NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

AGENDA

Meeting Title	Governing Body Part 1 Meeting	**Date**	Wednesday 12 January 2022
Chair	Dr John Pepper	**Time**	1pm
Minute Taker	Corporate PA	**Venue/ Location**	Via Microsoft Teams

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

Reference	Agenda Item	Presenter	Purpose	Paper	Time
GB-22-01.001	Introduction and Apologies	John Pepper	I	Verbal	1:00
GB-22-01.002	Members' Declarations of Interests	John Pepper	I	Enclosure	
GB-22-01.003	Minutes from previous meetings: • Shropshire, Telford and Wrekin CCG Governing Body Meeting – 10 November 2021 • Shropshire, Telford and Wrekin CCG Extraordinary Governing Body Meeting – 8 December 2021	John Pepper	A	Enclosure	1:05
GB-22-01.004	Action Tracker and Matters Arising from previous meeting	John Pepper	A	Enclosure	1:15
GB-22-01.005	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
GB-22-01.006	Accountable Officer's Report	Mark Brandreth	I	Verbal	1:35
Assurance Reports					
GB-22-01.007	Quality and Performance Quality and Performance Report	Zena Young / Julie Davies	S	Enclosure	1:45

GB-22-01.008	NHS Patient Safety Strategy Update	Zena Young	A	Enclosure	2:05
GB-22-01.009	Niche Recommendations	Zena Young	S	To Follow	2:15
GB-22-01.010	The Shrewsbury and Telford Hospital NHS Trust CQC Inspection Report – Published 18 November 2021 Full Report can be found at: https://api.cqc.org.uk/public/v1/reports/3b82926d-faae-4237-b326-bb4409d92959?20211223165050	Zena Young	S	Enclosure	2:25
GB-22-01.011	Finance 2021/2022 Month 8 Financial Position	Claire Skidmore	S	Enclosure	2:55
GB-22-01.012	Governance Board Assurance Framework	Alison Smith	S	Enclosure	3:05
GB-22.01.013	Constitution and Governance Handbook Annual Review 2021/22	Alison Smith	A	Enclosure	3:15
BREAK					
Strategic Transformation and other reports					
GB-22-01.014	Integrated Care System Update	Mark Brandreth	S	Verbal	3:35
Decision Making					
There are no items to report					
OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY (Issues or key points to be raised by exception with the Chairs of the Committees or report authors outside of the Governing Body meetings)					
GB-22-01.015	Quality and Performance Committee – 27 October	Meredith Vivian	S	Enclosure	
GB-22-01.016	Audit Committee – 17 November	Geoff Braden	S	Enclosure	
GB-22-01.017	Primary Care Commissioning Committee – 1 December	Donna MacArthur	S	Enclosure	
GB-22-01.018	Strategic Commissioning Committee – 15 December	Audrey Warren	S	Enclosure	3:45
GB-22-01.019	Centralisation of Temporary Inpatient Cardiology Services – Letter of Support	John Pepper	I	Enclosure	

GB-22.01.020	Any Other Business	John Pepper		Verbal	3:50
	Date and Time of Next Meeting – Wednesday 9 March 2022 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

Mr Mark Brandreth
Interim Accountable Officer

Members of NHS Shropshire, Telford and Wrekin CCG Governing Body
Register of Interests - January 2022

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 AIC = Assuring Involvement Committee	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From (ie review date form completed)	To	
Ahmed	Astakhar	Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion **Attendee**	SCC, F&PC, RC, AC					None declared	1.2.21		
Allen	Martin	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
					X		Direct	Undertakes work with the AHSN (Academic Health Science Networks) in the West Midlands supporting respiratory	14.7.21	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member for Governance & Audit - **Attendee**	F&PC, RC, AC, Q&PC				Direct	None declared	20.1.21		

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Brandreth	Mark	Interim Accountable Officer/ICS Executive Lead				X	Indirect	Close friends with Director of Innermost Consulting	2013	ongoing	Level 1 - Note on Register
						X	Indirect	Close friends with Corporate Team at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2012	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Bryceland	Rachael	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
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Medical Staffing in the West Midlands region	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

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Cawley	Lynn	Representative of Healthwatch Shropshire - **Attendee**	Q&PC					None declared	1.2.21		
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, Q&PC					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		
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

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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	Director of Partnerships - **Attendee**	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum			X	Indirect	Daughter worked as student temp in POD - 15/8/21 to 15/9/21	5.10.21	ongoing	Level 1 - Note on Register
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)	8.7.21	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	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Family member provided evidence to Ockenden Review	8.7.21	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.

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Pringle	Adam	Vice Clinical Chair and GP/ Healthcare Professional Governing Body Member	PCCC, TW Membership Forum	X			Direct	GP Partner, Teldoc General Practice	2.2.21	4.8.21	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	Partner at Churchmere Medical Practice	22.3.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Property owner of Lawley Medical Practice site	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - **Attendee**		X			Direct	Director of Public Health for Shropshire	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Interim Medical Director - **Attendee**	PCCC, Q&PC					None declared	19.1.21		
Skidmore	Claire	Executive Director of Finance	F&PC, AC, PCCC					None declared	17.09.21		
Smith	Alison	Director of Corporate Affairs - **Attendee**	AC, AIC, Q&PC			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
Tilley	Samantha	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

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Vivian	Meredith	Deputy Chair and Lay Member for Patient & Public Involvement (PPI)	Q&PC, RC, AC, PCCC, AIC		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
				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&PC					None declared	1.4.21		
Young	Zena	Executive Director of Quality	SCC, F&PC, Q&PC, PCCC					None declared	22.1.21		

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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		
Smith	Fiona	Joint GP/Healthcare Professional Governing Body Member	SCC	X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	20.1.21		Left STWCCG on 31.7.21
				X			Direct	Shawbirch Medical Practice is a Member of Newport/Central PCN	20.1.21		
					X		Indirect	Son-in-Law works as a technician for the Audiology Team at SaTH	17.2.21		

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Trenchard	Steve	Interim Executive Director of Transformation	SCC, PCCC, F&PC					None declared	22.1.21		Left STWCCG on 30.11.21

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

Wednesday 10th November, 2021 at 13:00pm
Via Microsoft Teams

Present from NHS Shropshire, Telford and Wrekin CCG:

Dr John Pepper	**Chair**
Mr Mark Brandreth	**Interim Accountable Officer**
Mr Meredith Vivian	**Deputy Chair and Lay Member for Patient and Public Involvement Governing Body Member**
Mr Ash Ahmed	**Lay Member for Patient and Public Involvement, Equality, Diversity and Inclusion Governing Body Member**
Mrs Donna MacArthur	**Lay member for Primary Care**
Mr Geoff Braden	**Lay member for Governance**
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 Rachel Bryceland	**GP Healthcare Professional Governing Body Member**
Mrs Claire Skidmore	**Executive Director of Finance**
Mr Steve Trenchard	**Interim Executive Director of Transformation**
Mrs Zena Young	**Executive Director of Nursing and Quality**

Attendees:

Dr Stephen James	**Interim Chief Clinical Information Officer**
Miss Alison Smith	**Director of Corporate Affairs**
Mrs Claire Parker	**Director of Partnerships**
Mrs Sam Tilley	**Director of Planning**
Dr Julie Davies	**Director of Performance**
Dr Deborah Shepherd	**Interim Medical Director**
Ms Rachel Robinson	**Director of Public Health Shropshire Council**
Miss Lynn Cawley	**Chief Officer, Healthwatch Shropshire**
Mr Barry Parnaby	**Chair Healthwatch Telford and Wrekin**

Mrs Michelle Campbell	**Personal Assistant – Transcription of minutes (not in attendance)**

Minute No. GB-21-11.077 – Introduction and Apologies

1.1 Dr Pepper welcomed Governing Body members and the public to the NHS Shropshire, Telford and Wrekin CCG Governing Body meeting (taking place over Microsoft Teams) and also being live-streamed via YouTube, a recording of which would also be available on the CCG's website following the meeting.

1.2 Apologies: Mrs Liz Noakes
Dr Martin Allen
Ms Rachel Robinson left the meeting at 14:00pm

Minute No. GB-21-11.078 – Members' Declarations of Interests

2.1 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/

2.2 Dr Pepper requested that all Governing Body members ensure that their conflicts of interest are updated and remain relevant.

2.3 It is noted that Mr Barry Parnaby declared interest for Healthwatch Telford and Wrekin and Dawley Town Council.

2.4 Dr Michael Matthee noted that the declaration of interest should reflect Dr Matthee's presence at the Strategic Commissioning Committee.

2.5 There were no further conflicts of interest declared at the time.

ACTION:

2.4 Dr Michael Matthee noted that the declaration of interest should reflect Dr Matthee's presence at the Strategic Commissioning Committee.

Minute No. GB-21-11.079 – Introductory Comments from the Chair

3.1 These were included during items 1.1.

Minute No. GB-21-11.080 – Accountable Officer's Report

4.1 Mr Mark Brandreth reported on the extreme pressure that the local urgent care system is currently facing with long wait times. In particular, for ambulances across the County and in Accident and Emergency, Hospital and Community Services, Social Care, Primary Care and Mental Health Services. Mr Brandreth conveyed his apologies to patients and residents who are experiencing long wait times for urgent care. Mr Brandreth reported on the work across all system partners, who are making every effort to provide support to patients but may be unable to provide the level of care that they aspire to.

4.2 Mr Brandreth reiterated to members of the importance of protecting others by taking up the offer of a Covid or Flu vaccine and also highlighted the importance of following the hands, face and space rule in indoor settings, where appropriate. Mr Brandreth reported that Covid continues to put pressure on the system with continued high prevalence rates in Telford and Wrekin and in Shropshire. Mr Brandreth reported that Covid patients are occupying beds and wards and there is a particular circulation of the virus amongst school aged children who are then passing it onto Parents and Grandparents. Mr Brandreth expressed his thanks to colleagues in the Primary Health Care team who continue to support the vaccine programme and Shropshire Community Trust who are co-ordinating the programme with assistance from the local authorities.

4.3 Mr Brandreth expressed his thanks to colleagues working in the NHS and in Social Care who are working for long hours in PPE equipment to protect others which is making working conditions additionally challenging for them.

4.4 Mr Brandreth reported on work underway on the Strategic Outline Case (SOC), for the Hospital Transformation Programme (HTP). Mr Brandreth advised that this is the next phase of the documentation process in terms of seeking approval. Mr Brandreth advised that it is very high level and is submitted by Shrewsbury and Telford Hospitals to the region and there will be a national review in December 2021. Mr Brandreth will provide an update in the coming weeks.

4.5 Mr Brandreth went on to mention the annual Shropshire Community Trust General Meeting which he attended and spoke at. Mr Brandreth thanked the Trust for the invitation and reported that it was a very interesting meeting.

4.6 Mr Brandreth extended his thanks to Co-Directors in the CCG who continue to work incredibly hard. Mr Brandreth conveyed that he could not be more impressed with the hard work and support they are providing. In particular, Mr Brandreth expressed his thanks to Mr Steve Trenchard for the hard work during his time in post and wished Mr Trenchard every success in his future career. Mr Brandreth also

congratulated Ms Angie Porter who was awarded the CCG Star of the Month Award for all her hard work and commitment to improving patient experience.

RESOLVED: Governing Body Members of NHS Shropshire, Telford and Wrekin CCG formally NOTED the Interim Accountable Officers verbal update report.

Minute No. GB-21-11.081 – Minutes of the Previous Meetings – Shropshire, Telford and Wrekin CCG Governing Body Meeting – 8 September 2021

5.1 The minutes of the previous NHS Shropshire Telford and Wrekin CCG Governing Body meeting held on the 8 September 2021, were presented and approved as a true and accurate record of the meeting subject to the following amendments:

5.2 Reference to "Mr Stephen James" should read "Dr Stephen James"..

5.3 Reference to "Mrs Lynn Cawley" should read "Miss Lynn Cawley".

5.4 Miss Lynn Cawley asked that item 12.7 in the minutes be updated to reflect the following amendments to the meeting minutes: "Miss Cawley expressed her support for the comments made by Mrs Noakes. Miss Cawley advised that those people who do not have access to technology or are not confident using technology need to be considered and asked if the system could support people to develop the skills needed to use technology and make technology available in the community for those who don't have their own and want to use it, for example in GP practices, hubs. Miss Cawley also noted that many people across the county feel there is currently a resistance by clinicians to see patients face-to-face."

RESOLVED: Governing Body Members of NHS Shropshire, Telford and Wrekin CCG formally RECEIVED and APPROVED the minutes presented with the amendments outlined above as an accurate record of the meeting of NHS Shropshire, Telford and Wrekin CCG held on the 8th September 2021 with the amendments outlined above.

Minute No. GB-21-11-082 – Action Tracker and Matters Arising from previous meetings held on 8th September 2021

6.1 Dr Pepper drew members' attention to the action tracker circulated with the agenda and referred to the matters arising from the last meetings on 8th September 2021. Members noted verbal updates (detail shown below) and accepted recommendations to close (as noted below).

6.2 Dr Pepper expressed his thanks for the updates to the action tracker which is now in an easier format for reviewing.

12th May 2021 - GB-21-05.014 – NHS Shropshire, Telford and Wrekin CCG Quality and Performance Report – Performance Report – Neurology Services

6.2 It was AGREED that the recommendation to close the action be accepted.

12th May 2021 - GB-21-05.015 - Niche Consultancy Report – agree a way forward to address recommendations

6.3 The report update is not yet available. System partners have been reminded to provide the update information in order for this action to progress. The item will be presented at a future meeting.

6.4 Discussions have been held to agree the best way forward to address the recommendations and Mrs Young and Dr Shepherd will take this forward. The item will be presented to the System Quality Group at a future meeting.

6.5 Dr Matthee felt that further time is required for this item and there should be an agreement with the Board. It is agreed that this action will be included in both the Governing Body and System Quality Group action trackers. The Chair suggested that Governing Body members contact Mr Brandreth and Mrs Young to discuss outside of the meeting and then bring back a further update to members.

14th July 2021 - GB-21-07.044 – Quality and Performance Report – prevention of falls

6.6 The Trust is updating their falls prevention action plan and will receive this at their internal Quality Committee (QSAC) in November. It has been agreed that the reporting and oversight undertaken by QPC will move to the new ICS quality governance arrangement by end Q3. With this in mind, the falls update will be scheduled for the December QPC meeting. Remains open until assurance work is presented here.

14th July 2021 - GB-21.07.046 – Governance – Proposed amendments to the Governance Handbook – delegation to the Governing Body Committee structure – development of the ICS

6.7 Ms Smith is actively working on the governance developments for the ICB in preparation for the transition and will flag any amendments required prior to transition and manage this through the governance structure accordingly. It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21-09.055 – Accountable Officer's Report – feedback given by staff on the work of the CCG

6.8 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21-09-059 – Assurance Reports Quality and Performance Exception Report – Data Quality

6.9 An update on the data quality item will be shared at a future meeting of the CCG Board and will be included on the agenda at the appropriate time.

8th September 2021 - GB-21-09-059 – Quality and Performance Exception Report – November

6.10 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21-09-059 – Quality and Performance Exception Report – Winter Plan

6.11 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21-09-059 – Quality and Performance Exception Report – ICS Chair's Report

6.12 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21-09-059 – Quality and Performance Exception Report – ICS Board Papers

6.13 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21.09.060 – 2021/2022 Month 4 Financial Position – 'worst case' position

6.14 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21.09.060 – 2021/2022 Month 4 Financial Position – prescribing costs

6.15 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - Planning & Restoration - GB-21.09.061 – Restoration and Recovery Update Report – circulation of report

6.16 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - Planning & Restoration - GB-21.09.061 – Restoration and Recovery Update Report – outcomes and inequalities

6.17 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - Strategic Transformation and other reports - GB-21-09.062 – Integrated Care System Update – 'events of interest' to board members

6.18 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - Strategic Transformation and other reports - GB-21-09.062 – Integrated Care System Update – Governing Body members - matters of concern

6.19 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21.09.065 – WRES Annual Assessment Submission and Action Plan

6.20 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21.07.047 – Any other business – Document presented to the Audit Committee

6.21 It was AGREED that the recommendation to close the action be accepted.

8th September 2021 - GB-21.07.047 – Any other business – ICS Board Papers

6.22 It was AGREED that the recommendation to close the action be accepted.

Minute No. GB-21-11.083 – Questions from Members of the Public

7.1 Dr Pepper advised that a member of the public has submitted a question which will be published on the CCG's website within 21 days together with the answers to the question.

ASSURANCE REPORTS

Quality and Performance

Minute No. GB-21-11.084 – Quality and Performance Exception Report

8.1 Dr Pepper asked that the Quality and Performance Exception report is taken as read and asked members for any comments or questions.

8.2 Mrs Bryceland asked for clarity on the plans around patient flow at the point of discharge and what interventions that have been put in place, with particular reference to Covid patients.

8.3 In response to the question from Mrs Bryceland on the discharge of patients, Dr Julie Davies responded by advising on the immense amount of work in place on discharge end of the process. Dr Davies commented that the System Integrated Discharge team are working incredibly hard to maintain the flow needed to assist the hospital to maintain the flow of patients through its internal systems. Davies updated on the challenges faced by the system which included processes, staffing and particularly the high level of agency staff within the hospital. Dr Davies advised that when patients are ready to be discharged there is an ongoing pressure on domicile, residential and nursing care. The local authorities are looking at initiatives to try and maximise the care capacity. Dr Davies advised that the virtual ward is an issue and colleagues in the Community Trust are leading on trying to resolve the issue. Dr Davies advised that Dr Martin Allen has also offered his support with a particular emphasis on Covid patients that

require a huge amount of nursing and medical attention. Dr Davies advised that the system is working within the constraints of our care capacity and workforce.

8.4 Mr Brandreth added that there have been significant changes put in place over the last few weeks with processes moving from a 'push model' to a 'pull model'. The Community Services are bringing patients through the system and there is funding in place to support the domicile care work by using health care assistants through the Community Trust.

8.5 Mrs Bryceland raised the issue with the West Midlands Ambulance Service with no exceptions included in the report. Mrs Bryceland raised a question on why this does not feature within the report as an issue. Mrs Bryceland commented that there is a considerable wait time for 999 ambulances which is an issue for the local community.

8.6 In response to Mrs Bryceland's question on 999 ambulance wait times. Mrs Young advised that the report was compiled with data from the serious incidents and quality issues. Mrs Young thought it would be useful to include this in the paper and will consider inclusion of no exceptions reporting for future reports.

8.7 Mrs Young updated on a published set of standards from NHS England, confirming the process as a provider attending to patients at the back of an ambulance waiting to be off loaded. Mrs Young confirmed that assurance has been received from the Trust who has confirmed that this process has been implemented. The CCG are supporting SaTH by carrying out a quality assurance visit to see this at first hand.

8.8 Mrs Warren raised a question on the further two SI's that caused harm included within the report. Mrs Warren commented on the continued work within the maternity service to improve safety and quality. Mrs Warren required assurance that improvement is happening within the maternity service. Mrs Warren also asked for clarity on the SI's and if it is part of an existing theme and trend or a new emerging theme and trend.

8.9. In response to Mrs Warren's question on the SI's, Mrs Young confirmed that the Trust has carried out a 'look back' exercise that started within the maternity service but now includes other serious incidents. Mrs Young updated on the work that started within the CCG but is now picked up by the Trust. Mrs Young advised on the complaints received not just for maternity but for the wider care which prompted the 'look back' exercise. Mrs Young confirmed that it is a minimal number with no anticipation for any further retrospective incidents. Mrs Young confirmed that one of the SI's did fulfil the criteria for referral for the Health & Safety Investigatory Branch due to the fact that the new born required cooling. Mrs Young updated that a baby requiring cooling is highlighted as an automatic flag for an SI requiring further investigation as to cause and effect. Mrs Young also confirmed that there is a very transparent process with the Review and Learning Improvement Group who meet weekly basis with a CCG presence. Mrs Young confirmed that at this meeting they review not only reported incidents but those that are likely to be reported. Mrs Young is happy to take any further questions from Mrs Warren outside of the meeting and will provide more detail within the report.

8.10 Mrs Warren commented that it was a real success story with the appointment of twenty new midwives who are due to join the Trust.

8.11 In response, Mrs Young advised that this will allow the Trust to look to reopen the Midwifery Unit for Intrapartum Care as we have maintained the anti-natal and post Intrapartum Care in each of the MLUs. Mrs Young advised that this will allow the Wrekin MLU to open more consistently.

8.12 Dr Pepper responded to Mrs Young's update on maternity units and asked for clarity on the staffing for the units. Dr Pepper asked that with only one unit opening, will this be an ongoing issue due to under staffing?

8.13 In response, Mrs Young advised that it is very positive that the Trust has managed to attract such numbers of new Midwives. Mrs Young advised that it is achieved due to the commitment to support new

Midwives out of training and the development and support package. Mrs Young expressed confidence in the risk assessment process for the requirement for closure. Mrs Young advised that the CCG has worked very closely with SaTH with both parties having a mutual understanding on the agreed level of risk.

