Enclosure 1A

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE JOINT STRATEGIC COMMISSIONING COMMITTEE HELD VIA MICROSOFT TEAMS ON WEDNESDAY 16TH DECEMBER 2020 AT 12.30PM PART 1 PUBLIC SECTION

Present

Dr John Pepper	GP/Primary Care Health Professional/Chair
Mr Ash Ahmed	Board Member/Chair
Mr Geoff Braden	Lay Member
Mr Steve Trenchard	Interim Executive Director of Transformation
Mrs Claire Skidmore	Executive Director of Finance
Ms Julie McCabe	Independent Joint Registered Nurse
Mrs Fiona Smith	GP/Primary Care Health Professional
Ms Michelle Davies	Service Manager, Shropshire Council
Mrs Zena Young	Executive Director of Quality
Mrs Cathy Davis	Commissioning and Redesign Lead – Mental Health
Mrs Lisa Cliffe	Deputy Director of Performance & Delivery
Ms Laura Clare	Deputy Chief Finance Officer
Dr Julie Davies	Director of Performance
Mrs Sam Tilley	Director of Planning
Mr Johnathan Rowe	Executive Director of Adults Social Care and Health and Wellbeing, Telford & Wrekin Council
Miss Hannah Davies	Personal Assistant (minute taker)

Apologies

Ms Alison Smith	Director of Corporate Affairs
Mr Dave Evans	Accountable Officer
Dr Julian Povey	STW CCG Chair
Dr Deborah Shepherd	Medical Director
Mrs Claire Parker	Director of Partnerships

JSCC-20-12.36 - Apologies

Apologies were noted as above.

JSCC20-12.37 - Members' Declaration of Interests

No Declarations of Interest were noted.

JSCC-20-12.38 – Minutes and Action Tracker of Previous Meeting – Wednesday 18th November

An amendment to her title, from Dr to Mrs Fiona Smith, was requested. It was established that the action log circulated related to both Part 1 and Part 2 of the meeting in error. Mr Steve Trenchard confirmed that the first two actions relate to Part 2.

Mr Trenchard confirmed that the action relating to the ASD pathway was complete with the information requested included in the paper on the agenda and the committee confirmed that Mr Charles Millar had circulated the information requested from his presentation. These actions will be closed on the log.

JSCC-20-12.39 – COVID Update

Mrs Sam Tilley provided a verbal update to the committee, highlights are listed below:

- There is an increase in cases following the easing of lockdown measures at the start of December but this has not yet led to an increase in hospital admissions.
- Modelling for an increase in admissions is underway and will take account of the relaxation of the rules over the Christmas period.
- The vaccination programme began on 8th December with just under 1000 vaccines administered in the first week.
- The South East PCN vaccination site came online this week with plans for further sites to be open in early January 2021.
- Feedback from NHS England so far has been positive.
- A recruitment programme is underway to mitigate any workforce issues although there is a risk to delivery of the programme if sufficient staff are not available.

Mrs Tilley confirmed that any expressions of interest in being involved in the vaccination programme are being passed on and followed up. Dr John Pepper provided some positive feedback for the CCG team working on the programme from Primary Care colleagues and asked whether the rollout was equitable across all PCN's in the county. Mrs Tilley explained that the locations were carefully selected with input from NHS England; a mixture of mass vaccination sites and smaller pods alongside mobile teams will be in place and utilised as necessary depending on the vaccination type, cohort of patients and IT facilities available. PCN's have the opportunity to engage with the programme and some will deliver the full model, others will deliver some aspects of it.

Mr Johnathan Rowe congratulated Angie Wallace and the team on the implementation of the programme and the partnership working but expressed some concern around communications to the public who may be expecting to be called in to their GP surgery for the vaccination soon. Mrs Tilley agreed that there is a need to manage public expectations around the vaccination and confirmed that any communications must be signed off by NHS England at a national level making local responses difficult. Mrs Tilley explained how the communication team from all partners and providers are linked in to the programme and pointed out that the programme will last for 38 weeks and people must adhere to the social distancing guidelines in place even after immunisation.

In response to a query from Dr Pepper around how people are being made aware of the vaccination position locally, Mrs Tilley confirmed that the local authority communications routes are being utilised and the CCG are working with MPs and local media outlets via media briefings, radio interviews and blogs.

JSCC-20-12.40 – Capacity & Demand

Added to the agenda in error.

Enclosure 1A

JSCC-20-12.41 – Addendum to SaTH Access Policy

Dr Julie Davies presented this item for information on behalf of Mrs Angie Parkes who was unable to attend the meeting. Dr Davies explained that in response to the pandemic the priority groups waiting for treatment were identified earlier in the year based on national guidance. Some amendments were made to give two further priority levels, levels 5 and 6. Dr Davies asked colleagues to note that the addendum will be in place for as long as the pandemic continues and that these are the levels against which the waiting list will be managed.

