Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 7 April 2021

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday 15 April 2021**
Time: **2.00 pm**
Venue: **This Virtual Meeting is being hosted by Telford and Wrekin Council. Please use the following link to access the meeting:**

Joint HOSC 15 April 21 access information

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Director of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Your Committee Officer is:

Members of Joint Health Overview and Scrutiny Committee

Shropshire	**Telford**
Cllr Karen Calder (Co-Chair)	Cllr Derek White (Co-Chair)
Madge Shineton	Cllr Stephen Burrell
Heather Kidd	Cllr Stephen Reynolds
Co-optees:	Co-optees:
David Beechey	Hilary Knight
Ian Hulme	Janet O'Loughlin
	Dag Saunders

Josef Galkowski
Tel: 01952 388356
Email: josef.galkowski@telford.gov.uk

AGENDA

1 Apologies for Absence

2 Declarations of Interest

3 Minutes of the previous meetings (Pages 1 - 14)

4 End of LIfe Care Update

To receive an update on End of Life Care from Tracy Jones, Shropshire, Telford and Wrekin CCG

5 Shropshire, Telford and Wrekin Integrated Care System (Pages 15 - 28)

To receive a report on the development of Shropshire, Telford & Wrekin Integrated Care System from Nicky O'Connor, STP Programme Director, Shropshire Telford & Wrekin STP

6 Co-Chair's Update

Shropshire Council	Joint Health Overview and Scrutiny Committee 15 April 2021 2.00 pm	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 22 OCTOBER 2020
2.00 PM – 3.55 PM

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Present
Councillor Karen Calder (Co-Chair), Councillor Heather Kidd, Councillor Derek White (Co-Chair), Councillor Stephen Burrell, Councillor Stephen Reynolds, Hilary Knight, Ian Hulme

1 **Apologies for Absence**

Apologies were received from Councillor Madge Shineton. David Beechey, Dag Saunders and Janet O Louglin were unable to access the meeting due to technical difficulties.

2 **Disposable Pecuniary Interests**

Members were reminded that they must not participate in any items in which they had a disclosable pecuniary interest.

3 **Minutes of the Previous Meeting**

The minutes of the meeting held on 6 August 2020 were confirmed as a correct record.

4 **System Winter Planning 2020 - 2021**

Sam Tilley, Director of Planning, Shropshire and Telford and Wrekin Clinical Commissioning Groups, and Nigel Lee, Chief Operating Officer, Shrewsbury and Telford Hospital Trust, were in attendance to present the report before members and answer questions. The report explained that the usual winter planning arrangements were set within a wider Restoration and Recovery Programme for the NHS as a result of the covid19 pandemic. It also explained the requirements set out in the most recent “Phase 3 letter” (12 August 2020) including the acceleration of return to near normal levels of non-covid19 health services and preparation for winter demand pressures alongside vigilance for covid19 spikes locally.

The report explained the differences in planning arrangements for this year and how the benefits to be realised from Covid19 specific learning were being taken on board by the system into the next phase. Planning has been undertaken on the basis of five key themes: Discharge, Hospital Front Door, Community, Primary Care and Acute Services

with the overall focus on demand management. Following a rigorous multi-agency process, 30 winter capacity schemes would be utilised in the winter plan across a range of system partners these would start coming on stream from November and there would be close oversight of implementation and impact through the Urgent and Emergency Care Delivery Group and Board and Gold Command. Examples of schemes related to attendance, admission avoidance and discharge to help preserve capacity in the acute trust over the winter months were provided.

The winter plan would be an iterative process and would be monitored and refined as real time data came through. It was also reiterated that the NHS was not closed and as much elective activity as possible was underway and this would be supported through the addition of an additional CT imaging unit and two mobile MRI scanners. Delivery of the vaccination programme would be a huge piece of work from December onwards.

Members asked a number of questions and received responses as follows:

What risk and challenges were there around staff resilience – in a system where this had already been an issue pre-covid?

It was acknowledged that the challenges already in the system had been exacerbated by covid 19. There was no easy answer, pressures were immense and staff were tired and stressed already. A System People Group was in place so that partners could manage the next few months and also the longer term. A Memorandum of Understanding had been agreed across key partners in order to redeploy staff to the areas of greatest need.