8.14 Dr Pepper asked Mrs Young for any indication that serious incidents have occurred through staffing shortages.

8.15 In response, Mrs Young advised that there is no evidence to indicate that serious incidents have occurred through staffing shortages. Mrs Young updated that the detail within the report refers to staffing red flags and there is a clear assessment for the level of acuity and dependency of mums in labour matched with the staffing assessment. Mrs Young confirmed that immediate measures are put in place where staffing levels are deemed to be unsatisfactory or safe. Mrs Young advised that on particular shifts there is a clear clinical leadership to look at the outcome for mums and babies.

8.16 In response, Mrs MacArthur raised the detail presented at the Quality and Performance Committee and asked if Governing Body members could have more assurance statements around some of the particular issues to be included in the report. Mrs MacArthur went onto request that more time be allocated to this item on the agenda in the future because it is so critical.

8.18 Mrs MacArthur highlighted for more clarity the low referral for potential lung cancer linking this to no access to walk in x-rays and requested further details.

8.19 In response, Dr Davies expressed to members in attendance for patients to please visit a GP if they are showing any kind of lung or upper gastro intestinal symptoms. Dr Davies advised that there are still low levels of demand and it is not possible to link this to the walk in x-ray access. Dr Davies advised that this is still being managed from an infection prevention and control perspective. Dr Davies advised that the planned care recovery is with the clinical leads and this is escalated through to the system clinical leads. Dr Davies updated that all provider colleagues are reporting as an interpretation of the new infection control guidance issued last week with feedback to follow. Dr Davies updated that it was right for Mrs McArthur to raise concern. Dr Davies reiterated to members and patients to please come forward and visit a GP should you show any signs or symptoms.

8.20 In response, Mr Barry Parnaby updated on a recent meeting with the Red Cross organisation in Shropshire who are ready to assist and raised if we consider using the Red Cross Service.

8.21 In response, Dr Davies confirmed that we do use the services of the Red Cross with a contract already in place. Dr Davies advised on a further paper with the Strategic Commissioning Committee for additional funding.

8.22 Mr Meredith Vivian raised the matter of flow in response to Mrs Bryceland's comments. Mr Vivian raised the Winter Plan and asked for clarity on how this has supported the arrangements that are currently in place to cope with the tremendous pressure through the system.

8.23 Mr Vivian also raised the matter of the Government's decision to make vaccines mandatory. Mr Vivian asked what impact this could have on the capacity and will this cause a capacity problem stopping us from 'pulling' or 'push'.

8.24 In response to Mr Vivian's question on Covid capacity. Mr Brandreth advised that with a lot of hard work the uptake of Covid vaccines from staff has been very high. Mr Brandreth updated that there are a very limited number of people who are exempt due to other clinical conditions or circumstances. Mr Brandreth updated that there are a small number of care staff who have looked to move from care settings into the NHS who require a vaccine. Mr Brandreth advised that there is an opportunity over the winter to have a set of questions with targeted group of staff about the benefits of the vaccine.

8.25 In response to Mr Meredith's question on the Winter Plan, Mrs Sam Tilley responded. Mrs Tilley advised that the plan is iterative and is hugely comprehensive and covers the entire basis. Mrs Tilley highlighted that this year we have endeavoured to carry out the planning much earlier and have involved the whole system making it a system plan. Mrs Tilley advised that all partner perspectives have been considered in terms of the challenges we will face. Mrs Tilley highlighted that it is important to note that we are starting

from an entirely different position this winter and it will be more difficult to determine the level of impact. In particular, the Covid position as the modelling had to be refined several times and did not predict the recent spike. Mrs Tilley advised that we have reacted and adjusted services to accommodate those issues and remodel.

8.26 Dr Matthee raised the matter of IT and things that could be used to simplify and assist such as electronically prescribing as previously mentioned. Dr Matthee asked if this is a consideration.

8.27 In response, Dr Davies advised that it is noted and we are aware of the benefits but this must be timed in terms of pressures and priorities.

8.28 In response, to Mr Vivian's question on the winter plan, Dr Davies updated members that we are doing all we can to support SaTH to maintain the highest urgent surgical priorities in cancer treatment. Dr Davies advised from a CCG perspective and system wide we are maximising the use of the independent sector with full support from NHSEI to help to target our long waits. Dr Davies advised that we are trying to free up local capacity to focus on our clinically urgent cancer patients. Dr Davies confirmed that that we are utilising the independent sector in the area and on periphery of the County and seeking mutual aid further afield. Dr Davies provided members with the assurance that we are doing everything we can to maintain as much as we can of the elective recovery. Dr Davies advised that the focus is on the patients that need it the most even during these challenging times.

8.29 Mrs Young wanted to update members on the most recent CQC inspection of SaTH published in the coming weeks. The report covers the four areas of inspection around maternity, urgent and emergency care, medical specialities wards and end of life care. Mrs Young advised that a communication will follow in the coming weeks around the publication date.

8.30 Dr Pepper thanked everyone for their input and the comprehensive discussion.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED receipt of the content of the Quality and Performance Exception report to note contents of report and actions being taken to address the issues identified for assurance and information.

ACTION:

8.5 Mrs Young to consider including the data for no exceptions when compiling the report. In particular, the issue with long wait times for 999 ambulances with the West Midlands Ambulance Service.

8.9 If required, Mrs Young to have an informal discussion with Mrs Warren on the details contained within the report on the improvements within the maternity service. In particular, the SI's and emerging themes and trends. Mrs Young to include further details in the next report.

8.16 Mrs MacArthur would like assurance statements to be included for particular issues within the report to provide more detailed information to GB members when reviewing the report. Mrs Young to update details within the report.

8.17 Mrs MacArthur also requested more time be allocated on the agenda to provide a more detailed update. Dr Pepper to consider when agenda stetting.

Finance

Minute No. GB-21.11.085 – 2021/2022 Month 6 Financial Position

9.1 Dr Pepper asked members for any questions they would like to address from the paper.

9.2 Dr Adam Pringle asked Mrs Skidmore for clarity on the position as it reads and wondered whether there is much increased uncertainty in the future. Dr Pringle asked whether there are unknown things that might have an impact on the financial improvement over time.

9.3 In response, Mrs Skidmore advised that the reality is that the report does mask the fact that it is really challenging in terms of the positon, in particular the underlying recurrent position. Mrs Skidmore advised that we are working hard to deliver the savings that we need to make. As we get into more of our conversations through Finance Committee and Board about next year and beyond the more challenged conversations will be held. Mrs Skidmore advised that this year we have a huge challenge ahead to land the H2 plan and deliver what we set out to deliver. Mrs Skidmore updated that equally we have to balance our energy in looking forward to our future because of the long road ahead in terms of our financial recovery.

9.4 In response, Dr Pepper raised the demand on acute delivery and asked for clarity on whether there is a potential impact on the elective recovery and future finances through the potential delay in the elective recovery.

9.5 In response, Mrs Skidmore advised that the potential risk is the ability to deliver the activity. Mrs Skidmore advised on the discussions in place with NHS England on the finances for this. There is an avenue for this to be funded which will not impact our financial position bottom line. Mrs Skidmore advised that the focus is on where we can secure the activity by trying to be creative such as using the independent sector and out of area providers.

9.6 In response, Dr Pepper raised if this should be a financial item that sits on the BAF.

9.7 In response, Mrs Skidmore advised that the BAF covers finance in its entirety and in the context of the underlying position and the recovery programme; I would expect us to have separate items on around the actual recovery itself.

9.8 With reference to Dr Pringle's question, Mr Geoff Braden reiterated assurance to the board to confirm that we are doing all we can to mitigate further risks and are focused on the key areas. Mr Braden drew members attention to point 30 to highlighted that there is no capacity in the plan. Mr Braden advised that we are moving historically to a busy time of year with emerging risks coming through. Mr Braden highlighted that there is an immense amount of work required to mitigate the risks. Mr Braden felt less optimistic and advised that there is still a way to go for this year before we move into next year.

9.9 Mrs MacArthur responded to Mr Braden's update in terms of the capacity in the plan and the significant cost pressures. Mrs MacArthur highlighted WMAS and the pressures to the system. Mrs MacArthur responded by asking if it is the worst case position. Mrs MacArthur also asked for clarity on whether the unquantified cost pressure around Phlebotomy was included or was an emerging risk.

9.10 In response Mrs Skidmore confirmed that Phlebotomy is an emerging risk and will appear in future reports. Mrs Skidmore advised on work underway by the Finance Team is looking at how we offset and mitigate costs.

9.11 In response to Mrs MacArthur's question on WMAS, Mrs Skidmore advised that there is no expectation for additional costs to manifest in year. Mrs Skidmore advised that we are presented with a range of costs and are modelling the costs in the mid-point of the range. Mrs Skidmore advised that this is working on the basis that we need to do more work on testing the activity levels to ensure they are sustainable. Mrs Skidmore advised that we are looking at ways to do things more efficiently and differently and are challenging ourselves and the ambulance trust to look at areas for improvement.
Mrs Skidmore advised that the future outlook is based on the assumption that for next year there will still be a level of non recurrent support for ambulance services. Mrs Skidmore advised that until we move into the planning guidance in December it is uncertain what that might be.

9.12 Dr Pepper offered Mrs Skidmore the opportunity to highlight any particular areas from the report.

9.13 In response, Mrs Skidmore acknowledged from the paper that in H1 we are ahead of the plan on our efficiency programme and are not delivering as much as we need to. Mrs Skidmore wanted to acknowledge the effort from the team in particular CHC and prescribing who in spite of difficult circumstances have delivered a good programme for the first half of the year.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED the information contained in this report and the continued need to focus effort on the delivery of the 3% recurrent efficiency target in order to meet the requirements of the sustainability plan.

To note:

10.1 At 14:10pm Dr Pepper called for a 10 minute comfort break. Dr Pepper advised that the meeting would continue to be live streamed and recorded and that the meeting would reconvene at 14:20pm.

Minute No. GB-21-11.086 – Board Assurance Framework

11.1 Dr Pepper advised that due to technical difficulties with the PDF software a page is missing from the BAF report. Dr Pepper advised that this page will be published and uploaded to the website to be available for information.

11.2 Dr Pepper asked members for any specific questions they would like to address from the BAF report.

11.3 In response, Mr Braden commented that Miss Smith had attended the Audit Committee and highlighted the strategic challenges of the CCG BAF and the mitigation that the Execs are taking against it. Mr Braden advised that we will be working with the ICS in the coming months to try and align and bring the two BAFS together. Mr Branden advised that the CCG BAF is being used as the model for the example to continue the work on the ICS BAF.

11.4 In response, Mrs Warren commented that the BAF is a tremendously comprehensive document. Mrs Warren drew members attention to Safeguarding contained in the report and asked if further details could be provided.

11.5 In response, Mrs Young advised that this is a new emerging risk since lockdown and the activity around safeguarding concerns has escalated significantly. Mrs Young advised that the amount of attention for looked after children has increased. Mrs Young advised that the risk was initially assessed as an extreme level of risk of 20 which is very high. Mrs Young updated on the gaps in controls around the volumes of rapid reviews attending to the safe guarding governance in both local authorities and the number of sub groups has increased significantly. Mrs Young advised that the amount of meetings that the safe guarding team need to attend has increased. There is a high number of out of area children that are looked after placed in our county. Mrs Young advised that we are the second highest in the country and this creates a lot of work for our looked after children's team. Mrs Young updated on the national shortage of NHSEI commissioned tier 4 beds. Mrs Young advised that we are holding a lot of risk in our system for children that would require a different level of care if those facilities were available. Mrs Young advised that one thing we are looking at overseeing is the health assessments that other systems should be doing on the children placed in Staffordshire who are not receiving the health assessments that they should be in a timely way. The additional resource has enabled the gaps in the assurance and this has resolved the issue. The risk will be mitigated at the next iteration and will move to a 16 with a further review.

11.6 Mrs Claire Parker raised the issue around children and young people's mental health and advised on the need to highlight further details within the BAF on some of the issues with section 31 and complex children with more detail to be included in next iteration of the document

11.7 In response, Dr Matthee advised that it is not just the issue with safeguarding children there is also the issue on the rise of domestic violence and abuse that is happening across the age groups and it is not just children but this should also be included as a further iteration to the document.

11.8 Dr Pepper asked members for any further questions or comments.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED the information contained in this report The Governing Body ACCEPTED assurance from the CCG Audit Committee that the principle risks of the CCG not achieving its strategic and operational priorities have been accurately identified and actions taken to manage them.

ACTION:

11.1 Miss Smith to publish and upload the missing page from the BAF report.

11.5 Mrs Young highlighted the new emerging risks since lockdown and safeguarding concerns for looked after children. Mrs Young to include in a new iteration of the BAF

11.6 Mrs Claire Parker raised the issue around children and young people's mental health and highlighted that she would include further details in the BAF on some of the issues with section 31 and complex children.

Strategic Transformation and other reports

Minute No. GB-21-11.087 – Integrated Care System Update

12.1 Mr Mark Brandreth provided members with a verbal update on the development of the Integrated Care System (ICS).

12.2 Mr Brandreth reported to members on the first ICS Annual General Meeting on the 14th October. Mr Brandreth advised that the meeting is not a statutory AGM due to the fact that we are not yet an ICS and do not have published accounts. Mr Brandreth updated that around 125 people attended virtually to receive an update on the progress of the ICS, in particular against the 10 pledges. Mr Brandreth advised that a short film on the ICS's progress on the 10 pledges was presented during the meeting and this would be shared via a link with members.

12.3 Mr Brandreth reported to members on the work around the Big 6 ticket items which is fundamentally the delivery of the ICS strategy. Mr Brandreth advised on a piece of work that puts this in context around the development and updated on a new Delivery Board to be chaired by Mr Brandreth. The Delivery Board will meet monthly to ensure that the Operation Boards and the delivery of the big 6 ticket items are aligned.

12.4 Mr Brandreth updated members on a recent meeting with Pharmacy leads and the importance of Pharmacy for the future ICS. Mr Brandreth advised that there are regular meetings with several professional groups to enable a more coherent way to work together in the coming months.

12.5 Mr Brandreth updated members on a 'Readiness to Operate Meeting' with colleagues from NHSE and the requirement for a form of checklist of the requirements as we move to transition. Mr Brandreth updated that the due diligence process for ICS transition had now started and was building on the recent experience of undertaking due diligence for the recent merger of the two CCGS.

12.6 Mr Brandreth updated members on his recent decision to not apply for the Chief Executive of the ICB role and advised that he will oversee the transition for the CCG through to the end of March. Sir Neil McKay is working hard to appoint a new Chief Executive and will be in a position in the coming weeks to advertise for this post following national approval. Mr Brandreth advised that he will continue to work hard with the CCG staff to support the transition and will keep staff dialogue open.

12.7 Mr Brandreth highlighted to members that the System Development Plan is due to be submitted shortly to NHS England/Improvement.

12.8 Dr Pepper thanked Mr Brandreth for his continued work.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED the content of the verbal ICS Update Report

ACTION:

12.2 Miss Smith to circulate the link to the ICS 10 pledges video shown at the recent ICS AGM held in October.

Decision Making

Minute No. GB-21.11.088 – WRES Annual Assessment Submission

13.1 Dr Pepper reported that this paper was previously postponed due to it containing erroneous data. The report is presented correctly today and Dr Pepper opened up to members for questions and discussions.

13.2 Dr Pepper noted that within the second part of recommendation many of the actions will overlap to when the CCG will no longer exist. Dr Pepper commented that will mean that there is not a full year to complete and questioned what will happen to those actions and how will this be communicated and reflected in the handover to the ICS.

13.3 In response, Miss Smith advised that Ms Victoria Rankin who is the Executive Lead for People for the ICS is collating WRES data from across all of the partners in the ICS, including the CCG's. Miss Smith confirmed that we are submitting through to Ms Rankin so that a comprehensive view of the data submitted for each organisation can be compiled. Miss Smith advised that based on her own assumption that the statutory requirement to report against the WRES standard will transfer to the ICB, the collation of the data across the system including the CCG information will ensure that the ICB has access to this information.

13.4 Dr Pepper asked Miss Smith to highlight any particular items from the report.

13.5 In response, Miss Smith highlighted the lack of diversity comparable from the Board to our staffing groups. Miss Smith advised that there is a push nationally on the recruitment process for the new ICB members which includes a very strong emphasis on the need to have a diverse collection of people on the Board and that this was welcomed.

13.6 Mr Brandreth added that both he and Sir Neil McKay, the ICB Chair Designate, were committed to recruiting a diverse set of ICB Board members and that this remains at the top of the priority list.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED the WRES data that was submitted on behalf of the NHS Shropshire CCG and NHS Telford and Wrekin CCG separately as the data was drawn on the 31st March 2021 when two CCGS are still in existence.

OTHER / COMMITTEE REPORTS FOR INFORMATION ONLY

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

Minute No. GB-21-11.089 Finance Committee – 22 September, 2021

Minute No. GB-21-11.090 Quality and Performance Committee – 25 August, 2021 and 29 September, 2021

Minute No. GB-21-11.091 Summary of CCG Locality Forum Meetings held on the following dates:

Shrewsbury and Atcham – 16 September
North Shropshire – 23 September
South Shropshire – 2 September
Telford and Wrekin – 21 September and 19 October

Minute No. GB-21-11.092 Audit Committee – 15 September, 2021

Minute No. GB-21-11.093 Primary Care Commissioning Committee – 6 October, 2021

Minute No. GB-21-11.094 Strategic Commissioning Committee – 18 August, 2021 and 15 September 2021

Minute No. GB-21-11.095 Assuring Involvement Committee – 23 September, 2021

Minute No. GB-21-11.096 Winter Plan 2021/22

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

Minute No. GB-21-11.097 – Any Other Business

15.1 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 12 January 2022 – time, venue and modality of the meeting to be confirmed nearer the time.

***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 Pepper officially closed the meeting at 14:39pm.

SIGNED …….. DATE ……

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Submitted Questions by Members of the Public for the Governing Body meeting on 10 November 2021

Name Date & Time	Submitted Questions	CCG Summary Response
Gill George	**1. End of Life Care / Palliative Care** Anecdotal evidence suggests variable standards of symptom management in end of life care, including variable practice by GPs (necessarily 'key players' in domiciliary care and community hospital care, and to their own patients and through Shropdoc). Do GPs in Shropshire follow standard guidelines around prescription for symptom management, or is this considered by commissioners to be solely a matter for individual clinical judgement? If guidelines are followed, are these the West Midlands Palliative Care Guidelines or the set of 'Symptom Control' guidance sheets agreed by the two predecessor CCGs and Severn Hospice? Does any systematic audit take place of GP practice around prescription for symptom management? Has the CCG considered encouragement to GPs to adhere to standard guidance, to reduce the variability of end of life symptom management? I am aware of course that the current End of Life System Review will solve every conceivable problem with every aspect of end of life care and I don't need to be told this. My interest is in what happens now, and what standards of prescription for symptom management have applied since April 2020/21.	STW have standard guidelines for the management of the most common end of life care symptoms, these guidelines are reviewed and updated as necessary by the CCG Medicines Management Senior Pharmaceutical Advisor and information and guidance updates are provided to GP Practices. The Symptom Control sheets, which form part of this guidance, are based on the original symptom control sheets agreed by the two previous CCGs and the Severn Hospice. They have been updated in line with further advice from the Severn Hospice and the nationally recognised guidance on the Palliative Care Adult Network Guidelines Plus website https://book.pallcare.info/. These are available on the CCG and Severn Hospice websites, alongside a number of other resources related to the care of a person at the end of life. Clinical judgement will be expected in every aspect of end of life care as it is recognised that standard guidelines will not always be

Name Date & Time	Submitted Questions	CCG Summary Response
		appropriate. GPs have access to a 24/7 Specialist Palliative Care advice and guidance. GP prescribing data is made available to the CCG and is routinely analysed and any anomalies investigated. There is no systematic audit of the prescribing of drugs for the management of symptoms at the end of life, however, Just in Case (JIC) Medication packs containing the most common drugs used to manage symptoms at the end of life can be prescribed in anticipation of these symptoms occurring, in order to enable administration without unnecessary delays. The prescriptions and documentation used for the provision of JIC packs are embedded into the GP clinical system. The CCG has no evidence that GPs are routinely or regularly prescribing outside of the guidelines mentioned, however, if the questioner has evidence to the contrary the CCG would be happy to investigate this further. ***Dr Julie Davies, Director of Performance***

Gill George	**2. Community Hospitals** What is the current system vision and/or CCG vision for community hospitals and for ensuring equitable access to care for Shropshire's rural communities?	The system is planning a county wide review of all its community beds in 22/23 by the ICS and the Community Trust. It will look at the need geographically as well as current provision to ensure we have the type and volume of capacity our local populations need. Equity of access is also important for other services delivered at community hospitals and they will also form part of the wider 'Local Care' programme led by the Community Trust with full wider system support over the coming period. This will incorporate our emerging place based strategies which look to match capacity to population need to reduce our wider health inequalities. This will also need to take into account our responsibility to ensure safe, high quality, sustainable service delivery. The local communities will be involved both in the reviews and in the proposed future provision to ensure we obtain the best outcomes for our population. ***Dr Julie Davies, Director of Performance***

Gill George	**3. Public Involvement** Also, are all Governing Body members clear about the CCG's duties with regard to public involvement (Section 14Z2 of the NHS Act 2006, as amended).	Yes the Governing Body is clear about its statutory duty to involve. At the May 2021 meeting the Governing Body received a briefing report on the new Assuring Involvement Committee (AIC) that has been created to assist the Governing Body to ensure that it is meeting this duty. At the same meeting the CCG Governing Body adopted its Communications and Engagement Strategy, which outlines how the CCG will meet its duty in more detail. The AIC Chair reports to the Governing Body after each AIC meeting. ***Miss Alison Smith, Director of Corporate Affairs***

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

Wednesday 8th December, 2021 at 1pm
Via Microsoft Teams

Present from NHS Shropshire, Telford and Wrekin CCG:

Dr John Pepper	**Chair**
Mr Mark Brandreth	**Interim Accountable Officer**
Mr Meredith Vivian	**Deputy Chair and Lay Member for Patient and Public Involvement Governing Body Member**
Mr Ash Ahmed	**Lay Member for Patient and Public Involvement, Equality, Diversity and Inclusion Governing Body Member**
Mrs Donna MacArthur	**Lay member for Primary Care**
Mr Geoff Braden	**Lay member for Governance**
Dr Martin Allen	**Secondary Care Doctor**
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**
Mrs Claire Skidmore	**Executive Director of Finance**
Mrs Zena Young	**Executive Director of Nursing and Quality –**

Attendees:

Dr Stephen James	**Interim Chief Clinical Information Officer**
Miss Alison Smith	**Director of Corporate Affairs**
Ms Claire Parker	**Director of Partnerships**
Mrs Sam Tilley	**Director of Planning**
Dr Julie Davies	**Director of Performance**
Mr Nigel Lee	**Chief Operating Officer, SaTH**
Dr Jayesh Makan	**Cardiology Consultant, SaTH**
Mrs Julia Clarke	**Director of Public Participation, SaTH**
Ms Debbie Houliston	**Cardiology Centre Manager, SaTH**
Mr Barrie Reis-Seymour	**Head of Transformation and System Commissioning – Elective Care**
Mrs Liz Noakes	**Director of Public Health Telford and Wrekin Council**
Miss Lynn Cawley	**Chief Officer, Healthwatch Shropshire**
Mr Barry Parnaby	**Chair, Healthwatch Telford and Wrekin**
Mrs Karen Ball	**Personal Assistant – Transcription of minutes (in attendance)**

1.1 Dr Pepper welcomed Governing Body members and representatives from the Shrewsbury and Telford Hospital NHS Trust (SaTH) to the NHS Shropshire, Telford and Wrekin CCG Governing Body meeting (taking place over Microsoft Teams). A recording of which would also be available on the CCG's website following the meeting.