Ms Julie McCabe asked for clarification that P5 and P6 have been added as per national guidance and Dr Davies confirmed that this was the case. In response to a question from Dr Pepper, Dr Davies explained her understanding was that P5 patients who were discharged to the care of their GP would remain on an active waiting list unless a clinician decides otherwise. P6 patients who have declined two possible dates for treatment are paused on the waiting list through their own choices to decline treatment options.

Any Other Business

Dr Pepper requested amendments to titles for Dr Julian Povey and Dr Deborah Shepherd in the minutes from the previous meeting.

Committee members thanked Dr Pepper for chairing the meeting at short notice.

Date and Time of Next Meeting

20th January 2021 – 12:30 – 14:30hrs via Microsoft Teams

Enclosure 1B

JSCC Part 1 (Public) Action Tracker – 16.12.2020

Action Reference	Action Required	Who	When	Comments
JSCC-20-11.028 Minutes & Action Tracker of previous meeting 21.10.2020	**Mrs Frances Sutherland to attend the next meeting with details around the ASD model and pathway development.**	Frances Sutherland	16.12.20	Completed
JSCC-20-11.031 Capacity & Demand Update	**Mr Millar to share the graphs from his presentation with the Committee. It was also agreed that high level headlines would be sufficient going forward and only reported in the Confidential part of the meeting.**	Charles Millar	ASAP	Completed

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Joint Strategic Commissioning Committee**

Item Number:	Agenda Item:
JSCC-21-01.046	Phase 3 Recovery in November

Executive Lead (s):	Author(s):
Dr Julie Davies	Julie Davies

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)**
JSCC	16/12/2020	ADI

Executive Summary (key points in the report):

The presentation provides JSCC with a detailed summary of the Phase 3 recovery plans for both SaTH and RJAH by month through to the end of March 2021. It also shows the actual levels delivered in September, October and November. Recent increases in COVID demand, the third wave, have mean that the current recovery plans will no longer be achievable and a revised forecast for Q4 needs to be agreed once the full extent of the current surge and the associated consequential impact is better understood.

Phase 3 Recovery

Elective and Outpatients

SaTH were planning to deliver ~80% NOP vs 100% target of pre COVID levels
100% FU vs 100% target " " " "
70% DC vs 90% target " " " "
~35% IP vs 90% target " " " "

The shortfall in NOP is predominately due to OP procedures. The loss of capacity due to IPC issues has been mitigated to some extent by the adoption of virtual clinics and patients waiting in the car. Some minor procedures are being conducted in the Vanguard theatre but the remaining challenge around aerosol generating procedures remains and further work is required in this area.
The impact on IP was mainly due to only 50% of the elective beds used last winter being available this winter due to the impact of new IPC measures and the required co-horting of patients. The Nuffield is continuing to be used to mitigate this to some extent but the capacity available under the national contract terms has more recently been 50% of what it was in wave one, equating to 20-25 procedures per week. However in light of the recent surge in COVID demand this is being renegotiated. These sessions are being prioritised for the clinical priority areas of breast surgery, gynae, urology and upper GI. The system has made a bid to NHSE/I for modular wards to support an improvement in this recovery but there is yet to be a decision.

RJAH were planning to deliver ~80% NOP vs 100% target of pre COVID levels
~80% FU vs 100% " " " " "
100% DC & IP vs 100% " " " " " by March 2021

RJAH have been working to improve their OP recovery with a combination of waiting list clinics, digital enablers, Pathway co-ordinator – virtual waiting admin and international recruitment to support with additional capacity. However due to the recent and urgent need to support the regional surge in critical care capacity they have temporarily paused their routine elective work to release anaesthetic and theatre staff to support increased ITU capacity at SaTH.

Further detailed monitoring had being put in place of all elements of elective and day case work, including theatre utilisation, staffing etc to ensure we were doing all we could to maximise our rate of recovery, but due to current pressures this has also been paused temporarily.

Diagnostics

SaTH is achieving the 100% target for CT and MRI currently due to the additional mobile units they have commissioned and/or been allocated by NHSEI. The current plans show that dropping off in the new year when this capacity ran out but the Trust has recently approved MRI business cases to extend the additional units for a further 3 months and similar cases are being drafted for CT. Based on current capacity SaTH is planning to achieve ~80% vs the 100% target for ultrasound (U/S) but a third party provider has been secured and community estate capacity is currently being sought for this to deliver additional capacity required to achieve the target from the latter half of January.

With regard to endoscopy SaTH were planning to achieve the national targets of 100% by Feb/March in Colonoscopy and Gastroscopy. However endoscopy capacity has had to be reduced once again to release staff to support the wave 3 COVID surge. Flexi-sig activity levels remain low due to the lower levels of bowel screening activity coming through as a result of the national suspension of the screening programme in response to the first wave of the pandemic. There are also national changes to the bowel screening programme in train which will move to FIT (Faecal Immunochemical Test) testing pathway and the plans for flexi sign will need to be amended to take account of this when the effect of the changes has been worked through.

