee terms of reference where that change:		Yes			

	• Will have no material impact; or • Is not to reserved powers of members; or • There has been no formal request by at least 50% of Governing Body Members that amendments be put before the membership for approval.					
	1.4 Consideration and approval of changes to terms of reference for the Group's or CCG Governing Body, non-statutory or non-mandated committees sub-committees, and membership of committees		Yes			
	1.5 Exercise or delegation of those functions of the Group which have not been retained as reserved by the Group, delegated to the Clinical Commissioning Group Governing Body, delegated to a committee or sub-committee of the Group or to one of its members or employees.			Yes		
	1.6 Prepare the Group's overarching scheme of reservation and delegation, which sets out those decisions reserved to the membership and those delegated to the Group's Clinical Commissioning Group Governing Body, committees and sub-committees, individuals or specified persons.			Yes		
	1.7 Approval of the Group's overarching scheme of reservation and delegation where that change: • Is proposed to the reserved powers of the membership; or • At least 50% of Governing Body member practice representatives (including the Chair) formally request that amendments be put before the membership for approval.	Yes				
	1.8 Approval of the Group's overarching scheme of reservation and delegation where that change: • Is not proposed to the reserved powers of the membership; or		Yes			

	• There has been no request by at least 50% of Governing Body member practice representatives (including the Chair) formally requesting that amendments be put before the membership for approval.					
	1.9 Prepare the Group's Prime Financial Policies.			Yes		
	1.10 Approval of the Group's Prime Financial Policies.		Yes			
	1.11 Prepare detailed financial policies that underpin the Group's prime financial policies.				Yes	
	1.12 Approve detailed financial policies.					**Finance Committee**
	1.13 Approve arrangements for managing exceptional funding requests.		Yes			
	1.14Approve exceptional individual funding requests					**Individual Funding Committee**
	1.15 Determine whether proper process has been followed by the Individual Funding Committee when considering an individual funding request.					**Individual Funding Appeal Panel**
	1.16 Set out who can execute a document by signature/use of the seal		Yes			
	1.17 Approval of changes to the provision or delivery of assurance services to the Group					**Audit Committee**
	1.18 Approval of the Group's banking arrangements		Yes			
	1.19 Approval of the Group's strategies, plans, policies and procedures, unless specified elsewhere in this scheme of reservation and delegation		Yes			

2. Practice Member Representatives and Members of the Clinical Commissioning Group Governing Body	2.1 Approve the arrangements for: (i) identifying practice members to represent practices in matters concerning the work of the Group; and (ii) appointing GP/Healthcare professionals to represent the Group's membership on the Group's Clinical Commissioning Group Governing Body, for example through election (if desired).	Yes				
	2.2 Approve the appointment of Clinical Commissioning Group Governing Body members other than those outlined above in 2.1 (ii), the process for recruiting and removing non-elected members to the Clinical Commissioning Group Governing Body (subject to any regulatory requirements) and succession planning.		Yes			
	2.3 Approve arrangements for identifying the Group's proposed Accountable Officer.		Yes			
	2.4 Approval of the arrangements, including policies and procedures for the management of conflicts of interest		Yes			
	2.5 Approval of the dismissal of a Clinical Commissioning Group Governing Body Member		Yes			
	2.6 Approval of the appointment of the Deputy Chair of the Clinical Commissioning Group Governing Body		Yes			
	2.7 Approval of the appointment of the Vice Clinical Chair		Yes			
3. Strategy and Planning	3.1 Agree the vision, values and overall strategic direction of the Group.		Yes			
	3.2 Approval of the Group's operating structure.		Yes			
	3.3 Approval of the Group's consultation arrangements for the commissioning plan.		Yes			
	3.4 Approval of the Group's commissioning plan.		Yes			
	3.5 Approval of the Group's corporate budgets that meet the		Yes			

	financial duties of the CCG.					
	3.6 Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure.		Yes			
	3.7 Approval of the Group's Procurement Strategy		Yes			
	3.8 Approval of the local health economy's Long Term Plan (LTP)		Yes			
	3.9 Approval of the total allotments received for the next financial year and their proposed distribution, including any sums held in reserve		Yes			
	3.10 Approval of the release of investment for QIPP schemes recommended by the QIPP Board where this is outside existing budget delegations and contract value and where assurance on affordability and availability has been provided by the Executive Director of Finance for all other services not listed in 3.11.		Yes			
	3.11 Approval of the release of investment for QIPP schemes recommended by the Strategic Commissioning Committee and QIPP Board where this is outside existing budget delegations and contract value.		Yes			
	3.12 Approval of QIPP schemes that are within budget delegations and existing contractual values.					**Strategic Commissioning committee**
	3.13 Approval and monitoring of the Section 75 pooled budget arrangements for Better Care Fund with the local authority					**Strategic Commissioning Committee**
4. Annual Reports and Accounts	4.1 Approval of the Group's annual report and annual accounts.		Yes			
	4.2 Recommend for approval to the Governing Body the Group's annual report and annual accounts					**Audit Committee**
	4.3 Approval of the arrangements for discharging the Group's statutory financial duties		Yes			

5. Human Resources	5.1 Approve the terms and conditions, remuneration and travelling or other allowances for Clinical Commissioning Group Governing Body members, including pensions and gratuities.		Yes			
	5.2 Approve terms and conditions of employment for all employees of the Group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.		Yes			
	5.3 Approve any other terms and conditions of services for the Group's employees.		Yes			
	5.4 Determine the terms and conditions of employment for all employees of the Group.		Yes			
	5.5 Determine pensions, remuneration, fees and allowances payable to governing body members, employees of the CCG (including GPs performing roles within the CCG) and to other persons providing services to the Group		Yes			
	5.6 Approve business cases for staff who wish to retire and return to employment with the CCG.		Yes			
	5.7 Recommend pensions, remuneration, fees and allowances payable to governing body members, employees of the CCG (including GPs performing roles within the CCG) and to other persons providing services to the Group not covered by Agenda for Change.					**Remuneration Committee**
	5.8 Recommend to the Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill					**Remuneration Committee**

	health and normal retirement, for all employees					
	5.9 Recommend to the Governing Body business cases for staff who wish to retire and then return to employment with the CCG that have been considered and recommended by the Executive team.					**Remuneration Committee**
	5.10 Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the Group) and for other persons working on behalf of the Group.		Yes			
	5.11 Review disciplinary arrangements where the Accountable Officer is an employee or member of another Group.		Yes			
	5.12 Approval of the arrangements, including supporting policies and procedures for discharging the Group's statutory health and safety duties as an employer.		Yes			
	5.13 Approve HR policies and procedures for employees and for other persons working on behalf of the Group.					**Audit Committee**
6. Quality and Safety	6.1 Approve arrangements, including supporting strategies and plans, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Yes			
	6.2 Approve policies and procedures, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.					**Quality and Performance Committee**
	6.3 Approve arrangements for supporting the NHS England/Improvement/Improvement in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.		Yes			

	6.4 Approval of the Group's Quality Strategy		Yes			
	6.5 Oversees delivery of the Group's Quality Strategy					**Quality and Performance committee**
	6.6 Oversees the effective reporting and learning from medication safety incidents					**Quality and Performance committee**
	6.7 Oversees the development of clinical pathways to enable clarity by general practice.					**Strategic Commissioning Committee**
	6.8 Approves the development of clinical pathways to enable clarity by general practice					**Strategic Commissioning Committee**
7. Operational and Risk Management	7.1 Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the Group.			Yes		
	7.2 Approve the Group's counter fraud and security management arrangements, including supporting plans, policies and procedures.					**Audit Committee**
	7.3 Approval of the Group's risk management strategy		Yes			
	7.4 Approval of the Group's risk management policies and procedures.					**Audit Committee**
	7.5 Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).		Yes			
	7.6 Approval of a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the Group.		Yes			

	7.7 Approve proposals for action on litigation against or on behalf of the Group.			Yes		
	7.8 Approve the Group's arrangements, including supporting plans, policies and procedures for business continuity and emergency planning.					**Audit Committee**
	7.9 Approve the use of the Group's resources out of hours for exceptional circumstances and limited to situations of necessity					**Director on Call**
8. Information Governance	8.1 Approve the Group's arrangements, including supporting policies and procedures for handling complaints.					**Quality and Performance Committee**
	8.2 Approval of the arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.					**Audit Committee**
9. Tendering and Contracting	9.1 Approval of the Group's contracts/contract variations for any healthcare services *within approved budgets* *With the exception of GMS, PMS and APMS – see separate delegation*			Yes	Yes	
	9.2 Approval of the Group's non-healthcare contracts *within approved budgets*.			Yes	Yes	
	9.3 Approval of the Group's healthcare and non-healthcare services *outside approved budgets*.		Yes			
	9.4 To approve, as recommended by the Strategic Commissioning committee that the CCG proceeds to procurement for healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.		Yes			

	9.5 To approve the award of healthcare services procurement.		Yes			
	9.6 To approve the extension of a contract, where provision for an extension has been made within the contract terms.					**Strategic Commissioning committee**
	9.~~6~~7 To approve that the CCG proceeds to procurement for non-healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.			Yes	Yes	
	9.~~8~~7 To approve the award of non-healthcare services procurement *within approved budgets*.			Yes	Yes	
10. Partnership Working	10.1 To the extent permitted by law, authority to enter into arrangements with one or more relevant Local Authority in respect of: • delegating specified commissioning functions to the Local Authority; • exercising specified commissioning functions jointly with the Local Authority; • exercising any specified health-related functions on behalf of the Local Authority.		Yes			
	10.2 Agree formal and legal arrangements to make payments to, or receive payments from, a Local Authority or pool funds for the purpose of joint commissioning.		Yes			
	10.3 For the purposes of collaborative commissioning arrangements with a Local Authority, make the services of its employees or any other resources available to the Local Authority; and receive the services of the employees or the resources from the Local Authority.		Yes			

	10.4 For the purposes of joint commissioning arrangements with other CCGs, to • delegate any of the CCGs commissioning functions to another CCG • exercise any of the Commissioning Functions of another CCG; or • exercise jointly the Commissioning Functions of the CCG and another CCG; and for the purposes of the above; to: • make payments to, or receive payments from, another CCG; or • make the services of its employees or any other resources available to another CCG; or • receive the services of the employees or the resources available to another CCG.		Yes			
	10.5 For the purposes of joint commissioning arrangements with other CCGs, to establish and maintain a pooled fund made up of contributions by all of the CCGs working together jointly.		Yes			
	10.6 Approve decisions that individual members or employees of the Group participating in joint arrangements on behalf of the Group can. Such delegated decisions must be disclosed in this scheme of reservation and delegation.		Yes			
	10.7 Approve decisions delegated to joint committees established under section 75 of the NHS Act 2006.		Yes			
	10.8 Authority to enter into strategic or other transformation discussions with its partner organisations, on behalf of the CCG		Yes			
	10.9 For the purposes of joint commissioning arrangements with NHS England/Improvement, to make arrangements to exercise any of their respective specified commissioning functions jointly.		Yes			

	And for the purposes of the above; • may include other CCGs, a combined authority or a local authority; • may establish a Joint Committee to exercise the commissioning functions in question; • may be on such terms and conditions (including terms of payment) as may be agreed between NHS England/Improvement/Improvement and the CCG • develop and agree with NHS England/Improvement/Improvement a framework setting out the arrangements of joint working.					
11.Commissioning and Contracting for Clinical Services	11.1 Approval of the arrangements for discharging the Group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.		Yes			
	11.2 Approve the Group's policies and procedures to support the arrangements for discharging the Group's statutory duties associated with its clinical and non-clinical commissioning functions.					**Strategic Commissioning Committee**
	11.3 Approve arrangements for co-ordinating the commissioning of services with other Groups and or with the local authority, where appropriate.		Yes			
12. Communications	12.1 Approving arrangements including supporting policies and procedures for handling Freedom of Information requests.					**Audit Committee**

	12.2 Determining arrangements for handling Freedom of Information requests.			Yes		
	12.3 Approval of the Group's Communications and Engagement Strategy		Yes			
13. Delegated functions related to the commissioning of primary medical services under section 83 of the NHS Act	13.1 Approval of GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract.					**Primary Care Commissioning Committee**
	13.2 Approval of newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services)					**Primary Care Commissioning Committee**
	13.3 Approval and design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)					**Primary Care Commissioning Committee**
	13.4 Approval to establish new GP practices in an area					**Primary Care Commissioning Committee**
	13.5 Approval of practice mergers					**Primary Care Commissioning Committee**
	13.6 Approval of discretionary payment (e.g. returner/retainer schemes)					**Primary Care Commissioning Committee**

Prime Financial Policies

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies are not incorporated into the Group's Constitution.

1.1.2. The prime financial policies are part of the CCG's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Executive Director of Finance to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation.

1.1.3. In support of these prime financial policies, the CCG has prepared more detailed policies, approved by the Executive Director of Finance, known as *detailed financial policies*. The CCG refers to these prime and detailed financial policies together as the CCG's financial policies.

1.1.4. The CCG's prime financial policies identify the financial responsibilities which apply to everyone working for the CCG and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with applicable detailed financial policies and procedures. The Executive Director of Finance is responsible for approving all detailed financial policies.

1.1.5. A list of the CCG's detailed financial policies will be published and maintained on the CCG's website at www.shropshiretelfordandwrekinccg@nhs.uk

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the CCG's financial policies then the advice of the Executive Director of Finance must be sought before acting. The user of the CCG's financial policies should also be familiar with and comply with the provisions of the CCG's Constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with the CCG's financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding prime financial policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non- compliance shall be reported to the next formal meeting of the Governing Body's Audit Committee for referring action or ratification. All of the CCG's members and employees have a duty to disclose any non-compliance with the CCG's financial policies to the Executive Director of Finance as soon as possible.

1.3. Responsibilities and delegation

1.3.1. The roles and responsibilities of CCG's members, employees, members of the Governing Body, members of the Governing Body's committees and sub-committees, members of the CCG's committees and sub-committees (if any) and persons working on behalf of the CCG are set out in chapters 3 and 5 of the Constitution.

1.3.2. The financial decisions delegated by members of the CCG are set out in the CCG's Scheme of Reservation and Delegation found in the CCG's Governance Handbook. The Financial Scheme of Delegation is set out in Appendix 4 of the Constitution.

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that all persons to whom the CCG's financial policies apply are made aware of this.

1.5. Amendment of prime financial policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Executive Director of Finance will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body's Audit Committee, the Executive Director of Finance will recommend amendments, as fitting, to the Governing Body for approval.

2. INTERNAL CONTROL

POLICY – the CCG will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

2.1. The Governing Body is required to establish an Audit Committee with Terms of Reference agreed by the Governing Body (see paragraph 5.10.2 of the CCG's Constitution for further information).

2.2. The Accountable Officer has overall responsibility for the CCG's systems of internal control.

2.3. The Executive Director of Finance will ensure that:

a) Financial policies are considered for review and update annually;
b) A system is in place for proper checking and reporting of all breaches of financial policies; and
c) A proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the CCG will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews.

3.1. In line with the Terms of Reference for the Governing Body's Audit Committee, the person appointed by the CCG to be responsible for internal audit and the appointed external auditor will have direct and unrestricted access to Audit Committee members and the Chair of the Governing Body, Accountable Officer and Executive Director of Finance for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the CCG to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Executive Director of Finance will ensure that:

a) The CCG has a professional and technically competent internal audit function; and
b) The Governing Body approves any changes to the provision or delivery of assurance services to the CCG.

3.4 In line with the requirements of the Local Audit and Accountability Act 2014, the CCG will appoint an Auditor Panel. In line with the requirement of the Act and subsequent regulations, the Panel will oversee and advise on the maintenance of an independent relationship between the CCG and its external auditor, and on the auditor's selection and appointment.

4. FRAUD AND CORRUPTION

POLICY – the CCG requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The CCG will not tolerate any fraud perpetrated against it and will actively chase any loss suffered.

4.1. The Governing Body's Audit Committee will satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The Governing Body's Audit Committee will ensure that the CCG has arrangements in place to work effectively with the NHS Counter Fraud Authority.

5. EXPENDITURE CONTROL

5.1. The CCG is required by statutory provisions[1] to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the CCG complies with its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

[1] See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

5.3. The Executive Director of Finance will:

a) Provide reports in the form required by NHS England;
b) Ensure money drawn from NHS England is required for approved expenditure only, and is drawn down only at the time of need and follows best practice;
c) Be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the CCG to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS[2]

6.1. The CCG's Executive Director of Finance will:

a) Periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the CCG's entitlement to funds;

b) Prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

c) Regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the CCG will produce and publish an annual commissioning plan[3] that explains how it proposes to discharge its financial duties. The CCG will support this with comprehensive medium term financial plans and annual budgets.

7.1. The Accountable Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.

7.3 The Executive Director of Finance shall monitor financial performance against budgets and plans, periodically review them, and report to the Governing Body. These reports should include explanations for variances. These variance explanations must explain any significant departures from agreed financial plans or budgets.

[2] See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
[3] See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

7.4. The Accountable Officer is responsible for ensuring that information relating to the CCG's accounts or to its income or expenditure, or its use of resources, is provided to NHS England as requested.