Minute No. GB-21-12.098 – Introduction and Apologies

2.1 Apologies: Dr Deborah Shepherd.

Minute No. GB-21-12.099 – 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/

3.2 Members were asked to confirm any additional conflicts of interest that they had relating to the agenda items.

3.3 Dr Pringle had informed Dr Pepper prior to the meeting that he is a partner at Churchmere Medical Group. There were no further declarations of interests declared.

Minute No. GB-21-12.100- Introductory Comments from the Chair

4.1 These were included during items 1.1.

Minute No. GB-21-12.101 – Proposed Changes to Inpatient SaTH Cardiology Services

5.1 Dr Pepper welcomed from Shrewsbury and Telford Hospital Trust; Mr Lee, Dr Makan, Mrs Clarke and Ms Houliston to the meeting.

5.2 Dr Makan shared a presentation with members on the proposed changes and it was noted that the presentation pack had been shared with the Governing Body members prior to the meeting taking place.

5.3 Currently cardiology services are provided at both the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH). At the RSH there are 20 beds including 8 Acute Coronary Care (ACCU) beds and at the PRH there are 25 beds including 5 ACCU beds.

5.4 Reasons to move the service to one site included workforce challenges at both sites; struggling to staff both wards adequately with nurses and to recruit cardiology consultants and trained cardiac nurses.

5.5 As a temporary measure, the proposal is to move all cardiology inpatient services to the PRH and once the Hospital Transformation Programme (HTP) progresses the service would relocated to a new facility at the RSH.

5.6 Following Dr Makan's presentation Dr Pepper opened the meeting to discussion and questions.

5.7 Dr Allen noted that the proposal was very ambitious and welcomed it. Dr Allen was however, concerned that if a patient arrived at the RSH with profound bradycardia how would they be transferred to the PRH for prompt pacing and was it something that was already well established in relation to the transportation of patients via West Midlands Ambulance Service (WMAS). Dr Makan responded that currently patients are stabilised with medication and transferred to the PRH, either for temporary wire or permanent pacing. Dr Makan went on to say that they are speaking to A&E to confirm if patients are sent directly to the PRH. A Bradycardia Pathway, a Complex Arrhythmia Pathway and a Chest Pain Pathway would be

put in place. Dr Makan recognised that there would still be walk-in patients, however this is rare.

5.8 Mr Lee went on to reinforce what Dr Makan had said and added that due to the service configuration of both sites there are already a number of specialist service pathways in place.

5.9 Dr Allen made a further point around the level of assurance relating to the cover at RSH for postoperative patients who may develop tachycardia or go into rapid atrial fibrillation and who would benefit from cardiac input and asked if there would be cover for these patients. Dr Makan responded that the new rota would include a cardiologist on site one session, Monday to Friday, who would see any referrals. Currently, due to staffing issues, one ward round takes place on Saturdays at the RSH and one ward round at the PRH on Sundays.

5.10 Dr Allen said that he fully supported the proposal and it was a sensible way forward.

5.11 Dr Pepper asked if some of the pathways that Dr Makan had mentioned still needed to be fully developed with WMAS and in terms of the pathways for patients self-presenting to A&E at the RSH how are these pathways in development. Dr Makan said that they are currently in process. A meeting is taking place shortly with physicians, which would be a question and answer session.

5.12 Dr Pepper went on to ask how sure they were that the increased efficiencies would cover the reduced cardiology bed base. Mr Makan responded that currently a patient; who required a pacemaker may start their journey at the RSH, seen in A&E and wait in AMU and are then transferred to the cardiology ward. They then have a wait to be transferred to the PRH, which can take a few days. If the patient goes straight to PRH they can generally be slotted in the next day to have their pacemaker fitted and go home the same day.

5.13 Mrs MacArthur asked if WMAS were content with the proposal and also asked if the current workforce were happy with the proposed move. Dr Makan answered that with regards to the consultant workforce there was overwhelming support as they wanted to have the expertise in one place. In relation to the nursing staff there were some nurses at the unit at the RSH who do not drive or have childcare issues. Ms Houliston commented that the nursing staff were very keen to move and were looking forward to the service being on one site. Mr Lee said in relation to those who have specific issues with travelling to the PRH there would be an opportunity for them to continue working at the RSH and their needs would be accommodated.

5.14 WMAS have indicated that they are very open to discussion and supported the changes. SaTH are also in dialogue with the Welsh Ambulance Services NHS Trust.

5.15 The 7 beds that would no longer be required would be transferred to the medical teams.

5.16 Dr Matthee asked if patients, with chest pain, would have direct access to the service and therefore would not have to be admitted via A&E. Dr Makan responded that they do not have the workforce to deal with direct admissions to the ward; however this was something they would work on for the future.

5.17 Mr Vivian said that it appeared that the Trust had engaged with the general patient population but not specifically cardiology patients and asked what the analysis from PALS and complaints showed from those who had used the services. Mrs Clarke responded that they had involved

cardiology and patient groups and engagement on this had also taken place in 2020. The overwhelming comment was around the delays, particularly relating to the RSH and delays in being transferred to the PRH. It had also been highlighted that it was not common to have a split site service.

5.18 Miss Cawley asked what were the next steps in relation to engaging with the public? Miss Cawley went on to say that the public would assume that the service at both sites was the same and it was important that patients were made aware that if they attended the RSH they would need to be transferred to the PRH.

5.19 Mr Lee said that the plan was to have the changes implemented from the middle of February 2022, which allowed time to continue the dialogue with both WMAS and the Welsh Ambulance Services NHS Trust. Mr Lee recognised that both Healthwatch's were a good source of advice and communication would continue with them and other groups.

5.20 Ms Clarke said that the main theme that had come through is the understanding that this is a temporary moved until HTP is in place.

5.21 Mr Lee reported that there would be an initial review of the service at 6 months. In relation to the timescales they were looking at the timescale for HTP and would expect a more significant review at either a year or two year point.

5.22 Mr Brandreth suggested that a clinical review should take place at 6 months. A second process review should take place at 18 months to 2 years.

5.23 Mrs Young said that there needed to be a clear mechanism for any issues that may affect one partner or another or may have wider system effects. There is work underway in the system to refine the documents used for Quality Impact Assessments and Equality Impact Assessments. Within those documents Mrs Young suggested that it would need to include the documentation is the recommendation for the type of reviews and it can then been agreed by whichever group is going to be reviewing them.

5.24 Mr Brandreth said there was a need to take advice on the consultation process, for the successor body, and to be very clear of the temporary nature of the changes.

5.25 Dr Davies noted that the proposal had been through the Joint HOSC.

5.26 Mr Brandreth suggested that the Governing Body resolve to approve in principle the proposal and then work on formulating a letter, which laid out what the Governing Body are approving, the terms of the agreement, the tenure, which Mr Brandreth suggested would be 18 months and how it would be reviewed. Dr Pepper supported Mr Brandreth's proposal.

5.27 Miss Cawley asked that Healthwatch be part of that process and ideally, in the future, do an enter and view process to enable them to speak with patients.

5.28 Mr Lee said that the recommendation of the CCG Governing Body would be noted in the SaTH Board meeting, which is taking place on 9th December.

5.29 Dr Pepper thanked Mr Lee, Dr Makan, Mrs Clarke and Ms Houliston for attending the meeting.

Action:

Mr Brandreth suggested that the Governing Body resolve to approve in principle the proposal and then work on formulating a letter, which laid out what the Governing Body are approving, the terms of the agreement, the tenure, which Mr Brandreth suggested would be 18 months and how it would be reviewed.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG NOTED the contents of the proposal and rationale for the centralisation of Cardiology, including its benefits and mitigation of risk.

RESOLVED: NHS Shropshire, Telford and Wrekin CCG APPROVED in principle subject to confirmation the proposal to proceed with the planned Cardiology centralisation and the move of RSH Ward 24 to be co-located with PRH Ward 6, and its approval already taken by the SaTH Trust Board. The approval would be clarified through the nature of a letter from NHS Shropshire, Telford and Wrekin CCG highlighting what exactly is being approved and supported setting out the terms of agreement as to how subsequent reviews of the centralisation proceed and continue.

Minute No. GB-21-12.102 – Any Other Business

6.1 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 12 January 2022 – time, venue and modality of the meeting to be confirmed nearer the time.

***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 Pepper officially closed the meeting at 1.45pm.

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
1.	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.	Zena Young	January meeting	The Interim AO has asked that an action plan, based on the report recommendations is prepared. Work on an action plan is underway. Progress will be reported to the January meeting. On agenda January meeting – Recommend action is closed.
2.	14th July 2021 Minute No. GB-21-07.044 – Quality and Performance Report	Tracey Slater to ensure that the work on prevention of falls is taken back to the Quality and Performance Committee for review and that the report headlines would be feed back to the Governing Body	Zena Young/ Tracy Slater	September Meeting	Update: the trust is updating their Falls Prevention Action Plan and will receive this to their internal Quality Committee (QSAC) in November. It has been agreed that the reporting and oversight undertaken by QPC will move to the new ICS quality governance arrangement by end Q3. With this in mind, the falls update will be scheduled for the December QPC meeting. 10/11/21 – remains open scheduled until assurance work is presented here The December QPC was deferred to a shorter January meeting which did not receive this as a discrete agenda item, therefore the update is not included in the January GB Q and P report.

	Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
					Assurance on the position for falls performance was received via the CCG attendance at SaTH's December internal governance meeting (Quality Oversight Committee). The trust are taking all mitigating actions and demonstrating learning from incidents is being applied in practice. There is enhanced senior nursing support to wards of concern. Falls with harm per 1000 OBD decreased in the first quarter of 2021/22, with a slight increase in Q2 (3 falls with harm). The trust remains low (positive) for rate of falls when benchmarked per 1000 OBD's at 5.4 (national rate is 6.6 per OBD) at end Q2. The trust has set an internal target of reducing the total number of falls by 10% from 20/21 incidence and is set to achieve this.
3.	8th September 2021 Assurance Reports Quality and Performance Minute No. GB-21-09-059 – Quality and Performance Exception Report	Mrs Young advised members that in terms of data quality, there was a reliance on SaTH as the data owners for the quality of the data. Mrs Young advised that there was increasing line of sight and a capacity to triangulate data with a variety of sources of assurance to ensure quality. Mrs Young reported that Quality Governance is receiving support, and that insights which increase confidence and access to data, is available (which is being validated) that shows that the still birth rate is coming down. Further Information on this matter to be shared at a	Zena Young	Future Meeting	This will be included on the agenda at the appropriate time. A report on maternity and neonates data quality assurance is scheduled planned for the January LMNS Programme Board and an update will be included in the papers for March Governing Body meeting.

	Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
		future meeting of the CCG Board.			
4.	10th November 2021 Minute No. GB-21-11.078 – Members' Declarations of Interests	Dr Michael Matthee noted that the declaration of interest should reflect Dr Matthee's presence at the Strategic Commissioning Committee.	Alison Smith	January	This action has been completed. Recommend action is closed.
5.	10th November 2021 Minute No. GB-21-11.084 – Quality and Performance Exception Report	Mrs Young to consider including the data for no exceptions when compiling the report. In particular, the issue with long wait times for 999 ambulances with the West Midlands Ambulance Service.	Zena Young	January	The Quality report to QPC received an update on serious incidents recorded by WMAS relating to STW patients experiencing delayed treatment or handover response as a contributory factor. This information will be included in future summary reports to GB. A region-wide thematic review of SI's reported relating to treatment delays has taken place and the results are being considered locally. Recommend action is closed.
6.	10th November 2021 Minute No. GB-21-11.084 – Quality and Performance Exception Report	If required, Mrs Young to have an informal discussion with Mrs Warren on the details contained within the report on the improvements within the maternity service. In particular, the SI's and emerging themes and trends. Mrs Young to include further details in the next report.	Zena Young	January	Mrs Warren has met with the Senior Quality Lead for peri-natal safety to further discuss this item. Recommend action is closed.
7.	10th November 2021 Minute No. GB-21-11.084 – Quality and Performance Exception Report	Mrs MacArthur would like assurance statements to be included for particular issues within the report to provide more detailed information to GB members when reviewing the report. Mrs MacArthur also requested more time be allocated on the agenda to provide a more detailed update.	Zena Young	January	The areas of quality concerns are identified on the Quality report to QPC. The CCG level of assurance will increase with the new approach of attendance at provider quality meetings and through.

	Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
8.	Minute No. GB-21-11.086 – Board Assurance Framework	Dr Pepper advised that due to technical difficulties with the PDF software a page is missing from the BAF Report. Miss Smith to publish and upload the missing page to the website	Alison Smith		This has been circulated and completed. Recommend action is closed.
9.	Minute No. GB-21-11.086 – Board Assurance Framework	Mrs Young highlighted the new emerging risks since lockdown and safeguarding concerns for looked after children. Mrs Claire Parker raised the issue around children and young people's mental health and highlighted that further details should be included in the BAF on some of the issues with section 31 and complex children.	Alison Smith Claire Parker Zena Young	January	This is complete and is captured on the BAF as NEW RISK 9 Recommend action is closed.
10.	Minute No. GB-21-11.087 – Integrated Care System Update 10 Pledges Presentation	Miss Smith to share with GB members the link to the film outlining the progress of the ICS's 10 pledges.	Alison Smith	January	This link has been circulated and completed. Recommend action is closed.
11.	Minute No. GB-21-12.101 – Proposed Changes to Inpatient SaTH Cardiology Services	Mr Brandreth suggested that the Governing Body resolve to approve in principle the proposal and then work on formulating a letter, which laid out what the Governing Body are approving, the terms of the agreement, the tenure, which Mr Brandreth suggested would be 18 months and how it would be reviewed.	Mark Brandreth	January	Complete. Letter sent to SATH. Recommend action is closed.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body meeting held in Public on 12th January 2022**

Item Number:	**Agenda Item:**
GB-22.01.007	Quality & Performance Report November & December 2021

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	David Ashford Deputy Director of Performance Dashford@nhs.net Tracey Slater Assistant Director of Quality Tracey.slater4@nhs.net Sharon Fletcher Senior Quality Lead & Patient Safety Specialist Sharon.fletcher9@nhs.net

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

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

Executive Summary (key points in the report):

*Please note that due to QPC December meeting being delayed Governing Body are receiving this report in advance of QPC scrutiny and discussion.

PERFORMANCE – November only due to data/reports availability

Covid: The disruption and pressure continues, the added UEC seasonal pressures with demand and increased length of stay is still impacting upon planned care recovery with the Acute provider focusing on P1 & 2 lists and Cancer. The winter plans are now in place which is mitigating any further risk at present, however this remains unstable.

Primary Care:

Demand for services increased for September beyond predicted levels with a shift from virtual/telephone appointments to 'face to face'. Winter & GP Access plans have been submitted to NHSE/I and awaiting approval, when agreed they will prove positive in increasing capacity. Key risks remain in workforce, in particular General practitioners, plans are in place to target recruit.

Shropshire Doctors:

Significant demand shift compared to month 6, Key Performance Indicators remain green for October, some concerns remain around staffing. Preparation is in place for the Single Point of Access (SPA) for STW which will help with avoidable attendances at A&E for front line staff.

Shropshire Community Services:

The performance team has received an update via the UEC Operations Group on Alternatives to Hospital Admissions (A2HA)

project, which is part of the local care programme phase 1. The roll out of the 2 hour rapid response has been met with some recruitment challenges, however just 1 postcode catchment area remains to complete by February 2022 and all other teams are now live on the Directory of Services and are receiving referrals. Advance Care Planning in Care Homes and Respiratory have recruited to permanent posts and are implementing the new models of care based on successful testing of the concepts in 2020/21. Operational and activity metrics are being reviewed at a service level.

Urgent and Emergency Care (UEC):

Remains challenged and do not currently meet the Constitutional/National standard, SATH Type 1 provider is currently ranked 19/20 in the region and 104/114 Nationally for the 4hr standard. Previously reported concerns relating to ambulance handover also sees SATH remain in the top 10 worst performing Acute Provider Nationally. The acute has been acknowledged for their efforts by NHSE/I in developing pathways avoiding the Emergency Department, in particular their Same Day Emergency Care. A working group has been formed to develop trajectories for improvement, measuring the impact of interventions. A further update will be available for the next meeting.

Planned Care:

UEC pressures are still impacting upon planned care recovery. No significant change in overall RTT performance, which remains at around 60% against a national target of 92%. The total number of waits therefore continues to increase, particularly in key specialties such as orthopaedics and general surgery. There are signs of recovery in ophthalmology, in which numbers waiting appear to have reached a plateau.

The STW system is managing its P2 and P2C clearance times to levels better than the regional averages but due to capacity constraints and UEC/COVID pressures little progress has been made with its P3 and P4 numbers. The admitted waiting list continues to be clinically prioritised.

Cancer Performance:

The two-week breast symptoms performance continues to improve, although both two-week wait metrics are still just short of the target. Other metrics are inconsistent (meeting target in one month and failing the next), with the exception of 31-day subsequent drug treatment which usually meets the required standard. The number of 62-day waits going beyond 104 days at SaTH appears to be increasing, largely demand driven, this has been noted as a key risk with the mitigation of additional CT capacity.

Mental Health:

IAPT recovery rates, recent investigations have highlighted potential IAPT data quality issues between the Shropshire and Telford and Wrekin practices, believing the metric to be currently under-reported. Dementia Diagnosis Rates among over-65s in primary care have dipped slightly but remain above the national average, recovery plan is expected to deliver improvement by year end, further updates in future meetings.

Elective Recovery Framework (ERF):

STW remains stable across all 5 gateways, this is broadly in line with other areas across the region/nationally.

QUALITY

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

The CQC recently published their inspection report following a number of visits across both sites at the trust between July and August 2021. Overall the trust was rated as Inadequate; with both Safe and Responsive remaining as this, Effective had improved to Requires Improvement, Caring had stayed the same at Requires Improvement and Well-led had improved to Requires Improvement.

MATERNITY: There were no Maternity Serious Incidents reported in November for the Trust and there is a further breakdown on incidents in the main body of the report.