RJAH is planning to deliver ~80% for both MRI and CT. The shortfall is workforce related. They are currently achieving ~90%+ but this is not sustainable and based on additional shifts and locum staffing. Despite having opened two additional rooms for U/S due to the shared waiting area this is still only planned to achieve ~70-80& vs 100% target but current IPC constraints are being reviewed to see what else can be done to increase the throughput.

>52wks position

At the end of November our main providers have 857 patients waiting longer than 52 weeks at SaTH (296 in Ophthalmology, 199 in General Surgery, 109 in ENT and 99 in T&O): and 540 at RJAH (all but 5 in T&O). Unfortunately this position will continue to worsen as a result of Wave 3.

There is ongoing clinical review of patients waiting to minimise the risk of harm and when patients are treated harm pro-formas are completed and reviewed through our Clinical Quality Review process. This will continue to be reported via the CCGs Quality & Performance Committee.

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). The full recovery required post pandemic is still to be fully quantified. This is being managed through the System Planning & Performance Group and will form a key part of the contracting for the 21/22 and beyond. It will cover the financial and workforce consequences.*	Yes
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated). The cost of addressing the backlogs that have arisen as a result of the pandemic will need to be quantified and the central funding to be made available for this agreed. The recovery plans will be an opportunity for innovation to improve efficiencies, minimise the financial consequences and also improve clinical sustainability of pathways and services. There is a national & regional NHSE/I Elective Recovery Programme dedicated to this which was launched on 15th December. The first three specialities being looked at are ENT, Ophthalmology and Orthopaedics.*	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). Equity of access as services are recovered will be key and delivering shared Patient Tracking Lists across the system and their clinical prioritisation will help deliver equity in access as services are recovered and backlogs reduced.*	Yes
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement). System clinical leads for each specialty will be needed to support the Elective recovery programme mentioned in item 3.*	Yes
7.	Is there a patient and public engagement requirement? *There will be for longer term recovery of backlogs. This will be included within the elective recovery programme work at a specialty level.*	Yes

Recommendations/Actions Required:

The committee are asked to :-

1) Note the content of the summary report and presentation with regard to the STW system's Phase 3 recovery up to and including November.
2) Take limited assurance on the delivery of some of the phase 3 targets to date.
3) Note that the current third wave of COVID is now preventing any further recovery and a new recovery plan and forecast will be required when the current pressures subside.
4) Note the worsening position of 52wk waiters and the ongoing clinical review and oversight of those waiting to minimise harm.
5) Note that regular updates on this will be brought to the committee on a monthly basis.