7.5. The Governing Body will approve consultation arrangements for the CCG's commissioning plan[4].

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the CCG will produce and submit to NHS England accounts and reports in accordance with all statutory obligations[5], relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The Executive Director of Finance will ensure the CCG:

a) Prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Audit Committee;

b) Prepares the accounts according to the timetable approved by the Audit Committee;

c) Considers the external auditor's management letter and fully addresses all issues within agreed timescales.

8.2. The Director of Corporate Affairs will ensure the CCG:

a) Complies with statutory requirements and relevant directions for the publication of an annual report;

b) Receives the annual report and accounts in a session held in public for review and scrutiny at the earliest opportunity;

c) Publishes the external auditor's management letter on the website at www.shropshiretelfordandwrekinccg@nhs.uk

[4] See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act
[5] See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.

9. INFORMATION TECHNOLOGY

POLICY – the CCG will ensure the accuracy and security of the CCG's computerised financial data.

9.1. The Executive Director of Finance is responsible for the accuracy and security of the CCG's computerised financial data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the applicable Data Protection legislation and regulation;

b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Executive Director of Finance may consider necessary are being carried out.

9.2. In addition the Executive Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from that organisation prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the CCG will run an accounting system that creates management and financial accounts.

10.1. The Executive Director of Finance will ensure:
a) The CCG has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;

b) That contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director of Finance shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the CCG will keep enough liquidity to meet its current commitments.

11.1. The Executive Director of Finance will:

a) Review the banking arrangements of the CCG at regular intervals to ensure they are in accordance with Secretary of State directions[6], best practice and represent best value for money;

b) Manage the CCG's banking arrangements and advise the CCG on the provision of banking services and operation of accounts;

c) Prepare detailed instructions on the operation of bank accounts.

11.2. The Audit Committee shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

The CCG will:

a) Operate a sound system for prompt recording, invoicing and collection of all monies due;
b) Seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the CCG or its functions[7]
c) Ensure its power to make grants and loans is used to discharge its functions effectively.[8]

[6] See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
[7] See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
[8] See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act

12.1. The Executive Director of Finance is responsible for:

a) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;

b) Establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

c) Approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

d) For developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

The CCG:

a) Will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending;
b) Will seek value for money for all goods and services;
c) Shall ensure that competitive tenders are invited for:
   - The supply of goods, materials and manufactured articles;
   - The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
   - Any design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.

13.1. The CCG shall ensure that the firms/individuals invited to tender (and where appropriate, quote), are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Executive Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the CCG's Governing Body.

13.2. The Governing Body may only negotiate contracts on behalf of the CCG, and the CCG may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) The CCG's standing orders;
b) The Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
c) Take into account as appropriate any applicable NHS England or NHS Improvement guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the CCG shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the CCG.

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders, the CCG will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility.

14.1. The CCG will coordinate its work with NHS England, other Clinical Commissioning Groups, local providers of services, local authorities, including through Health and Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

14.3. The Executive Director of Finance will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND ASSURANCE

POLICY the CCG will put arrangements in place for the identification, evaluation and management of its risks.

15.1. CCG Governing Body – The Assurance Framework consists of risks which have the potential to affect the delivery of the Governing Body's key principles. The majority of these risks are likely to be identified as part of the Governing Body or Governing Body sub-committee management processes. However some risks may be identified at any level of the risk management process and may be of sufficient stature to warrant inclusion in the Assurance Framework.

15.2. The CCG Governing Body will receive the Assurance Framework at least quarterly. It will consider the risk associated with the entries, especially in relation to its management decisions which impact on the identified risks to seek assurance that the listed mitigation is being effective for each risk

15.3. Audit Committee – the Audit Committee provides an overarching governance role and reviews the work of other committees and processes, including the establishment and maintenance of risk management and internal control. In particular it will use the Assurance Framework to guide its work. The Committee will review the Assurance Framework quarterly and will make recommendations to the Governing Body relating to its findings on the management of the risks associated with the entries and the assurance it has received. The Committee will consider the Assurance Framework quarterly and Directorate / Programme Risk Registers on a rolling programme.

16. PAYROLL

POLICY the CCG will put arrangements in place for an effective payroll service.

16.1. The Executive Director of Finance will ensure that the payroll service selected:

a) Is supported by appropriate (i.e. contracted) terms and conditions;
b) Has adequate internal controls and audit review processes;
c) Has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Executive Director of Finance shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY the CCG will seek to obtain the best value for money for goods and services received.

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Executive Director of Finance will:

a) Advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. These are set out in the CCG's Financial Scheme of Delegation;

b) Be responsible for the prompt payment of all properly authorised accounts and claims;

c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

18.1. **POLICY** the CCG will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place policies to secure the safe storage of the CCG's fixed assets.
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a) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including any capital charges;

d) be responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The CCG will delegate to the Executive Director of Finance the duty to prepare detailed procedures for the disposals of assets – agreeing relevant thresholds.

19. RETENTION OF RECORDS

POLICY the CCG will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance.

19.1. The Accountable Officer shall:

a) Be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2016 and other relevant notified guidance;

b) Ensure that arrangements are in place for effective responses to Freedom of Information requests;

c) Publish and maintain a Freedom of Information Publication Scheme.

19.2. The Executive Director of Finance will act as the group's Senior Information Risk Owner.

20. TRUST FUNDS AND TRUSTEES

POLICY the CCG will put arrangements in place to provide for the appointment of trustees if the CCG holds property on trust.

20.1. The Executive Director of Finance shall ensure that each trust fund which the CCG is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

21 DIRECTOR/SENIOR MANAGER ON CALL – DELEGATED DECISION MAKING

POLICY the CCG will put arrangements in place to provide for delegated decision making by CCG staff where a Director/Senior Manager on call arrangement is in place.

21.1 The CCG operates a Director/Senior Manager on call system. The responsibilities of the member of staff on call are laid out in the Urgent Care on call pack but they are principally made up of the following:

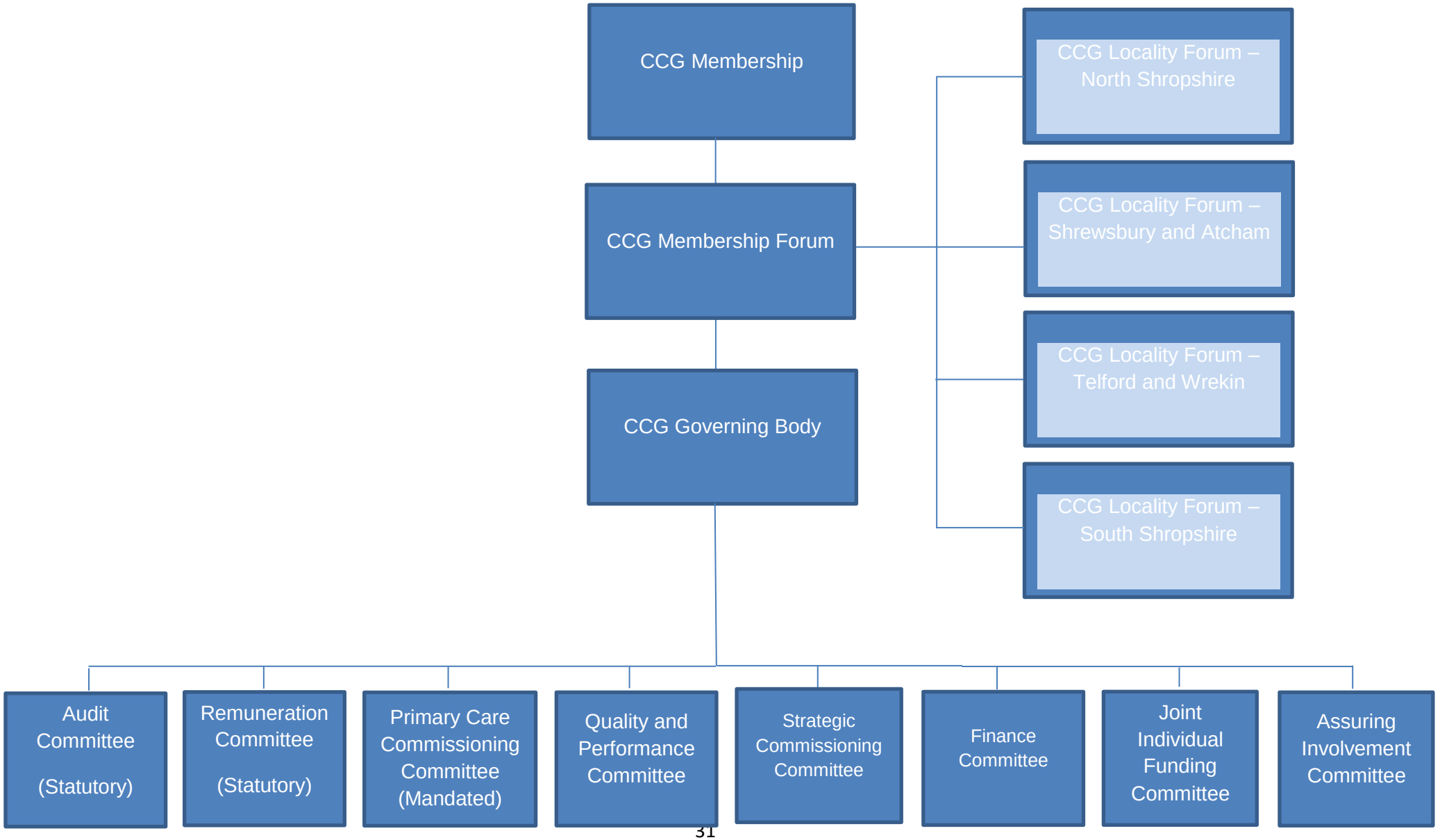
a) To be aware of capacity pressures in the system and take action as set out in the on call pack as appropriate (i.e. escalation management);
b) To follow the Incident Reporting Protocol;
c) To follow the 12 hour Trolley Breach Protocol;
d) To be the local Commissioner point of contact for a major incident (per the Emergency Preparedness Resilience and Response Plan);
e) To be the out of hours point of contact when commissioning decisions are required to be made.

21.2 The following authority delegation has been agreed for those members of staff on call:

a) That the delegated authority to commit resources is **only** applicable out of hours. During office hours i.e. between 9am and 5pm the Director/Senior Manager on call should refer these decisions to the relevant CCG lead for authorisation.
b) That the authority should only be used in exceptional circumstances and limited to situations of necessity, i.e. where it would cause risk to patient safety and/or the discharge of the CCG's statutory duties. Examples of such might include:
    - Patients sectioned under the Mental Health Act where there is no local capacity to admit and the patient's safety is at risk;
    - If a major incident is declared after following all relevant escalation procedures;
    - To prevent a major incident from occurring (e.g. trust at escalation level 4).

21.3 Should the Director/Senior Manager on call need to commit resources they should communicate this by email to the relevant lead Director by the end of the first working day following the decision, at the latest.

Shropshire, Telford and Wrekin CCG Committee Structure



CCG Committee Summary

The following table briefly describes the roles of each of the committees reporting to the Group and the Governing Body:

Governing Body Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
Quality and Performance Committee	Oversees and provides assurance to the Clinical Commissioning Group Governing Body on performance and quality of commissioned services.
Finance Committee	Oversees delivery of the financial plan and the development and delivery of QIPP savings.
Individual Funding Committee	Approves commissioning decisions for individual funding requests on behalf of the Group.
Strategic Commissioning Committee	Advises and makes decisions on the development of strategic commissioning that includes business plans and service redesign.
Assuring Involvement Committee	Provides assurance to the CCG Governing Body that the CCG is meeting its statutory duties with regard to securing patient involvement in proposals on new or changing services and in meeting its public sector equality duty.
Governing Body Committees outlined in more detail in the CCG Constitution which are statutory or mandated:	
Audit Committee (Statutory)	Provides the Group's Clinical Commissioning Group Governing Body with an independent and objective view of the Group's internal control system.
Remuneration Committee (Statutory)	Makes recommendations to the Clinical Commissioning Group Governing Body about the remuneration, fees and other allowances for employees and for people who provide services to the Group.
Primary Care Commissioning Committee (Mandated)	Considers and approves primary care commissioning decisions, delegated to the Clinical Commissioning Group from NHS England/Improvement.
Group Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
Locality Forum	Provides the engagement and involvement mechanism between the CCG Governing Body and the membership as a whole.

Non-statutory/mandated CCG Committee Terms of Reference

Finance Committee

Terms of Reference

1. Introduction

1.1 The Finance Committee (the committee) is established by the Governing Body in accordance with NHS Shropshire, 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 Finance Committee (the Committee) is responsible for the oversight and monitoring of:

- the delivery of the CCG's statutory financial duties;
- the development and achievement of the CCG's Medium Term Financial Strategy and Financial Recovery Plan;
- the delivery of organisational Quality, Innovation, Productivity and Prevention (QIPP) plans;
- the monthly financial performance against plan;

and to provide assurance to the Governing Body and identify key issues and risks requiring discussion or decision by the Governing Body.

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

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

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

1.6 The Finance Committee may meet 'in-common' with the Finance Committee of another CCG.

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

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to:
    - Financial policies and procedures;
    - Contracting and procurement policies and procedures.

2. Membership

2.1 The membership of the committee will be as follows:

- 2 lay members
- 1 GP/Primary Health Care Professional Governing Body members
- Board Secondary Care Doctor

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

- Executive Director for Finance (CFO)
- Executive Director for Transformation

3. Chairing Arrangements

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

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

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

3.4 In exceptional circumstances, where urgent action is required, the Chair is authorised to take urgent action with prior discussion with one other committee member. A report should be made to the full committee at the earliest next opportunity.

4. Secretary

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

5. Quorum

5.1 The quorum is a minimum of 2 members.

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

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

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

- proceed if those attending agree, but no decisions may be taken; or
- 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 Finance Committee will be sent to those in attendance at the Committee.

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

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

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

7 Remit and responsibilities of the committee

The Committee will be responsible for exercising the following functions:

7.1 Oversee the development of the CCGs' finance strategies and annual financial plans including, underlying assumptions and methodology used, ahead of review and approval by the CCG Governing Body.

7.2 Monitor progress against financial plans and approved budgets, scrutinising the adequacy of proposed remedial action plans where plan delivery is off target.

7.3 Scrutinise the reported position on finance, triangulating finance, QIPP and contract activity information.

7.4 Scrutinise major shifts in spending, demand pressures and triangulation with financial recovery/turnaround plans.

7.5 Review the CCG's monthly financial performance (including performance against savings programmes) and provide assurance to the Governing Body and identify the key issues and risks requiring discussion or decision by the Governing Body.

7.6 Review at the request of the CCG Governing Body specific aspects of financial performance where the Governing Body requires additional scrutiny and assurance.

7.7 Review performance against the "finance and use of resources" elements of the NHS Assurance Framework including value for money.

7.8 Review programme delivery, ensuring delivery of clinical objectives and value for money, including the delivery of QIPP objectives, and the appropriate management of risks and opportunities.

7.9 Address particular financial performance matters referred to it by the Governing Body or Joint Commissioning Committee, and provide reports to the Governing Body or Joint Commissioning Committee on areas of financial performance as requested.

7.10 Oversee arrangements for data quality to ensure confidence in the contract activity and finance information being used for monitoring and reporting purposes.

7.11 To monitor the use of CCG Charitable Funds.

7.12 To monitor the CCGs cash limit and resource limit.

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

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

7.15 Ensuring economy, efficiency and effectiveness in the use of CCG resources.

8. Relationship with the Governing Body

8.1 The Chair will prepare reports from the Finance Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and decisions made by the Committee. A summary regarding issues relating to primary medical care services will be submitted to the subsequent meeting of the Primary Care Commissioning Committee.

9. Policy and best practice

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

10 Conduct of the committee

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

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

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

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

Quality and Performance Committee

Terms of Reference

1. Introduction

1.1 The Quality and Performance Committee (the committee) is established by the Governing Body in accordance with NHS Shropshire, 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 Quality and Performance Committee (the Committee) is responsible for the oversight and monitoring of:

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

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

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

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

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

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

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

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

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

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

2 Membership

2.1 The membership of the committee will be as follows:

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

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

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

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

3 Chairing arrangements

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

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

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

3.4 In exceptional circumstances, where urgent action is required, the Chair is authorised to take urgent action with prior discussion with one other committee member. A report should be made to the full committee at the earliest next opportunity.

4 Secretary

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

5 Quorum

5.1 The quorum is a minimum of 2 members.

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

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

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

- proceed if those attending agree, but no decisions may be taken; or
- may be postponed at the discretion of the Chair.

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

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

5.7 Where only two members in attendance the Chair will highlight this in the Chair's report to the Governing Body.

6 Frequency and notice of meetings

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

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

6.3 Full minutes of the Finance Committee will be sent to those in attendance at the Committee.

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

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

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

7 Remit and responsibilities of the committee

The Committee will be responsible for exercising the following functions:

7.1 Performance: Oversee the management of the CCG's performance and delivery of agreed outcomes by:

a) monitoring performance against national and local targets.

b) monitoring performance against the standards, targets and outcomes set out in the CCG's operational and strategic plans.

c) reviewing the CCG's benchmarked performance against statutory frameworks including the NHS Outcomes Framework and Improvement and Assessment Framework.

d) ensuring action plans are developed and implemented to address any areas of unsatisfactory performance and drive improvement.

e) overseeing the continuous development of the scope, format, presentation and mechanisms of the system of performance reporting

f) reviewing those risks on the CCG risk register and Governing Body Assurance Framework which have been assigned to the committee and ensure that appropriate and effective mitigating actions are in place

g) seeking assurance that the CCG is fulfilling its statutory duties for equality and diversity, as set out in the Equality Act 2010

h) Ensuring economy, efficiency and effectiveness in the use of CCG resources.