Support for care homes had been provided in relation to infection control and PPE training was available. As the first wave had arrived later in Shropshire than other parts of the country there had been the opportunity to utilise lessons learnt in relation to discharge into care homes and there was a very strict process of swabbing in place.

There had been an active bring back staff programme and although overseas recruitment had been held up due to covid travel restrictions, workforce recruits from India were now starting to arrive. Additional staff from private companies were being utilised, eg radiography staff for imaging.

Are more beds needed – how will this be achieved within the limitations of buildings? Is the community bed capacity required available?

Nigel Lee, Chief Operating Officer, SATH said that Future Fit had brought additional capital in order to deliver capacity fit for purpose. The Ambulatory space linked to A&E front door was reducing the need for admissions. The move of the Midwifery Led Unit at PRH alongside the Consultant Led Unit had also provided an increase in capacity but concerns remained. Optimisation of discharge work on a daily basis was a priority and the Trust supported the national agenda of ringing 111 for guidance first. The Director of Planning confirmed that capacity in Community Hospitals was currently good but that 'home first' remained the priority with care wrapped around patients as necessary.

What was being done to speed up discharges which were delayed due to waits for medication? Could external pharmacies be used?

This was an issue that SATH had been trying to tackle for a while. Wards were very busy and rounds were led by a consultant, delays stemmed from a wait for discharge summaries and approval for medications. It was intended that wherever possible one or two junior doctors could produce discharge summaries and order medications the day before discharge wherever possible. This remained a challenge as the right level of authority was required to access the medication software. Some improvement had been made but there was still a way to go. A balance between safety and timely discharge was needed. The Chief Operating Officer said he would have to check whether it would be possible to use external pharmacies via using local agreements - there would need to be appropriate stocks and processes in place as there were at the hospital pharmacy.

Discharge – were there delays discharging patients over weekends, (an example was cited of a recent case of a delay in discharge)

Many services were active over weekends although not necessarily on both days or at both sites. Pharmacy, medical staff and additional discharge consultants were on duty every weekend at both sites to facilitate weekend discharge.

At a recent LGA meeting it had been identified that hospitals were very full – not just with covid patients but with others needing critical care. What was the position locally?

Mr Lee reported that SaTH had not stopped urgent cancer surgery during the pandemic. He confirmed that the hospitals were extremely busy and that critical care covered both covid patients and those with other conditions. The challenge of managing pathways and separating patients with covid or potentially with covid was significant.

A critical care surge plan was in place involving use of two operating theatres along with additional equipment. Formal collaboration arrangements were in place with University Hospital North Midlands at Stoke. The Adult Critical Care Network was also active and SATH had recently received some patients from Walsall, as part of providing mutual aid across the network. Active dialogue was maintained across the local, neighbouring and regional system. It would be a continued challenge across the Winter

Is there a dashboard picture showing take up of beds by covid patients/other acute conditions?

This changed on a daily basis – as of now there were covid cases in the mid 20s out of a bed base of about 680. Around a third of critical care capacity was taken up with covid/potential covid cases. Some of the additional capacity planned would not be in place until closer to Christmas. Mr Lee suggested that if the Joint HOSC wanted more information that he discuss specific requirements with the Chair outside of the meeting.

The report referred to 'what had not worked well with previous winter planning arrangements but must this year'. What more being done to ensure that what not gone well previously would deliver this year?

Whereas lack of flexibility across organisational boundaries and staffing issues had been a feature of the past, covid had helped to move that agenda forward quite significantly. Multi-agency arrangements for sharing staff across the system were now in place and strides forward had been made in working as a system with shared priorities with a default setting of problem solving.

What more was being done to address ambulance handover issues?

Investment and capacity at the front door were essential to addressing this issue, RSH in particular had a small A&E and peaks in demand were harder to manage than they would be in a larger organisation. The investment which would come on line at Christmas involving an ambulatory environment would help provide a better pathway for some patients. Some patients could be supported, treated and discharged the same day with appropriate support at home.