There is good timeliness of response from SaTH on RCA reports and action plans.

The Maternity and Neonatal Dashboard exceptions are included in the main body of the report.

- Data quality remains an issue as the Trust has previously advised that outmoded IT and hand held records approach to data capture is impacting on data quality, the implementation and roll out of Badgernet IT maternity record system is starting to improve data quality and there is on-going assurance work with the provider to review and improve data quality for the

future, however there is ongoing improvement work both locally and Nationally to improve the quality of information reported and improve assurance.

- There were no neonatal exceptions reported however data is still limited at present. There is ongoing work to ensure that the Neonatal dashboard, SI's and incident reporting will be shared at PNQSG and LMNS as a combined report for assurance.
- Service user satisfaction remains good, with ongoing work being carried out to increase response rates. There is continued work with Maternity Voices Partnership (MVP) to ensure that patient experiences are captured and acted upon, with recruitment to the volunteers to ensure a targeted approach to the more hard to reach patients.
- All of the MLUs across the county are operational, however some are not providing intrapartum care in line with risk assessments which are reviewed regularly and PNQSG and LMNS have oversight.

MPFT: IAPT long waits have been discussed at CQRM. The CCG Transformation/Commissioning team are working with the trust on the model of care. The trust advised they are losing expertise in this workforce which will provide a further challenge. The Eating Disorders Service at the Trust is experiencing workforce difficulties with recruitment of staff with extended waiting times.
RJAH: The CCG Quality Team attended RJAH on 25/10/2021 to undertake a Serious Incidents Quality Assurance Visit to theatres following three Never Events since April 21. A number of emerging themes have been identified from CCG review of RJAH investigation reports.

SCHT: Staff survey: update on actions following concerns raised by BAME staff – a BAME network is now in place whose remit is to work on actions from the survey. They are also scrutinising the recruitment and application process for SCHT posts.

SAFEGUARDING

- Free prescriptions for Care Leavers commenced on the 1st November 2021.
- A backlog of review health assessments in Stafford continues to receive review.
- CCG Internal Safeguarding Audits have been completed.

- A business case has been agreed as part of the review of health contribution to the Multi-Agency Safeguarding Hub (MASH) Compass.
- A Quality / Safeguarding Visit took place at the Redwood Centre.
- Training continues to GPs across Shropshire, Telford and Wrekin.
- Partnership sub-group work continues.
- Liberty Protection Safeguards: DHSC have announced that the introduction is to be formerly delayed and have not identified a new date instead stating “it would be premature to set a new implementation date or confirm any funding to support implementation before we have been able to consider responses to the consultation. We will therefore update you on our plans, including any associated funding, after the consultation.”
- Work has commenced to address the LPS/MCA: National CRG information about optimising the 2022 & 2023 1.25% baseline budget for LPS implementation (as an innovation) for the coming 18 months. Further information will be provided in the Adult Safeguarding report to the Systems Quality Group
- NHS Providers COVID 19 change deployment monitoring in safeguarding teams and safeguarding capacity face to face front line staff visiting.
- Local Safeguarding Datasets to be updated for STW
- Increased Sudden Unexpected Child Deaths in Infancy requiring urgent rapid responses and review.

IPC: RJAH reported a further increase in surgical site infections in December

A MRSA bacteraemia case has been reported by University Hospitals Birmingham NHS Foundation Trust relating to a Shropshire resident who tested positive within 48 hours of admission.

The CCG senior IPC lead undertook a visit to Ludlow Community Hospital as part of an announced quality assurance visit;

Suboptimal IPC standards reported. The CCG senior IPC lead joined an internal Exemplar assessment organised by SaTH at their RSH site in November; suboptimal standards of IPC were observed during the visit.

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:
Governing Body are asked to note the content of the report and the actions being taken to address the issues identified.

1 Key Performance Challenges

1.1 Urgent Care

Key Risks/Mitigating Actions

Key Risks	Mitigating action	Group/Sub group responsible
Front door demand	Direct to SDEC went live 17th October with Surgical SDEC aimed at 21st November, there were 48 additional ambulance referrals straight to SDEC in the first month of operation, and this in itself has seen benefits with metrics such as 'initial assessment in 15minutes' and ambulance handover > 60 minutes at the RSH site. In plan over the next 4-6 weeks, the discharge lounge will go live, front door streaming and a 'Single' point of access/referral will be developed. In addition, identification of high volume service user groups such as GP practices has been identified and plans are in development with primary care.	Ambulance handover sub group 111 Demand and Capacity group Transformation Tuesday delivery group UEC Group & Board overarching responsibility
Initial assessment within 15 minutes	There are some issues with data compliancy; a Bi-weekly BI group has been formed to tackle compliancy issues, SATH have taken an action to look at the data and why it's not being captured/inputted. The reported position is holding and tracks c.20% below the national average.	Chief Operating Officer – SATH
Ambulance handover >15 Min (60 min focus)	The focus group has highlighted a number of opportunities, cohorting processes have been defined and are working well; front door navigation/navigator role has developed in line with additional pathways. WMAS area manager now fully engaged and is working well with the wider group supporting with change management and rapid PDSA's. Ambulance handover has started to show some early signs of recovery, however still not meeting the standard.	Ambulance handover group – UEC board have overarching responsibility
Emergency department flow	Actions to reduce admitted volume of patients are progressing well, attendance to admission (conversion) remains one of the lowest in the region c.28%, issues still remain in the timeliness of discharges, an absolute focus on discharge earlier in the day and a working collaborative is in development with community services to create a 'pull model' similar to Local Authority arrangements.	System UEC group and Support from NHSEI on flow.

1.2 Elective Care

Key Risks/Mitigating actions

Key Risk	Mitigating action	Group/Sub group responsible
Referral to Treatment (RTT)	Elective activity at local providers continues to recover steadily across the system, but in recent weeks the impact from UEC pressure, in particular managing the surge in COVID related activity has slowed recovery. The delivery of activity against the new system recovery plan is monitored at the monthly System Elective/Cancer Recovery meeting	Elective/Cancer Recovery group
Imaging	Recruitment is now underway for the CT/MRI Pod with an aim of being operational in October and the system has gone at risk to secure an additional staffed modular CT unit (in place since early Oct) to increase capacity, reduce the current backlog and aid overall elective recovery.	Elective/Cancer Recovery group
Non-Obstetric Ultrasound	Negotiations with a third-party provider for Non-Obstetric US have broken down but the Trust is continuing to achieve its activity plans submitted within the system H1 plan	Elective/Cancer Recovery group
Endoscopy	Recruitment continues to support the delivery of Trans Nasal Endoscopy (TNE); this will improve the overall rate of endoscopy.	Elective/Cancer Recovery group
Diagnostic waiting list	Now clinically prioritised and submitted to region	Elective/Cancer Recovery group
Audiology	Waiting lists are increasing as demand returns there remains capacity to decrease the position for over six week waiters	Elective/Cancer Recovery group

1.3 Cancer Care

Key Risks/Mitigating Actions

Key Risk	Mitigating Action	Ownership
Gynaecology - On going - One Stop PMB (post-menopausal bleeding). Sickness in Gynae Oncology Consultant Team – No locum found currently	One Stop PMB process – new pathway being looked at to allow patients to go direct to radiology, also for gynaecology Consultants to carry out their own scans	SATH

	Oncology team working on plan to provide cover	
Head & Neck – Radiology delays; barium swallows continue to be an issue along with other diagnostics; Consultant work force	New Consultant started. UHNM collaborative working. Skin - BCCs & SCCs are being monitored closely with relevant actions.	SATH
Upper GI – On-going issue with EUS capacity - reliant on x1 consultant who is covering medical director role	Capacity is now increased but this is heavily reliant on one member of staff which makes it fragile, another Consultant carrying out EUS training. Additional CT and staff member sourced and funded (scanner on site, now awaiting sign off).	SATH
Urology - Locum workforce instability	TRUS Biopsy results clinics set up to align with additional lists; Funding granted for 12-month Band 6/7 CNS Kidney via Cancer Alliance and 12-month Band 3 to support with faster diagnosis day 28, both jobs out to advert.	SATH
Breast - 62-day target continues to be impacted by delayed diagnosis and limited theatre capacity. Increasing delays for staging scans resulting in patients having to be discussed at MDT or deferred at MDT on multiple occasions.	Breast pain clinic to commenced in November with clinics with 40 plus patients already referred and first patients now seen	SATH
Colorectal - Increasing waits for radiology, both diagnostic and staging delaying MDT discussions and treatment. Reduced theatre template from 6/9/2021 (3 sessions per week) – may impact on ability to TCI in target as well as ability to provide lists for endoscopic investigations under GA	TCI planning list – weekly planning list working well, patients listed with next available Consultant Referral Management Service – follow-ups to be added into RMS system – template letter agreed to send out to patients to offer entry to RMS following review of surveillance investigations.	SATH
Lung - Capacity is not sufficient to meet demand. Business case has still not been presented to IIC for	Working closely with consultants to set up additional WLI's to accommodate increase in referrals although none were available	SATH

additional workforce; Insufficient clinic rooms for clinical staffing visiting from UHNM; Access to hot slots for CT; Bed Issue for Biopsies at RSH; Radiology Capacity	during October	
Haematology - Radiology Capacity issues – Causing delays in 62-day pathway potential breaches related to delayed scans; staff shortages in Consultant body	Out to advert for locums, currently one has been added to the team	SATH
Skin - CNS workforce remains fragile to cope with demand. Additional funding has been awarded by the cancer alliance for 1.0wte CSN for 12 months; theatre space is an issue	Planning with Health Harmonie to try and reduce the impact of increased referrals to ensure additional capacity is in place; Additional WLIs also being worked at SaTH; Additional Weekly Minor Ops session commencing in November until the end of January to help reduce waiting times; Communication with Surgical Division has recommenced to highlight and track patients being referred across for treatment	SATH/Alliance

1.4 Mental Health & LD Care

Key Risks/Mitigating actions

Key Risk	Mitigating action	Group/Sub group responsible
IAPT recovery - Recovery rates have deteriorated from Quarter 1 21/22 to Quarter 2, particularly in the Shropshire service and notably for BAME service users in September.	There is an urgent meeting scheduled with MPFT on 19th November to go through recent and proposed actions to address not only the access rates, waiting lists and also in light of the September recovery rate performance, this issue. Alongside this, there is a fuller update on IAPT services in the paper to Q&P this month which will describe further agreed actions and mitigations and impact of these.	MPFT
Dementia Diagnosis performance remains below the national target	Referrals to the dementia team increased from Shropshire GPs around 20% from 2019/20, but have reduced from Telford and Wrekin GPs by 9% same period – so there is still work to do to promote this in Telford through	MPFT

	locality leads. Performance for month 6 is close to the national performance figure of 62% but it is recognized that proposals in the recovery plan will improve future performance. The recovery plan has been shared with this committee. In addition, the dementia vision/strategy has been co-produced with people living with dementia and carers, looking at what services might look like in the future compared to current services and provisions. This was approved in October 2021.	

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.

The CQC recently published their inspection report following a number of visits across both sites at the trust between July and August 2021. Overall the trust was rated as Inadequate; with both Safe and Responsive remaining as this, Effective had improved to Requires Improvement, Caring had stayed the same at Requires Improvement and Well-led had improved to Requires Improvement. The report recognised areas of outstanding practice, as well as areas which require further targeted work. The trust is working through the required and recommended actions identified in the report.

Falls: The number of falls continues to remain an area of concern. The falls per 1000 bed days remains above the local stretch target for improvement, however the falls with harm per 1000 bed days is delivering at the national standard. System Quality Group has received an update of ongoing work for falls prevention and the CCG are confident the right actions are identified and the challenge remains with a small number of wards that are receiving additional management support and clinical supervision.

Pressure Ulcers: The Trust is on course to deliver the year end improvement target internally set.

Update in relation to the CQC Section 31 conditions imposed following the CQC inspections: A scheduled CCG led Quality Assurance visit to RSH ED due to take place on Wednesday 17th November has been deferred due to CQC also inspecting ED on the same date. A further arranged date has been stepped down due to C-19 redeployment workforce pressures. At the time of writing the report an alternative date is being sought.

Performance in October (04/10/2021 – 31/10/2021) for sepsis screening on admission across the Emergency Departments was 97% on average for both sites.

Performance in relation to patients screened as 'high risk' having had the appropriate action taken as per Sepsis 6 was 97% on average across both sites showing significant improvement.

Compliance against the 15 minute Paediatric triage standard has improved at RSH in October 2021 to an average of 53% (from 46%) at RSH and declined to 28% (from 29%) at PRH for the 4 week period up to the 31st October 2021. The trust continues to work with their teams in relation to ongoing actions to improve compliance. Triage staff are protected to ensure availability and access to triage for paediatric patients at all times. All paediatric patients' ED attendance records continue to be reviewed regardless of time to be triaged to ensure no harm occurred and all appropriate assessments and referrals have been made. Incident reporting occurs for every child not triaged within 15 minutes and relevant staff are alerted so the circumstances around any breaches are recorded and mitigations immediately put in place. Further work is being undertaken to identify how triage times during surges in paediatric activity can be improved.

Serious Incidents: There was one Never Event reported by the trust in October and this related to wrong site surgery. The trust is investigating this in accordance with NHSE/I SI framework and immediate mitigation has been actioned.

Complaints: The response time for concerns remains unsatisfactory; the improvement trajectory for elimination of the overdue responses by December 2021 is showing the plan is on track at the end of September 2021.

Mortality: Mortality indices remain better than the reference level of 100 and are forecast to continue to perform better than peers. Both HMSR and RAMI exclude COVID-19 deaths from the indices. Recent data indicates that SATH is not an outlier for deaths associated with COVID-19 during the second wave of the pandemic; October 2020-March 2021.

Quality Assurance visits: The CCG continue to support SATH exemplar visits.

Maternity:

The following items are reported as exceptions from the Maternity & Neonatal Dashboard:

The table below identifies the parameters which are or have recently been outside of the expected target range when reviewed against either local or national expected figures /targets.

Indicator	Standard Figure	Oct 21	Action
Bookings less than 13 weeks	90%	83.5%	Medway pulls data based on LMP (current dashboard figure) Screening/Booking data is based on accurate EDD. Booking data is manually validated by Specialist Screening lead midwife to ensure accuracy in data reported to Public Health England. This also captures imports and exports- OOA bookings. **Data validated actual booking figures** for:- July 21 = 89% August 21= 88% Sept 21= 86% **A report has been run by the Badgernet Lead, which has shown that 91.9% is the reported compliance for the month of October and further work is now underway with the performance team to move to reporting from Badgernet into the clinical dashboard.**
Induction of labour (IOL)	29.2% (NMPA 2019)	34.3%	Nationally increasing rates. Increased comorbidities nationally recognised. Care bundles such as SBL and National ambition to reduce Still Birth and NeoNatal Death impacts IOL rate along with women's choice. The revised clinical dashboard is looking at standards that as a trust should be setting for IOL rates as the NMPA 2019 standard is now old data to benchmark against. HES (hospital episode statistics) data: rate in 2019-20 = 39% taken from recent GIRFT data report.
1:1 care in labour	100%	99.7%	An ongoing review of any case where the dashboard indicates that 1:1 care in labour does not look like it has been achieved and is ongoing.

			These results are reassuring that staffing is being managed with acuity tool to ensure 121 care in labour is achieved.
Smoking rate at delivery	Government Target 6% By 2022	9.8%	Smoking rates at delivery continue to decrease across the county, towards the current national average (9.5%) despite social deprivation and associated health inequalities/co-morbidities. Significant reduction on month noted for smoking at time of delivery. Scoping of carbon monoxide monitoring is ongoing. **Booking data has improved, however some bookings are carried out remotely, mitigation for these service users to have monitoring at a later date with routine blood test.** Working towards government target-smoking cessation team has expanded and progress being made for new HPSS service to address barriers and health inequality.
VBAC rate	20% Public View	13.8%	This is only women who are having their second baby and had a CS first time. It does not include women on baby number 3 or 4 who have had a CS and a VB previously.
Caesarean Section rate of Robson Group 1 deliveries.	3.5% Public View	12.2%	Group 1- Nulliparous, single cephalic, ≥37 weeks, in spontaneous labour. Primip term women. A recent study showed that groups 2, 5, and 1 were the major contributors to the overall CS rate. This can be influenced by maternal choice, which is nationally supported. **September cases reviewed, as concerned high %, all were correctly categorised into this group. Further work ongoing to review Group 2 cases to review if these are correctly categorised and not impacting on group 1 underway**. **Also standard using is also being reviewed.**
Caesarean Section rate of Robson Group 2 deliveries.	42% Public View	50%	Group 2 - Nulliparous, single cephalic, ≥37 weeks, induced or caesarean section (CS) before labour. Representative of higher IOL rate – corresponding with failed IOL.
Caesarean Section rate of Robson Group 5 deliveries	85% Public View	85.7%	Group 5 - Previous CS, single cephalic, ≥ 37 weeks. Performance consistent with standard, this group presented on dashboard on monthly basis.
Spontaneous birth rate	60% Public View	61.5%	Mean rate = 64.8%
PPH rate	2.5% Public View	3%	All individual PPH cases above 1500mls are reported via datix and are reviewed at local Noir meeting and learning shared in teams.
Still Birth		1	Un booked lady. Baby appeared to be 38-40 weeks gestation at birth. No Antenatal care provided as unaware of pregnancy. Baby taken for post-mortem.

			Referred to HSIB and triaged, based on no antenatal care and condition of baby at birth. Rejected as did not fit intrapartum criteria for referral. Reported to MRRACE
Born before arrival	3- Locally agreed.	4	All BBAs are being reviewed for any issues with care and levels monitored. All will be reviewed via NOIR or locally by ward managers for deeper understanding. Learning is shared with teams.
Breast Feeding- first feed	70% Public View	68%	Data remaining consistent. Communications are continuing from infant feeding lead locally regarding Importance of Breast feeding, also importance of correct data recording. Whilst first feed is noted to be slightly under national standard, discharge from hospital breast feeding rates are significantly higher at 68.5% when the standard figure id 60%.
Delivery Suite (DS) acuity	85% (Birth Rate Plus)	48.2 %	**It is important to note that this acuity report is for DS only, the unit acuity data is assessed at the SMT huddle twice daily, where staff are deployed to areas with high acuity to manage safety within the unit.** From July this acuity level is taken from a rolling 13 week period to reflect accurate data. 48.2 % DS have been in positive acuity. 32.4% DS have been in Amber acuity (up to 2 mws short) 10.6 % in Red acuity. (>2mws short) All have been appropriately escalated and managed to maintain safety across the unit. All aspects of the escalation policy have been followed and consideration to use of divert of services have been discussed at appropriate levels. The MLU service is on divert to consolidate staffing – which again is an appropriate measure to maintain safety. **10.2 WTE Band 5 midwives have now commenced with the service. Rosters are looking to improve from November in response to this. A further 2.8 WTE band 5s are due to commence in November 21.**
DS red flags	No target range	61	**Red flags are indicators that staffing levels are not quite right in area. Also may reflect occupancy on delivery suite.** Twice daily SMT huddles in place, increased to 3 when acuity and staffing needs closer monitoring. A review of October red flag data has revealed that 20 women accounted for 44 red flag events. These were affected by a delay of more than 8 hours for ARM/Augmentation, there were no negative safety implications due to these delays, and this has been triangulated with data from Datix and the MIS**.** The 6 red flags for delay in PROM IOL affected 3 women. Their care has been reviewed and there were no adverse outcomes because of the delay. 1: 1 care in labour was not provided to 3 patients for a very limited time while staff were redeployed to assist from other areas. This was appropriately escalated and managed with no impact on outcome. 3 of

			the red flags for the co-ordinator being unable to maintain supernumerary status are during these episodes. On 2 other occasions the co-ordinator were not supernumerary for brief periods as they were caring for PN patients and one occasion for a PROM IOL that had yet to be commenced. In all cases the necessary clinical actions had been taken to maintain safety and the situation had been escalated to the managers.

Maternity Serious Incidents (SIs): There were no maternity related incidents reported during November.

Month of incident	January 21	February 21	March 21	April 21	May 21	June 21	July 21	August 21	September 21	October 21	November 21
Number reported	1	4	*2 (reported in June)	1	1	2*	6 Inc. 2* reported from prior period	2	2	0	0

The CCG attend the Review, Action and Learning from Incidents Group (RALIG). The purpose of RALIG is to review incidents and near misses in the trust in an objective, thematic and clinically focussed forum. To discuss and agree actions that improve safety and quality of clinical care for our patients and to agree, share and implement learning points and themes across all Divisions and the wider organisation and to provide assurance to the Quality, Safety and Assurance Committee (QSAC).

IPC: A number of concurrent Covid-19 outbreaks has been reported across both trust sites and these have been managed in accordance with the Incident Management process.