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

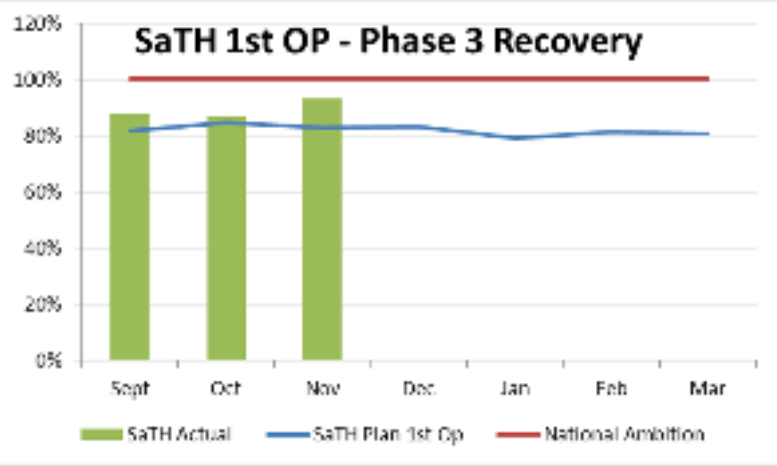
JSCC

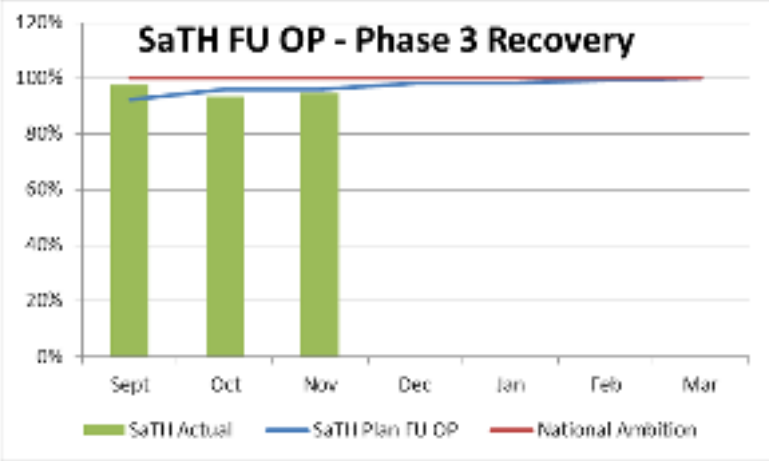
STW Phase 3 Recovery Summary

20th January

Julie Davies

SATH Outpatient Phase 3 Recovery Plan





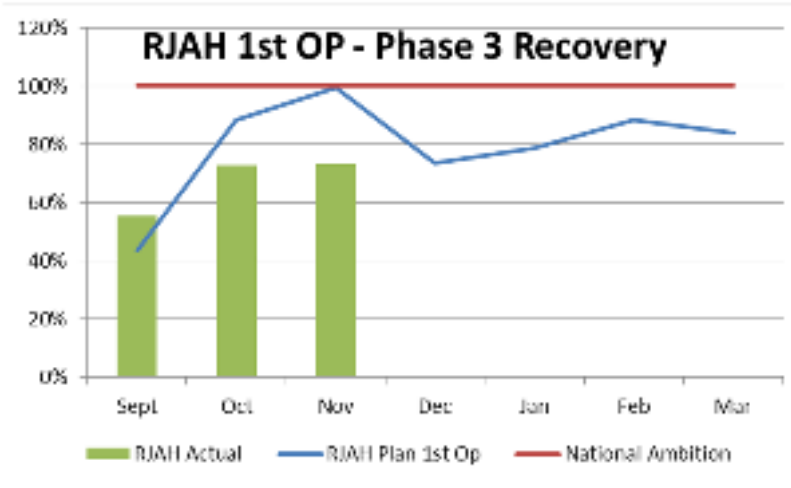
Issues:

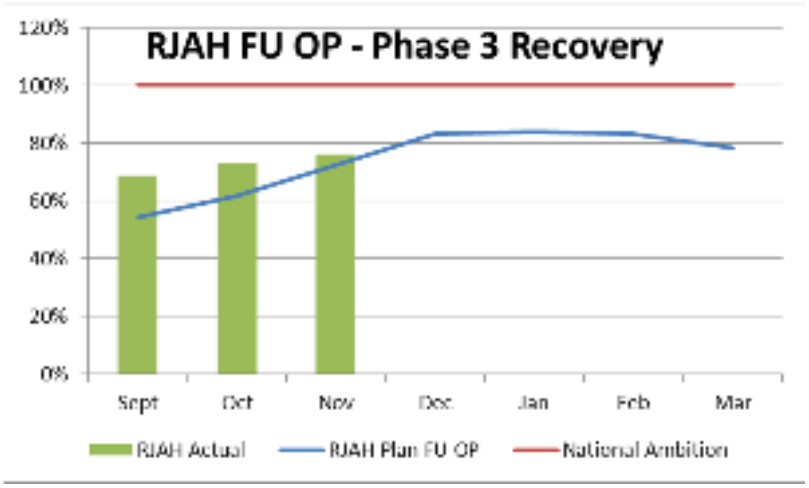
- Social distancing in waiting rooms,
- Physical space,
- Availability for Aerosol generating outpatient procedures,
- DNA and Patient Cancellations due to Covid-19 and concern re: Covid-19

Mitigations:

- Risk assessment and PPE applied,
- Waiting in car and room booking systems procured to optimise space,
- Virtual telephone clinics in place,
- Use of Nuffield optimised during November,
- Expansion of non-face to face activity
- Patient Initiated Follow Up (PIFU) project started
- Virtual OPD activity 36% of activity
- Minor Ops being undertaken in Vanguard Theatre
- Further work required to improve OPPROC

RJAH Outpatient Phase 3 Recovery Plan





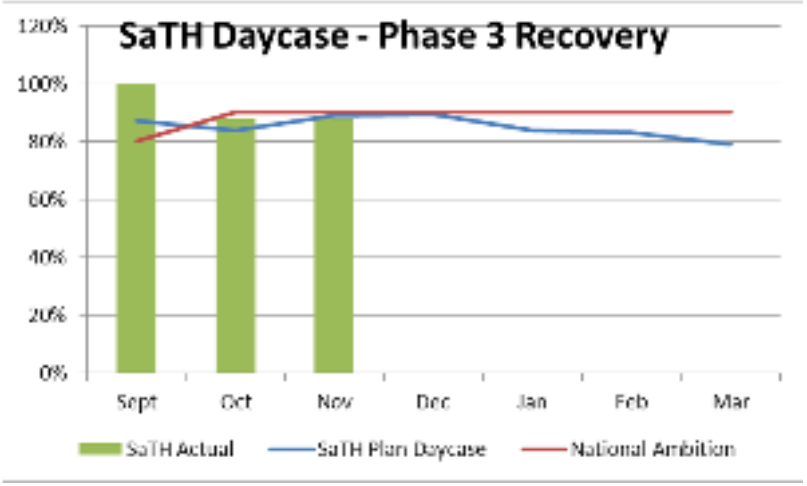
Issues:

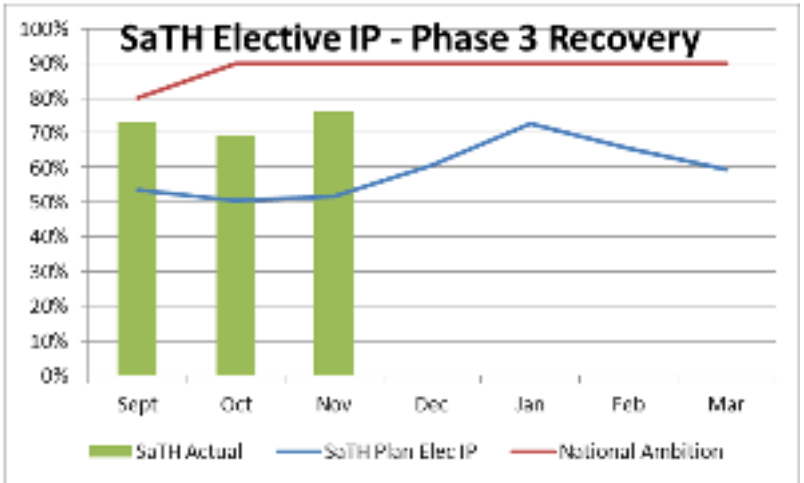
- Insufficient Workforce for extra hours
- Estate
- Patient throughput – IPC limitations
- Co-dependency of imaging capacity core hours and out of hours in outpatients delivery (radiographer shortfall)

Mitigations:

- Utilisation of bank/agency/extra hours
- Space Utilisation – clinical priority/digital enablers
- Pathway co-ordinator – virtual waiting admin
- Progressing with international recruitment to support with additional capacity

SaTH Elective In-patient and Day Case Phase 3 Recovery Plan





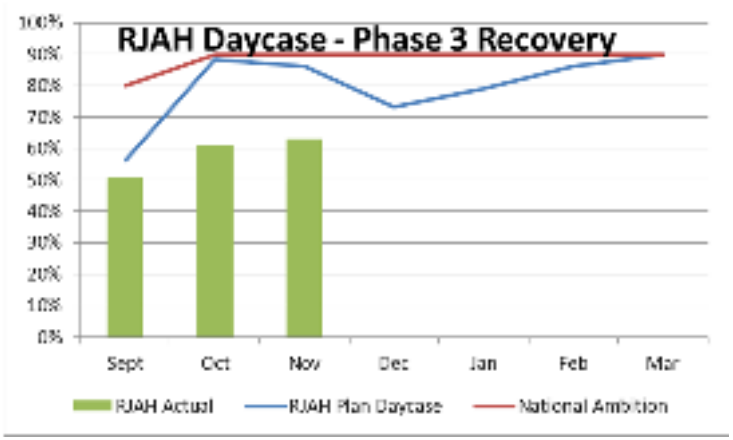
Issues:

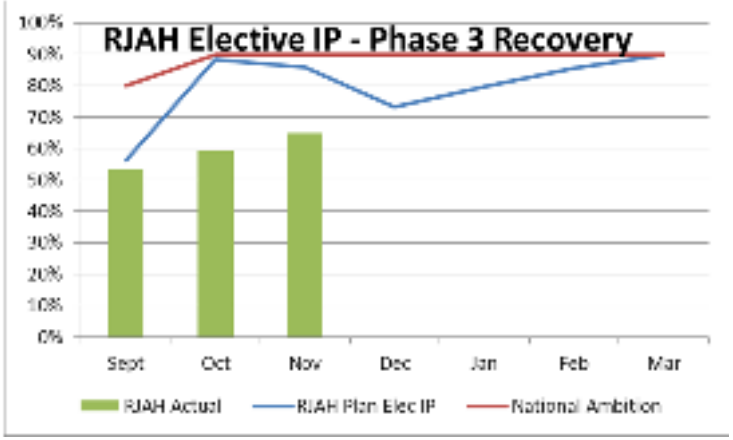
- Lose of flexibility resulting from safe management through cohorting patients
- Maintaining green pathways as USC and Covid-19 demand changes,
- Loss of beds from outbreaks,
- Early activation of winter capacity plan on PRH site resulting in loss of Day Case Unit.
- Mutual Aid in Critical Care Provided to other Trusts
- Use of Theatre Capacity for Critical Care PODs
- Re-deployment of theatre staffing to support Critical Care
- Suspension of Priority3-4 activity to support Critical Care, Covid-19 waves and winter plan
- 60% Loss of elective bed capacity compared to 19/20.