Why are patients coming to A&E if this is not the right place for them?

Work on establishing the right pathways for patients was underway – with a number of these pathways and options being available and evident to primary care, 111 colleagues and also users directly to help avoid admissions.

The Chair thanked Sam Tilley and Nigel Lee for attending the meeting and answering questions. The Committee requested a similar report again in a year's time with more detail so that members could understand what high level actions would actually look like on the ground. This would help to assure members as lay people. Sam Tilley welcomed this guidance.

5 Sustainability and Transformation Partnership (STP) End of Life Review Update

Tracy Jones, Deputy Director Integrated Care, CCG and Alison Massey, Senior Project Manager End of Life Review were welcomed to the meeting.

Alison Massey took Members through a short presentation outlining the proposed scope and approach of the review – this would not be taking a traditional approach, rather one that involved using information already held - using a collaborative approach across organisational boundaries to design solutions. The expected timescale was six months and the purpose of the review was not to develop a strategy, rather to review how to make an impactful change on individual experiences.

Phase 1 of the review had just commenced and all stakeholders had been asked to review information they held and to identify themes and feedback to pose some questions and inform the work going forward.

Members asked a number of questions and received the following responses:

The report stated that a strategy was not the expected outcome but referred to 'aspirations' and appendix 1 was labelled as a strategy. What status did the document at appendix 1 have – who did it apply to, who had signed up to it and how was it co-ordinated

throughout the system? What influence would this piece of work have across the whole system once completed?

Tracey Jones reported that the proposed methodology for the review had been shared with the groups across the system identified in section 1 of the report, and each had signed up to it. These included the organisations containing lead end of life clinicians.

The End of Life Review Group had been established as a sub section of the STP Community and Place Based Cluster which reported into the ICS Shadow Board. Phase 1 involved each organisation collating the information it held already to identify areas for action. Part 2 involved implementing that action through four key areas. Each area would have a system working group which would be made up of front line clinicians, managers and Healthwatch amongst others - key to developing solutions to the questions.

Some changes could be made by clinicians throughout the duration of the review to see if they could be made to work. This was an STP priority area and where any areas of difference or difficulty were identified, these would be escalated up to system leaders to identify how to remove barriers.

What quantity and kind of data has been collected - the Joint HOSC had experienced difficulties previously in seeking such data and information.

Each individual stakeholder had been asked to review information they already held to produce four questions. They had been asked to consider issues which were not to do with a single organisation but a pathway of care which was not connecting across the system.

Tracy Jones reported that the level of detail in PALS reports alone would be supplemented by individual one to one in depth interviews. If any JHOSC members knew of anyone willing to contribute to the review and share their experiences this would be welcome.

How many people would be interviewed as part of the review? The Joint HOSC felt that qualitative data was particularly valuable in this area

Tracey Jones stated that that feedback would be sought from as many individuals as were willing to give it within the timeframe.

The Chair observed that the proposals sounded excellent but was aware of a person who was about to disengage with the process of giving feedback and hoped that any trauma experienced by others would not be exacerbated by participation.

Tracy Jones provided reassurance that she would be speaking to people individually to ascertain their willingness and readiness to participate in the review and would outline boundaries and expectations around contribution. She would be very supportive of anyone coming forward to share their story.

The Co-Chair referred to action proposed in the past to address end of life issues, which had not been successful. It was good to hear that a new approach was to be taken. He had heard of cases where do not resuscitate instructions had been applied without permission and it was essential that families be involved and treated in a respectful way.

It was acknowledged that the old approach had not delivered the changes needed and all organisations involved had accepted this new methodology. Consistency of approach would be very important. The whole end of life pathway was vast but the four areas would be identified collectively by stakeholders. The Joint HOSC were asked to identify if it felt that any stakeholders were missing from section 7 of the report

The Co-Chair felt that the PALS system should be replaced by one organisation that applied across the whole of the system to enable a full picture when things went wrong.

Tracey Jones suggested that wider issues relating to PALS be raised with the Chief Officer of the CCGs.

How would the four areas to take forward be identified and agreed collectively?