7.2 Quality of commissioned services***:*** The committee will ensure the effective delivery of quality performance across the full range of commissioned services and seek assurances that sound systems for quality improvement and clinical governance are in place in line with statutory requirements, by:

a) monitoring the quality performance of all providers, including detailed reports on services that are commissioned across acute, community and primary care

b) reviewing specific action plans or recovery plans as they relate to quality

c) approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes, including the arrangements for dealing with exceptional funding requests

d) reviewing quality performance with regard to commissioning for value

e) approving the process for undertaking Quality Impact Assessments.

7.3 Patient experience**:** The committee will seek assurance that effective systems are in place to monitor and improve patient experience by:

a) scrutinising arrangements for ensuring that patient feedback and engagement are embedded in the commissioning cycle and meet legal duties.

b) reviewing themes and trends and ensuring lessons learned are translated into changes in way services are provided.

c) approving the CCG's arrangements for the handling of patient complaints, concerns or enquiries in accordance with relevant regulations.

d) reviewing the delivery of the CCG's equality improvement plan in relation to Goals 1 and 2 of the NHS Equality Delivery System (better health outcomes for all/improved patient access and experience).

e) approving the process for undertaking Equality Impact Assessments.

f) reviewing the CCG's benchmarked performance against NHS Oversight Framework, Patient and Community Engagement Indicator.

7.4 Clinical Effectiveness**:** The Committee seeks to gain assurance that there are effective systems and processes in place to monitor and gain oversight of clinical effectiveness. This will include:

a) receiving assurance that there is appropriate monitoring of compliance with guidance including NICE guidelines and technical appraisals

b) monitoring the performance of trusts against the agreed Commissioning for Quality and Innovation scheme (CQUINs)

c) receiving Quality Account updates

d) receiving assurance that providers have robust clinical audit procedures that address trust priorities, facilitate service improvement and provide assurances that agreed clinical standards are being met

7.5 Safety**:** The committee shall seek assurances regarding safety by:

a) receiving assurance that the accepted recommendations of national inquiries and national and local reviews have been considered and actioned with respect to the CCG and commissioned services including primary care

b) overseeing safeguarding arrangements to assure that the CCG's statutory responsibilities for safeguarding children and adults at risk are met and that robust actions are taken to address concerns via receipt of regular reports

c) overseeing and seeking assurance that effective systems are in place in relation to CCG services including serious incident management, continuing healthcare and medicines management

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

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

8. Relationship with the Governing Body

8.1 The Chair will prepare reports from the Quality and Performance Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and decisions made by the Committee. A summary regarding issues relating to primary medical care services will be submitted to the subsequent meeting of the Primary Care Commissioning Committee.

9. Policy and best practice

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

10. Conduct of the committee

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

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

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

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

Strategic Commissioning Committee

Terms of Reference

1. Introduction

1.1 The Strategic Commissioning 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 Committee is responsible for evaluating, scrutinising and quality assuring the clinical and cost effectiveness of business case proposals for new healthcare commissioning investments, recurrent funding allocations and decommissioning and disinvestment of services. This will include assessment of any associated equality and quality impacts arising from proposals and feedback from patient involvement activities where necessary. The Committee will also ensure that the CCG's procurement responsibilities are appropriately discharged, including oversight of annual procurement plans.

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

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

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

1.6 The Strategic Commissioning Committee may meet 'in-common' with the Commissioning Committee of another CCG.

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

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to Clinical and Non clinical commissioning policies.

- Approval of QIPP schemes that are within budget delegations and existing contractual values.

- Approval and monitoring of the Section 75 pooled budget arrangements for Better Care Fund with the local authority

- Oversees and approves the development of clinical pathways to enable clarity by general practice.
- Approval of the extension of a contract, where provision for an extension has been made within the contract terms.

2. Membership

2.1 The membership of the committee will be as follows:

- Lay member PPI - EDI
- Lay member Primary Care
- 2 GP/Primary Health Care Professional Board members
- Registered Nurse

2.2 The committee will be chaired by the Lay Member for PPI - EDI

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

- Accountable Officer
- Executive Director Finance
- Executive Director of Nursing and Quality
- Executive Director Transformation
- Director for Partnerships
- Director for Performance
- Director for Planning
- Director for Corporate Affairs
- Medical Director

3. Chairing Arrangements

3.1 The Committee will be chaired by the Lay Member for PPI – Equality, Diversity and Inclusion.

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

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

3.4 In exceptional circumstances, where urgent action is required, the Chair is authorised to take urgent action with prior discussion with one other committee member. A report should be made to the full committee at the earliest next opportunity.

4. Secretary

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

5. Quorum

5.1 The quorum is a minimum of 2 members.

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

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

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

- proceed if those attending agree, but no decisions may be taken; or
- may be postponed at the discretion of the Chair.

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

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

5.7 Where only two members in attendance the Chair will highlight this in the Chair's report to the Governing Body.

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 Committee will be sent to those in attendance at the Committee.

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

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

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

7 Remit and responsibilities of the committee

The Committee will be responsible for exercising the following functions:

7.1 Oversee the development of the CCG's Commissioning Strategy and commissioning intentions for approval by the CCG Governing Body.

The Committee will be responsible for exercising the following functions with regard to the commissioning of healthcare services:

7.2 Make commissioning recommendations to the Governing Body, which will include but not limited to:

- Reviewing and recommending business cases and service change requests and redesign
- Reviewing and recommending needs assessment and demand and capacity planning
- Overseeing procurement processes and recommending the award of tenders
- Overseeing contract and contract management
- Identifying and recommending joint work with local authorities
- Recommending the setting outcomes for providers and monitoring outcomes
- Recommending decommissioning services

7.3 When making recommendations the Committee will ensure that:

- Appropriate evidence is available to demonstrate clinical and cost effectiveness, including consideration of benchmarking information where available;
- Appropriate Quality, Equality and Data Protection Impact assessments are completed and their findings considered as part of the decision making. This will include consideration of collective impact of previous decisions and current and future proposals.
- Appropriate patient, public and stakeholder engagement and consultation where appropriate, takes place and feedback in the form of a formal engagement report is presented and is considered as part of the recommendation process to the Governing Body;

- Appropriate information on wider commissioning decisions and services across the health and social care system is considered.
- Ensure economy, efficiency and effectiveness in the use of CCG resources.

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

7.5 Oversee development and ongoing review of the Commissioning Strategy of the CCG for recommendation to the Governing Body for approval.

7.6 Oversee development and ongoing review of strategies of the CCG for recommendation to the Governing Body of specific to the Committee's remit.

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

7.8 Oversee development of annual procurement plans.

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

7.10 Evaluate the return on investment of funded healthcare services in terms of reduced health inequalities and improved health putcomes.

8. Relationship with the Governing Body

8.1 The Chair will prepare reports from the Committee which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and decisions made by the Committee.

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

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

Individual Funding Committee

Terms of Reference

1. Introduction

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

2. Membership

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

2.2 The following are members of the committee:

- 1 lay member
- Director of Public Health (or deputy)
- 2 CCG GP/Primary Care Health Professional Board members of the CCG Governing Body
- Pharmaceutical Adviser

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

3. Chairing Arrangements

3.1 The Committee will be chaired by the Lay Member.

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

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

3.4 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.

3. Secretary

3.1 Secretarial support for the committee will be provided by the CCG IFC designated administrative support. Their role will be to support the chair in the management of the committee's business.

4. Quorum

4.1 The Committee's quorum will include 3 of the members listed in section 2 above, one of whom must be a lay member and one a clinical member.

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

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

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

- proceed if those attending agree, but no decisions may be taken; or
- may be postponed at the discretion of the Chair.

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

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

5. Frequency and notice of meetings

5.1 Meetings will be held monthly. Where individual funding requests are not forthcoming the scheduled meeting may be cancelled by the Executive Director Lead for Transformation (or Deputy). Where individual funding requests are received prior to the next scheduled meeting, the Executive Director for Transformation and a CCG GP/Primary Care Health Professional Board member of the CCG Governing Body, may exercise their discretion to convene an urgent meeting of the stage 2 IFC.

5.2 The Committee meeting will be formally minuted and a record of the committee's decision will be kept on the patient's file. Once minutes are approved as an accurate account of the meeting, they will be signed off by the chair. 6.1 The committee will meet as required, but at least four times per year and meetings will be called by the chair of the Committee giving at least 5 working days notice.

5.3 Draft minutes will be produced by the minute taker within 7 days of the meeting and circulated to the Chair of the committee for comment within 5 days and the chair will then sign them within 5 days. Copies of minutes will not be circulated to committee members for their retention and will not be placed in the public domain in order to preserve patient confidentiality.

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

6. Remit and responsibilities of the panel

6.1 The IFC has delegated authority from NHS Shropshire, Telford and Wrekin Clinical Commissioning Group Governing Body to make decisions in respect of funding for individual cases.

6.2 Requests for funding will be considered on exceptional grounds and must demonstrate exceptionality on:

- Clinical grounds (based on evidence from the referring clinician)

and/or

- As a result of NHS Shropshire, Telford and Wrekin CCG's internal systems failure (e.g. where delay on the part of the CCG has placed a patient outside of any time limits).

6.3 Requests for funding on exceptional grounds will be considered against the limited resources available to the CCG at the time the particular funding request is being determined. Other exceptional circumstances not envisaged by CCG may emerge in individual requests.

6.4To discharge the remit and responsibilities set out in these terms of reference through a committees in common approach with other CCGs if this is required to support collaborative commissioning.

7. Relationship with the CCG Governing Body

7.1 The committee will produce for the CCG Governing Body an annual report which outlines as a minimum the numbers of requests received, the areas of service

provision they related to, how many were upheld, the numbers of appeals made and numbers upheld.

8. Policy and best practice

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

9. Conduct of the committee

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

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

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

10. Decision Making

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

10.2 A record of the date and outcome of reviews is kept in the CCG governance handbook

Date of Governing Body approval: 14/04/21

Individual Funding Appeal Panel

Terms of Reference

1. Introduction

1.1 The Individual Funding Appeal Panel (Stage 3) (IFAP) is established in accordance with NHS Shropshire, Telford and Wrekin Clinical Commissioning Groups' Constitution. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the panel and shall have the effect as if incorporated into the constitution.

2. Membership

2.1 The membership of the Appeal Panel will be:

- 1 lay member

- 1 Executive Director or Director (any executive director or director involved in the original review of the funding request cannot be a member of the appeal panel)

2.2 The panel will be chaired by a lay member.

2.3 Members of the appeal panel should not have been involved in previous considerations of the request.

3. Secretary

3.1 Secretarial support for the panel will be provided by the CCG IFC designated officer support. Their role will be to support the chair in the management of the panel's business and for drawing the panel's attention to best practice, national guidance and other relevant documents.

4. Quorum

4.1 The quorum will be two members from section 2 above, with one a lay member and one an Executive Lead.

4.2 In exceptional circumstances and where agreed with the Chair prior to the meeting, members of the Individual Funding Appeal Panel may participate in meetings by telephone, by use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

5. Frequency and notice of meetings

5.1 The appeal panel will be convened when necessary to consider appeals against individual funding requests. Meetings must be convened within 1 month of the receipt of an appeals letter, or as soon as is reasonably practicable thereafter.

5.2 The designated officer will provide the following information to the appeal panel at least 5 working days prior to the meeting taking place:

- Background to the request
- Personal details of the patient
- Information in relation to the condition
- Notes of the meeting of the stage 2 IFP
- The decision of the panel conveyed to the patient
- All other relevant information.

6. Remit and responsibilities of the panel

6.1 The Panel is responsible for determining whether proper process has been followed when considering an individual funding request. The panel must decide whether, based on the information presented, there is:

- No evidence of a failure to consider the request through the process outlined in this document – decision upheld;

Or

- Evidence of a failure to consider the request through the process outlined in this document – request is referred back to stage 2 – IFC

6.2 It is important to note that the appeal panel will not consider new information which was not previously considered by the stage 2 IFC in support of the case. If new information becomes available the stage 2 IFC should be asked to reconsider the case in light of this.

6.3 The patient may represent himself/herself at the meeting and/or be represented by a parent, guardian, carer or appropriate advocate.

6.4 At its discretion the appeal panel may permit others to attend where it is deemed it would be necessary or helpful for those to be invited. The designated officer support may give guidance on who it would be relevant to invite.

6.5 The appeal panel will notify the patient and the referring clinician in writing of its decision within 5 working days of the appeal hearing.

6.6 To discharge the remit and responsibilities set out in these terms of reference through a committees in common approach with other CCGs if this is required to support collaborative commissioning.

7. Policy and best practice

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

8. Conduct of the panel

8.1 The panel is expected to conduct its business in accordance with the national guidance and relevant codes of conduct/good governance practice.

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

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

9. Decision Making

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

9.2 A record of the date and outcome of reviews is kept in the CCG governance handbook

Date of Governing Body approval: 14/04/21

Locality Forums

Terms of Reference

1. Introduction

1.1 The Locality Forums (the Forums) are established by the Group 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 Forum.

1.2 The Forums are constituted as Committees of the Group and there are four covering the following geographical areas:

North Shropshire
Shrewsbury and Atcham
South Shropshire
Telford and Wrekin

1.3 The Forums have been established by the Group to assist the Governing Body to secure effective participation of each member of the Group.

1.4 The Locality Forums exist to provide the Governing Body with advice in order that it is informed by the clinical commissioning Group members (members) within the locality. This recognises the importance of local knowledge and its application in allowing the clinical commissioning Group to discharge its functions successfully.

1.5 The Forums also provide a conduit for the Governing Body to communicate effectively with practice representatives and the membership of the Clinical Commissioning Group.

1.6 The Forums will actively contribute to the identification of quality improvements and key priorities of the CCG. The Forums will own the delivery of these improvements and key priorities, together with its members within its locality. This committee is responsible for raising awareness with its members and ensuring two way dialogue and feedback.

1.7 The Forums are jointly accountable to the member practices within the locality.

2. Membership

2.1 The membership of the Forums is composed of the Practice Representatives nominated by their practices to represent their practice within the designated geographical boundaries of the respective Locality Forum.

2.2 Also attending are practice managers from each practice within the designated area.

2.3 The Forums will be chaired by a GP or healthcare professional or practice manager elected by the Practice Representatives of each Forum by a simple majority for a tenure of 3 years. This individual can be a GP, other healthcare professional or practice manager working within the CCG as a whole but does not have to be from within the locality area.

2.4 Other directors and senior managers will be invited to attend where appropriate.

3. Secretary

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

4. Quorum

4.1 The quorum is 50% of the total number of practices within the designated locality area.

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

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

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

5 Frequency and notice of meetings

5.1 The Forums will meet as required, but at least four times per year and meetings will be called by the chair of the respective Forum giving at least 5 working days notice.

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

5.3 Full minutes of the Forums meetings will be sent to those in attendance at the Forum.

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

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

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

6 Remit and responsibilities of the Forum

6.1 The Forums are responsible for ensuring the Governing Body is informed by the members of the clinical commissioning Group and that local knowledge is fed into the decision making process of the Group.

6.2 The Forums are responsible for ensuring that members have the opportunity to contribute to the development of policy and commissioning strategy.

6.3 The roles will include, but are not limited to:

2.3.1 advising the Board of locality forum priorities;

2.3.2 advising members in the locality of the work of the Forum and CCG;

2.3.3 consulting with members in the locality on behalf of the Governing Body where requested to do so or otherwise appropriate;

6.4 supporting the Governing body in delivering the objectives of the clinical commissioning Group;

6.5 supporting members of the locality to engage with the clinical commissioning Group (CCG);

6.6 participation and engagement with other locality forums on the development of the CCGs commissioning plans;

6.8 participation in the development of clinical pathways in accordance with best practice.

6.9 Additionally the Forums are accountable for:

- communication of the CCGs policies to locality members; and
- upholding the Standing Financial Instructions, Standing Orders and Delegation of Powers.

7. Relationship with the Governing Body

7.1 The Chair of each Locality Forum will prepare reports from the Forum meeting which will be presented to the Governing Body at its next scheduled meeting. The reports will include the main items discussed and any issues that require escalation.

7.2 The Chair of each Forum will meet regularly with the CCG Chair to discuss issues in more detail and share with other Forum Chairs.

8 Conduct of the committee

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

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

8.3 Annually the committee will review its own performance, membership and terms of reference. Any resulting changes to the terms of reference should be approved by the Group at a Membership meeting.

8.4 A record of the date and outcome of reviews is kept in the CCG governance handbook

Date of the Group’s approval: 16/02/2021

7. Conflicts of Interest Policy and Declaration of Gifts, Hospitality and Sponsorship and Anti Bribery Policy.

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship.

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group receives a significant amount of public funds to spend on healthcare for its population. We therefore have to ensure that individuals acting on behalf of the CCG, whether this is a GP, staff member or a contractor, act with impartiality when making decisions on how the CCG's budget is spent, and they do not use their role in the CCG to further their own private interests or those of anyone known to them.