The CCG senior IPC lead joined an internal Exemplar assessment organised by SaTH at their RSH site in November; suboptimal standards of IPC were observed during the visit to ward 25 relating to environmental cleanliness, patient equipment cleanliness, adherence of staff to national guidance for wearing of personal protective equipment, lack of documentation for patients declining to wear a face mask and no

documentation for a patient with a urinary catheter. The CCG IPC lead has discussed the finding with the IPC lead at SaTH who has arranged a meeting with ward and department managers and advised SaTH's IPC team will monitor IPC standards on the ward.

2.2 Robert Jones and Agnes Hunt Orthopaedic Hospital

Quality of care: Following the reporting of 3 Never Events, members of the CCG Quality Team attended RJAH on 25/10/2021 to undertake a Serious Incidents Quality Assurance Visit to theatres. A number of emerging themes have been identified and RJAH have action plans in place to address these. It is reported that The Trust is continuing to work to identify innovative ways of disseminating and embedding learning from incidents.

In advance of working towards an ICS by April 2022 and stepping down CQRM meetings, a member of the CCG Quality Team attended RJAH Quality and Safety Committee on 18/11/2021. The scrutiny applied to those present was observed to be rigorous, and no significant concerns regarding the quality of care have been identified. The Never Events previously reported are progressing in accordance with the NHSE Serious Incident Framework. A number of immediate corrective actions have already been implemented.

IPC: Following the report of an increase in surgical site infections in quarter 1, the trust have reported a further increase for Quarter 2 a meeting between CCG and RJAH IPC leads has been arranged. RJAH are continuing with the 'One Together' assessment toolkit for reviewing IPC practice across the surgical pathway. Actions relating to the increased surgical site infections continue to be monitored through attendance at monthly IPC committee. The CCG Senior IPC Lead will be undertaking a visit to RJAH during January.

2.3 Midlands Partnership FT

Quality of care: A CQC Mental Health Act review has been undertaken at MPFT during 15-19th November 2021. The inspectors gave positive feedback during this review regarding inpatient management of children and young people, the final report is awaited.

The Health & Safety Executive (HSE) re-inspected the trust during October 2021, this was a virtual review and the HSE gave positive feedback to the trust. There has been progress with regards to improvement notices served two years ago. The HSE were impressed overall and in particular with Covid measures in place for Shropshire, Wrekin, and Telford. The Eating Disorders Service at the Trust is experiencing

workforce difficulties with recruitment of staff and extended waiting lists. The CCG are working with the trust and other provider partners to review this.
Improving access to psychological therapies (IAPT) long waits has been discussed at CQRM. The CCG Transformation/Commissioning team are working with the trust on the model of care. The trust advised they are losing expertise in the workforce which will provide a further challenge to delivering an improved performance.

A follow-up annual suicide report and a report on Female suicide rates were presented at October CQRM. Both reports considered robust national processes in learning from suicides, themes and trends. The report provided detail on the work ongoing within Shropshire Care Group in preventing suicide, the learning from recommendations and actions following the death of a service user.
The report concluded that the trust have seen an increase in suicides in Shropshire in particular over recent years but this is not statistically significant given the variation in suicide rates each year and the relatively small numbers recorded. Additionally, the increase itself has brought Shropshire in line with England rates overall per 100,000 populations, it does not indicate that Shropshire nor Telford and Wrekin are outliers in terms of rates. However, the trust have advised this does not mean they are complacent when it comes to understanding individual and general risk factors to suicide, they continue to proactively equip staff and service users with the means to reduce these.

IPC: A further Covid-19 outbreak was reported at Redwoods which resulted in a ward closure due to numerous contacts, none of which converted to being positive.

2.4 Shropshire Community Healthcare NHS Trust

Quality of care: SCHT have identified that there was an increase in incidents of pressure ulcers of all grades in recent months, the trust are taking actions to address the issue to include a rapid improvement plan and this will be monitored via CQRM.

Quality Assurance Visit: CCG continue to support trust quality assurance visits.

IPC: A CCG quality assurance visit was undertaken at Ludlow Community Hospital, the CCG senior IPC lead observed suboptimal standards of IPC during the visit relating to: Not following trust process for cleaning and checking a bed space following discharge of a patient resulting in

two mattresses being disposed of during the visit, one of the mattresses was a pressure relieving mattress and the hospital did not have a replacement on site. Missed quality checks; recordings of fridge and freezer temperatures in the ward kitchen and relatives room. Suboptimal cleanliness of patient clinical equipment. Feedback was given at the time of the visit to the ward sister and later the same day to the trusts Director of Nursing and Director of IPC. Development of an IPC action plan has been requested this will be monitored through attendance at the trust's IPC group.

One case of MRSA bacteraemia originally assigned to CCG was assigned to SCHT following a post infection review of all care delivered by the patient's GP practice, The Queen Elizabeth Hospital, SaTH and SCHT. The investigation was concluded and at a post infection review meeting the final assignment of the case was assigned to SCHT. Areas of learning included nurse's indication to swab a wound, where a patient declines referral to GP due to concerns, use of ADDER Tool as framework for concordance conversation.

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: Shropshire, Telford and Wrekin (STW) CCG and partners are continuing work to improve the offer of and uptake of Annual Health Checks for people with a Learning Disability. A system wide approach through the 3 Year Road Map is in place to ensure buy-in to improve this area of work and to expand its reach. STW CCG are committed to the aspiration of offering 100% of people with a learning disability an annual health check with clear reasons recorded and reviewed if an individual chooses not to attend or DNAs. High performing practices are encouraged to share good practice across their Primary Care Network (PCN).

For 2021/22 the Learning Disability Annual Health Checks LDAHC 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 LDAHCs are embedded within services i.e. Education Health Care Plans and that young people are captured on the GP LD register and offered a LDAHC.

2.7 West Midlands Ambulance Service (WMAS)

West Midlands Ambulance Service (WMAS): have identified via the SI process when delays in attending to a patient due to severe demand on service has resulted in serious harm or above. WMAS continue to report high demands for their service which in conjunction with delays in handover of patients at acute hospitals has caused significant delays in ambulance response times across the region. All are reviewed by local and regional CCGs and comments fed back to WMAS.

NHS 111: are continuing their recruitment campaign for advisors and clinicians to meet demand of number of calls. They are working to increase the number of category 3 and 4 ambulance validations following pathways dispositions which has reduced the number of ambulances requested.

2.8 Care Homes

Homes requiring increased monitoring/cause for concern: Concerns have been raised by Telford and Wrekin Council quality monitoring officer and other local healthcare professionals following visits to a nursing home in Telford. The CCG IPC team offered to support a joint visit to the home with the quality monitoring officer. The visit highlighted poor standards of IPC, suboptimal environmental and equipment cleanliness and non-adherence to IPC national guidance. An IPC report has been shared with the provider's senior management team and the home's manager; a service improvement plan has been requested. Due to the number of IPC concerns the report has been escalated to CQC. Support and monitoring will be undertaken by Telford and Wrekin council and CCG IPC.

2.9 Independent Providers

There are no significant quality concerns to report by exception.

3.0 Safeguarding

Looked After Children (LAC):

There are currently 980 LAC pan Shropshire, in addition the hosted LAC population is 786.

- The Free prescriptions for Care Leavers process has been launched on the 1st November 2021 and currently have purchased the first pre-payment certificate for one of our Care Leavers.
- Additional data has been requested in relation to face to face contacts for children and young people to complete Review Health Assessments; data has suggested the vast majority have been completed via video / telephone contact; comparatively other regional areas. This has received Executive to Executive escalation and is likely to need to receive scrutiny at Corporate Parenting Strategic Meetings.
- There is a historical backlog with the health team in Staffordshire; currently this is 8 LAC children pan-Shropshire. The Team in Staffordshire continue to keep the Designate Team updated on the current situation for STW young people and prioritise on the level of health need. This has been escalated to Staffordshire CCG and NHSE, and is on the risk register for MPFT and the Staffordshire CCG. We continue to monitor and liaise with colleagues in Staffordshire and will escalate further if needed.
- The Designate Nurses continue to quality assure review health assessments for children placed out of area; the vast majority of reviews are satisfactory. Any escalations in terms of additional information which may be required takes place at the time of review. This continues to be an electronic process.

Safeguarding Children:

- CCG Internal Safeguarding Audit has been completed for child and adult safeguarding; the reports have been submitted to Audit Committee with a further review / timelines added in January 2022.
- An escalation has occurred to the CCG concerning health contribution to the single point of access 'Compass' - Multi-agency Safeguarding Hub (MASH) due to capacity / workload challenges; an immediate plan is in place; a working group has considered a longer term solution; the Designate Nurse will be reviewing quality metrics. A business case was submitted and agreed to ensure adequate staffing of the Hub.
- Children G Serious Case Review neglect case has been published in September 2021; the Designated Nurse chaired a meeting to review some queries around the information shared as part of the review.

- There continues to be a notable increase in both referrals to MPFT and Child or Young Person presenting at Accident and Emergency (A&E) with mental health deterioration following the easing of lockdown. There has been additional access to crisis mental health hubs locally to prevent A&E attendance.
- A quality visit took place to MPFT Redwoods Centre to review provision due to a child being cared for on an adult ward. A report has been finalised which took account of some additional actions required around the child's care planning.
- Level 3 child safeguarding staff training in Adult ward areas has been a key focus of improvement in Shrewsbury and Telford NHS Hospital Trust (SaTH) and Robert Jones and Agnes Hunt NHS Hospital Trust (RJAH).
- The easing of COVID-19 lockdown nationally, regionally and locally have showed increasing child abuse concerns and mental health issues in children and young people with an increased demand on services providers and number of children subjected to child protection plans.
- There has been a reported national rise in rape cases / sexual offences especially to women requiring Safeguarding Partnership's safer community actions across the UK. Shropshire and Telford and Wrekin Partnerships are exploring local priority areas to prevent crimes.
- The Telford Independent Inquiry Child Sexual Exploitation (IICSE) and Ockenden Maternity Inquiry have continued with case note information being requested from providers. The CCG continue to cooperate with the Inquiry and are awaiting any further requests for assistance based upon when the Inquiry announces the next phase of their work in terms of reviewing individual cases.
- Shropshire and Telford & Wrekin Safeguarding Children multi-agency case file audits in progress with multi-agency recommendations being acted upon to improve local practice.
- The monthly Maternity Supporting Women with Additional Needs (SWwAN) meeting is ongoing with rising case numbers across Shropshire and Telford and Wrekin Maternity. Safeguarding limited capacity has been escalated on SaTH risk register to deliver supervision and training in the summer of 2021. Consequently, the Named Midwife for SaTH is now full time and not a job share position; additionally a Band 6 safeguarding midwife post will be recruited to mitigate and lower the risk on SaTH risk register.
- The CCG risk register has been reviewed and updated for this quarter which now includes a review of health attendance at Compass Shropshire.

- A level 3 children safeguarding training course is being delivered by Dr Baines and Dr Wong. This is going well and one session has taken place, next session later this month.
- An adult safeguarding level 3 training course will be delivered by Dr Baines and Dr Wong in the new year.
- Domestic Abuse resource pack has been produced by Rachel Jones and is currently under review. This will be disseminated to all practice when finalised and will provide a wealth of information and guidance when primary care colleagues have concerns about a person
- The GP safeguarding forum continues and Domestic Abuse will be included again as a topic in the Spring. All practices are encouraged to suggest items for inclusion in a future forum learning session
- 7 practices responded to the safeguarding survey and the Named GPs for Safeguarding are leading the review of this information to see how the support offer to practices can be strengthened
- The CCG Designated Children Safeguarding Team and Named GPs continue to work with GP practices to complete Safeguarding Initial Scoping/ Child Safeguarding Practice Reviews (CSPRs) and Multi-Agency Safeguarding Case File Audits (MACFA) for both Shropshire and Telford and Wrekin Safeguarding Partnerships.
- The CCG Safeguarding team is reviewing with NHS providers health representation at Local Authority Multi-Agency Safeguarding Hubs (MASHs) child protection / strategy meetings.

Safeguarding Adults

- The Safeguarding Partnership arrangements continue to be strong both operationally and strategically; with activity taking place to support safeguarding strategic meetings. The TW Care Act compliance audit has been positive with no ongoing actions identified
- GP safeguarding Forum continues with suicide prevention being the subject of the latest meeting and addition MCA training has taken place for a specific GP practice.
- LPS remains a significant issue with essential implementation documents still not available. The CCG and ICS continue to work collaboratively to address

- There has been a high risk Channel case which the CCG have supported the chair with and the person in question is now detained under the Mental Health Act.
- The data analysis section at APPENDIX 2 indicates some ongoing challenges at SATH and these are being addressed via the Safeguarding Adult Operational Group and CQC action plan work.
- Support has been offered to assist Severn Hospice address the action plan from their CQC inspection. The CQC had contacted the CCG to see if assistance could be offered and were appreciative of the actions already in place

3.1 Infection Prevention and Control

The vacancy within the IPC team which in part is mitigated by temporary staffing solutions is currently out to advert.

The IPC team supported the care sector to take part in International Infection Prevention week, an event which takes place each year. The theme this year was ‘Make your intention infection prevention’ the IPC team chose different theme for each day of the event and sent out key messages and resources to care homes and domiciliary care providers within STW.

3.2 Patient Experience

Nothing to report by Exception

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 12 January 2022**

Item Number:	Agenda Item:
GB-22.01.008	NHS Patient Safety Specialist Q3 Update

Executive Lead (s):	Author(s):
Zena Young – Executive Director Nursing and Quality	Sharon Fletcher – Senior Quality Lead and Patient Safety Specialist

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
A report on the Patient Safety Specialist was brought to Board in March 2021; this paper provides an update on progress and has not been received elsewhere.		

Executive Summary (key points in the report):

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, was published by NHSE/I in July 2019. This report provides an update on progress against the ambitions of the Strategy and details progress made and training plans.

The published update to the Patient Safety Strategy in February 2021 continued to focus on the principles and high-level strategic objectives. A paper to GB in March 2021 described these and this report is an update on progress over the last 9 months

Key updates are:
The CCG were successful in appointing a Patient Safety Specialist since August 2021 who is leading our system work.
The preparation to implement the new Patient Safety Incident Response Framework (PSIRF) is underway and when it is launched in 2022 will be for roll out across systems during 2022/23
An online training programme has been launched in the form of the Patient Safety Syllabus: Level 1 and 2 are available for all staff currently, including the board. Monitoring of compliance will be provided, however training will be rolled out in phases.

Recommendations/Actions Required:
It is recommended that CCG Governing Body: - Note and discuss the local progress made with implementing the NHS Patient Safety Strategy - Approve the recommendation that an update to ICS board is brought on a bi-annual basis

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).* The Patient Safety Strategy Update requires collaboration with Patient Safety Partners; we have a system wide group with good engagement.	Yes
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 successful transition of the CCG's function to the new ICS Integrated Care Board addresses all of the CCGs Strategic Priorities	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	As Above
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).*	As above
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).*	As above
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	As above

1. Introduction

The NHS Patient Safety Strategy: Safer culture, safer system, safer patients, was published by NHSE/I in July 2019 with an update in February 2021.

The Strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework. When the NHS Patient Safety Strategy was published there was a commitment to periodically updating it in order to maintain the focus of evolving healthcare landscape on activities that would have the greatest impact on patient safety. The NHS patient Safety Strategy 2021 update continues to focus on the principles and high-level strategic objectives however there has been an acknowledgement of the need for some shift in scope.

Since November 2020 organisations have identified their Patient Safety Specialists. Since August 2021 there is now a Patient Safety Specialist (PSS) in post for the CCG, who has a leadership role across our system.

The PSS role is involved in work to develop the role notably:

- The expansion of the Patient Safety Specialist network
- Publication of the patient safety incident reporting system (PSIRF)
- Publication of the patient safety partners framework
- Patients safety syllabus
- Patient safety education and training
- Pilot phase of the adoption of the patient safety Incident Response Framework (early adopter sites)

2. National/Regional Update

During 2021 there have been regular National and Regional online events to discuss the implementation of the changes as well as how oversight by the ICS can be achieved. This work is on-going with Task and Finish groups set up and feeding back to NHSE/I. The aim is to decrease the number of investigations whilst increasing more meaningful responses to incidents.

The preparation to implement the new Patient Safety Incident Response Framework (PSIRF) is underway and when it is launched in 2022 will be for roll out across systems during 2022/23

3. Local Update

As a PSS there are opportunities to network and share insights and solutions both as a system but also regionally and nationally. The individual will work within their organisation to develop and create an environment where clinicians can practice safety. In order to achieve this, the first NHS wide patient safety syllabus is being developed and will be applicable to all staff. It reflects:

- best practice in building safe systems
- focus on prevention of harm whilst improving learning from incidents and applying system
- thinking
- encompasses all national safety initiatives including national alerts, key safety regulations and safety campaigns

STW has established a system Patient Safety Group across the system, chaired by the CCG and is attended by all main provider Patient Safety Specialists. This forum is the system PSS platform to deliver the Strategy and share learning with clinical areas for improvement and a system approach to collaboration to ensure safety.

This group has an agreed Terms of Reference to include a remit for system learning and peer support and over time will establish links with Patient Safety Specialist's in smaller provider services across the system.

4. Timeline in Summary

There has been national progress with the role and the CCG representative has contributed to work of the steering group to shape this, supported by national webinar events.

The PPS short term plan published April 2021 includes:

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022 for roll out across systems during 2022/23
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support

The training has five levels, which build on each other; the first two levels 'Essentials for patient safety' and 'Access to practice' are already available.
Patient safety training materials have been published by Health Education England, NHS England and NHS Improvement, The Academy of Medical Royal Colleges and eLearning for healthcare, elements of which are expected to be completed by all NHS employees, even those in roles which are not patient facing. Completion of the training will help to ensure health and care services are as safe as possible for patients and service users.
The training materials can be found on the e-learning for healthcare hub.
Level 1 - Essentials for patient safety, this is a foundation and all NHS staff are encouraged to complete it. There is also: Essentials of patient safety for boards and senior leadership teams. The plan for the CCG will be launch the training for the following groups, Quality Team and the Board members; followed by Safeguarding and Medicines Management teams. This will be followed by a roll out across the system including Primary Care and the Independent Sector.
Level 2 - Access to practice is intended for those who have an interest in understanding more about patient safety and those who want to go on to access the higher levels of training. This learning will again be rolled out in the same phases as outlined for Level 1.
The syllabus sets out a new approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors, all of which has been incorporated into the training.

5. Conclusion

Work is progressing locally to meet the target date for implementation of the Patient Safety Strategy by the April 2022, taking learning from the Covid-19 pandemic experience.
Our system remains committed to implementing the Strategy, the Patient Safety Incident Reporting Framework and now there is a platform to do this with a PSS in post, the first 2 modules of the Patient Safety Syllabus as well as the Patient Safety Group meeting regularly across the System. However there is an understanding throughout the system that Covid-19 may have an impact on the timeline for implementation.

6. Recommendations

It is recommended that CCG Governing Body:
- Note and discuss the local progress made with implementing the NHS Patient Safety Strategy and the Patient Safety Syllabus training plan.
- Approve the recommendation that an update ICS to board is brought on a bi-annual basis

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held on 12th January 2022

Item Number:	Agenda Item:
GB-22-01.011	Month 8 Financial Position

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Laura Clare Deputy Director of Finance Laura.clare@nhs.net Angus Hughes Associate Director of Finance- Financial Management Angus.hughes1@nhs.net

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

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

Executive Summary (key points in the report):

The CCG control total for 21/22 is a £9.984m deficit, the current forecast actual position against this plan at M8 is a deficit of £9.783m and therefore there is a small favourable variance of £201k.

The slight improvement in the CCG forecast position is mainly due to non recurrent prior year benefits offsetting the running cost overspend and the individual commissioning overspend flagged as a risk in both the H1 and H2 plan submissions.

The underlying position against the sustainability plan remains the key focus across the system. As at Month 8 reporting the CCG is reporting a £2.6m adverse variance against the expenditure control total for 21/22 due to the regional cost pressure from WMAS and the overspend on running costs. Risk around the underlying position is highlighted in this report.

Work continues to develop and refine the 22/23 financial plan and guidance is expected before Christmas. The main risk to the plan development continues to be identification of efficiency plans.

Recommendations/Actions Required:

The Governing Body is asked to :

- Note the M8 financial position against plan
- - Note the work in progress to develop the 22/23 financial plan and the risk around identification of efficiency plans

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:

No table of figures entries found.

.Month 8 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 8 - November 2021.

21/22 Financial Plan

2. The financial plan for H2 (second half of the financial year) was submitted to NHSEI on 18th November and detail was provided to Finance committee at the November meeting. Table 1 shows the CCG summary of both the H1 actual position against plan, the H2 plan submitted and the combined full year position.

Table 1: 21/22 Financial Plan

System plan	H1			H2			Total 21/22		
Surplus /(Deficit)	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CCG	(4,754)	(4,569)	185	(5,230)	(5,214)	16	(9,984)	(9,783)	201
System adj shown in CCG	6,005	0	(6,005)	0	0	0	6,005	0	(6,005)
CCG total with system adj	**1,251**	**(4,569)**	**(5,820)**	**(5,230)**	**(5,214)**	**16**	**(3,979)**	**(9,783)**	**(5,804)**

3. In H1 the system submitted a break even plan which required a £6m high risk adjustment held with the CCG. After discussions with NSHEI the system has submitted a deficit plan for H2 and therefore the risk adjustment is not required.