All stakeholders should have an input in taking the long list into short list. The methodology used would depend on how many and how apart the areas identified were when responses came back from all stakeholders

Can you provide the Joint HOSC with assurance that the stakeholders participating in the review will be of sufficient seniority to make the commitments needed in progressing this work?

The system had made a commitment to the work and lead clinicians in end of life care from each organisation were involved. There had also been a commitment made that the thoughts of front line staff be supported.

How will you measure impact of the work?

Measuring patient experience was difficult and comparing like with like was not possible. One reason there would be a focus on questions was to provide a basis for measurement – 'how do you know that things have improved'. Participants in the review would be asked 'how will we know if we make the change that we've got it right'. This might involve staff surveys and looking at both quantitative and qualitative data.

The timescale appears to be ambitious, particularly with activity planned over the coming weeks

The timescales in the report provided an indication of the process but there would be a flexible approach if needed.

Would the Leads for the four areas be able to provide the time needed to the Review?

Key individuals leading on end of life in different organisations would provide the leads for each area. If there were any issues with availability then this could be escalated through the Cluster Board. The working day of individuals involved in the project involved end of life as their day job and contributing to service, system and patient improvements was part of their roles.

Lynne Cawley, Chief Officer Healthwatch Shropshire, emphasised the importance when talking to people of establishing when the event had happened, as some people could take a very long time to feel able to talk about experiences. She also suggested contact

be established with the bereavement team at SATH where there might be an opportunity to ask questions that fit into the review.

It was also reported that Gordon Kochane and Jo Robins, Public Health at Shropshire Council had been working on bereavement support and may be useful contacts.

Tracey Jones welcomed these suggestions and said she would follow these up after the meeting.

The Committee thanked Tracey Jones and Alison Massey for attending the meeting and it was agreed that an update would be provided to the Committee at its 11 March 2021 meeting.

6 **Co-Chair's Update**

An additional meeting of the Committee will be arranged in November focusing on children's mental health.

The Chair encouraged any members of the committee or members of the public to make contact if they had any observations, comments or questions related to the Committee's work.

Signed …… (Chairman)

Date:

This page is intentionally left blank

Shropshire Council	Joint Health Overview and Scrutiny Committee 15 April 2021	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 24 NOVEMBER 2020

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Present
Councillors Karen Calder (Chair), Derek White (Co-Chair), Heather Kidd, Stephen Reynolds, Madge Shineton
Co-optees: David Beechey, Ian Hulme, Hilary Knight, Janet O'Loughlin,

Also present:

David Evans, Chief Officer, CCG
Cllr Peggy Mullock, Chair of People Overview Committee, Shropshire Council
Cllr Ed Potter, Portfolio Holder for Children's Services, Shropshire Council
Zara Bowden, Shropshire Parent and Carer Council
Danial Webb, Overview and Scrutiny Officer, Shropshire Council
Josef Galkowski, Democratic Services and Scrutiny Officer, Telford and Wrekin Council
Cllr Andy Burford, Cabinet Member for Health and Social Care,Telford and Wrekin Council
Amanda Holyoak, Committee Officer, Shropshire Council

1 Apologies for Absence

There were no apologies for absence.

2 Disposable Pecuniary Interests

No interests were declared.

3 Minutes of the Last Meetings

The Chair reported that the minutes of the meetings held on 22 October 2021 and 19 November 2021 would be presented for approval at the next meeting.

4 Children's Mental Health Services

The Chair welcomed David Evans, Chief Officer Shropshire and Telford and Wrekin CCGs to the meeting.

Mr Evans provided the background to the transformation around the CAMHS Service three years previously and the reasons for it. The service was now predominantly delivered by MPFT and covered an age range of 0 – 25 which allowed for a good transition from children's services into adult services. The aim was to provide as good a quality service as possible that intervened early when mental health started to cause concern to prevent the risk of escalation.

Members and participants in the meeting made a number of observations and asked questions to which Mr Evans responded:

What happens to a young person if they are referred into the service at around the age of 18?

An 18 year old would normally be referred directly into adult mental health services. The idea of the BeeU 0 – 25 service was to facilitate a gentle transition from one team to another for those who were already receiving support.