Conflicts of interest are inevitable when commissioning services, so how we manage them is crucial. The CCG does this by adopting a Conflicts of Interest Policy and Declaration of Gifts, Hospitality and Sponsorship and Anti Bribery Policy and Procedure which set out how the CCG wishes its GP membership, Board and Committee members, Staff and Contractors to behave and the measures the CCG will take to manage conflicts of interest which can be found here:

www.shropshiretelfordandwrekinccg@nhs.uk

8. Review table for Committee Terms of reference

Committee	Date of Review
Governing Body Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
Quality and Performance Committee	March 2022
Finance Committee	March 2022
Individual Funding Committee	March 2022
Strategic Commissioning Committee	March 2022
Assuring involvement Committee	March 2022
Governing Body Committees outlined in more detail in the CCG Constitution which are statutory or mandated:	
Audit Committee (Statutory)	March 2022
Remuneration Committee (Statutory)	March 2022
Primary Care Commissioning Committee (Mandated)	March 2022
Group Committees outlined in this CCG Governance Handbook which are not statutory or mandated:	
North Shropshire Locality Forum	March 2022
Shrewsbury and Atcham Locality Forum	March 2022
South Shropshire Locality Forum	March 2022
Telford and Wrekin Locality Forum	March 2022

Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire,Telford and Wrekin CCG Governing Body meeting on 14th July 2021**

Item Number:	Agenda Item:
GB-21.07.047	Board Assurance Framework 2021/22

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	X	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):

1. Introduction

The Board Assurance Framework (BAF) provides a structure and process that enables the CCG to focus on the risks that might compromise achieving the CCGs' strategic priorities. It maps the controls that should be in place to manage those priorities and to confirm the Governing Body has gained sufficient assurance about the effectiveness of those controls.

2. Board Assurance Framework (BAF) 2021/22

The BAF has been updated with the strategic priorities agreed at the Governing Body meeting in May for 2021/22. In addition the Governing Body undertook a facilitated workshop session in June to agree the risks that should appear on the BAF in light of the newly agreed strategic priorities. The attached appendix A has been updated with all of this new information.

3. Board Assurance Framework (BAF)

The BAF was updated by the strategic risk owners during June 2021 as part of the preparation for the facilitated Governing Body workshop and as part of the routine bi-monthly review cycle.

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? The BAF appropriately captures and reports the strategic risks of financial and other resource implications.	Yes
3.	Is there a risk to financial and clinical sustainability? The BAF appropriately captures and reports the strategic risks to financial and clinical sustainability.	Yes
4.	Is there a legal impact to the organisation? Sound risk management systems are an essential component of internal control processes. NHS organisations are required to sign an annual governance statement to provide reasonable assurance that they have been properly informed about the totality of their risks and can evidence that they have identified the organisational objectives and managed the principal risks to them. There is a mandatory annual internal audit review into aspects of risk management and the BAF.	Yes
5.	Are there human rights, equality and diversity requirements? An Equality Impact Assessment is not required for this process.	No
6.	Is there a clinical engagement requirement? This is an internal process and clinical engagement is not required for the process itself.	No
7.	Is there a patient and public engagement requirement? This is an internal process and patient engagement is not required for the process itself.	No

Recommendations/Actions Required:
The Governing Body is recommended to review and **approve** the BAF as at 30 June 2021.

STW CCG - Board Assurance Framework (BAF) 2021/22 - July 2021

Appendix A

CCG Strategic Priorities:

1. To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.
2. To identify and improve **health outcomes** for our local population
3. To ensure the health services we commission are **high quality**, safe, sustainable and value for money.
4. To achieve **financial balance** by working more efficiently.
5. To improve **joint working** with our local partners, leading the way as we become an Integrated Care System.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Risk ID	Strategi Priority	Opened / added by	Risk and description	Opportunity	Existing key controls	Existing sources of assurance	Gaps in controls or assurances	Risk score (consequences x likelihood)	Risk score trend	Action plan / cost / action lead /(target date) /sufficient mitigation	Target risk score for end of financial year	Director or Risk Owner	Risk Owner	Committee GB Oversight	Amendments: name and date
1	1 and 3	A Smith	Patient and Public Involvement There is a risk that the CCGs fails to meet its statutory duty to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change existing services or to cease existing services resulting in judicial review and services not meeting peoples needs.	To ensure that service redesign and ransformation is informed by consistent and robust involvement of patients and the public	Interim Communications and Engagement Strategy for STW CCG approved by Governing Body Communications and Engagement teams working jointly across CCG, ICS and Providers providing more capacity and expertise in planning and delivery Reports to Governing bodies/Committees require section completing on Patient involvement Interim ICS Diector of Comms and Engagement overseeing both ICS and CCG functions Presence of Healthwatch for both areas at Governing body meetings and Quality Committees Lay Member for PPI and Lay Member for PPI - EDI in place on Governing Body to act as specific check and balance with reagrd to patient involvement AIC recruitment completed	IAF Engagement Rating of Outstanding for T&W and Good for Shropshire retained for 2019/20 Reporting to Assuring Involvement Committee Reporting on Engagement as part of wider reporting and decision making at SCC and Q&P Committee Updates on ICS Pledge to ICS Board Health and Overview Scrutiny Committees (HOSC)	Gaps in controls: 1) ICS Communications and Engagement Strategy yet to be developed 2) Reporting on interim CCG Comms and Engagement Strategy to AIC yet to start 3) Communications and Engagement proceses being reviewed by new interim ICS Director and Interim Assistant Director Gaps in assurance: 4) New AIC yet to be have first business meeting to receive assurance on Involvement activities and engagement plans	**likely x major = High 16**	⇔	1) Communications and Engagement Director overseeing the production of a Comms and Engagement Forward Plan to cover the period to the end of the financial year. The forward plan will then be used as a basis to formulate a more formal C&E Strategy for the ICS. 2) New AIC has been appointed. Members attending training workshops on 1 and 8 July, with the first formal meeting of the committee being planned for late July. The Interim Director of Communications and Engagement will also be meeting with AIC members at their second training session to talk through her role, the role of her team, and the way they will work with the AIC. 3) The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity. 4) New AIC has been appointed. Members attending training workshops on 1 and 8 July, with the first formal meeting of the committee being planned for late July.	**Unlikely x major = Moderate 8**	A Smith	E Boampong	AIC	AS 24.05.21 AS 21.06.21 CH 30.06.21
2	5	A Smith	Transition to a statutory ICS There is a risk that the CCG does not have sufficient capacity and capability to to undertake the transition to the ICS which results in the ICS being unable to discharge its new statutory duties.	The CCGs to lead the development, with partners of the ICS, to plan and deliver improved services for the population.	Governing Body members taking lead roles in ICS governance and delivery functions. CCG Directors have dual roles with CCG and ICS Joint CCG/ICS maagement team meetings Transition meetings taking place with CCG AO ICS Director, ICS Workforce, CCG Director of CA ICS has been authorised by NHSE/I Project lead idnetified by ICS Some natioonal guidance has been released on ICS Design Franework and employment commitment	ICS Shadow Board. Regular reports to CCG Governing Bodies. Programme Boards of the ICS reporting to the ICS Shadow Board. ICS Transition Grouo involves CCG AO and Director of CA	Gaps in controls: 1. Capacity within the system. 2. Transition Plan to move functions and assets of CCG to and ICS/ICP Gaps in assurance: 3. ICS Governance structure and reporting requirements still being defined	**20 = likely x catastrophic**	⇑	1. Work is being shared between ICS/CCG and providers, with key leads being identified 2. Transition Group created and has started to meet. Initial discussions taking place to scope possible transition requirements around workforce, governance and legally mandated rel CS quirements 3. ICS Governance structure in early stages of meetings of new committees and fromulation of new delivery Boards ad relaignment of soem existing Boards to different reporting routes June 2021.	**Unlikely x major = Moderate 8**	C Skidmore AO	A Smith	GB/Audit	AS 24.05.21 AS 21.06.21
3	All priorities	A Smith	CCG Workforce There is a risk that due to the number of secondments, staff vacancies and sickness that the resilience of our workforce (including capacity and capbability) is unable to meet the demands of ongoing secondnment requirements of the Covid Vaccination Centres, the growing expectation of the new ICS operational structure, and expectation to freeze vacancies given the ICS process resulting in the CCG being unable to meet its strategic priorities.	Ensure our workforce is focussed on the CCG/ICS priority areas, effective planning processes, adoption of technology, remote working	1. Directors as budget holders capturing staffing issues within directorates; appraisal policy, training and development,	2. Directors sharing directorate risk at Exec meeting weekly, audit of training compliance,	Gaps in controls 1. No overview of the workforce pressures across all directorates and where they are eminating from and why Gaps in Assurance 2. No reporting currently on capacity issues across the whole CCG.	**Almost Certain x Catastrophic = Extreme 25**	⇑	1a Mapping of staff vacancies/secondments/ with level of risk identified and Mapping of solutions to capacity issues 1b. Ensure workforce are aware of the STW system TRiM psychological support offer. 1c.. Effective prioritisation of workload to system Big 6 priorities and other quality and safety priorities. 2. HR to capture overview of capacity issues across whole CCG for onards assurance to Audit Committee	**Possible x Moderate = Moderate 9**	A Smith	A Smith/ L Kell	Audit/GB	AS 24.05.21

4	3 and 4	Laura Clare	Finan cial Sustainability Failure to deliver the CCG element of the system financial sustainability plan for 21/22. The underlying financial position of the CCG and the system as a whole is currently a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHSEI approval. As part of the system sustainability plan the CCG has been set an expenditure envelope to deliver in 21/22 which stablises spend over the year. The CCG will also need to be able to demonstrate 3% efficiency savings delivered on a recurrent full year basis by the end of 21/22.	This offers the CCG the opportunity to fully assess commissioned services to ensure best clinical value as well as financial efficiencies.	Detailed YTD and forecasting information provided at both organisation and system level Regular CCG budget holder meetings and budget holder training programme in place PMO function set up within Transformation directorate to help leads to develop efficiency programme and accurately monitor progress and delivery.	Regular CCG and System level financial reporting to CCG finance committee and Governing Body. Sustainabilty working group within CCG chaired by Director of Transformation to ensure efficiency programme is mature and realistic. Detailed efficiency programme reporting to CCG finance committee from transformation directorate.	Gaps in Controls: 1) Full CCG reccurent efficiency target of 3% not yet identified and needs to be urgently addressed. 2) CCG staff resource issue to deliver all plans Gaps in assurances: None	**Almost Certain x Catastrophic = Extreme 25**	↑	1) Sustainability working group set up to meet monthly chaired by DoT to increase pace and deliverability of efficiency schemes. PMO team now in place for CCG and system scheme development and reporting. FYE and 22/23 plans to be in place by Sept 21. ST Sept 21 2) Staff resource mapping to internal and system plans to be completed to identify gaps ST July 21	**likely x major = High 16**	Laura Clare	Laura Clare Steve Trenchard/ Kate Owen	Finance	Laura Clare 26.5.21 28.6.21
5	3 and 4	Laura Clare	System failure to deliver overall long term sustainability plan. The underlying financial position of the CCG and the system as a whole is currently a significant deficit. The system is therefore in a recovery process and unable to make investment decisions without being through the 'triple lock' process of organisation, system and NHSEI approval. As well as delivering the CCG element of the sustainability plan, the CCG will also play a key part in the whole system delivering the longer term sustainability plan and the cE30m transformational saving every year	There is huge opportunity in working together across the healthcare system on transformational projects. The COVID19 situation also presents opportunity to reset to a 'new normal' which may assist in driving out inefficiency in the cost base of the system.	Risk management framework in place across the system as part of development of system sustainability plan. System governance arrangements in place through sustainability committee and investment task and finish group to ensure that investments can't be made in the system until efficiencies are found.	Regular CCG and System level financial reporting to CCG finance committee and Governing Body. Regular system level financial reporting to system sustainability committee.	Gaps in controls: 1) Detailed financial model behind the sustainability plan currently in place for 21/22 with organisational expenditure control totals established. Further work now to be done across the system on the longer term financial plan inlcuding modelling key assumptions and working through financial implications of the transformational projects. 2) System transformational projects ('big 6') currently in development stage and firm plans need to be in place. Resource needs to be assigned to projects to ensure delivery Gaps in assurance: 3) Risk management framework to be drafted and agreed across the system to ensure collective ownership of risk and mitgation.	**Almost Certain x Catastrophic = Extreme 25**		1) Significant work underway across system to model long term plan. Modelling task and finish group assembled and reviewing system wide financial model available from NHSEI. Future years of plan due to be presented to system in September , to include delivery of 'big 6' transformational projects. LC Sept 21. 2) System wide development of 'big 6' underway with SRO assigned to each, modelling to be presented to the system in July 21. CCG resources mapped to each of the 'big 6' projects and further projects being reviewed. ST July 21 3) System risk management framework in first draft and being discussed at both system DoFs and system CEOs. LC/CS July 21	**likely x major = High 16**	Laura Clare	Laura Clare Steve Trenchard/ Kate Owen	Finance	Laura Clare 26.5.21 28.6.21
6	1, 3 and 5	Z Young links to STW ICS risk register (in development)	Quality and Safety If the CCG fails to commission safe, quality, services for our populations then there is a risk that patients will come to harm, that regulatory action or commissioning decisions will result in closure of services. There is a risk that our population may have less locally accessible services, with a risk of adverse publicity and public loss of confidence in our services.	There is opportunity for the CCG to lead the development of our system quality governance approach, aligned to NQB and NHSEI guidance, adopting a distributive leadership approach to harness the talents and strengths within our system.	1. Establishment of our System Quality Group (SQG) which reports to the ICS Q&S Committee, a sub-committee of the ICS Board. 2. The SQG has ToR, reporting cycles, milestones and metrics for success, and maintains a risk register detailing management of quality and safety risks. 3. Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. 4. Considering our agreed quality priority areas for focus, establishment of the following SQG subgroups, each having executive sponsorship from within our system. Each sub-group has ToR, reporting cycles, milestones and metrics for success, along with a risk register. • Continuous Improvement Group • Learning from Deaths Group • Patient Safety Group. • Medicines safety group • Perinatal Quality Surveillance (PNQSG) • Infection Prevention & Control 5. CCG/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2021/22. 6. STW LMNS function is developing to encompass the new responsibilites for PNQSG and ToR and risk register have been revised in light of this requirement. 7. SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership.	1. CCG/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2021/22. 2. Monthly Quality & Performance Committee with business reporting cycle, CCG Board reporting and scrutiny 3. Enhanced Monitoring processes of SI's following the NHSE SI framework. Number of overdue SI reports is reducing and quality of investigatory reports and action plans improving for acute provider 4. Quality monitoring of providers in place based on concerns escalation 5. Information sharing and benchmarking via LMNS and MatNeo Clinical Network. Maternity & Neonatal network to independently review maternity position - SBLCB v2. 6. External Audit (Grant Thornton) report 2021/22 details level of assurance on the CCG's actions to ensure patient protection and safety, especially in relation to maternity services; A&E; and SI learning. 7. Recent QA visit demonstrated person-centred care and adherence to safeguarding policy requirements.	Gaps in Control: 1. Provider workforce vacancy and staff turnover for skilled workers. Necessary workforce is not in place/do not have capacity/capability, or achieved with temporary staffing solutions. 2. Backlog in key performance areas leading to poor outcomes, patient experience 3. Time lag of 2 years for MBRRACE-UK nationally validated and published comparative perinatal mortality data 4. New system Quality and Safety governance arrangements yet to be fully implemented and embedded. Gaps in assurance: 6. Triangulated information indicates areas of concern within providers. Specific performance and quality concerns with Culture and Leadership, aspects of clinical care 7. Provider failing to meet required performance and quality standards and progress at pace; pace of maternity improvements requiring workforce changes is slow. 8. Acute provider rated by CQC as inadequate for 'safe and well-led' domains and CQC regulatory and warning notices applied in a range of areas, recently including CYP MH provision and associated safeguarding assurances. 9. Quality governance processes in acute provider not fully formed and embedded. 10. Unvalidated provider metrics/data quality issues - particularly for maternity services. 11. Establishment of system approaches to quality governance at early stages and not fully developed or embedded. 12. Increasing levels of safeguarding concerns noted post-lockdown. 13. LAC Health Assessments not conducted at a timely rate.	**Almost certain x Major = Extreme 20**	↔	1. Continue to monitor quality risks and workforce plans at provider level. 2. Undertake themed reviews for individual providers and system quality concerns and issues. 3. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. 4. Further develop the maternity metrics dashboard. 5 Further develop and embed the system-wide revised approach to quality governance during 2021/22. 6. Targeted quality improvement work relating to CYP MH. 7. Oversight of Safeguarding and LAC risks via system safeguarding assurance mechanisms.	**Possible x catastrophic = High 15**	Z Young EDoN&Q	T Slater M Hadley	QPC	01.06.2021
7	1, 2	Julie Davies	Restoration of Services Post Covid 19 There is a risk that the restoration of health services following the Covid19 pandemic will not keep pace with patient need resulting in patients suffering harm.	Opportunity to develop innovative and more effective approaches to patient care Opportunity to develop a system approaches to patient pathways and care	Demand and Capacity Modelling 6 Big Ticket Items Development of digital and virtual capabilities Developing system infrastruture H1 Plan People Plan and workforce planning	Demand and Capacity Groups Covid19 Management Group	Gaps in controls: 1) Balance of workforce gaps, overseas recruitment impact of Covid19 and management of staff health & wellbeing wil impact on the ability to produce the workforce needed to recover at the necessary rate 2) Estate limitations 3) Equipment limitations	**Almost certain x Major = Extreme 20**	↑	1a)Elective Recovery trajectories set out in H1 plan. Big 6 items addressing key elements of sustainability and transformation 1b) Demand and capacity and performance monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. 1c) Work ongoing on implementation of People Plan 2 &3) Ongoing dialogue with NHSE regarding equipment and estate	**Likely x Major = High 16**	Julie Davies, Sam Tilley,	Julie Davies	QPC/GB	S Tilley