4. The CCG only control total for 21/22 is therefore a £9.984m deficit, the current forecast actual position against this plan at M8 is a deficit of £9.783m and therefore there is a small favourable variance of £201k.

5. When taking into account the £6m system adjustment in H1, the overall CCG control total for the year including the system adjustment is a £3.979m deficit, our actual position including the system adjustment is therefore a deficit of £9.783m which is a £5.804m variance to plan.

Summary Financial Performance

Financial Performance Dashboard

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

Table 2: Financial Performance Dashboard - Key Indicators

Target/Duty	Target	Actual FOT	RAG
Statutory duty to break-even	Break-Even	£9.783m deficit	
Control Total (exc System adjs)	£9.984m deficit	£9.783m deficit	
Control Total (inc System adjs)	£3.979m deficit	£9.783m deficit	
Sustainability Plan			
Statutory duty to break-even	Break-Even	£56.4m	
Control Total (non-system expenditure total)	£461.5m	£464m	
Cash	<=1.25% of monthly drawdown	0.62%	G
Better Payment Practice within 30 days (Number of invoices)	>=95%	99.1%	G

7. The CCG is on track to deliver its element of the full year system plan but this does breach our statutory duty to break even.

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

9. The Better Payment Practice targets were also met in Month 8 as over 95% of invoices were paid within 30 days.

M8 Position

Table 3: M8 Position

	YTD			FOT		
Category	**M8 Budget**	**M8 Actual**	**M8 variance**	**Annual Budget**	**Annual Forecast**	**Annual Variance**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Allocation:						
Programme	574,276	574,276	0	859,413	859,413	0
Running Costs	6,120	6,120	0	9,180	9,180	0
Co commissioning	51,266	51,266	0	78,113	78,113	0
HDP/ERF	6,236	6,236	0	20,116	20,116	0
Planned surplus	493	493	0	3,979	3,979	0
Retrospective HDP expected	1,861	1,861	0	5,033	5,033	0
	640,252	**640,252**	**0**	**975,834**	**975,834**	**0**
Expenditure:						
In system:						
SaTH	242,408	242,410	(2)	373,115	373,115	0
RJAH	33,171	33,171	(0)	49,249	49,249	0
Shropcomm	50,247	50,247	(0)	75,086	75,086	(0)
In system total	**325,826**	**325,828**	**-2**	**497,450**	**497,450**	**0**
Out of system:						
Acute	50,420	49,616	803	76,895	76,578	317
Community	9,119	8,935	184	16,958	16,857	101
Individual Commissioning/	105,731	107,747	(2,015)	158,550	162,690	(4,140)
Primary Care (inc Co	125,007	122,452	2,555	185,679	182,515	3,164
Other	24,000	23,194	806	37,129	36,108	1,021
Running Costs	6,153	5,929	223	9,178	9,439	(261)
Unidentified QIPP	0	0	0	0	0	0
Out of system total	**320,431**	**317,874**	**2,557**	**484,389**	**484,188**	**201**
System Affordability Gap	(6,005)	0	(6,005)	(6,005)	0	(6,005)
TOTAL	**640,252**	**643,702**	**(3,450)**	**975,834**	**981,638**	**(5,804)**

10. Year to date financial performance is an overspend of £3.450m against the planned deficit of £0.493m, i.e. an overall £3.942m deficit. However, this includes the H1 system affordability gap of £6.005m meaning that CCG performance reflects an improved position against plan year to date of £2.557m.

11. The forecast position is an overspend of £5.804m against the planned deficit of £3.979m, i.e. an overall £9.783m deficit. However, this includes the H1 system affordability gap of £6.005m meaning that CCG performance reflects an improved position against plan of £0.201m.

12. This position includes anticipated year to date allocations in relation to the Hospital Discharge Programme of £1,861k, £243k relates to HDP expenditure within individual commissioning and £1,618k relates to HDP expenditure repayable to the Local Authorities. If this funding is not approved this will deteriorate the financial position. £3.706m of HDP income in relation to prior months was received in July and October.

13. This position also includes Elective Recovery Fund income to the CCG of £1.3m which is committed against independent sector activity. The system as a whole is in receipt of £13.7m ERF income in H2, resulting in total ERF income for the year of £16.51m. Elective recovery will be monitored on a monthly basis by NHSEI.

14. The slight improvement in the CCG forecast position is mainly due to non recurrent prior year benefits offsetting the running cost overspend and the individual commissioning overspend flagged as a risk in both the H1 and H2 plan submissions.

15. The year to date position holds the benefit of the release of prior year benefits that do not continue to accrue further as we progress through the year.

16. Acute expenditure currently shows a forecast underspend of £0.3m. An overspend in the acute NCA position is offset with an underspend due to the delay in the start date of the neurology transfer and prior year benefits of £0.5m released into the Month 8 position.

17. Community expenditure continues to show a small favourable variance due to reduced expenditure in the Powys contract.

18. Across Individual Commissioning and Mental Health expenditure there is a total forecast overspend for the year of £4.1m, with £2m of this showing in the year to date position. The overall cost pressure has been offset partially with prior year benefits. As previously described there has been an increase in TCP patients in Month 4 & 5 and increased activity within Broadcare compared to the level of budget set in the plan. Risk around this budget was flagged in both the H1 and H2 plan submissions. The overall recurrent expenditure position in this area remains in line with the sustainability plan.

19. Primary care expenditure overall is due to underspend by £3.2m. The majority of this underspend is non recurrent and relates to the release of prior year benefits in QoF (£0.6m), Prescribing (£1.2m) and PCN ARRS released in M8 (£1.4m). Average growth in prescribing has reduced from the rate seen in earlier months to an average of 3.9%, though this remains above the planned level of growth of 3.3%.

20. Other expenditure shows a forecast £1.0m underspend. The majority of this underspend is in the COVID budget which is being used to offset some of the pressure within Individual Commissioning in relation to COVID patients no longer funded through HDP. There are also underspends in relation to vacancies earlier in the year in programme pay. The overspends in H1 in relation to ICS support to WMAS agreed regionally and a cost pressure in the BCF have been funded in the H2 plan budget.

21. The ring fenced running costs allocation is due to overspend by £0.3m. This is due to some non recurrent double running costs in 2021/22 (eg the cost of the AO Post), the fact that the allocation was not uplifted for the 3% pay award and other non recurrent agency costs in the position. The year to

date position shows an underspend due to the prior year benefit in H1 around last year's redundancy provision being more than was required following the management of change process.

22. In year efficiency plans are currently delivering above the YTD plan with recurrent savings so far of £5.263m and forecast savings for the year of £7.279m. Table 4 details how savings are due to be met against each of the programme areas.

Table 4: 21/22 Efficiency Forecast

Programme Area	Recurrent full year effect net savings £000's
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Sustainability and Underlying Position

23. The CCG continues to work with system partners and NHSEI on the development of the system sustainability plan. Although the system as a whole is currently forecasting a £13m deficit against the 2021/22 system envelope this position remains in line with the system sustainability plan projected expenditure for 2021/22.

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

25. The full year CCG recurrent expenditure control total in the system sustainability plan is expenditure on non system providers of £461.558m. Based on the information that we currently have on recurrent expenditure the CCG is currently £2.6m away from delivering that control total. This is mainly due to:

- a £2.2m overspend due to the recurrent contribution required on a regional basis to support the WMAS contract and the cost pressure relating to the regionally commissioned NHS 111 and 999 services that has arisen in year (within Other).
- A £0.4m recurrent cost pressure on Running Costs.

26. This is also reflected in the YTD recurrent position which shows the CCG at underlying non system expenditure at M8 of £309.0m against a target of £307.7m, a variance YTD of £1.3m.

Table 5: Forecast against underlying sustainability plan

Category of Expenditure	Sustainability plan 21/22	Current underlying position	Variance
OUT OF SYSTEM	**£m**	**£m**	**£m**
Acute	79.9	80.4	(0.5)
Community	13.2	12.8	0.4
Individual Commissioning/Mental Health	154.9	154.8	0.1
Primary Care (inc co commissioning)	177.1	177.1	-
Other	27.1	29.3	(2.20)
Running Costs	9.4	9.8	(0.4)

Total	**461.6**	**464.2**	**(2.6)**

27. The M12 Budget shown in table 4 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. Some of the categories of spend values have also changed since the original plan due to identified efficiency moving up from the unidentified line and some minor coding changes between categories.

28. 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. For the CCG this is a total plan of £7m that needs to be delivered to meet the expenditure control total shown above.

29. The CCG will continue to focus all efforts on improving the overall system position thus improving our ability to invest in key priorities by aiming to deliver further efficiencies. Future year's schemes are also being identified as part of the longer term plan. CCG leads and the programme management office are currently working up further schemes and a detailed report is provided to finance committee on a monthly basis.

Risk and Mitigation

30. The forecasts in this report are based on the most up to date information available but risk remains in certain categories of expenditure.

In Year Risk

31. The national requirement is for us to break even although we have agreed with NHSEI to submit a deficit plan. Our focus is on delivering that plan which in doing so meets our ambition to stabilise the underlying spend position. For the 21/22 position the main risk is around the Individual Commissioning position which is currently quantified at £2.1m. We believe that we can mitigate this level of risk in year through non recurrent mitigations.

Underlying Risk

32. The main focus is on risk around the underlying position of the CCG.

33. Known underlying risks identified are:

    a. Individual commissioning due to volatility around forecasting and staff shortages within the team.
    b. The acute NCA pressure being seen with private providers has been treated as non recurrent as a result of clearing the elective backlog. We are not yet in a position to see whether this working assumption will hold true and this will be closely monitored as we progress through the year. If these increased activity levels prove to be recurrent this will deteriorate the overall financial position.
    c. Prescribing growth risk if the average increase seen in April- September continues throughout the year. The level of risk continues to reduce as the average growth comes down to be more in line with the original planned %.
    d. A potential cost pressure in the Phlebotomy service is currently being discussed with the Primary Care Team. Non recurrent funding solutions are available in 20/21 and a number of routes are currently being explored at the Phlebotomy steering group in order to address the recurrent problem and assess long term service delivery options. Any recurrent pressure will need to be discussed at the system investment panel and go through the system triple lock process.

e. A potential cost pressure in the Non Patient Transport service (transport of bloods, tests, notes etc) across the system is being discussed and worked through as part of the implementation phase of the new contract. Additional sites that have been attributed to the CCG as part of the new contract are currently under query with the new provider.
f. The full year effect of additional costs coming through on the Non Emergency patient transport contract is being flagged as a risk. An activity query notice is in place and the increase appears to be in case mix. It is assumed to be a non recurrent issue but the longer term impact is being reviewed.

Table 6; Risk and Mitigation on Underlying Position

	Full year/underlying Risk (£m)	**Full year/underlying mitigation (£m)**
Individual Commissioning	3.4	-
Acute NCA pressure	2.6	-
Prescribing	0.6	-
Phlebotomy	1.3	-
Non patient transport (bloods, notes etc)	0.1	-
Non Emergency Patient Transport	0.4	
	8.4	**-**

34. The CCG has very little mitigation to offset the risks outlined in Table 5 if they materialise as it does not hold a contingency reserve. It is late in the year to expect material additional efficiency savings to be delivered that would benefit the in-year position.

35. If all of the risks highlighted in Table 5 were to materialise the 'CCG only' underlying position would see a £8.4m additional hit to the current sustainability plan forecast adverse variance of £2.6m. (i.e. total adverse variance of £11.0m). This is demonstrated in the 'worst case' underlying position below.

Best Case (£m)	Most Likely (£m)	Worst Case (£m)
£2.6m adverse	£2.6m adverse	£11.0 m adverse

36. A risk management framework is currently in discussion across the system so that risks can be addressed and system solutions developed.

22/23 Financial Planning

37. The first draft of the system long term financial plan covering the next 10 years has been discussed with the finance committee as part of a paper on the System Financial Framework. This was also shared with Governing Body in November.

38. Further detail around the 22/23 financial plan and efficiency programmes is now being drafted by all organisations. A first cut of updated positions was reviewed at system DoFs in early December. The position will be further refined for the 22/23 detailed planning guidance expected late December.

39. Each organisation is required to deliver 1.6% of its expenditure base in efficiencies during 2022/23 in order to meet the requirement of the system's financial plan, for the CCG, this is approximately £7.2m of savings that need to be found from out of system expenditure. Work is underway to identify how savings can be made in addition to those already scoped through the systems transformation

programmes. A meeting of Executives has been arranged in Mid December to discuss how opportunities and programmes of work can be taken forward.

40. The main risk for the current plan is the identification of organisational efficiency schemes and system transformation mobilisation. Regular updates will be provided to the new system Integrated Delivery Board and the System Sustainability committee.

Conclusion

41. For 2021/22 the CCG is forecasting a deficit of £9.783m which is £0.201m better than the CCG plan of £9.984m deficit.

42. The system overall (ie incorporating the provider positions as well as the CCG) is working to a £13m deficit control total for the year.

43. M8 forecast expenditure is broadly in line with plan overall and key variances at category level are explained throughout this report. The year to date position shows an underspend due to the release of prior year benefits.

44. CCG underlying expenditure is currently £2.6m away from the expenditure control total set. The two main reasons for this are an overspend on running costs and the regional cost pressure around the NHS 111 and 999 services. Delivery of the recurrent efficiency target remains a priority of all CCG teams.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body meeting on 12th January 2022**

Item Number:	Agenda Item:
GB-22-01.012	Board Assurance Framework (BAF) 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		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)**
Audit Committee	17th November 2021	S and D

Executive Summary (key points in the report):

1. Introduction

The purpose of the report is to present to the Governing Body the latest iteration of the Board Assurance Framework (BAF) as presented to the Audit Committee at its November meeting to provide; assurance that the principle risks of the CCG not meetings its strategic priorities have been captured and are actively being managed and to allow the Governing Body to review the detail of the risks set out in the document.

2. Risk Management Framework

The CCG has in place a Board Assurance Framework (BAF), supported by the Directorate Risk Register (DRR) which are the mechanisms used to record high level strategic and directorate level risks and opportunities across all functions of the CCG, including delegated co-commissioning of primary care.

The BAF and DRR are linked to the defined objectives of the CCG, the Primary Care Commissioning Risk Register (PCCRR) is linked to the defined objectives of the Primary Care Strategy and together reflect the risk appetite of the organisation.

3. BAF 2020/21

The attached BAF is shown in appendix A, with appendix B outlining the CCG's

risk matrix criteria.

The BAF was updated by the strategic risk owners during November 2021 as part of the routine bi-monthly review cycle. The following report highlights the changes and updates to the BAF which are shown in more detail as tracked changed text in red on the BAF appended to this report. This was presented to the Audit Committee for assurance purposes at its meeting in November and the Committee recommends the BAF with the highlighted changes as attached.

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 and operational 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 the BAF and consider if any additional assurances are necessary that the risks to the strategic objectives are being properly managed.
- Accept assurance from the CCG Audit Committee that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.
- Note that further work is taking place to review risks associated with commissioning and transformation with a view to these being presented to the Audit Committee at its meeting in January 2022.

Report: Board Assurance Framework (BAF) and Directorate Risk Register 2021/22

Governing Body: 12th January 2022

Author: Alison Smith, Director of Corporate Affairs

This report highlights by exception changes to the BAF. Changes are shown in red text on the BAF.

Board Assurance Framework

Risk 1 – Patient and Public Involvement – amendments to the narrative reflecting the work that is ongoing with a recommended reduction in the risk score of 16 High to 12 High.

Risk 2 – ICS Transition – amendments to both the risk score decreasing from 16 to 12 due to the ICS Transition Steering Group now meeting and national guidance has begun to be released and an approach to due diligence has been agreed by the CCG Governing Body and ICS Board and information collation against the due diligence checklist has begun with first position statement reporting begun in November.

Risk 3 – CCG Workforce – risk score has increased from 16 to 20 as capacity remains very challenging with potentially more redeployment requirements to the Covid vaccination centres.

Risk 4 – Financial sustainability – some narrative amendments.

Risk 5 – Inability to delivery long term sustainability plan – some narrative amendments.

New Risk 10 has been added around the risk of sustained urgent and emergency care pressures in the system.

The Board is asked to note that due to the transfer of parts of the Transformation portfolio to the Directors of Planning, Performance and Partnerships, following the departure of the Executive Director of Transformation, these Directors are currently reviewing the existing identified risks in this area and will provide an updated risk assessment which will be included in the next iteration of the Board Assurance Framework at the Audit Committee in January.

The Governing Body is recommended to:

- Review the BAF and DRR and consider if any additional assurances are necessary that the risks to the strategic objectives are being properly managed.

- Accept assurance from the CCG Audit Committee that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.

- Note that further work is taking place to review risks associated with commissioning and transformation with a view to these being presented to the Audit Committee at its meeting in January 2022.

STW CCG - Board Assurance Framework (BAF) 2021/22 - Nov 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	7	8	9	10	11	12	13	14	15	16
Risk ID	Strategic Priority	Opened / added by	Risk and description	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 CCG may 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. There is also a risk that the transition of the statutory duty to consult and engage from the CCG to the ICS may not be done without disruption to engagement on any consultation/engagement activity and/or reputational damage to the CCG/ICS	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) AIC now receiving comms and engagement plans from commissioners and providing Chair reports to the Governing Body The CCG is managing the challenges around engagement effectively and due diligence work is ongoing around the transfer of CCG functions to the ICS for 1 April 2021 Work is ongoing to make the ICS more transparent and accountable. For example the ICS AGM was held in public and its Board meetings will soon also be held in public	Gaps in controls: 1) ICS Communications and Engagement Strategy yet to be developed 2) Communications and Engagement processes being reviewed by new ICS Communications and Engagement Director and Interim Assistant Director Gaps in assurance: None	**possible x major = High 12**	↓	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) The Interim Director and Assistant Director have established processes with their new-look team and are now developing a forward plan of activity.	**possible x minor = Low 6**	E Boampong	C Hudson	AIC	AS 24.05.21 AS 21.06.21 CH 30.06.21 EB 02.09.21 EB 09.11.21
2	5	A Smith	Transition to a statutory ICS There is a risk that the CCG does not have sufficient capacity and capability to undertake the transition to the ICS satisfactorily, which results in the ICS being	ICS Shadow Board. Regular reports to CCG Governing Bodies. Programme Boards of the ICS reporting to the ICS Shadow Board. ICS Transition Group involves CCG ED for F, ED for Quality and Nursing, D of Partnerships and Director of CA Transition plan in place with PMO support. Due Diligence plan approved and work is ongoing. Additional PMO support has been secured via NHS EI to support capacity challenges	Gaps in controls: 1. Capacity within the system. Gaps in assurance: 3. ICS Governance structure and reporting requirements still being	**Likely x major = High 12**	↓	1. National guidance is now being released which will assist in determining any gaps in capacity. 2. Guidance on model constitution and place and ICB structures has been rerleased. Discussions ongoing with ICS partners on what "place" will look like in ICB end of August and ongoing which will inform the transition plan.	**Unlikely x major = Moderate 8**	C Skidmore Deputy AO	A Smith	GB/Audit	AS 24.05.21 AS 21.06.21 AS 02.09.21

			unable to discharge its new statutory duties.		defined									
3	All priorities	A Smith	CCG Workforce capacity There is a risk that due to the number of secondments, staff vacancies, recruitment freeze and staff sickness levels that the capacity, capability and resilience of our workforce is unable to meet the demands of ongoing secondnment/redeployment requirements of the Covid Vaccination Centres and the ongoing need to service both CCG and ICS operational functions running in parallel which will result in the CCG being unable to meet its strategic priorities.	1. Directors sharing directorate risk at Exec meeting weekly, audit of training compliance,	Gaps in controls 1. Supporting staff to undertake their roles effectively whilst under considerable pressure. Gaps in Assurance 2. No reporting currently on ongoing capacity issues across the whole CCG.	**Likely x Catastrophic = Extreme 20**	↑	1c.. Effective prioritisation of workload to system Big 6 priorities and other quality and safety priorities. ongoing 2 Capacity issues in directorates to be captured in DRR Nov 21	**Possible x Moderate = Moderate 9**	A Smith	A Smith	Audit/GB	AS 24.05.21 AS 02.09.21 AS 09.11.21
4	3 and 4	Laura Clare	Financial 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	Regular CCG and System level financial reporting to CCG directors, 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 3) No contingency in plan to mitigate emerging risks - particular risk around the WMAS contract being discussed at a regional level. Would need increased efficiency plans to mitigate. Gaps in assurances: None	**Almost Certain x Catastrophic = Extreme 25**	↔	1) Workshops held and draft plans being developed to inform 22/23 plans to be in place by Dec 21. [CS/JD Dec 21]~~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.~~ ~~A 12 week plan has been developed for Programmes that are in development to help provide further pace of delivery.~~ ~~Weekly Dashboard presented to Executives setting out the current status of plans highlighting the unidentified gap and any risks in the development of new plans.~~ ~~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]~~ 2) Staff resource mapping to internal and system plans ongoing - gaps identified and added to Directorate and system risk registers [JD Nov 21] 3) CCG EDOF part of regional discussions regarding recurrent funding solutions for WMAS pressures. [CS Dec 21].	**likely x major = High 16**	Claire Skidmore	Claire Skidmore/ Laura Clare Steve Trenchard/ Kate Owen	Finance	Laura Clare 26.5.21 28.6.21 Kate Owen 20.08.21 Laura Clare 21.10.21