Would tier 4 count as the 'getting more help' step or 'intensive help'

Tier 4 represented intensive help – this was very specialist support commissioned by NHS England, not the CCG, there were no tier 4 beds locally.

There are currently children in hospital at the moment with mental health conditions – would two be the normal number? Do children arriving at A&E because of a mental health issue usually known to the service already?

It is unusual to have two children in hospital at the same time. Children with mental health conditions sometimes present at A&E if they reach a crisis point

Who can refer into the system and who would progress the child onto the next step if additional support is needed??

A GP, social worker, or someone in education would normally make an initial referral. The level of support required would be determined by the BeeU service which would also determine when that level of support needed to change

Can parents/carers refer into service?

The normal referral route was through a school or GP, but if the child was already in the service and there was parental concern about deterioration then the service could be contacted directly.

Getting help is a time limited service – was there a possibility that a young person could be returned back to the very start of a referral process once they were in it?

That would only occur if a child was discharged from the service completely, but a child was likely to be seen directly if parent/carers concerned about deterioration

The Chair invited Zara Bowden from Shropshire Parent and Carer Council to speak. She raised a number of issues around the referral system, and the quality of the information considered at triage. Parents had described GP referrals being sent back with a request

that the referral be instead made by a school. However, in order for a school to make a referral, the child needed to be demonstrating the behaviours in the school setting and these were not always in a structured setting.

She also reported that BeeU determined the pathway on the basis of referral information that a parent had not always seen, and that a child was often discharged without the parent having the opportunity to speak to any practitioner at all. This meant that the family's whole picture was not taken into account. Children's needs, especially those related to neurodevelopment were not being met with the right support at the right time. Families were being told they could not access the neurodevelopmental system to get the support needed until they had a diagnosis but the assessment was not effective.

She referred to the CCG's Dynamic Support Register used to manage the system tier 4 and felt this could be used to commission more effective support pathways earlier on to prevent escalation.

In response, Mr Evans confirmed that the team had been working on the referral process and that he would take these comments back to them. The assessment at triage should happen appropriately and clear information provided to parents if it was decided that ongoing support was not the right course of action. He endeavoured to meet with Zara in a few weeks to ascertain whether an effective change had happened.

A Member referred to a case she was aware of where linkages were broken and referral paths became very difficult at the age of 16 when a Looked After Child progressed from school to further training.

Mr Evans said this highlighted the need for a 0 – 25 service and that support for a child through such a transition period should have been maintained. Without knowing the circumstances of the particular case he could not explain why if the young person was already in the service and getting support from BEEU that this had not continued.

What evidence and information was used to support commissioning of services at lower tiers?

Mr Evans explained the process for commissioning any service but explained that the direction of CCG commissioning was changing, to focus more on outcomes for individuals. This would involve a move away from transactional commissioning with the risk of over specification and towards an alliance of providers to determine how best to deliver the outcomes needed based on the sum of money available.

When designing a service based on outcomes – is the CCG co-producing with parent carers such as PACC and PODS. Will this be from the very outcome rather than designing a service and then asking for comments?

Mr Evans referred to a recent meeting with PACC and PODS where an absolute commitment was given to co-design.

The Co-Chair referred to the large amount of direct feedback he had received related to difficulties of obtaining referrals into the service, and very long waits, even just for a telephone call. He was pleased to hear about commissioning by outcome but asked if the CCG would direct any more money into mental health services.

Mr Evans said the BeeU Service had been given a challenge to construct and deliver a new modern service. He acknowledged the current issues with commissioning and delivery and said there was a joint responsibility to get this right. He said that the difficulties of families and young people in being referred to the service would be looked at urgently.

Money was always going to be a challenge within an overall financial envelope and it would be essential to get the best service possible to achieve the right level of service at the right time. There was a commitment to spend more on mental health services and additional government money to meet the mental health standard would be used for this. However, to go further, money would have to come from elsewhere and it had not been clearly identified from where.