8	1,2	Sam Tilley	Population Health Needs There is a risk that the CCG fails to understand its population health needs and how this contributes to health inequalities across the footprint resulting in widening health inequalities.	To develop stronger partnerships with Local Authorities, public health and other stakeholders to develop a system strategy for health inequalities and population needs To tailor health and wellbeing services more accurately to populaton need ensuring they have a greater impact	Inequalities sits within the portfolio for Director of Planning and Parnerships and Population Health Management sits with the portfolio of the Director of Planning. JSNA work lead by Councils.	Health Inequalities outline startegy and bid. Personalisation agenda to meet population needs supported by regional funding and bid. New partnership arrangements for SEND with both local authority groups. Shropshire CCtH board and TWIPP working towards a place based delivery model on the needs of the populations.	1) lack of specific PHM expertise within the CCGs (recruitment to 2 x joint PHM posts with Councils not yet complete) 2) System infrastructure and agreed reporting lines to support impact assesments, BI outputs and resultant plan to be finalised 3) Need to co-ordinate system BI platforms to enable and support the cevelopment of a system approach to BI and PHM 4) Comprehensive engagement and communication strategy required for the public patient engagement exercise (SCCtH & TWIPP) 5) Lack of recurrent funding to ensure capacity in workforce to deliver needs of populations both internally and with providers.	**Likely x Major = High 16**	⇔	1) CSU Strategy Unit undertaking system review of BI capacity & capability to provide recommnedations on future system model for BI including PHM. Recruitment underway for 2 x PMH joint post with our two LAs. 2/3) PHM SRO within ICS structure but reporting lines and working group arrangements to be developed 4) Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with Local Authority to develop partnership and place based working to deliver the needs of the population PHM SRO within ICS structure but reporting lines and working group arrangements to be developed 5) Funding rerquirement linked to output of the CSU Strategy Unit review	**Possible x Moderate = Moderate 9**	Claire Parker/ Sam Tilley	Claire Parker/ Sam Tilley	SCC/GB	S Tilley
1	1, 2 & 3	J Davies	2wk cancer target achievement	To ensure that breast service achieves 2wk target from referral to appointment		Reports through CCG Quality & Performance Committee and on to Governing Body	Gaps in assurance: 1) Currently not achieving 2wk target , booking at 19days	**almost certain x major = Extreme 20**	⇓	1) Delivery of recovery plan by the end of June. Achieve 2wk target from July onwards	**Unlikely x major = Moderate 8**	J Davies	D Whiting	Q&P C	JD 02.06.21
2	1,2,3	J Davies	Inequalities in 12month cancer survival	To reduce the variation in rate of 12month cancer survival across STW	No formal reporting of cancer survival rates within the CCG.	Reporting variation in survival rates through SaTH Cancer Strategy Group	Gaps in controls: 1. Lack of awareness of inequalties in cancer survival across STW. 2. No plan to understand causes of the variation and take action to address them Gaps in assurance: 1. No place based forum to oversee this as ICS Governance structure and reporting requirements still being defined	**Almost certain x catastrophic = Extreme 25**	⇑	1. Analysis has been shared with Q&P Committee and a way forward agreed 2. Cancer Strategy group tasked with investigating inequalities and identifying actions required to reduce variation 3. SaTH CQRM to be asked to overee review of adherence to NICE guidance in cancer pathways	**Almost certain x catastrophic = Extreme 25**	J Davies	TBA	Q&P C	JD 02.06.21
3	1,2,3	J Davies	Risk of patients coming to harm during elective recovery	To clinically prioritise all patients during recovery to minimise risk of harm and ensure sufficent capacity to treat patients within the clinical priority timescales	1. National clincial prioritisation of admitted patients - local system adhering to this 2. National prioritisation of patients waiting diagnostics process agreed - local system working to implement this by end of July 3. Monthly reporting of waiting lists by clincial priority and average clearance	1. Reporting monthly waiting list and clincial priority profiles and clearance tiems to Q&P Committee and Governing Body	Gaps in controls 1. No consistent clinical prioritisation of OP Gaps in Assurance 1. No consistent system approach to reporting of Harm.	**Likely x Major = 16 High**	⇑	1 Agree a risk based approach to managing OP - seeking external support as required - End of June 21 2. Agree system wide approach to the measurement and reporting of harm - end of June	**Possible x Major = 12 High**	J Davies	TBA	Q&PC	JD 02.06.21
4	2,3	J Davies	Unable to fully implement the new UEC standards	To full implement the new UEC standards to improve patient outcomes and experience in ED	New Urgent & Emergency Care Operational Group	Reporting to Q&P Committee via monthly performance report	Gaps in controls 1. No shadow reporting visible to the CCG yet Gaps in Assurance	**Possible x Moderate = 9 Moderate**	⇓	External capacity brough in to the CCG to support the delviery of these new metrics	**Unlikely x Moderate = 6 low**	J Davies	S,Tilley	Q&P C	JD 02.06.21
5	1,2,3	J Davies	Risk of insufficent CYP crisis capacity leads to CYP being managed in acute ED	To ensure the majority of CYP menta health crisis demand is mananged away from an acute hospital	Measure the no. CYP who present to SaTH with acute MH need	Reporting incidence through the UEC Operational group via new UEC dashboard	Gaps in controls 1. TBC Gaps in Assurance	**Likely x Major = 16 High**	⇑	TBC	**TBC**	S.Trenchard	TBC	Q&P C	JD 02.06.21
6	1,2	J Davies	STW do not complete all the required healthchecks for peope with SMI	To ensure all people with SMI have their healthchecks	Regular monitoring of SMI healthchecks in primary care	None at this point	Gaps in controls 1. No regular performance reporting on primary care Gaps in Assurance 1. No regular detailed peformance report for priamry care to Q&P Committee.	**Likely x Major = 16 High**	⇔	Working with partnership managers to develop a plan to deliver SMI healthchecks as required in 21/22 subject to appropriate funding	**Unlikely x Moderate = 6 low**	J Davies	TBC	Q&P C	JD 02.06.21
	3	L Clare	STW do not implement the required digital work programme/actions due to lack of capacity	Opportunity to work collaboratively across the system with an integrated digital strategy		No formal assurance in place at this point. Weekly digtial operational group chaired by CIO but doesn't report into any formal committee	Gaps in assurance: 1) no formal IT/digital reporting to a committee 2) no CCG IT/digital strategy in place 3) very limited internal CCG IT resource	**Likely x Major = 16 High**	⇑	1) Governance being reviewed in line with development of an ICS and overall system integration of digital agenda 2) Work programme reported to governing body for first time in May 21- regular updates on progress to be provided 3) Work commenced on creation of a CCG/ICS digital strategy in line with system digital roadmap	**Possible x Major = 12 High**	L Clare	S Spencer	None	LC 28.06.21

	3	L Clare	Poor records management could lead to a loss of corporate memory	To ensure that the ICS begins with the correct records in place and that information assets are logged correctly		IG updates to audit committee through bi-monthly reporting from the CSU IG team. Records management discussion at quarterly IG steering group meetings	Gaps in assurance: No formal reporting in place on progress towards shared drive actions by department, gaps remain in information asset logging on u-assure system particularly around incomplete data flows	**Possible x Moderate = 9 Moderate**		1) IG manager working with directorates to update shared drive and delete/archive old records 2) New shared drive to be in place for ICS and new u-assure system through the CSU 3) Inormation Asset Owner (IAO)/Information Asset Administrator training programme in place 4) ICS IG transition plan in place to ensure robust records management process in place and all data sharing agreements are updated	**Unlikely x Moderate = 6 low**	L Clare	S Spencer	Audit Committee	LC 28.06.21
	3	Z Young	There is a statutory need to comply with the new law on LPS. The transition from Deprivation of Liberty Safeguards (DoLS) to the Liberty Protection Safeguards should occur from 01/04/22.	The new scheme is to be implemented by the 1st April, 2022.	The current legislative arrangements of DoLS are in place. There is system oversight via the local safeguarding boards arrangements.	There is a national framework for this transition and a local implmentation group (STING)which has good engagement from system partners.	Gaps in controls: The national guidance has not yet been released and systems have been instructed not to commence local training ahead of this.	**Possible x Moderate = 9 Moderate**	same	Once the national guidance is released, a gap analysis will be undertaken and a training plan will be developed and delivered.	**Unlikely x Moderate = 6 Low**	Z Young	P Cooper	QPC	ZY 28/06/21
	3	Z Young	Child safeguarding team activity and resource. There is an increase in child safeguarding concerns noted since lockdown restrictions are easing, with a consequent increase in activity because of both this and the SaTH s31 notice within the CCG safeguarding team.	To ensure all safeguarding statutory duties and improvement / oversight activities are carried out.	A range of system safeguarding oversight arrangements in place. CCG safeguarding team fully recruited to and stabilising post Management of Change process.	Robust intelligence and data measurement in place. Experienced team and excellent professional links between providers and commissioners of services across STW. CCG staffing plan for designated nurses adheres to Intercollegiate guidance according to population size.	Gaps in controls: The volume of rapid reviews requiring CCG inputs is increasing. Gaps in assurance: The CCG's arrangements for Designated Child Safeguarding Doctor and Designated LAC Doctor require confirming and funding, with associated job plans in place.	**Likely x Major = 16 High**	Increase	Continue to monitor activity and outcomes and factor into annual establishment reviews. Confirm funded staffing plan for Designated Drs - SG and LAC. Confirm assocated SLAs/Job Plans	**Unlikely x Major = 8 Moderate**	Z Young	M Hadley	QPC	ZY 28/06/21
7	1	S Tilley	Insufficient BI capacity & capacility to progress essential work on addressing health inequalities and develping place based priorities	Reduce health inequalities and improve health and wellbeing	Population Health Management Board	Population Health Management plan in development	Population Health Management Plan not yet complete	**Possible x moderate = 9 Moderate**		BI Capability and capacity mapping underway. Review of current BI workstrems underway. Population Health Management Plan to be completed	**Possible x Minor = 6 Low**				

Audit Committee Meeting - Appendix B

RISK MANAGEMENT MATRIX

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

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

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.**	**Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal. Informal complain/injury.**	**Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.**	**totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.**

Human resources/organisational /development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality. Low staff morale.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.

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**
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				
Service/business interruption/environmental impact	**Loss/interruption of >1 hour.** **Minimal or no impact on the environment.**	**Loss/interruption of >8 hours.** **Minor impact on environment.**	**Loss/interruption of >1 day.** **Moderate impact on environment.**	**Loss/interruption of >1 week.** **Major impact on environment.**	**Permanent loss of service or facility.** **Catastrophic impact on environment.**

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body Part 1 meeting held in Public on 14th July 2021**

Item Number:	Agenda Item:
GB-21-07.049	Integrated Care System Update

Executive Lead (s):	Author(s):
Claire Skidmore Interim Accountable Officer claire.skidmore@nhs.net	Nicky OConnor ICS Programme Director

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)**
N/A		

Executive Summary (key points in the report):
This paper provides a brief update on local and national thinking on the progress of becoming a formal statutory ICS in April 2022. The paper also provides a brief update on the 10 system pledges outlined in the original System Development Plan which remain the key parts of our system strategy for 22021-2022.

Recommendations/Actions Required:
Governing Body Members are asked to note the information provided in this report

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

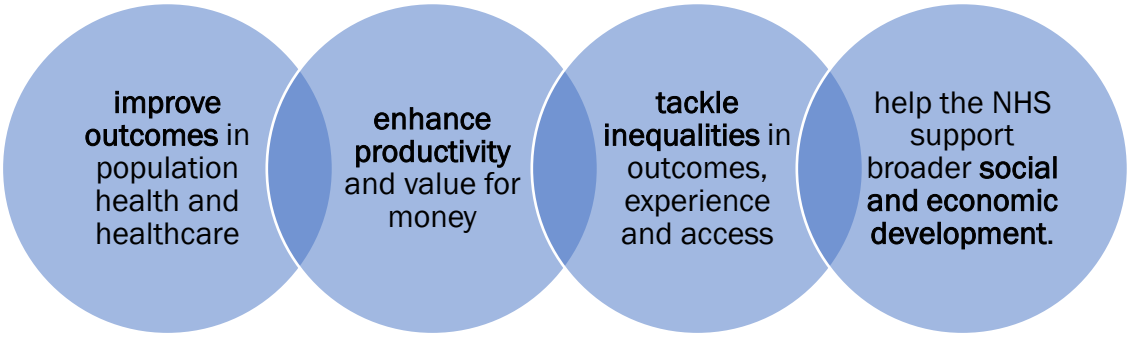
Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	This second section of this report provides an update on work to address the ICS pledges which are aligned to the CCG strategic priorities.
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	

BOARD PAPER – CCG GOVERNING BODY

UPDATE ON PROGRESS OF STW ICS AND SYSTEM PLEDGES

UPDATE ON ICS PROGRESS AND NATIONAL FRAMEWORK

1. Nationally, NHSEI have outlined the four core purposes of every statutory ICS within the ICS Design Framework.



2. We know by working together as one we can deliver on our four core purposes, achieve greater benefits for our community and improve the financial sustainability of our system.

3. We can tackle some of the big problems we are facing by tailoring care to individual needs using a better, data-driven understanding about local people's health, drawing on the expertise of all our partners and improving communication between staff.

4. The recently published ICS Design Framework gives more detail about the structure and function of ICSs which helps frame our thinking about what works for the STW system. The framework is permissive for systems but does outline the following requirements for each system:

    a. An ICS NHS Board - Developing a plan to meet the health needs of the population within their area, Allocating resources to deliver the plan Establishing joint working arrangements with partners that embed collaboration, Establishing governance arrangements to support collective accountability between partners, Arranging for the provision of health services in line with the allocated resources, Leading system implementation of the People Plan, Leading system-wide action on digital and data to drive system working , working on system estate solutions, EPRR and all still relevant CCG functions.
    b. An ICS Partnership Board - responsible for agreeing an integrated care strategy for improving health care, social care and public health across their whole population

c. Place based partnerships - with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise
d. Provider Collaboratives - From April 2022, trusts providing acute and/or mental health services will be expected to be part of one or more provider collaboratives

5. Further detail on expected aspects of every ICS is given below:

Clinical and professional leadership

6. All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

Working with people and communities

7. ICSs will need to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. It is expected this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and FT duties in relation to patient and public involvement, including the role of FT governors.

Approach to NHS oversight within ICSs

8. The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF). NHSEI expects these arrangements to confirm ICSs' formal role in oversight. Each ICS will be placed within one of 4 levels of oversight by NHSEI. For the STW system we have already been informed that this is level 4 – this reflects the considerable challenges for the system with quality and financial recovery.

ICS allocations

9. NHSE will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies. This will include the budgets for:

a. acute, community and mental health services (currently CCG commissioned)
b. primary medical care (general practice) services (currently delegated to CCGs)
c. running cost allowance for the ICS NHS body.
d. This may also include the allocations for a range of functions currently held by NHSE, including other primary care budgets and appropriate specialised commissioning.

Data and digital standards and requirements

10. From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Managing the transition to statutory ICSs

11. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. This does not apply to those people in senior/board level roles who are likely to be affected by the new ICS board structure and will have to go through organisational change as part of the abolition and establishment process.