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	Regular CCG and System level financial reporting to CCG finance committee and Governing Body. Regular system level financial reporting to system sustainability committee and Integrated Care Board	Gaps in controls: 1) Detailed financial model behind the sustainability plan currently in place for 21/22 with organisational expenditure control totals established. Long term plan developed with high level assumptions but further work now to be done across the system to refine assumptions and work through financial implications of the transformational projects. 2) System transformational projects ('big ticket 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 has been drafted and agreed across the system to ensure collective ownership of risk and mitgation. This needs to be refined as plans develop.	**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 presented to the system in September- this included a ten year plan showing agreed high level assumptions. This was supported by system partners. Plan now to be further refined and include delivery of 'big 6' transformational projects. [CS Dec 21] 2) System wide development of 'big 6' underway with SRO assigned to each, further work on modelling underway to align to system financial plan. ~~modelling to be presented to the system in July 21.~~ Progress Review planned for November, focus on mobilisaton plans. [David Stout Nov '21] ~~CCG resources mapped to each of the 'big 6' projects and further projects being prioritised. ST August 21.~~ 3) System risk management framework shared with sustainability committee and system CEOs in September 21. Refinement ongoing to ensure non financial risk is adequately captured. [CS Dec 21].	**likely x major = High 16**	Claire Skidmore	Claire Skidmore/ Laura Clare ~~Steve Trenchard/ Kate Owen~~	Finance	Laura Clare 26.5.21 28.6.21 20.8.21 Steve Trenchard 26.8.21 C Skidmore 09/11/21
6	1, 3 and 5	Z Young	Quality and Safety Without a robust quality governance framework in place, the system will not be able to monitor quality and safety and mitigate risks in a timely manner. Patients may experience poorer outcomes and experience.	1. Good attendance from system partners at the SQG. 2. Distributive leadership approach in evidence through leadership of quality improvement groups. 3. Number of overdue SI reports is reducing and quality of investigatory reports and action plans improving for acute provider. 4. Information sharing and benchmarking via LMNS and MatNeo Clinical Network. Maternity & Neonatal network independently review maternity position for SBLCB v2 bi-monthly. LMNS receives a Perinatal Quality Surveillance report and updates on progress with implementing the recommendations arising from the Ockenden review of maternity services 2020. 5. Recent QA visit to SaTH demonstrated person-centred care and adherence to safeguarding policy requirements for CYP/MH cases. 6. CQC inspection of SaTH July 2021 has not generated additional enforcement action. 7. External Audit (Grant Thornton) report July 2021 details 'good 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.	**Gaps in Control:** 1. Backlog in key performance areas impacted on by continued C-19 pandemic response, leading to poorer patient experience and possible harms due to delay in access for diagnostics and treatment. 2. Quality governance processes in SaTH not fully formed and embedded; reliant upon external support. 3. SaTH vacancy and staff turnover for skilled workers. Necessary workforce is not in place/do not have capacity/capability, or is achieved with temporary staffing solutions or external support. 4. New system Quality and Safety governance arrangements yet to be fully shaped up, implemented and embedded. Resource to be identified to progress this work. **Gaps in assurance:** 5. Triangulated information indicates areas of concern within providers. o SaTH in NHSEI Quality Special Measures - 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. CQC report expected publication September 2021 o SaTH Maternity Transformation schemes (Continuity of Carer/SBLCBv2) and Ockenden Maternity Review recommendations not yet fully implemented. o MPFT access to services for CYP MH and suicide prevention strategy. 6. Unvalidated SaTH provider metrics/data quality issues - particularly for maternity services. 7. Time lag of 2 years for MBRRACE-UK nationally validated and published comparative perinatal mortality data. 8. Closure/divert of some maternity birthing services at SaTH due to staff shortages as a result of vacancy and also Covid-related absence. 9. Establishment of system approaches to quality governance at early stages and not fully developed or embedded. In particular the quality governance at 'place' is yet to be defined.	**Possible x catastrophic = High 15**	⇔	1. Further develop and embed the system-wide revised approach to quality governance during 2021/22, including quality governance at 'place'. Identify senior resource (DDoN) to lead this work. Q3 2. Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance fora. (nb Workforce reported to ICS People Board which has agreed key priority areas for action). Ongoing 3. Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. Ongoing 4. Undertake themed reviews for individual providers and system quality concerns and issues. Ongoing Develop system dashboard for Quality Indicators for SQG members peer review and mutual accountability. Oct 21 5. SaTH undertaking a programme of Quality Improvement with UHB as their Improvement Alliance partner - Getting to Good Programme - reported monthly to SOAG for oversight & scrutiny. SOAG is co-chaired by ICS and NHSE/I directors. Ongoing during 2021/22 6. Further develop the maternity metrics dashboard at LMNS level. Nov 21 7. Negotiate access to SaTH real-time (unvalidated) data submissions to MBRRACE-UK. Oct 21 8. Support to SaTH to further develop the content and accuracy of their internal maternity dashboard and improve exception reporting. Oct 21 9. SaTH implementing the 'Badgernet' electronic maternity records sytem from in a phased roll out programme which over time will improve confidence in audit information. Aug 2021 onwards 10. CCG Quality Lead to join SaTH Maternity Safety Champion programme of clinical quality assurance. Oct 21 11. Continue to monitor Maternity service closure and impact, ensuring appropriate escalation process are followed in each occurrence. Ongoing 12. Targeted quality improvement work relating to CYP MH. Ongoing 13. Oversight of Safeguarding and LAC risks via system safeguarding assurance mechanisms. Ongoing 14. Continue to monitor LAC standards (which are improving), supporting with revised referral processes. Ongoing 15. Implement recommendations of CCG internal audit of Safeguarding Adult and Child processes. Oct 21 16. Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. GB development event Oct 21. 17. Review CCG Quality Team staffing plans as part of budget setting. Q4 2021/22	**Possible x Major = High 12**	Z Young EDoN&Q	T Slater	QPC	ZY: 03/09/21 Revised risk. Additional assurance/controls/actions added.

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.	Demand and Capacity Groups Covid19 Management Group System Planned Care Operational Group (Elective & Cancer recovery) and System Planned Care Board	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	J Davies 30.08.21
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.	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 undertaken for 2 x PMH joint post with our two LAs. One now in post and the other will commence in October 21 2/3) PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Need for appropriate dats shring arrangements to be finalised to support this work 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 27.08.21
9	1,2,3,5	Zena Young	Safeguarding / Looked After Child (LAC) There may be insufficient capacity to carry out statutory safeguarding responsibilites for Adults and Children within our system with the increase in safeguarding activity associated with C-19 pandemic. Lessons may not be learned quickly enough to fully protect our population from avoidable harm.	1. The safeguarding and LAC governance infrastructure is well attended by all statutory partners. 2. The GP forum is well attended. 3. STW Designate professionals are networked at regional and national level, contributing to a variety of expert groups. 4. A quality assurance visit to SaTH regarding s31 found a good level of safeguarding assurance.	Gaps in controls 1. The volume of rapid reviews and Safeguarding Governance assurance meetings requiring inputs has increased post C-19 lockdown. 2. A high number of children from Out of Area are placed in Shropshire Children's care homes; frequently their escalating or specialist needs are unable to be met by those care homes and they become 'stranded' in ED in crisis. This is beyond the control of STW system, being the responsibility of the placing organisation and private care homes. 3. A shortage nationally of NHSEI commissioned Tier 4 specialist beds, particularly for eating disorder specialist placements. 4. A delay in mental health assessment for persons presenting in ED due to a local shortage of MH assessors. 5. For Shropshire LA, LAC notifications not received/not timely which impacts on achievement of Health Assessments being conducted in a timely manner. Gaps in assurance: 6. Increased level of safeguarding concerns and associated volume of work generated post-lockdown within system. 7. On occasion there are some CYP solely with mental health needs at SaTH which breaches the CQC s31 notice issued in February 2021. 8. On occasion older YP are cared for on adult MH wards or for long periods in the s136 suite.	**Almost certain x Major = Extreme 20**	New risk	1. Maintain attendance of designated and named professionals at safeguarding and LAC governance fora. 2. Continue to triangulate information and outcomes and address areas of concern. 3. Continue to undertake quality assurance visits. 4. Scope out development of a proactive/reactive support offer to CYP care homes with system partners. 5. Continue to support commissioners and providers in implementing new models of care.	**Likely x Major = High 16**	Zena Young	Maria Hadley	QPC	Z Young 03/09/21
10 New Risk	2,3	S Tilley	Risk of sutained UEC pressure There is a risk that demand for urgent and emergency care consistenly oustrips capacity and that this will result in patients suffering harm.	UEC Group UEC Board UEC Sub Groups	Workforce pressures and covid prevalence is putting significant pressure on service delivery. CCG UEC team resource depleted	**Almost certain x Major = Extreme 20**	New Risk	Several improvement workstreams in place but capacity to deliver change is limited during times of such heightened pressure Winter Comms plan in place, Winter Plan and specific winter schemes in place CCG UEC staffing resurce structure developed and requires further discussion at Exec level regarding poteitial to implement Specific development in place regarding discharge and attendance avoidance	**likely x major = High 16**	S Tilley	S Tilley	UEC Board All CCG Committees	S Tilley 02.11.21

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.	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, Telford and Wrekin CCG Governing Body Meeting held in Public on 12th January 2022**

Item Number:	Agenda Item:
GB-22-01.013	Constitution and Governance Handbook Annual Review 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		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):

This report summarises some proposed amendments to the Governance Handbook, following the annual review of the CCG's Constitution and Governance Handbook. It also seeks to share with the Governing Body a recent letter advising Trusts and CCGs to streamline their decision making processes in light of the additional burden of supporting the Covid response and Covid booster vaccination programme.

The CCG Governing Body is asked to note that the CCG Governing Body adopted the new CCG Constitution and Governance Handbook at its extraordinary meeting held on 14th April 2021. Further to this, additional amendments were proposed and approved by the Governing Body at its meeting in July 2021 to the Scheme of Reservation and Delegation contained in the Governance Handbook, to clarify decision making on varying health contracts.

The Director of Corporate Affairs has reviewed the content of the Constitution and Governance Handbook as part of an annual process and identified the need for a small amendment to the latter. The new proposed amendments to the Governance Handbook are to amend the Chair of the Strategic Commissioning Committee from the Lay Member for PPI – Equality, Diversity and Inclusion to Registered Nurse Governing Body member to address an in-balance in the Lay Member for PPI - Equality, Diversity and Inclusion CCG commitments.

The proposed amendments are contained in section 2.2 and 3.1 in the terms of reference for the Strategic Commissioning Committee on page 47 of the Governance Handbook, draft version 3 which is attached as **appendix A** with amendments shown as tracked changes for ease.

The Governing Body are able to vary the content of the Governance Handbook as required without the need to ratify any amendments with the CCG membership. Therefore in order to ensure the CCG maintains effective and efficient decision making through its committee structure

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.

In addition the Governing Body is asked to note the content of the letter attached as **appendix B** from Sir David Dolman, Chief Operating Officer NHS England, entitled 'Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic'. The letter outlines a number of areas that NHS England expect CCGs and Trusts to consider reducing or streamlining to release capacity to tackle the current priorities around Covid and vaccination centres and this includes annual accounts/annual reporting and mandatory training.

The Governing Body is asked to specifically note the following:

- Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (e.g. because of self-isolation).
- For board committee meetings, trusts should continue quality committees, but consider streamlining other committees.
- While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation.
- All system meetings to be virtual unless there is a specific business reason to meet face to face.

These areas have already been actioned in December/January for the Governing Body and its committees, but further action will be considered by the Accountable Officer and Director of Corporate Affairs that can be taken over the coming months, consulting with the Chair and a proposal will be circulated to the Governing Body virtually for comment and support.

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 amended Governance Handbook with the highlighted amendments as outlined in the report and appendix A attached; and**
- **NOTE the letter from the Chief operating Officer, NHS England.**

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 2	14/07/21	n/a
Version 3 Draft		

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.

It is acknowledged that the CCG is likely to be dissolved on 1st April 2022 and replaced by a statutory Integrated Care System (ICS), dependent on the outcome of draft legislation currently being considered by Parliament. The Governance Handbook describes the governance structure of the CCG and does not seek to include any governance information pertaining to the Shropshire, Telford and Wrekin Integrated Care System.

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**
	9.7 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 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:

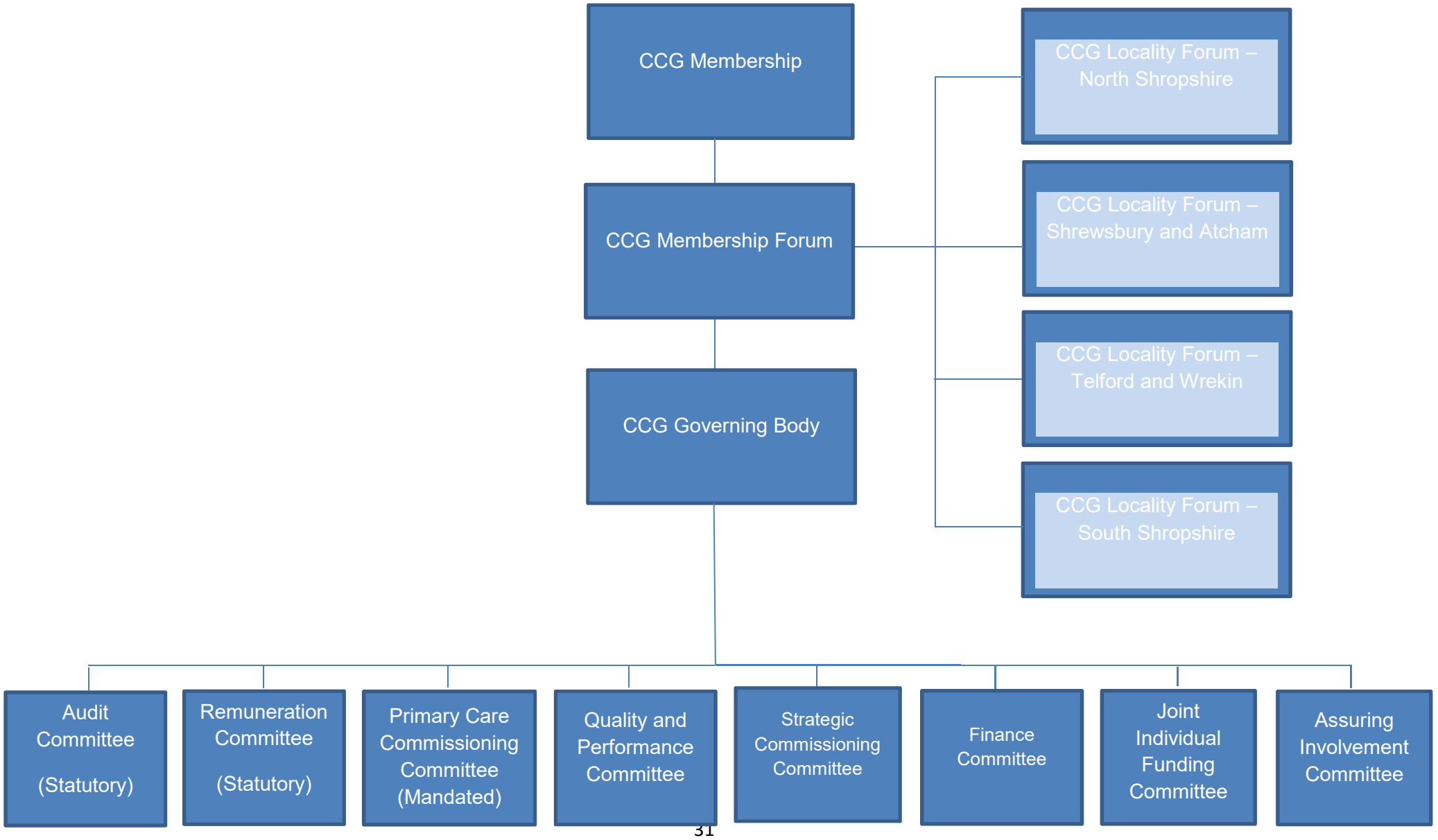
a) To be aware of capacity pressures in the system and take action as set out in the on call pack as appropriate (i.e. escalation management);
b) To follow the Incident Reporting Protocol;
c) To follow the 12 hour Trolley Breach Protocol;
d) To be the local Commissioner point of contact for a major incident (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 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 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~~ Registered Nurse

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.~~Registered Nurse

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 outcomes.

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

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS 111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

24 December 2021

Dear Colleague

Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

Once again, the NHS is facing a significant challenge from COVID-19. As we continue to manage infections from the Delta variant, the Omicron variant is growing substantially and once again there is a risk of significant levels of COVID-19 hospitalisations with the challenges these place across the whole NHS. At the same time, the NHS is delivering a national COVID booster vaccination programme and continuing to provide essential non-COVID care.

This letter should be read in conjunction with 'Preparing the NHS for the potential impact of the Omicron variant and other winter pressures', which declared a Level 4 National Incident.

Following our letters in March and July last year and January, this letter updates our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- streamlining oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focusing our improvement resources on COVID-19, vaccination, discharge, UEC and elective recovery priorities
- only maintaining development workstreams that support recovery and safety.

Our intention is that the measures here will collectively help you free up resource to address the priorities we have set out.

We will keep this under close review, making further changes where necessary to support you and remaining mindful of the balance between timely information and not flooding the service with requests. We will review and update the measures set out in this letter in Q1 2022/23.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenge of COVID-19 since March 2020.

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

A) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (eg because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation. All system meetings to be virtual unless there is a specific business reason to meet face to face.	Organisations to inform audit firms where necessary
2.	FT governor meetings	Face-to-face meetings should be stopped wherever possible at the current time[1] – virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19, eg via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor
4.	Annual accounts and audit	Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	Organisations to continue with year-end planning in light of updated guidance
5.	Quality accounts – preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	No action for organisations at the current time

[1] This may be a technical breach of foundation trusts' constitution but acceptable given government guidance on social isolation.

No.	Areas of activity	Detail	Actions
6.	Quality accounts and quality reports – assurance	We are removing requirements for FTs to include quality reports within their 2021/22 annual report and removing the need for assurance of quality reports and quality accounts from all trusts.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January 2021 confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 and kept for 2020/21 are available for 2021/22.	Organisations to continue with year-end planning in light of updated guidance
8.	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

B) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, cancer, ambulance waits, mental health and learning disability measures)	See Annex A
2.	Friends and Family Test	Reporting requirement to NHS England and NHS Improvement has been resumed. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. We emphasise local discretion.
3.	Long Term Plan: mental health	NHS England and NHS Improvement will maintain the Mental Health Investment Guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
4.	Long Term Plan: learning disability and autism	Systems should continue learning disability and autism investment and transformation to support the LTP.
5.	Long Term Plan: cancer	NHS England and NHS improvement will maintain their commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response

No.	Areas of activity	Detail
		and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6.	Long Term Plan: maternity and neonatal	Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report. We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.
7.	GIRFT and transformation programmes	Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.
8.	NHS England and NHS Improvement oversight meetings	Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9.	ICS development activity	System working is essential in managing the response to COVID-19 and delivering the NHS's priorities in 2022/23. Work to establish ICSs – and ICBs as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.
10.	Corporate data collections (eg licence self-certs, annual governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the forward plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.

No.	Areas of activity	Detail
11.	CQC routine assessments, Use of Resources assessments, HSIB investigations	With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced.
12.	Provider transaction appraisals – mergers and subsidiaries Service reconfigurations	Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors. Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13.	7-day services assurance	No changes – self-cert statements to continue.
14.	Clinical audit	Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.

C) Other areas including primary care, HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.
2.	Appraisals and revalidation	Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.

		The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022.
3.	Primary care	We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy.
4.	CCG clinical staff deployment	Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. CCG governing body GPs to focus on primary care provision and booster campaign.
5.	Repurposing non-clinical staff from CCGs	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.
6.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

Annex A – constitutional standards and reporting requirements

While existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below.

A&E and ambulance performance – Monitoring and management against the four-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

Discharge – Monitoring and management of delayed discharge for patients who no longer meet the reasons to reside will continue, and from Tuesday 21 December daily calls will take place in every region with every ICS discharge SRO to discuss performance and actions to decrease the number of people with a delayed discharge.