Why is it only now that the CCG is talking to PACC and PODS? Can you convene a meeting or open forum for those involved to share their experiences and so they can be informed of what is being planned? Early intervention in mental health will save significant amounts of money later. Are there people who can diagnose available?

Mr Evans said the CCG was very clear about the need for a service that intervened in the right way as quickly as possible to ensure children could live fulfilling lives and get the best start. The CCG could not do this in isolation and needed to work with local authority partners, education, parents and families to co-design and co-produce the right services for children. He confirmed that meetings with POD and PACC had already taken place and that he would be happy to convene another meeting including families and providers.
.
Zara Bowden commented that the current system did not have flexibility built into it. It needed to allow for multiple pathways to be met simultaneously to ensure needs could be met at the right time, referrals were usually made for one reason but there may be a catalogue of needs. Children required their needs to be met whilst waiting for diagnosis. The providers were not equipped to do that or commissioned adequately to do this.

She emphasised the necessity of working together with parents. Although parents had felt they had a voice during a previous commissioning process, they did not feel that it had been heard. She reiterated that co-production should be from the beginning and asked that the CCG set expectations for the provider to allow this.

Mr Evans said the service was not delivering a responsive service for children and young people and families and clarity around desired outcomes was needed. Co-production had to involve those who lived the experience as well as providers. The overall aim and aspirations of the NHS was for preventative, self-care management with interventions at the right point to deliver the desired outcomes. It might be that more than one provider would be needed to deliver this. He also emphasised the need to be clear that the CCG wished to meet need but might not always be able to meet wants.

In response to a question about who would manage a number of providers, it would likely be through one lead provider who would hold the others to account.

Mr Evans was asked if the local authority had been fully cited and involved in developing the CAMHS Service Improvement plan and he said he check on this and report back.

A question was asked about the crisis support and home treatments in place for young people with eating disorders

Support could be sought through the normal out of hours service and BeeU were about to start a 24 hour crisis service for all young people. He believed there was support for children and parents at home but as he had not got specifics to hand agreed to report back on this outside of the meeting.

The report stated that ASD diagnosis had not been clearly commissioned – what had been the impact of that. There was no information on waiting lists available previously. The report said the expected 18 week wait would not be achieved for 18 – 24 months – what would that mean for children approaching the age of 18.

Mr Evans agreed to supply information on the waiting list outside of the meeting. It was a service requiring specialised practitioners so there was a capacity problem. He accepted that children and young people were waiting longer than we would want them to.

How is priority given to making these diagnoses?

This was made on presenting clinical need

How are you updated as a CCG on progress.

*A q*uarterly report was made to the CCG Board

Zara Bowden said that no clinicians were currently involved in determination as to whether a referral would be added to the waiting list or not and parents were not involved in this decision which was made on only the advice received on the referral document.
.
The Chair observed that if there was an expert clinical approach from start, this would be likely to reduce turmoil for a child. Mr Evans said he was surprised to hear that there was not more clinical involvement at triage and that he would look into this.

Members discussed how as a scrutiny committee it could take this piece of work forward and obtain assurance that what the CCG was saying would happen. Mr Evans suggested that the CCG report back to the Committee after a period of 6 months.

The Chair thanked David Evans and Zara Bowden for their time in attending the meeting and Mr Evans for answering questions. The Committee would be moving on to look at transition at a future meeting.

5 **Accident and Emergency**

David Evans provided an update on A&E activity as requested by the Committee. The trend overall for Shropshire and Telford and Wrekin patients was below that of 2019 activity - at PRH 25% lower and at RSH about 5% lower. During October 2020 120 patients had been admitted from A&E at PRH, in October 2019 this had been 160. At RSH 130 patients had been admitted from A&E in October 2019 but this had increased to 145 in October 2020. Arrivals at PRH by ambulance had decreased by about 10 – 15%

and walk ins were much lower. At RSH ambulance attendance has increased slightly since June but walk in attendances were slightly lower.

Responding to questions on the reasons for the differences between the two sites, he said this was partly due to age profile of the population and partly related to complexity of case mix as emergency surgery was carried out at RSH. There had been increasing activity levels over the last 10 days and it was expected that this increase would continue with covid and winter pressures combined.