10 SYSTEM PLEDGES – UPDATE BY PLEDGE

No.	Pledge Description
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 our services we aim to use digital innovation and data to enable our workforce to drive improvements in quality and safety and improve outcomes. • System wide Quality and Safety Strategy approved at ICS Board in June 2021 • Elective Procedures recovery process agreed as part of the System's Operational Planning response. Targets for April and May achieved. However, capacity to deliver our full recovery trajectory remains a challenge and system partners are working on solutions for this • CQC informal visit to SaTH in May. Date for a formal visit has yet to be notified.
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. • Good progress for both TWIPP and SHIPP in the areas of population health and service transformation • CEO of ShropCom asked to lead the further development of Place, working closely with CCG and other system partners to co-produce next steps including thoughts around leadership structures and accountability arrangements with ICS NHS Body
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. • Progress on identifying learning from COVID (which has

No.	Pledge Description
	increased health inequalities in all areas of the NHS) • Population health strategy approved by ICS Board and operational board now up and running chaired by CEO of Shropshire LA
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. • NHSEI oversight for LD&A de-escalated • Mental Health update to next ICS Board in July
Pledge 5	**Economic regeneration** – we recognise that economic regeneration will be essential throughout the pandemic and thereafter. For the citizens of Shropshire, Telford & Wrekin. • Outline approach to economic regeneration delivered to June ICS Board led by both local authorities • Considerable scope for joint working identified – particularly around employment
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. • Initial climate change approach outlined to ICS Board in March. Update due to July. • Further NHSEI targets for climate change expected by the Autumn
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 an emphasis on place, neighbourhood and provider collaborative arrangements by 1st April 2021. • Initial reshaping of governance including 4 ICS sub committees now established • Consideration now being given to the shape and make up of ICS NHS Body and ICS Partnership Board with a view to concluding engagement with partners and bringing forward proposals by September
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 & Wrekin including committing to an annual report by September 2021 and

No.	Pledge Description
	starting to hold Shadow ICS NHS Board meetings in public. • Outline communications and engagement approach to ICS Board in May • STW ICS AGM being planned for October as a virtual event
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. • Work continues the 6 big ticket items to quantify expected financial and system benefits • Work has commenced on a system sustainability strategy including board workshops in July, with a view to completing the strategy by September • NHSEI national oversight meeting planned for 22nd July to check on progress • Triple lock system for investments remains in place and working effectively, however, progress on releasing efficiency savings has stalled therefore a round of support and challenge meetings are planned
Pledge 10	**Workforce** - 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. • Workforce shortages remain a concern for the system with further options for international recruitment being considered. • Work on the workforce 6 big ticket item continues with a focus on reducing agency costs through improved procurement • System People Strategy approved by ICS Board in May

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body Part 1 meeting held in Public on 14th July 2021**

Item Number:	Agenda Item:
GB-21-07.050	Armed Forces Covenant

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Tom Brettell, Primary Care Partnership Manager Kate Manning, Senior Communications and Engagement Officer

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)**

Executive Summary (key points in the report):

Pledging our support to those who have served in the Armed Forces as a single CCG

We are asking the Governing Board to commit to signing up to the Armed Forces Covenant as a single CCG for the whole of Shropshire, Telford and Wrekin.

The Armed Forces Covenant is a pledge from the nation to those who have served (and their immediate families) in the British Armed Forces ensuring that they do not suffer disadvantages as a result of their service.

Shropshire CCG and Telford & Wrekin CCG both signed the Armed Forces Covenant prior to becoming a single CCG. This demonstrated both CCGs' commitment to ensuring no member of the armed forces community living within Shropshire and Telford & Wrekin should face disadvantage in the provision of services compared to any other citizen and that in some circumstances special treatment may be appropriate especially for the injured or bereaved.

Recently, over a series of weeks, as a CCG we have also been undertaking planned communications with GP practices, sharing helpful information and resources, asking individual practices across Shropshire, Telford and Wrekin to sign up to the Armed Forces Covenant and to become Veteran Aware.

Working towards and achieving Veteran Aware status ensures that practices adopt a range of practical measures to identify and support veterans and their families. The CCG Primary Care Team is able to support practices to implement these measures utilising a framework provided by the national Armed Forces Covenant Programme.

Feedback from practices to date has been very positive and a number are already looking to progress this work. The ambition is to support all our practices to sign up to the covenant and to embrace the Veteran Aware approach.

We would welcome the support of some clinical champions to help promote the Covenant and support practices to adopt it. This role would be entirely voluntary and would ideally suit clinicians who have served in the Forces.

About the covenant

The Armed Forces Covenant sets out a number of health commitments for the Armed Forces community:

- The Armed Forces community should enjoy the same standard of, and access to healthcare as that received by any other UK citizen in the area they live.
- Family members should retain their place on any NHS waiting list, if moved around the UK due to the service person being posted.
- Veterans should receive priority treatment for a condition which relates to their service, subject to clinical need.
- Those injured in service should be cared for in a way which reflects the nation's moral obligation to them, by healthcare professionals who have an understanding of the Armed Forces culture.

To find out more, visit: www.armedforcescovenant.gov.uk

or to sign up to the covenant to show your support visit:
https://www.armedforcescovenant.gov.uk/get-involved/sign-the-covenant/

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? Signing up to the Covenant and supporting our practices to become Veteran Aware ensures that all veterans and their families are treated and enjoy the same standard of, and access to healthcare as that received by any other UK citizen in the area they live	Yes
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement?	No

Recommendations/Actions Required:
The Governing Body are requested to sign up to the Armed Forces Covenant as the new CCG.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 28th April 2021**

Item Number:	Agenda Item:
GB-21.07.051	Finance Committee Summary

Executive Lead (s):	Author(s):
Laura Clare Executive Director of Finance laura.clare@nhs.net	Geoff Braden Finance Committee Chair g.braden@nhs.net

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

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

Executive Summary (key points in the report):

- Update received on ICS Shadow board report showing system deficit being in line with expectations. A presentation was shared with committee members with further detail and insight.
- Executive Director of Finance gave an update on the month 12 position giving 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.
- 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.
- The annual accounts were on track for completion to the agreed timescales in May.
- Continued discussions took place on the underlying deficit position of £71m which still requires updating to the Governing Body.
- The system backlog was discussed and the financial impact on the CCG and saving 3%. Further work and additional detail was requested for the May meeting.
- 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 £13.5m for the CCG with additional scrutiny and discussion of the plans. The plans will be reviewed on a monthly basis with additional details to both bridge the gap but also ensure that the deadlines and benefits are realized..
- There still is 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 £13.5m 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?	No
2.	Is there a financial or additional staffing resource implication?	Yes
3.	Is there a risk to financial and clinical sustainability?	Yes
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:

Board to note the contents of the report and recognise the improved financial position against forecast. Also requested that it notes the ongoing work that requires executive focus to address the financial shortfall and plan.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 26th May 2021**

Item Number:	Agenda Item:
GB-21-07.051	Finance Committee Summary

Executive Lead (s):	Author(s):
Laura Clare Executive Director of Finance laura.clare@nhs.net	Geoff Braden Finance Committee Chair g.braden@nhs.net

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Finance Committee	26th May 2021	A

Executive Summary (key points in the report):

- A paper was received on the annual planning cycle, completing an ICS system plan. This is a 6 month plan, which will be submitted to board in an extraordinary meeting for sign off. It includes three key strands: Finance element, narrative element and an activity and workforce element. The Finance piece was completed in May with draft elements submitted for the other sections. The final narrative plan with the activity and workforce will be submitted to NHS England on the 3rd June.
- The Recovery Plan for Elective care was received showing the plan for recover over the next 6 months. Refinements to the plan and its trajectories to set our elective recovery within the guidance. There are trajectories that are set out which take us to recovery to a position of 85% of our 2019/2020 position. There are complex financial arrangement that sits alongside the recovery trajectory with additional monies coming into the system to support the elective recovery which the committee discussion. It was agreed that a further presentation would be received in the June meeting.
- STP update was received giving details of the latest system plan and the further work being done towards a 3/5/10 year window. Details were shared on the ongoing work with additional updates requested.
- Executive Director of Finance gave an update on the financial work currently taking place as we await the first monthly reporting in month 2. Details were shared on the risk and the work taking place particularly against the different financial landscape in H2.
- It was confirmed that the BAF has been updated to ensure that the executive team are focused on the gap for the CGG of 3%.

- The Value for Money QIPP update was presented to the committee which demonstrated the underlying position of the CCG vs the 3% task. This roughly equates to just over £13.5m for the CCG outside of the system sustainability plan.
- 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.
- Significant risk still remains as there is still a significant £3m gap of opportunity to identify with staffing gaps on key projects a real issue.
- 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 £13.5m 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?	No
2.	Is there a financial or additional staffing resource implication?	Yes
3.	Is there a risk to financial and clinical sustainability?	Yes
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:

Board to note the ongoing work to ensure that H1 plans and processes are in place with increasing focus on H2 and the Value for Money QIPP plans. To note that there still remains gaps in the identified savings and the need to finalise and confirm the opportunities against the £13.5m plan.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 14 July 2021**

Item Number:	Agenda Item:
GB-21.07.051	Summary Report of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated 28th April 2021

Executive Lead (s):	Author(s):
Zena Young Julie Davies	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

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)**
Full minutes approved at the Shropshire, Telford and Wrekin CCG Quality and Performance Committee on 26th May 2021.		

Executive Summary (key points in the report):

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

Recommendations/Actions Required:

The Governing Body is asked to note for assurance and information.

Report Monitoring Form

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? *This item is for information only and all conflicts are recorded through the locality meeting at the time*	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? *This report is for information only and any specific issues or risks would be identified through the appropriate governance route.*	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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *This report is for information only and any issues will be addresses vis the appropriate governance route.*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *This report is for information only and any commissioning decisions would be informed through the appropriate governance route*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

To provide a summary of the main items reviewed at the 28th April 2021 meeting

Performance

- The CCG Governing Body, at a recent board development workshop, agreed to adopt the 'Making Data Count' Methodology for its data reporting. The new approach will be implemented over the following months.
- 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.
- 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.

Quality

- The monthly average for sepsis screening on SaTH admission across the Emergency Departments continues to be above 95% for both sites Performance in relation to patients screened as 'high risk' having had the appropriate action taken as per Sepsis 6 remains below the target.
- The CCG has been made aware that a number of senior midwifery staff are not currently at work, coupled with other senior vacancies and has asked for assurances on the thresholds for departmental safety and mitigating actions.
- **Antenatal prescribing:** task and finish group has been established to seek to resolve the issues around antenatal prescribing of certain medications.
- **MPFT:** The CCG has raised concerns around the interpretation of data and conclusions drawn within MPFT's Suicide Report and is awaiting a response from the trust.
- The CCG continues to liaise with MPFT regarding the request for extensions to report submissions for Serious Incidents.
- **IPC**: A reducing number of Covid-19 outbreaks have been reported in NHS providers managed in accordance with Incident Management Processes. IPC team is undertaking assurance visits to care homes and delivering training refresh within Care Home and Domiciliary settings.
- The CCG Quality Leads are currently in discussion with providers to re- establish face to face quality assurance visits.
- **The initiative to develop eleven teams of maternity continuity of care is well under the target: at this stage there should be seven teams in place but currently there are only two.**
- **Additional capacity has been put in place to address long waiting times for children requiring ASD assessments: waiting times are reducing as a result.**

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 14 July 2021**

Item Number:	Agenda Item:
GB-21.07.051	Summary Report of the Shropshire Telford and Wrekin CCG Quality and Performance Committee dated 26th May 2021

Executive Lead (s):	Author(s):
Zena Young Julie Davies	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

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)**
Full minutes approved at the Shropshire, Telford and Wrekin CCG Quality and Performance Committee on 23rd June 2021.		

Executive Summary (key points in the report):

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

Recommendations/Actions Required:

The Governing Body is asked to note for assurance and information.

Report Monitoring Form

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? *This item is for information only and all conflicts are recorded through the locality meeting at the time*	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? *This report is for information only and any specific issues or risks would be identified through the appropriate governance route.*	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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *This report is for information only and any issues will be addresses vis the appropriate governance route.*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *This report is for information only and any commissioning decisions would be informed through the appropriate governance route*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

To provide a summary of the main items reviewed at the 26th May 2021 meeting.

Performance

- Performance measures related to the Urgent and Emergency Care (UEC) environment locally remain challenging in particular in relation to the 4 hour treatment standard for A&E and recent gains in performance are proving hard to maintain as overall numbers of A&E attendances and emergency admissions have increased in recent weeks.
- Ambulance handover delays in excess of 1 hour remain a challenge.
- Elective activity at local providers is now recovering steadily across the system. Unvalidated data indicates that planned levels of activity were achieved in April and are on track for May for all local providers. Encouragingly, modifications to physical estate and confirmation of retention of mobile diagnostic units have had a benefit in allowing imaging activity to keep pace with plans though there is some risk as the modular CT (national arrangement) at SaTH will move on to another Trust.
- In general, cancer performance held up reasonably well until the latest Covid surge disrupted efforts to maintain this position, but now that has subsided, performance is improving again. Capacity issues in the breast pathway have been resolved by recent estates work and the position is now slowly improving although that rate of improvement is directly related to the level of incoming demand.
- IAPT referrals have increased and are back to pre-COVID levels and the full capacity of the service is back in place. Despite that the CCGs could not achieve the year end cumulative target given the accumulated shortfall in performance.
- A review of tumour sites (breast, gynaecology, colorectal (lower GI), lung and urology) undertaken by the Performance Team found that:
  - there are a number of cancer tumour sites where 1 year survival in Telford and Wrekin is significantly below the national average – breast, colorectal and lung (Shropshire as well for lung)
- Late staging, which may be directly linked to late presentation by the patient. It is also possible that many patients did not have their cancer diagnosed via a related referral at all.
  - There are some specific issues that may relate to patient education regarding awareness of breast symptoms for those under the age of 50, colorectal symptoms, ovarian cancer symptoms and prostate cancer symptoms.
  - Rates of smoking in Telford and Wrekin remain a concern, especially amongst pregnant women (this group is also a particular concern for Shropshire).
  - The local health economy wide cancer strategy group is best placed to oversee actions.

Quality

- Work continues to address the Section 31 conditions and Section 29A warning notices at SaTH in relation to CYP with mental health needs at the PRH hospital.
- The CCG has raised concerns around the interpretation of data and conclusions drawn within MPFT's suicide report. MPFT has acknowledged receipt of these concerns and will provide a response via CQRM.
- STWCCG and partners are continuing work to improve the uptake and quality of Annual Health Checks for people with a Learning Disability.
- As a result of patients sharing their concerns about the lack of food choice during inpatient stays SaTH has launched a revitalised food service on the wards. They have also made changes to the way feedback is collated within the A&E department following a theme identified from patient experience feedback.
- The quarterly Children's Safeguarding review highlighted that COVID-19 lockdown nationally, regionally and locally showed increasing domestic violence and mental health concerns were key features across the Child Safeguarding Practice Rapid Reviews.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held in Public on 14 July 2021

Item Number:	Agenda Item:
GB-21.07.051	Locality Chair's Summary report to the Board

Executive Lead (s):	Author(s):
Claire Parker	Claire Parker

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

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

Executive Summary (key points in the report):
This paper is a brief summary for information only of the matters discussed at the four locality boards- overarching themes and any individual items pertinent to the locality are included within the report.

Recommendations/Actions Required:
This report is for information only

Report Monitoring Form

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? *This item is for information only and all conflicts are recorded through the locality meeting at the time*	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? *This report is for information only and any specific issues or risks would be identified through the appropriate governance route.*	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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *This report is for information only and any issues will be addresses vis the appropriate governance route.*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *This report is for information only and any commissioning decisions would be informed through the appropriate governance route*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

Summary Briefing to the Governing Body from the CCG Locality Chairs

The four localities met during April and May 2021. The localities are Shrewsbury and Atcham (chaired by Dr Ella Baines), Telford and Wrekin(chaired by Dr Ian Chan), South Shropshire (chaired by Dr Matthew Bird) and North Shropshire (chaired by Dr Katy Lewis).

Each locality was given an update on the ICS progression. The localities fed back on the importance of primary care and the practice voice into the system. Ensuring the right representation at all levels of the system and at 'place' was identified by all the localities as a priority. Primary care needs to be at the heart of the discussion and shaping the system.

There is overwhelming concern from practices across all the localities about the unprecedented increase in primary care activity; this is being exacerbated by an increase in secondary care work being pushed down to primary care. This needs to be addressed if there is to be a left shift, as primary care does not have capacity or workforce for additional work. All localities raised issues such as removal of phlebotomy services and the issues that phlebotomy is still presenting and that it is not funded appropriately. Examples of secondary care issues are being passed to primary care team to address with contract and performance colleagues.

The localities received a number of presentations and updates from services – these included phlebotomy, mental health services, respiratory, drug and alcohol service and sexual health service.

An update on the integrated care record was given to all localities. One Health and Care is a confidential digital shared record for patients living in Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent. It brings data together from different organisations involved in health and social care and allows appropriate professionals to access one record to improve patient care. The localities were taken through the governance processes, the fair processing campaign on direct care and leave secondary use of data to a later date.Patients have the right to object and this will need to be recorded on the GP patient record.

The medicines management teams presented an update to the practices on the care homes work and how the team are working with practices.

Secondary care colleagues presented the upper GI referral form and this was circulated for comment and input from primary care.

Each locality raised the issue of restarting spirometry services. The CCG has circulated updated guidance to practices if they wish to restart spirometry.

Telford GP forum had an update from the vaccination team in May 2021.

All the localities raised the issue of the mental health survey results not being sent back to practices- this has now been actioned and was sent to all practices across the CCG in May 2021.

Telford and North locality had raised issues about the adult ADHD pathway and ASD pathways. Although these pathways remain a concern for all the localities. Further work is being undertaken by the CYP and MH leads to ensure these items remain a focus for each locality over the coming months. These items are regular agenda items for all four localities.

All localities had a presentation on respiratory services and the development of the services going forward being led by Dr Katy Lewis, with a particular focus on those patients waiting longer than 52 weeks.

South locality have raised concerns about the giant cell arteritis pathway.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

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

Item Number:	Agenda Item:
GB-21-07.051	TWCCG CCG Practice Forum – 16th March 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	

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

Mr Evans highlighted that the new CCG would be in place from the 1st April 2021 and there would continue to be GP Practice Forum meetings as part of the locality structure.