Mitigations:

- Waiting list clinically risk stratified,
- Patients with decision to admit contacted and needs captured (to go ahead or pause treatment)
- Green pathway protected on RSH site with Day Surgery now Elective IP for Priority 2 cancer and urgent surgery cases,
- Vanguard theatre utilised for day case and minor ops,
- Cataract LA surgery off main site,
- Use of Independent sector -10 theatre sessions per week until end of December (plan now being renegotiated to the end of March 2021 - under national contractual terms)
- Using RJAH capacity for some elective orthopaedics
- Development of single MSK waiting list

RJAH Elective Phase 3 Recovery Plan





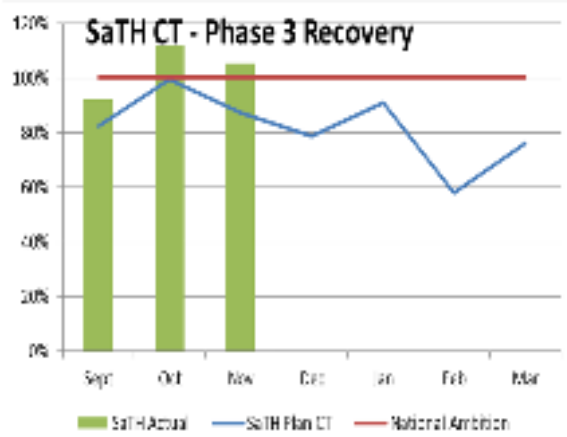
Issues:

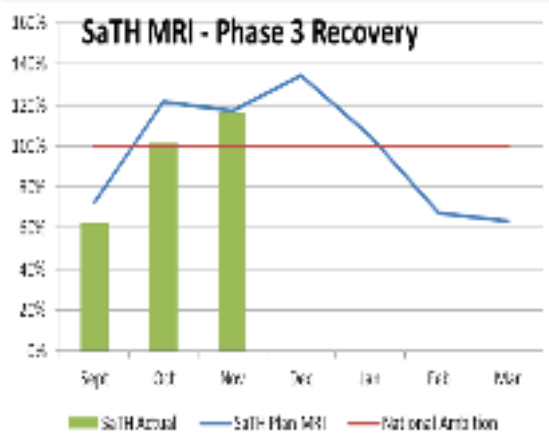
- Insufficient core substantive staff in theatres (scrub/ODP/ Anaesthetists)to deliver plan (23% vacancies)
- Increase in unavailability of staff due to contact tracing/lateral flow testing/outbreaks/mutual aid SATH/vaccination programme
- Inability to flex staffing in theatres above 15%
- Unable to meet planned cases per session
- Patients self isolating for 14 days reduces pool of patients to backfill at short notice (particular risk over Christmas)

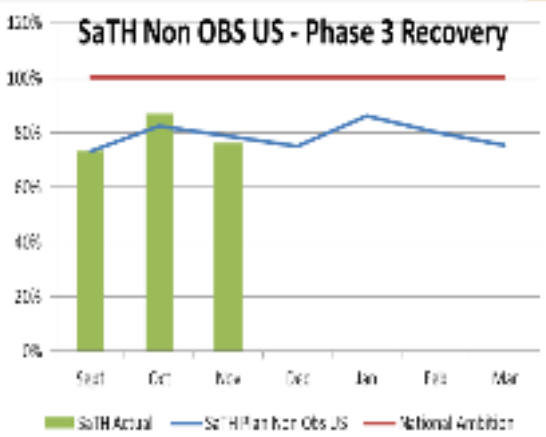
Mitigations:

- Recruitment plan in place/Request mutual aid SATH/Flexible workforce up to 15%/Redesign of workforce
- Sickness action plan in place/Daily comm cell meetings/Reallocation of staff where possible
- Reallocation of staff/Daily comms cell meetings
- Clinical directors reviewing session useage and case mix complexity
- Increasing no of sessions if staffing available
- Pre-op pool of patients (10%)/Planned more day cases around Christmas

SATH Diagnostics – Radiology Phase 3 Recovery Plan







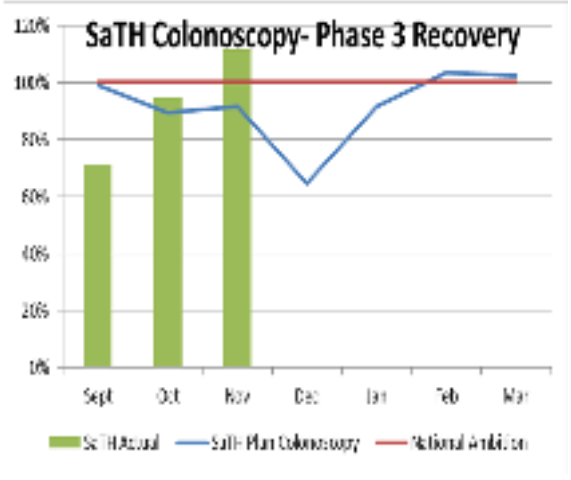
Issues:

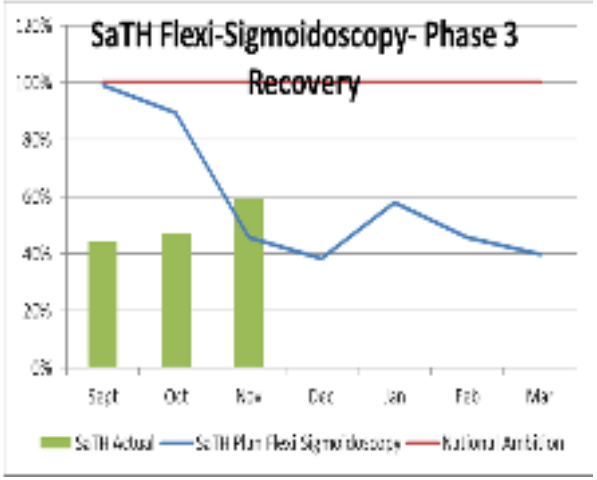
- Social distancing,
- Additional cleaning time,
- IT connectivity in IS for Image Transfer,
- Staffing impact of Covid-19

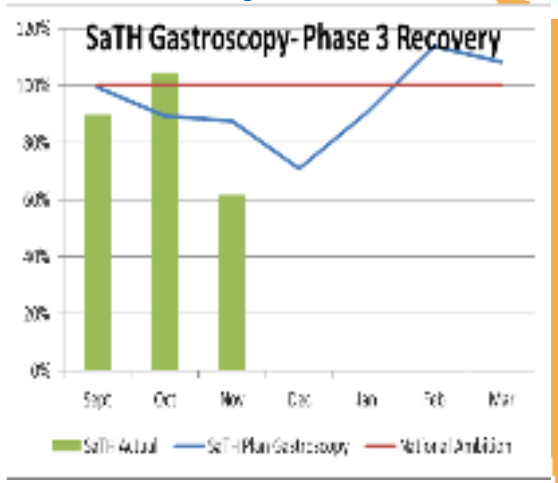
Mitigations:

- 2 additional CT and MRI mobile scanners secured
- Additional non-recurrent sessions in place
- Nuffield MRI and Plain film commenced in December.
- Transfer of 15 CT and MRI tests to RJAH weekly reflected in revised plan
- Pod due for operation in 2021-22- 1 CT and 1 MRI,
- Replacement CT scanner PRH in Q4 2020-21,
- Ultrasound progressing with commissioning of external provider from January to increase capacity
- Opportunity - Business case to extend MRI until end of July approved - CT Business case being progressed to extend until end of Sept 2021 being progressed . This will maintain current level of delivery which would improve present year end forecast

SaTH Diagnostics –Endoscopy Phase 3 Recovery Plan







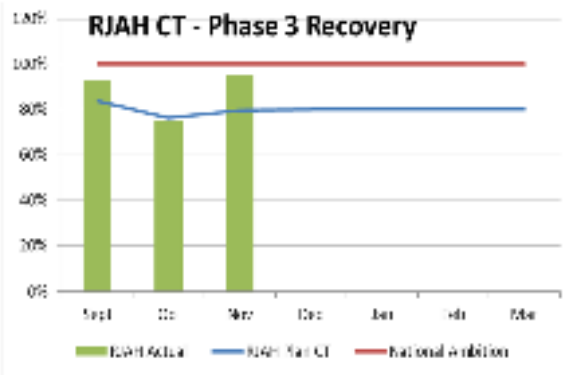
Issues:

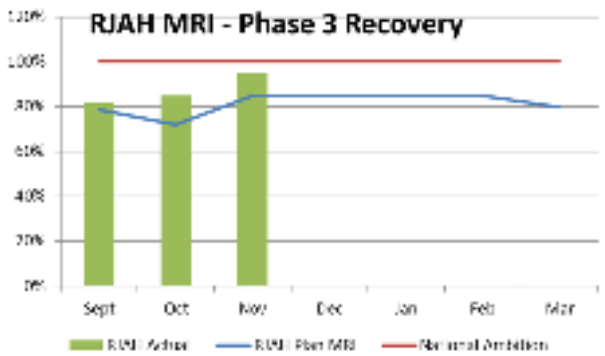
- Interventions planned have not been fully realised or delayed in their implementations
- Bowel Screening has not recovered as priority given to symptomatic patients and Urgent Suspected Cancer patients.
- Social distancing and space for aerosol generating procedures
- Staffing challenges with Gastro-enterologists supporting medical in-patients.
- Staffing challenges to deliver Sunday lists
- Community swabbing capacity required to sustain green pathway
- Trans-nasal endoscopes will be commissioned later than planned
- Patient compliance with self-isolation post swabbing

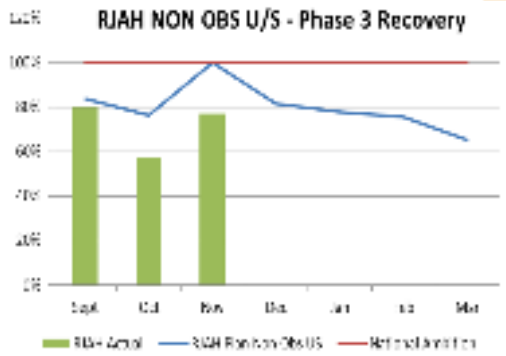
Mitigations:

- Business case approved for trans nasal endoscopes
- Plan re-phased to takes account of time required to procure trans-nasal scopes, staffing issues and swabbing
- Community swabbing increased
- Re-enforced communications re: requirement for patients to self-isolate
- Continuing to seek additional staff
- Flexi sig – national ambition no longer achievable due to changes in national bowel screening – re calculating the new requirement.