Cancer: referrals and treatments – Cancer treatment remains a priority and should be protected. We will continue to track cancer referral and treatment volumes to provide oversight of the delivery of timely identification, diagnosis and treatment for cancer patients. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Screening: cancer (breast, bowel and cervical) and non-cancer (abdominal aortic aneurysm, diabetic eye and antenatal, newborn screening and targeted lung checks) – Screening remains a priority and should be protected.

Immunisations – All routine invitations should continue to be monitored via the NHS England and NHS Improvement regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and through the urgent and emergency care daily SitRep return we now capture data on the clinical priority ('P code') of elective cancellations and patients who have not yet been booked for treatment. This is vital management information to support our operational response to the pandemic, and we require 100% completion of this data with immediate effect. Guidance can be found here.

Note: it has been necessary to institute a number of additional central data collections to support management of COVID – for example, the daily Covid SitRep and the Critical Care Directory of Service (DoS) collections. These collections continue to be essential during the pandemic response, but to offset some of the additional reporting burden that this has created, the following collections will be suspended:

Title	Designation	Frequency
Critical care bed capacity and urgent operations cancelled	Official Statistics	Monthly
Delayed transfers of care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex accommodation	Official Statistics	Monthly
Venous thromboembolism (VTE)	Official Statistics	Quarterly
Mental health community teams activity	Official Statistics	Quarterly
Dementia assessment and referral return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week patient choice offer	n.a. - trial	weekly

(This has already been communicated to data submission leads via NHS Digital.)

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body Meeting held in Public on 12 January 2022**

Item Number:	Agenda Item:
GB-22-01.015	Summary Report of the NHS Shropshire, Telford and Wrekin CCG Quality and Performance Committee dated 27th October 2021

Executive Lead (s):	Author(s):
Zena Young Executive Director of Nursing and Quality zena.young@nhs.net	Meredith Vivian, Chair, Shropshire Telford and Wrekin Quality and Performance Committee

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

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.	24th November 2021.	S/I

Executive Summary

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.

To provide a summary of the main items reviewed at the 27th October 2021 meeting.

Performance

- Covid demand spiked in early September c.20% above the system forecast for admissions, this spike has however flattened, but still remains above forecast @ c10%, as previously reported this is having an impact upon planned care recovery; Acute providers are looking to mitigate this with early implementation of the winter plans.

- The Quality and Performance measures relating to Urgent and Emergency Care (UEC) remain challenged and do not currently meet the Constitutional/National standard; SATH Type 1 provider is currently ranked 19/20 in the region and 98/114 Nationally for the 4hr standard. Previously reported concerns relating to ambulance handover also sees SATH in the top 10 worst performing Acute Provider Nationally. A number of key actions are in place to improve the UEC performance position, the committee was requested to acknowledge and support in particular the programme of collaborative work between NHSE/I and the ICS (Transformation Tuesday).

- UEC pressures are still impacting upon planned care recovery. Diagnostic tests within six weeks of referral remain an outlier but are on target to meet the national standard by year end due to the additional funded CT support. Referral To Treatment eighteen weeks is consistently around 61%,

a dedicated System Elective Delivery Programme Steering Group is currently being established by SaTH, which will drive through delivery of the recommendations and efficiencies suggested by the Midlands Elective Delivery Programme (MEDP). Due to the interdependencies and potential overlap, this group will report into the Planned Care Board to ensure absolute alignment. Through its intended operational efficiencies, this work is also an enabler in supporting the recovery of waiting lists and sustained improvement of RTT delivery & performance. MEDP work is phased as follows:

- Phase 1 – ENT, Orthopedics and Ophthalmology, underway with plans being developed since April 2020.

- Phase 2 – Gynaecology, General Surgery, and Urology, baseline data currently under review with improvement plans in development.

- Cancer care; referrals are in line with 2019/20 activity, with the exception of the lung pathway, as referral numbers have not yet returned to pre-covid levels. Numbers of Skin referrals are much higher than pre-covid and appear to correspond with the drop in community dermatology referrals; this is being investigated with a further update to be provided in the November report.

- Cancer performance; Cancer wait 28-day faster diagnosis and two week wait from urgent referral to first appointment are narrowly missing national targets, but benchmark considerably well against other regions, transformation work and support with the Cancer Alliance and additional Breast Screening should see a considerable positive shift in recovery over Q3 &Q4 of this financial year. The sixty-two day from urgent referral to cancer treatment although below the standard is broadly in line with other ICS's/Regions as pressure continues across oncology and radiology services, local improvement work across Skin and Breast pathways will have a positive impact upon this metric. The STW Cancer strategy has been refreshed with a number of key priorities, one of which is to work with GRAIL (an independent organisation specialising in clinical cancer trials. NHSEI have entered a partnership with GRAIL to participate in a study for multi-cancer early detection tests (named "Galleri") and we are working with the West Midlands Cancer Alliance to be part of this study.

- IAPT recovery rates have previously exceeded the 50% national target but have dipped below target this month. IAPT referral to first treatment activity is below both national and locally commissioned targets, although activity is expected to increase during quarters 3 and 4 based on historic trends. 2021/22 national targets will not be met in year but service re-design and additional planned funding in 2022/23 should then achieve national targets in Q1. Dementia Diagnosis Rates among over-65s in primary care have dipped slightly but remain above the national average, recovery plan is expected to deliver improvement by year end.

Learning Disability and Autism Update

- Annual health checks performance is on plan although the plan is weighted to the end of the year and may be at risk if there are increased levels of COVID and other winter pressures.

- In-patient beds is above trajectory however, this remains a challenge because following COVID, a lot of people with autism have struggled with isolation. The LD & A team have been working closely with MPFT provider colleagues to ensure that patients are discharged from Redwoods in a timely manner.

Quality Exception Report

<u>SaTH</u>

- The number of falls continues to remain an area of focus, with 109 reported in July 21. The falls per 1000 bed days remains above target for improvement; however the falls with harm per 1000 bed days is low. The fall action plan from the Trust is awaited.

- The response time for complaints remains unsatisfactory, work is underway in SATH to reduce delays in the process. 45% of complaints are responded to within the required timeframe. The Trust is undertaking some improvement work around the structure of the patient experience time.

- Ward 27 has had an increase in category 3 pressure ulcers and additional support from the Tissue Viability Nurse is being provided.

- There were two maternity related SIs reported during September 2021, both related to harm caused to the baby.

- There is a high level of service user satisfaction Patient Experience; there is a lower response rate in post-natal with ongoing work being carried out to increase response rates. There is continued work with Maternity Voices Partnership (MVP) to ensure that patient experiences are captured and acted upon.

ShropCom

- Work is being undertaken with Shropcom regarding End of Life care.

Robert Jones and Agnes Hunt

- The CCG has undertaken two visits to RJAH given the three never events occurring within a short period of time (April and May). During the visit it was apparent that there is significant corrective action being put in place by the Trust around 'pre-op', 'stop before you block' and significant work around human factors. However, there appears to be disconnect with some of the investigations being undertaken in isolation, i.e. limited sharing of lessons learned and limited or no involvement or input from staff whose names are against the action. This was fed back to the Trust.

Looked-after Children Safeguarding

- Numbers of children that are coming into care continues to rise.

- Free prescriptions for care leavers have been approved by the Executive Team.

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.	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:
The Governing Body is asked to note for assurance and information.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, NHS Telford and Wrekin CCG Governing Body meeting held in public on 12th January 2022**

Item Number:	Agenda Item:
GB-22-01.016	Summary Report of the Shropshire, Telford and Wrekin CCG Audit Committee held on 17th November 2021

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	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 Committee received the Business Continuity Plan for the single CCG. The plan included learning from COVID along with a more detailed inclusion for agile and home working arrangements. The Committee approved adoption of the plan.
- The Audit committee has taken delegated oversight of the due diligence process to transition to the ICS The committee received the updated approach for parallel reporting to the ICS Audit & Risk committee. An additional two-day panel meeting was discussed and its composition, with the due diligence guidance giving the CCG a low risk & complexity classification.
  The Due Diligence checklist was reviewed and considered that the process was robust and highlighted areas for additional information to enhance assurance..
- BAF and Directorate Risk Register was presented and agreed with up to date risks and mitigation to address. The committee noted and recognized the two new risks . one related to sustained pressure on the UEC and on the DRR relating to staffing of the incident management function. The committee noted that some risks were not being updated or had no risk owner identified. Limited assurance was provided that the strategic and operational risks had been Identified, and mitigation was presented. IT is critical that the BAF and DDR are seen as the key documents and are therefore kept up to date with strong and regularly reviewed mitigation.
- Flexible working Policy was received and approved with some suggested amendments.
- Information Governance update was received with an update on the 2021/22 DSPT, the latest bi monthly report from CSU IG team, the content of the SARs log and SIRO report. Further updates will be received at future Audit Committees.. the 95% target was achieved in a rolling 12 month period this year and this is a significant achievement for the IG team.

- An update was received around Policy alignment with eight polices that needed to be aligned for the new organization. Work was taken away to achieve the year end deadline with some additional oversight in January meeting.
- 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.
- Losses, Special Payments and Waivers were received with no losses or special payments in the period. It was noted that six waivers had been completed with the Committee given assurance that normal service reviews will be reinstated.
- Internal Audit Progress was received for both Child & Adult Safeguarding. It was noted that there were some positives but the key aspects of the report did not provide assurance with a lack of actions and ownership of the plans.. The committee recognized the work that the safeguarding team were doing against a challenging backdrop, but felt unable to assure the board of the plan. A further update was requested for the January meeting.
  Internal Audit Progress report showed progress was on track.
- External Audit advised that there was still some dialogue on the audit with the deadline moved to 26th April and completion to 8th June. There was little update on any proposed changes to the audit or accounting standards for 2021/22. With the concern of the financial sustainability for CCG and the subsequent single organization.
- Counter Fraud progress report was received and details discussed. With no issues raised from National Fraud Initiative 2020/21 for either Telford & Wrekin or Shropshire being raised.

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 policies approved.

Board to note the need for the BAF and DRR to be working documents and regularly updated and strengthened.

Board to note the ongoing work and current unassured Adult & Child Safeguarding internal audit action plans.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing Body**
Meeting held in Public on 12 January 2022

Item Number:	Agenda Item:
GB-22-01.017	Primary Care Commissioning Committee (PCCC) Summary Report (December 2021)

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

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

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Primary Care Commissioning Committee (summary of meeting)	01/12/2021	

Executive Summary (key points in the report):

The detail below provides a short summary of the items, discussion and actions from Primary Care Commissioning Committee 1st December 2021.

Finance update:

- Month 7 showed a total spend within Primary Care of £15.1m; £107m year to date.
- Co-commissioning spend in Month 7 was £6.4m which is comparable with year to date Month 6 run rate.
- Non-delegated Primary Care spend in Month 7 was £8.7m compared to year to date Month 6 run rate of £9m. The reduced expenditure in Month 7 was due to the non-recurrent allocation received in H1 for the Health and Wellbeing Hub for which expenditure was accrued throughout H1. There is an expectation that some of this funding will be returned to NHSE/I over the coming months due to delays in development of the scheme.
- Overall, the underlying expenditure for the full year remains in line with that published in the System Sustainability Plan. Co-commissioning is approximately £1.5m above the ring fenced allocation for that area.
- The efficiency challenge within Primary Care continues to attempt to reduce the gap. The total efficiency target for the year is £2.3m and year to date STW CCG is above that target due to efficiencies within the Prescription Ordering Direct scheme. The total full year forecast is reporting an under-achievement of £324k.
- Primary Care transformation funding received is still expected to be spent in this financial year. However, there is a risk associated with the Fellowship Scheme due to lack of applicants. This is a regional issue and is not merely specific to Shropshire Telford and

Wrekin.

- The CCG is currently expecting an expenditure shortfall of £1.6m against the ARRS funding. All PCNs are reviewing options for additional staffing in order to reduce this.
- Ongoing financial risks have been identified and include expenditure on prescribing where the growth rates in earlier months exceeded plan in the first half of the year but now appear to be reducing month on month. Phlebotomy is highlighting a potential cost pressure for next year and long term service delivery options are being considered.

Estates update:

A report on the work to date around development of a Shrewsbury Health and Well-Being Hub was presented. It described the background of Primary Care estates, the case for change, outline proposals and the public engagement undertaken so far. The development was being led by Primary Care as part of a national pilot but involved all parts of the system in identifying potential service delivery. The project is in very early stages and is an iterative process involving the following key partners. Further public engagement will continue as the project develops.

Pauls Moss Business Case was approved at both regional and national level and contracts have been exchanged for the construction work to begin in Whitchurch in 2022.

A extraordinary PCCC will be need in January 2022 to consider the Shifnal full business case (FBC)

General Practice Nurse Strategy:

Key points of the strategy were:-

- General Practice Nurse (GPN) development is an area of focus for Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) in order to retain an agile workforce to support the needs of the population.
- The strategy covered all grades of nursing staff and looks to support and develop Health Care Assistants and new roles such as Nursing Associates.
- The strategy is based on the three overarching principles from the GPN 10 Point Action Plan – Recruitment, Retention, and Reform - and explores local opportunities to achieve these ambitions. It also reflects the need to ensure the nursing workforce had opportunities to continue with professional development and is able to deliver safe, harm free care.
- The aims of the strategy have been consolidated into a key deliverables plan which will provide more granular detail on how the ambitions are to be achieved.

Primary Care Quality:

- Since the Q4 report, two Practices had been inspected by CQC - Severn Fields in Shrewsbury, and Brown Clee in Ditton Priors. Severn Fields was rated as Requires Improvement overall.
- Since the report was presented at Quality & Performance Committee, the inspection report for Brown Clee Practice had been published on the CQC website with an overall rating of Good.
- Additional support will be given to practices where any RI ratings are received either overall or under the domains.
- Risk register was reviewed and updated

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

Recommendations/Actions Required:
Board representatives 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 on 19th December 2021**

Item Number:	Agenda Item:
GB-22.01.018	Chairs Report for Strategic Commissioning Committee

Executive Lead (s):	Author(s):
Dr Julie Davies, Director of Performance & Contracting	Mrs Audrey Warren, Nominated Chair & Registered Nurse Governing Body Member

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)	15th December 2021	A

Executive Summary (key points in the report):

Policy Update: Continuous Insulin Infusion- Without continuous glucose monitoring in adults and children with Diabetes Type 1

The SCC received and approved the above updated Policy

Policy Update :Continuous Glucose Monitoring for Type 1 Diabetes in Children and Young People up to the age of 19 years for the use withing Shropshire, Telford and Wrekin

The SCC received and approved this updated Policy.

Policy update :Continuous glucose Monitoring for Type 1 Diabetes in Adults and Pregnant Women, with Type 1 or Type 2 Diabetes on Insulin Therapy

The SCC received and approved this updated policy

Policy Update :The use of Flash Glucose Monitoring systems in eligible diabetic patients.

The SCC received and approved the updated Policy

Updated Value Based Commissioning Policy(VBC)

Mr Reis-Seymour advised that the VBC Policy had been updated and redesigned by considering the latest NICE and Evidence Based Interventions (EBI) guidance, organisational changes within the local system, a review of similar policies held by other CCGs and updated processes and policies from other CCG directorates. There had been significant clinician engagement in refreshing this Policy both through input from providers and CCG colleagues as well as full clinical review undertaken by the nominated GP Leads for VBC – Dr Katy Lewis and Dr Ian Chan.

The policy had also been reformatted and restructured to be more user-friendly, effective, and easier to navigate.

Mr Reis-Seymour gave background information on the history of the policy and that that there were separate, slightly different VBC policies for Shropshire CCG and Telford & Wrekin CCG, as they were separate organisations at that time. The last updated versions of these were approved by CCC and PCC in March 2020. While these were approved, Covid19 was beginning to impact on the health and social care system, requiring services and staff to be diverted into crisis response roles, and therefore business as usual at that time was paused. Therefore, the approved update policies were never implemented. In parallel with the response to Covid19, 2020 saw the integrating of both CCG's to become the combined STW CCG and the Management of Change process that resulted in staff moving into various different posts. During 2021 the diminishing levels and impact of Covid19 on the system meant that some of the previously paused pieces of work could be re-started. The Policy for 2022/23 had been amended from previous versions to :

1) Ensure its contents are up to date and accurate
2) Combines previous Policies into one aligned STW Policy
3) Includes a range of new EBI conditions
4) Includes a change to the audit and management process
5) And is used to specify , referrals
   Referrals that require Local Referral interface approval
   Interventions that will be subject to audit
   Interventions that are not funded

The SCC received and approved the Policy.

Action

Mr Reis- Seymour and Dr Davies to take forward feedback from members on the implementation of the VBC , including communications in relation to Evidence Based Interventions (EBI)and BMI threshold and to review cost efficiency

Recommendations/Actions Required:
The Board are asked to note the record of this meeting.

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

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NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Our Ref: JP/AS/CAT

4 January 2022

Dr Catriona McMahon
Chair
Shrewsbury and Telford Hospital NHS Trust
Royal Shrewsbury Hospital
Mytton Oak Road
SHREWSBURY
Shropshire SY3 8XQ

Dear Catriona

Letter of Support to the Board of SaTH in relation to the Proposal to Temporarily Relocate Inpatient Cardiology Services

The Governing Body of NHS Shropshire, Telford and Wrekin CCG met on 8 December 2021 to consider the proposal to centralise, on a temporary basis, inpatient Cardiology services onto the Princess Royal Hospital site.

We recognise that the ongoing staffing shortages the Trust continues to experience in both Consultant and Cardiology nursing workforce, which has been exacerbated by further retirements and the lack of successful recruitment drives, has now made the service unsustainable and of a significant risk to the Trust in maintaining the safety of patients.

We have noted the proposal is expected to deliver the following:

- Cardiology patients would benefit from improved pathways, increased levels of care and reduction in length of stay for patients requiring intervention and standardisation of processes.
- Consolidation of the Consultant workforce would provide greater resilience within this staffing group and specialty.
- Improve recruitment and retention and enable more specialised job plans without the need for cross site working.
- Centralise the remaining highly skilled Cardiology nursing team and help to support reducing the risk associated with staffing numbers, in particular those staff with the necessary skills required to support the Acute Coronary Care Unit (ACCU).

It was also noted that the Trust had undertaken patient engagement to seek the views of patients on the proposal and that there was general support and that the proposal had also been shared with the Joint Health Overview and Scrutiny Committee of Shropshire Council and Telford and Wrekin Council who were also supportive.

The Governing Body are supportive of the proposal and have agreed to the temporary centralisation of inpatient Cardiology services as this will significantly reduce the risks in respect of the inpatient service and associated Consultant workforce and specialist trained ACCU staff and will also allow for growth and future proofing of the Cardiology service which in turn will secure a sustainable, safe and quality service

for our population. However, the Governing Body were cognisant that as the proposal is a temporary solution whilst the Trust continues to progress its Hospital Transformation Programme, it would want as conditions of the approval the following actions to be undertaken to support continuing sustainable delivery of Cardiology services at SaTH:

1) That the Clinical Director of the service undertakes a clinical review of the centralised service six months after it is commissioned to ensure that the benefits outlined above are being delivered for patients and staff and that this is shared with the CCG's successor body, the Integrated Care Board and the Joint Health Overview and Scrutiny Committee.

2) That a review of the timescales for relocation back to Royal Shrewsbury Hospital and the workforce situation, linked to the temporary nature of the move is undertaken by the Integrated Care Board no later than 18 months after the service has been centralised to take into account any known Hospital Transformation Programme timescales and a review of the workforce position to ascertain if the service can be relocated back to Royal Shrewsbury Hospital site any earlier than the Hospital Transformation programme timescales.

3) That the Equality Impact Assessment and Quality Impact Assessment which were dated prior to the conclusion of the patient engagement exercise are updated now that this has been concluded to be clear what the impact of the proposal is on equality issues and to be able to demonstrate that the quality assessment, strategy and outcomes have been updated and finalised following the engagement exercise and prior to implementation of the proposal. These assessments should also be reviewed and updated on a regular basis ie after six months to ensure the identified mitigation is having the desired effect.

4) That the Trust undertake a staffing review following implementation to; determine if the one site model is alleviating staffing and recruitment issues, what plans the Trust have to grow the service and to ensure an appropriate skill mix across the clinical disciplines.

5) That the Trust clarifies its plans to review patient and public involvement after six months which was outlined in the papers presented to the CCG Governing Body. The CCG Governing Body also suggests that any regular updates on the consolidation are not only shared with community members, but also key stakeholders ie HOSC.

We are requesting these actions in order to help manage the transition from the NHS Shropshire, Telford and Wrekin Clinical Commissioning Group to the newly formed Shropshire, Telford and Wrekin Integrated Care Board and to support the new organisation in its role of oversight and assurance on behalf of the NHS across Shropshire, Telford & Wrekin.

Yours sincerely

Dr John Pepper
Chair
Shropshire Telford and Wrekin CCG

cc Mark Brandreth
Neil Mckay
Louise Barnett
Nigel Lee