There is currently some uncertainty with regards to CCGs in relation to the White Paper and the implementation of Integrated Care Systems (ICS) from April 2022. The ICS is in a state of development and Mr Mark Brandreth is the Lead CEO for this across the system. One of the uncertainties; which is not clear within the White Paper, is where Primary Care sits within the ICS. Primary Care will have a significant role moving forward and Telford will be a 'place' within the ICS but there is a degree of uncertainty as to how it will be represented.

The appointment of an Accountable Officer for the new CCG is ongoing and this will be clarified as soon as this process has been completed. Dr John Pepper assumes Chair of the CCG from 1st April.

Dr Chan commented that with Mr Evans going on secondment and the appointment of a new CCG Chair this will leave a massive gap in relation to skill mix and corporate memory. Dr Chan was therefore concerned for the future of the leadership within placed based commissioning. Mr Evans responded that he did understand Dr Chan's concerns and had spoken to Dr Pepper and said that he was more than happy for Dr Pepper to contact him over the next few months so that he can retain some of the continuity and corporate memory available to Dr Pepper moving forward. Mr Evans said that he had every confidence that Mrs Parker and her team would be able to take the placed based agenda forward and maintain the importance of that as the CCG moves forward into an ICS. Mrs Parker said that it was really important to keep the locality meetings going and strengthening the commissioning / primary care voice and start to think about how it has an influence on

the ICS and this was something that could be done at GP Practice Forum meetings along with looking at how the PCN part of 'place' can be shaped along with ensure that the GP voice is heard within the ICS

GP Practice Forum Chair's Update

Dr Chan said that members would be aware that today was Mr Evans last GP Practice Forum and wanted to thank him on behalf of himself and Forum members for the last 9 years of his vital leadership of the CCG during some of the most turbulent times within the local health system. Dr Chan also recognised his massive contribution to Primary Care within Telford and Wrekin. Dr Chan went on to say that it is sad to see Mr Evans leave and it he will be a big loss to the local health economy. Mr Evans recognised that it had been a hugely challenging time and noted the lively debates that had taken place over the direction of the CCG and commented that he had never worked anywhere for as long as nine years, however there was something about Telford that had kept him here and he would miss the people and the membership. Mr Evans said that he would like to thank the members for being as supportive as they had and he had worked with a fantastic group of people in the CCG and wished everyone all the success for the future in taking the CCG forward into the ICS.

Dr Chan highlighted that Dr Caroline Freeman was stepping down after 12 years of leading GP education in Telford and Wrekin and thanked Dr Freeman. Dr Chan went on to note some of the fantastic PLT events that had taken place and recognised Dr Freeman's contribution to PLT events and GP education. Dr Freeman said that she was sad to be leaving this role and commented that it had played to her strengths; she had loved the networking element and organising the PLTs. Dr Freeman went on to say that the PLT had really helped with the liaison with Secondary Care. Dr Freeman said that it would be extremely beneficial to get some Primary / Secondary Care liaison in place. Dr Freeman also highlighted the TMPA Christmas parties and noted that this year's is due to take place on 3rd December, COVID allowing. Dr Freeman finished by thanking members for all their support.

Dr Chan finished by saying that Mrs Karen Ball, administrator to the GP Practice Forum and CCG PA, was retiring after 18 years with the PCT and CCG, and thanked her for her contribution to the Forum and wished her all the best.

Clinical Commissioning Developments / Proposals

Mental Health Service Update

Mrs Cathy Davis attended and gave a verbal update.
The number of Learning Disability annual health checks carried out has gone up to 58% as of 9th March, which was a fantastic improvement. Hoping to make the same achievement on the mental health, health checks. Winter monies are in place and are being used to support the LD&A community via the ASD hub and is currently being run virtually. The ASD Pathway is now up and running for children and young people. All children have now started the assessment process and the waits have reduced considerably down to around 12 weeks. There are, unfortunately, longer waits for adults requiring ASD assessments and the waiting time has increased to over 12 months. The service is looking to do some work to bring this back on track. The Children and Young People's Crisis Team is now 24/7 offering crisis intervention for urgent cases and also offering home treatment to prevent admissions. In relation to services within SaTH, new pathways are being put in place to ensure that those children with mental health issues that can no longer be admitted have a secure and safe pathway, which uses the crisis team and also looking to expand psychiatric liaison to support those requirements. Calm Cafes are taking place virtually within Telford and additional telephone support has been added along with additional virtual counselling sessions. Branches remains open offering a twilight service 7 days a week. Proactively working with the Crisis Team to ensure that the people who need extra support get it and introduced to community services.

Implementation of the New Maternity Data System – "BadgerNet"

Ms Tina Gallagher, Head of Business Change and Ms Lisa Yeaman, Specialist Digital Midwife, Digital Transformation Programme, SaTH attended the meeting and gave a presentation, Ms Gallagher informed members that the Trust is developing an Electronic Patient Record (EPR) programme, one of which relates to maternity. It is an end to end maternity care system, which follows all of the pathways and is across primary and secondary care and works in both consultant and midwifery led units and GP and community midwife settings. BadgerNet is a nationally hosted system and therefore has the advantage that if a woman is booked

in at SaTH but is taken ill elsewhere in the country they will have access to her pregnancy records. The handheld records are held via either a smartphone app or a website URL, where the patient is able to log on and look at records. It can also hold pictures and diary entries, which can remain visible to the patient but no one else. Leaflets that the patient receives can be published through the system. The information the patients sees is by clinician requirement therefore certain information can be held back and won't be visible. Currently looking at the end of May 2021 to switch on the system. Ms Gallagher felt that it would be useful to come to the May meeting so that they can give an update on the exact switch on date. Dr Chan agreed that this would be a good idea and if they contact him he will ensure it is on the agenda.

Phlebotomy Service Review

Mrs Parker gave a presentation and wanted to make it clear that this was not about taking phlebotomy services out of GP Practices but making sure there was a consistent offer for phlebotomy. It was felt that now was the right time to review the services. This is a whole system review and it is about allowing patients to get a phlebotomy referral. Mrs Ralph had put together a governance structure and working groups around the review. Mrs Parker is the SRO for the CCG and Mr Chris Preston is the SRO for SaTH. Ms Katy Lewis is the Clinical Lead and chairs the steering group. An engagement phase had taken place with both clinicians and the public. Mrs Ralph had done an incredible job with engaging with GP Practice, IT and through referrals and using every avenue to gain opinion and also appeared on Radio Shropshire promoting the engagement of the review. Currently collating the information and Mr Meredith Vivian, Lay Governing Body for PPI is helping to support this. There are a number of ongoing pieces of work included access to laboratories, collection, referral and booking and forward thinking in relation to estates requirements. The most contentious part is around the booking system and the plan is that it will go to the Chief Executives group for sign off. The next steps are to finish the project plan, get the feedback from the engagement work and then develop the options for the service delivery. It is anticipated that the services will go live from September this year. Regular updates will be brought to the GP Practice Forum. Dr Freeman asked would GP Practices have the opportunity to commission phlebotomy services. Mrs Parker responded that the service was not being taken out of Primary Care and there would be some form of the service commissioned through primary care, PCNs and GP Practices. Currently Mrs Ralph is undertaking a piece of work looking at this and it would be a mix of options. Dr Innes said that he wanted to be clear that this was not around the blood tests GP Practices do for QOF but other phlebotomy services. Mrs Parker responded that yes, it was around other phlebotomy services that are provided. Dr Chan said that he would be chairing the task and finish group for the clinical subgroup with Dr Nigel Capps, Director of Research and Innovation at SaTH, to look at the different ways the service would be commissioned and said that thought would need to be given to how a more consistent offer can be made across the board that does not disadvantage patients. Dr Hudson said that in relation to full blood count test it was really important to make sure everything ties together and links up so that patients can get their tests done, primarily in a Primary Care setting. Mrs Parker responded that they need to make sure everything lines up as currently there is a mismatch from the services.

Pulse Oximetry and Virtual Ward

Mr Tom Brettell attended the meeting and gave a verbal update and the following key points where noted:
A review of Pulse Oximetry at Home and Virtual Ward services and a report is being presented to Gold Command on the 17th March. Some of the report will be shared with Primary Care. It has been an extremely positive piece of work and had enabled the health system to come up with solutions at real pace and had broken down boundaries. Worked very closely with Shropdoc, SaTH and the Community Trust. Also with the West Midlands Academic Health Science Network and NHSEI for both design and delivery. The health systems are mandated to have both Pulse Oximetry at Home and a Virtual Ward in place, the design and how it works is flexible in order for it to fit with the system. Mrs Ralph led the initial consultation with GP Practice and design work. The Pulse Oximetry service began on 18th December 2020. Comments and feedback from GPs is welcomed. There had been a total of 433 patients managed through the Pulse Oximetry at Home Service and 358 of those patients were referred directly by GP Practices. Some of the other referrals came via Shropcom and the Out of Hours Service.

The Virtual Ward is a secondary care mandated service. An integrated approach had been taken to design and deliver the Virtual Ward and it is the same group of partners and clinicians that also set up Pulse Oximetry at Home. There had been some challenges on how activity is reported. Part of the detailed work that had been undertaken was to unpick activity, as it appeared the Virtual Ward was not performing particularly well. However, it had been recognised that some of the figures being reported for Pulse Oximetry could be allocated

to the Virtual Ward. Both services are mandated to remain active but with the reduction in COVID cases they are becoming less busy. The feeling is that they need to remain in place in case there is a further surge in cases. Ther is work planned to implement a digital element to the work to link how the oximeters are utilised by patients and how they are manged remotely. There is a desire to build on this work, particularly the integrated approach to both design and delivery and to utilise it further with the management of long term conditions. Dr Chan said that through the process it had shown how stakeholders come together and deliver services at pace. In terms of the governance there is some work to be done but in relation to further models this paves the way for a more integrated approach in relation to streams of work coming through. The GP Practices will welcome a report at some point.

Proxy Access for Ordering Medicines within Care Homes

Ms Olivia Marshall-Bowater, Pharmacy Technician in the Care Homes, Medicines Management Team, attended the meeting and gave a verbal update; a presentation had been shared with the papers for the meeting. Staff within care homes are set up with a user account on Patient Access, which is linked to all the residents within that care home or unit within the care home. The approach being taking is supported by NHSEI and there are many benefits to the system. It will save time within Primary Care in relation to administration teams no longer needed to process the prescriptions and will reduce the footfall into GP Practices. It will create a very clear audit trail of the ordering of repeat medicines and will help to improve the medicines safety element. In turn it will reduce the amount of drugs wasted. It will also give the care homes ownership of their ordering. There will be transitioning from the Prescription Ordering Department (POD) onto which every system GP Practices use. Support will be given to train Practice staff with the changeover and liaising between GP Practices, care homes and community pharmacies. Dr Chan said that in terms of implementation what was required from GP Practices to implement the scheme. Ms Marshall-Bowater responded that there are many supportive tools that NHSEI have issued. Data sharing agreement between the GP Practice and the care homes would have to be set up although there may already be one in place but would recommend that a new one is put in place. Will need to work out how the GP Practice communications the new process for prescription ordering. Care homes would need to use an nhs.net email address. The care Homes will need to communication with their residents in relation to getting consent. There are forms that can support this and they will be encouraged to send this to the GP Practice so that they can be added to EMIS and Patient Access. Would recommend that the email account set up for the member of staff in the care home is an NHS.net email account and they are happy to support this with the GP Practice. When setting up in EMIS will need to set up the user with the care home residents linking it to Patient Access. Support will be given by the care home management team to do this. Dr Chan asked if the proxy user would be able to access repeat medication area. Miss Marshall-Bowater responded that it was up to the GP Practice as to what access they give to the member of staff in the care home in relation to what they can see in Patient Access but would recommended that at this time it is just repeat medication but it is up to the GP Practices as to whether they want to give access to the allergy status and appointments.

COVID Update / Vaccinations

Mrs Parker said that Telford and Wrekin was nationally in the highest percentage for the number of COVID vaccinations that had been administered and thanked everyone for all their efforts in making this possible. Mr Ellis would be looking at the 18 to 49 year old cohort and whether PCNs will be signing up to this and whether GP Practices will be able to deliver their core work as well as the additional work that is coming on and this is the next piece of work the CCGs would be looking at.

Dr Chan noted that PCNs have weekly meetings with Mr Ellis to discuss the progress and hopefully there would be more information available shortly in relation to the development of the vaccination programme and return to normal.

Mr Brettell also highlighted the weekly telephone calls and if there was anything that needed to be clarified just let them know

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?	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication?	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability?	~~Yes~~/No
4.	Is there a legal impact to the organisation?	~~Yes/~~No
5.	Are there human rights, equality and diversity requirements?	~~Yes~~/No
6.	Is there a clinical engagement requirement?	~~Yes~~/No
7.	Is there a patient and public engagement requirement?	~~Yes~~/No

Recommendations/Actions Required:
For the board to note the comments in the report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

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

Item Number:	Agenda Item:
GB-21-05.000	TWCCG CCG Practice Forum – 20th April 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		

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

Dr Chan formally introduced Dr John Pepper, new Chair of Shropshire, Telford & Wrekin CCG. Dr Pepper gave a brief background to the forum and informed members that there is now a new constitution in place and recruitment is on going to find a new Accountable Officer for the organisation. With regards to the new Governing Body, Audrey Warren has joined the Board as Registered Nurse and new GP representative is Mary Ellis-Sandley. There is also one less Lay Member now than previously. Going forward focus will be on quality issues, waiting times/backlogs, financial stabilisation, COVID recovery and the move to ICS and system working. Dr Pepper confirmed he would like to attend the meeting each month if diary commitments allow.

There is a 5 year financial plan in place looking at stabilisation within the first 12 months. Dr Chan queried whether General Practice funding would be ring-fenced going forward to protect budgets and Dr Pepper did not think this would be required.

Concern was raised regarding leaders on the Board generally being from the Shropshire Area but Dr Pepper felt that going forward this would be an inclusive CCG and everyone would be involved equally and that there are lots of benefits to working together as well as plenty of new opportunities whilst moving to an ICS. Health and Care Partnership within the ICS will be key.

GP Practice Forum Chair's Update

Dr Chan shared the Health and Care White Paper: The BMA View with members and gave a brief overview. He highlighted the 2 slides which show the key changes in terms of NHS structure and the ICS body which

focuses on NHS services and the ICS Health and Partnership Board which will focus on wider services. GP representation will be required at every level. Dr Chan also shared a slide around ICP Contracts for members information and would circulate the slides following the meeting.

Mental Health Service Update

Frances Sutherland joined the meeting for this agenda item. She congratulated everyone on the recent annual health checks for Learning Disabilities which hit an all time high of 77%.

More investment is expected over the next 3 years for both Learning Disabilities and Autism and a road map is being developed.

All deaths of anyone with a learning disability are now being investigated and case notes are reviewed.

The Children's Autism Pathway is now up and running and Ms Sutherland would welcome any feedback around this. Referrals generally come from schools to a panel made up from Education, Health and Social Care colleagues.

With regards to Adult Mental Health disappointing results were received around the annual mental health checks and Ms Sutherland would encourage support and feedback as to how this rate can be improved. It was felt that COVID had impacted greatly on the checks being carried out.

COVID Update/Vaccinations

Jenny Stevenson informed members that updates are being provided to GP Practices on a daily basis as well as weekly meetings with the PCN leads.

Spirometry

There are a number of issues around Spirometry in Primary Care and whether practices should be carrying this out. Dr Innes declared an interest as his brother is a Respiratory Physician. It is believed that Spirometry is still being carried out in Secondary Care setting although without the appropriate PPE. With regards to the Spirometry Hub suggestion workload and volume of demand would need to be considered to move this forward. Ms Stevenson informed that this is still being discussed at the CCG and any feedback from practices would be welcomed. Concern was raised around the delay with finding a solution. Dr Pepper agreed to provide feedback to the CCG around this.

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?	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication?	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability?	~~Yes~~/No
4.	Is there a legal impact to the organisation?	~~Yes~~/No
5.	Are there human rights, equality and diversity requirements?	~~Yes~~/No
6.	Is there a clinical engagement requirement?	~~Yes/~~No
7.	Is there a patient and public engagement requirement?	~~Yes~~/No

Recommendations/Actions Required:
For the board to note the comments in the report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

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

Item Number:	Agenda Item:
GB-21-07.051	TWCCG CCG Practice Forum – 18th May 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		

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

It was noted that work was ongoing with the ICS development and the financial sustainability plan. Dr Chan and Dr Pringle reported they were not aware of any further changes. Ms Parker agreed there had been no further major changes in last month and reported that an email had been sent out recently which included a statement from the LMC and CCG in relation to the NHSE/I letter and face to face consultations.

GP Practice Forum Chair's Update

Dr Chan raised a point about spirometry, advising the service would need to be restarted noting that some further guidance had been issued regarding infection, prevention and Control (IPC). The CCG and IPC were now working on a protocol and Katy Lewis was the clinical lead for this work. It was noted the risk was with the filters and the potential risk of covid transmission. Some adjustments would also be needed to rooms for the spirometry service to continue.

In relation to ICS development, Dr Chan advised he had attended the ICS meeting with Dr Lyttle recently and noted that the membership was still forming. General Practice representation at present was low and the focus was on the big 6 items at present and the structure and governance for the future. It was noted that Deloitte were helping to develop the ICS and there was a drive to increase the influence of Primary Care.