RJAH Imaging Phase 3 Recovery Plan







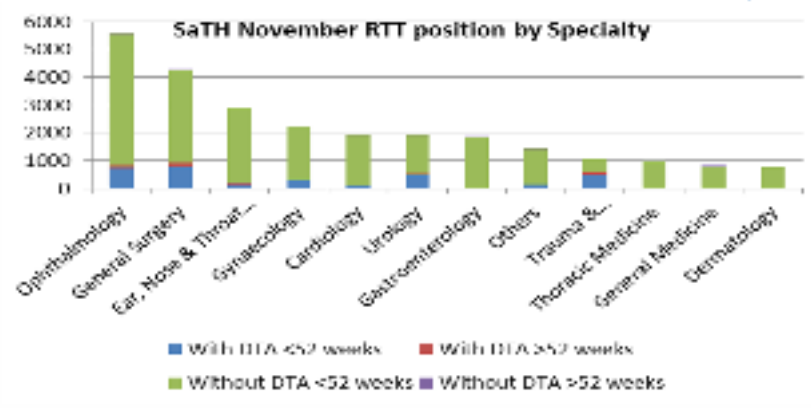
Issues:

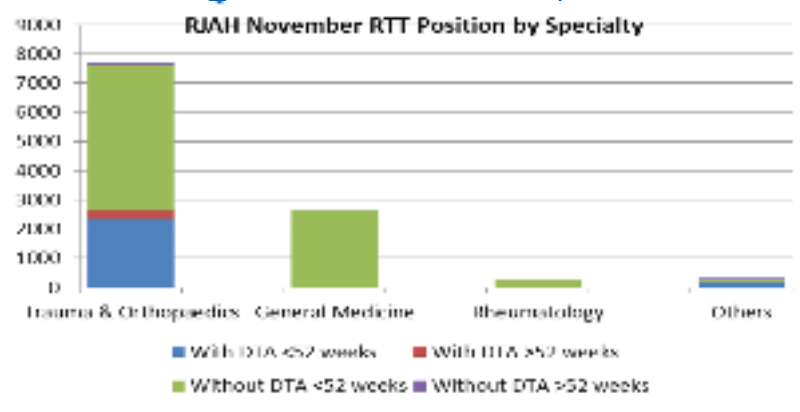
- Workforce – 20% vacancy
- Estate
  - Patient flow: - waiting areas

Mitigations:

- International recruitment – offers made
- Flexing staff out of hours
- Overtime/weekend working
- 2 more U/S rooms made available
  - IPC and flow of patients being reviewed

RTT Position – November (Provider English Waiters)





- Majority of waits concentrated into a smaller number of specialties
- 857 patients waiting longer than 52 weeks at SaTH (296 in Ophthalmology, 199 in General Surgery, 109 in ENT and 99 in T&O): and 540 at RJAH (all but 5 in T&O) at the end of November
- 6 specialties account for most of this waiting who have a decision to admit (Ophthalmology, Gen Surgery, T&O, ENT, Gynaecology, and Cardiology)
- Within these, most patients are waiting for an OP appointment highlighting the need to address OP capacity and throughput
- Patients with a decision to admit are a relatively small percentage (15%) of total waiters
- Patients waiting over 52 weeks are predominantly with a Decision to Admit and concentrated in Ophthalmology, General Surgery and T&O
- Solutions to increasing OP & diagnostics throughput will get patients more quickly to a clear diagnosis and treatment plan but also make a bigger impact on the total numbers waiting.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

NHS Shropshire and NHS Telford & Wrekin CCGs
Joint Strategic Commissioning Committee Part 1 Public

to be held on Wednesday 20th January 2021
at 1.30pm via Teams

AGENDA

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

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
JSCC-21-01.043	Apologies	Ash Ahmed	I	Verbal	1.30
JSCC-21-01.044	Members' Declaration of Interests	All	I	Verbal	1.35
JSCC-21-01.045	Minutes and Action Tracker of Previous Meeting held on Wednesday 16th December 2020	Ash Ahmed	A	Enclosure 1A and 1B	1.40
JSCC-21-01.046	COVID Phase 3 Recovery	Julie Davies	I	Enclosure 2A and 2B	1.45
JSCC-21-01.047	Update from ICS Transformation Programme Boards: • Acute & Specialist • Community & Place Based • Mental Health • Children, Young People & Families	Lisa Cliffe Steve Trenchard	I	Verbal	1.55
JSCC-21-01.048	Any Other Business	Ash Ahmed	I	Verbal	2.25
Date and Time of Next Meeting - Wednesday 17th February 2021 at 1:30pm					