Dr Chan reported the Council had developed the Independent Living Centre in relation to access, ideas and support for family and carers and also advice and guidance for community support as well as occupational therapy (OT) assessment.

Dr Innes emphasized the importance of primary care representation in the structure and governance of the ICS and other committee meetings. Dr Chan confirmed primary care representation membership had been discussed at locality chairs, PCNs and LMC meetings and also commented that future funding streams were part of discussions too at ICS meetings to ensure services are protected such as LES and DES.

Dr Hudson commented that he had seen some information relating to the ICS at Wolverhampton and their proposal to have 50% of the voting members of the ICS Board as general practitioners. Dr Chan agreed and noted the importance of all PCN clinical leads and locality leads needed to attend the ICS meetings, but also recognised that not everyone could attend the meetings. Dr Chan agreed to raise GP membership at his meeting with Jane Povey and Mark Brandreth in June.

Dr Eli advised further GPs needed to come forward and to be involved noting that LMC elections were held in March and there are still a few places available. Dr McDonnell advised that if any GPs were interested to contact Dr Ian Rummens direct and agreed that further representation was needed especially for the Telford area.

Dr Hudson raised spirometry and IPC changes with rooms alongside ARTP training to undertake spirometry tests and the increasing costs for this. Dr Chan confirmed he had spoken with Dr Martin Allen who sits on national board for spirometry and it was noted the quickest option was to restart the service in primary care, however, this service was not part of GMS and it was be a temporary measure. It was recognised a longer term solution would need to be found and for the service to be commissioned in future. Work on the commissioning requirement for spirometry was ongoing. Discussion was held regarding skill mixing and Dr Hudson reported that the service would need an ACPT spirometer and interpreter in order to make diagnoses.

Practice Managers Update

Ms Craddock asked about the covid vaccine update and for any further information regarding reimbursement for Practices for moving second doses forward. Mrs Stevenson confirmed that Mr Steve Ellis would be attending to day to give an update on covid.

Ms Caddock also raised face to face meetings and asked if and when the CCG Board envisaged face to face meetings. Dr Pringle confirmed that risk assessments were currently being done and could not see face to face meetings coming back too soon due to further covid outbreaks. Many members agreed that meeting via Teams was better in terms of saving time.

Clinical Commissioning Developments/Proposals

Mental Health Service Update

Ms Frances Sutherland joined the meeting for this agenda item. She advised the community transformation steering group was due to take place this week and representatives from PCNs were down to attend this meeting. Invites would sent out this week to locality leads in order to start discussions regarding primary care and shared care prescribing and Cathy Davis was leading on this work. Dementia diagnostics were down across the country and high risk groups were not coming forward to be assessed. Telford referrals were down from last year; however Shropshire referrals were not down. Ms Sutheralnd reminded members that if there were any referrals to take into account nursing and care homes. The wait time was currently 10 weeks, with an aim to get it down to 6 weeks. It was noted that 96 from Telford & Wrekin were on waiting list with 46 already allocated.

SMI physical health – Ms Sutherland advised Carly's contact details were available if needed and noted Carly would be going on maternity leave shortly. A task a finish group was in the process of being set up to look at SMI physical health and how processes could be improved for SMI physical health and also how to support practices.

IAPT model – It was noted that there were currently two different models and work had started on this with looking to have primary care as part of this.

LD&A – It was reported there were significant waits in adult autism, LD&A and that pathway which had been made worse by covid. Plans were being developed in order to increase capacity.

Annual health checks – Janet Gittins was commencing work on the best way to get young people on the register and how they get diagnosed. An autism champion would be put in place for the system over the next few months and Ms Sutherland asked if there were any interested GPs for the autism champion and if so to contact Ms Sutherland direct.

Dr Innes raised children's mental health and health support teams in schools. It was noted that parents were asking GPs for letters as proof of non-attendance at school. Patients and parents were being referred to BEAM and the children's society however, there was no support being given for anxiety in children. Dr Bufton agreed that the feedback from BEAM was unsatisfactory. Ms Sutherland advised there was a lot of funding going into the children and young people, however, requested that any information relating to BEAM and any particular schools requesting letters to be sent through to Ms Sutherland so she could take this work forward and look into this. Dr Innes, Ms Hallet and Dr Waldendorf would send some information and examples through to Ms Sutherland.

Dr Thompson raised adult ADHD pathways and the issue with patients being seen in London for example under the right to choose rule in order to get a 2 week diagnosis. This then causes a problem with prescribing mediation as the medication cannot be prescribed from the GP and the patient needs to go back through the system locally. Ms Sutherland advised she had raised this issue with her Director and understood the challenge; however, as it stood, the patient would still need to go back through the local system. Dr Chan confirmed that mental health remained a challenge confirming the community mental health steering group was due to be held tomorrow.

COVID Update/Vaccinations

Mr Steve Ellis attended to present this item and advised the CCG were continuing to deliver a successful programme across the county. Mr Ellis thanked all the GPs/PCNS that had made the programme a success noting that the CCG were over the 80% target in virtually every cohort (in cohorts 1-9, in the over 50s cohort and clinically vulnerable) except for the social worker cohort due to issues such as vaccine hesitancy and work was ongoing with the council in looking how to resolve this. Cohort 6 and the clinically at risk patients had been really successful and this was hugely down to it being led by GPs with only 14.7% remaining in this cohort to be vaccinated. This cohort was also the most performing cohort in the region.

To date just over 478,000 vaccines have been delivered in Shropshire, Telford & Wrekin and of that 180,000 are now second doses. Vaccinations were now being delivered to cohort 10 which was nearing the end and also commenced cohort 11 from the middle of last week, booking 36/37 year olds. Expecting to go live with cohort 12 in early June but this is dependent on national decisions.

Changes regarding delivery of vaccine in the under 40s and Pfizer was now being given to the under 40s. It was noted that Pfizer vaccines were already at RJAH vaccine centre and Pfizer vaccines would go live at the Shrewsbury Bowling Centre tomorrow and live in Telford a week on Monday. The delays around this were because of national sign off.

Second doses are being brought forward to 8 weeks from 11/12 weeks due to the Indian variant concern. This is being done through local vaccination centres, community vaccination services and through local pharmacies who are delivering the vaccines. Plans around this were being worked on over the weekend and Mr Ellis thanked PCN leads for their help with the planning. Mr Ellis further reported a plan was in place for vaccination centres and how patients would be contacted to bring forward their second does date adding that those that booked through the booking service were now beginning to receive texts. It was also announced on a webinar last night that support and funding would be available for GP Practices for re-booking covid vaccination appointments and for template letters and scripts

Phase 3 and the lightly booster campaign – Mr Ellis confirmed planning was underway for the covid booster campaign and discussions were taking place with PCN leads to start work on this and a meeting would be held on Thursday this week to discuss further. MR Ellis would also be meeting with the Community Trust in relation to vaccinating in schools, however, national guidance around contracting and what the expected involvement is for primary care is still awaited.

Telford mobile covid vaccine unit – Mr Ellis advised a mobile unit was being put in place in Telford to try and get to the hard to reach areas.

Sexual Health Services

Ms Stacey Norwood attended for this item and took members through her presentation. She advised the council were looking to consult with various stakeholders due to the current sexual health contract coming to an end with the current MPFT provider.

In Telford & Wrekin there had not been a significant rise in STIs, chlamydia was the most prevalent STI diagnosed locally, but there had been an increase in gonorrhea diagnoses. Sexual health needs assessments will be shared with people and there. Delivery of LARC and GP Practices delivering this was high in Telford.

The current model of service delivery with MPFT who are responsible for delivering the integrated sexual health services, provide pre-covid outreach services and Spokes which is based in Wellington and Newport. An online provision is also delivered and this has been well received during covid and is through SH24. Patients can order kits for STI screening and some treatments can be ordered online too with GPs delivering LARC and pharmacies delivering EHC.

Dr Pringle suggested taking into account other age groups such as the 40s too for sexual health services and agreed that SH24 has come into its own due to covid. Dr Innes suggested liaising with the LUSH group. Dr Thompson would pass Ms Norwood's details onto the group and invite her to one of the meetings.

Ms Norward advised she was aware that some GPs were unable to provide LARC and if Practices wanted to deliver LARC the council could arrange for training to be set up for GPs. In relation to PCNs Ms Norwood noted the council were keen to engage with PCNs around this service.

Locality Meetings - ICR

Dr Steve James attended to present this item and took members through the presentation. Marc Talbot from CSU was also available to answer questions. The following points were noted:

One Health and Care is a confidential digital shared care record for patients living in Staffordshire, Stoke-on-Trent, Shropshire, Telford and Wrekin. One Health and Care brings data together from the different organisations involved in health and social care. It allows doctors, nurses and other registered health and social care professionals directly involved in patient care to view relevant information in order to provide better and safer care.

Patients had a right to object and this would need to be recorded on the GP system with instructions on how to do this included in the toolkit. It was possible that some patients may not have been included due to already having a summary care record.

All practices are registered and Dr James encouraged all practices to look at this adding the IG team were there to support practices and help them sign up to the health information sharing agreement. Dr James reported the LMC had raised some concerns about IG and the main concern was regarding a possibility in the increase of data breaches and subsequent possible increase of fines. The LMC has since received further information which has been forwarded onto the committee who have been asked to look at the process (the combined GPC and the Royal College of General Practitioner Committee). Further approval and decision is awaited.

Dr Innes asked about how it would work and look from a GP point of view and if there would be training available. Dr James confirmed GPs would access the system through EMIS and there will be tabs for One Health and Care on this page.

Dr Chan enquired about data breaches and what the possible repercussions would be for Practices in the case where the Practice was not responsible for the data breach but the practice data was used in the breach. Dr James noted that the organisation that had made the breach would need to report it.

Dr Chan thanked Dr James for the presentation. Dr James added that secondary care data would be the last to be added to the system and it was envisaged this data would be available at the end of September.

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?	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication?	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability?	~~Yes~~/No
4.	Is there a legal impact to the organisation?	~~Yes~~/No
5.	Are there human rights, equality and diversity requirements?	~~Yes~~/No
6.	Is there a clinical engagement requirement?	~~Yes~~/No
7.	Is there a patient and public engagement requirement?	~~Yes~~/No

Recommendations/Actions Required:
For the board to note the comments in the report.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting on 19th May 2021**

Item Number:	Agenda Item:
GB-21-07.051	Audit Committee Summary

Executive Lead (s):	Author(s):
Alison Smith Director of Corporate Affairs alison.smith112@nhs.net	Geoff Braden Audit Chair g.braden@nhs.net

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

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

Executive Summary (key points in the report):

- Updated Head of Internal Audit opinion was received with significant assurance across the summary report. Recommendations were received and included in future monitoring based upon previous updates included in the draft plan.
- Post the meeting with execs the work plan for 2021/22 was agreed and this will be followed up and progressed through the year.
- Confirmation that the CCG Data Security and Protection toolkit had been completed and progress made towards the submission deadline.
- Information Governance Policies received and confirmed, based upon previous CCG policies:
    - IG Handbook
    - IG Data Protection and Security Policy
    - Code of Conduct
    - Privacy Notice
    - Employee Privacy Notice
    - IG Management Framework
    - Local Records Management Schedule
    - Information Governance Breach reporting (SOP)
    - Standard Operating Procedures for the management of Subject Access Requests
- Two Financial Policies were approved:
    - Detailed Financial Policies
    - Fraud, Bribery and Corruption Policy
- Health & Safety Suite of Policies approved
- Gifts, Hospitality and Sponsorship Policy approved
- Volunteer Policy approved
- HR Policies approved

- Losses, Special Payments and Waivers were received with the main issue being around Opthalmology Suricube and IT assets.
- Counter Fraud Annual report was received which was due for submission 31st May 2021. The changes in the Counter Fraud Functional standards have changed with a standard return required. No issues were foreseen to achieve this deadline.

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:

Board to note the update and the suite of policies, many of which are very similar to legacy CCG documents, approved.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on**

Item Number:	Agenda Item:
GB-21.07.051	Primary Care Commissioning Committee (PCCC) Summary Report (Meeting date:)

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

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

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

Executive Summary (key points in the report):

The detail below provides a short summary of the items, discussion and actions from Primary Care Commissioning Commitee.

Finance update:

The underlying position for the delegated co-commissioning budget is an over-spend against the ring fenced allocation which must be addressed in the long term financial plan. Key points of his report were:-

- Year 1 2021/22 is a year of stabilisation. Any further spending growth across the system is limited to no more than growth in resources received.
- Years 2 to 5 2022/23 – 2025/26 are Transformation Recovery Years. An actual recurrent expenditure reduction by 3% per annum which is equal to reducing the deficit by £30m each year
- As part of the systems journey to achieving financial sustainability in 21/22 the investment framework will ensure that only essential investments are made within the resources available. Individual organisations no longer have the autonomy to make investment decisions unless it relates to a specific ring fenced budget/allocation.

Estates update:

- Shifnal Outline Business Case (OBC) approved at PCCC in May 2021
- Shawbirch Full Business Case (FBC) –building is now underway

- ‘Cavell’ Centre Project Initiation Document (PID) signed off and now progressing to FBC
- A total of £350k had been received to fund small capital projects and Business As Usual projects this financial year. Several schemes have been in a queue waiting for support. The majority of those have been through Committee already and are relatively minor, largely around IPC and DDA compliance. .

Other issues:

- Significant integration work with the STW Training Hub to support workforce including specific focus on diversity in the workforce
- Investment to support Primary Care in dealing with COVID including protection of income for core services
- Formation of a new PCN in Telford

A previous paper submitted to PCCC stated that the Pauls Moss protesters were going to put in an appeal against the ruling of the Judicial Review. It was noted that this should have stated ‘may’ put in an appeal but no appeal was submitted. The Pauls Moss development is going forward and the Project Board has been re-started.

The CCG believes that demand in primary care has increased by 50%. This is in relation to face to face and telephone appointments but also e-consult enquiries. The CCG provided a statement for Practices to use advising patients that all our Practices have been seeing patients face to face, they are using telephone triage and will monitor access into surgeries. In addition, Practices were given the option to switch off E-Consult over weekends and Bank Holidays. However the situation is currently being monitored.

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?	~~Yes~~/No

	(If yes, please provide details of the clinical engagement).	
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 NHS Shropshire, and Telford and Wrekin CCG are asked to receive this paper for information

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held in Public on 14 July 2021 Part 1

Item Number:	Agenda Item:
GB-21-07.051g	Chairs Report for Strategic Commissioning Committee (Part 1)

Executive Lead (s):	Author(s):
Steve Trenchard, Executive Director of Transformation	Steve Trenchard, Executive Director of Transformation

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)**
Strategic Commissioning Committee (SCC - Part 1)	23rd June 2021	A

Executive Summary (key points in the report):

April & May Elective Recovery Delivery v H1 Plan

The SCC discussed the performance report presented by Dr. Davies. System challenges in performance and were noted (inc. diagnostics, endoscopy, ultrasound) and mitigations in place highlighted. Significant work is underway to address the impact from covid.

IVF Policy Update

The first step has been to align the two previous CCG policies and discussions underway with Specialist Fertility Unit at SaTH. The new policy is being consulted with SaTH and will be brought back to the next SCC for approval.

Enhanced Health in Care Homes & Community Support

The committee were updated on the different elements of a business case which had previously been to SCC and then separated as it went to the system investment committee. Ms Alison Massey explained that there is a senior nurse in each location and their role has been extended up until July. However, doctors working on this business case in both community and hospitals have not progressed – one doctor is gone and the other will be returning to his old position as senior registrar for the medical team. The digital element of the case is working in places however it has not yet received project management support to bring it all together and no update has been provided as to the progress of the pilots taking place in Telford and Wrekin.

There was discussion on whether the SCC where having full oversight of all commissioning decisions to fulfil its statutory duty on behalf of the CCG. The potential inequity between Telford and Shropshire service models was discussed. SCC noted that this case highlighted a potential gap in system oversight during the CCG transition to ICS and agreed that register of all NHSEI and system business cases to be established, and closer links with the system Sustainability Committee to be established. Also that the business cases for future models brought to SCC.

Flash Glucose Monitoring

An update to the committee on current status of Flash Glucose Monitoring which is now being continued at the cost of the CCG. An audit conducted between Shropshire and Telford areas showed that 820 patients were being provided with this technology. There have been good outcomes from implementing this technology however, long-term outcomes cannot be confirmed at this point.

The next stage is to look at the two policies for initiation of flash glucose and aligning the two areas based on the audit dates. Also, expanding initiation in Shropshire to general GP surgeries.

Dr Deborah Shephard mentioned that she is pleased about the progress as it has improved care and kept within the agreed budget. The Committee agreed that future monitoring will be business as usual rather than through specifically through SCC.

Optum Accelerate Switch Programme

Robust discussion and support for this project to be delivered in primary care, subject to further system ratification. This will form part of future efficiencies programme.

Audiology Services

Paper presented informing SCC of changes to a service and the plans to safely manage transition of patients to an alternative provider.

Community Vasectomy Service

Paper presented informing SCC of changes to a service and the plans to safely manage transition of patients to alternative pathways.

Recommendations/Actions Required:
Reports on the above areas were noted and accepted.

Report Monitoring Form

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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	Yes
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	Yes