SATH and Shropshire Community Health Trust both currently had as many patients with Covid as they had back in April. There were however less patients in ITU although more on oxygen therapy overall.

A member drew attention to a recent long delay for an ambulance to arrive the south of the county. Mr Evans reported that the ambulance service was under a lot of pressure, particularly when large numbers of ambulances arrived at A&E at one time and there were long waits to offload patients.

Members asked if measures taken to address covid, such as social distancing and wearing of masks might help to alleviate normal winter pressures. It was hoped that this might be the case but patients did seem to be sicker and putting more strain on services, particularly at RSH.

The Committee thanked Mr Evans for the update and said they would welcome another update in approximately six months time.

6 **Co-Chair's Update**

The Committee agreed that more work on children's mental health would be undertaken next year particularly to follow up on progress in addressing the issues raised at the meeting, and also around transition.

A Member felt that there were questions around covid which needed to be asked and she was encouraged to circulate her thoughts to all members for informal discussion in the first instance.

Signed …… (Chairman)

Date:

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Update and Outline ICS Roadmap

Nicky O'Connor
ICS Programme Director

Key Points from the White Paper

- Integrated care systems (ICSs) are to be established on a statutory footing through both an 'NHS ICS board' (though this will also include representatives from local authorities) and an ICS health and care partnership. The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of their system.
- A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. This will apply to all partners within systems, including local authorities.
- There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.
- Certain new duties on the Secretary of State will also be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care (such as district nurses).

Key Points from the White Paper

- There will be significant changes to procurement. It is proposed that section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime. However, it is important that we avoid ending up with local monopolies and continue to work effectively with the independent and voluntary sector.

- The white paper does not address other key areas where reform is expected. Reforms to social care and public health will be dealt with "later in 2021" outside the Health and Care Bill addressed in the white paper, with some minor exceptions

- The new statutory powers for integrated care systems should not overlap and duplicate with the statutory powers of NHS trusts and foundation trusts, and further clarity is needed on how the NHS ICS board will operate alongside the wider health and care partnership board that will involve local government.

Four Core Purposes

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development

10 System Pledges

The STW ICS application submitted on 11th January contained 11 pledges that were subsequently refined to 10:

- **Improving safety and quality**
  Making sure our services are clinically safe throughout the system, delivering the System Improvement Plan and tackling the backlog of elective procedures as a system. Specifically this pledge commits us to ensure SATH is rated 'Good' by CQC and that the Ockenden Review's findings are implemented. Across all of our services we aim to use digital innovation and data to enable our workforce to drive improvements in quality and safety and improve outcomes.

- **Integrating services at place and neighbourhood level**
  Integrating services at Place and Neighbourhood level – developing local health and care hubs to improve not just the physical but mental health of people, build on the principles of one public estate and the assets of individual communities, better manage the volume of hospital admissions and establish new models of care to best serve all our communities.

- **Tackling the problems of ill health, health inequalities and access to health care**
  Working with our voluntary and community sector, and the public, we will agree measurable outcomes for accelerated Smoking Cessation, improving respiratory health, and reducing the incidence of type 2 diabetes and obesity. We will have a strategy for the implementation of segmented population health management (PHM) approach by April 2021 and undertake a post COVID-19 review of access to all services by September 2021.

- **Delivering improvements in Mental Health and Learning Disability/Autism provision**
  Through our transformation programmes, working through whole system approaches, we will deliver improvements in qualify of life for people with learning disabilities by March 2022 and meet the national milestones for mental health transformation by 2023/24.

10 System Pledges

- **Economic regeneration**
  We recognise that economic regeneration will be essential throughout the pandemic and thereafter. For the citizens of Shropshire, Telford and Wrekin we aim to harness the potential of the health and care system together with wider public services to contribute to innovation, productivity and good quality work opportunities. In turn this will create economic prospects that will help improve the health and wellbeing of our population.

- **Climate change**
  We will consult on a multi agency strategy setting out our response to the threat of climate change by 30th June 2021. This will be designed to create a social movement across our system by agreeing and delivering carbon reduction targets.

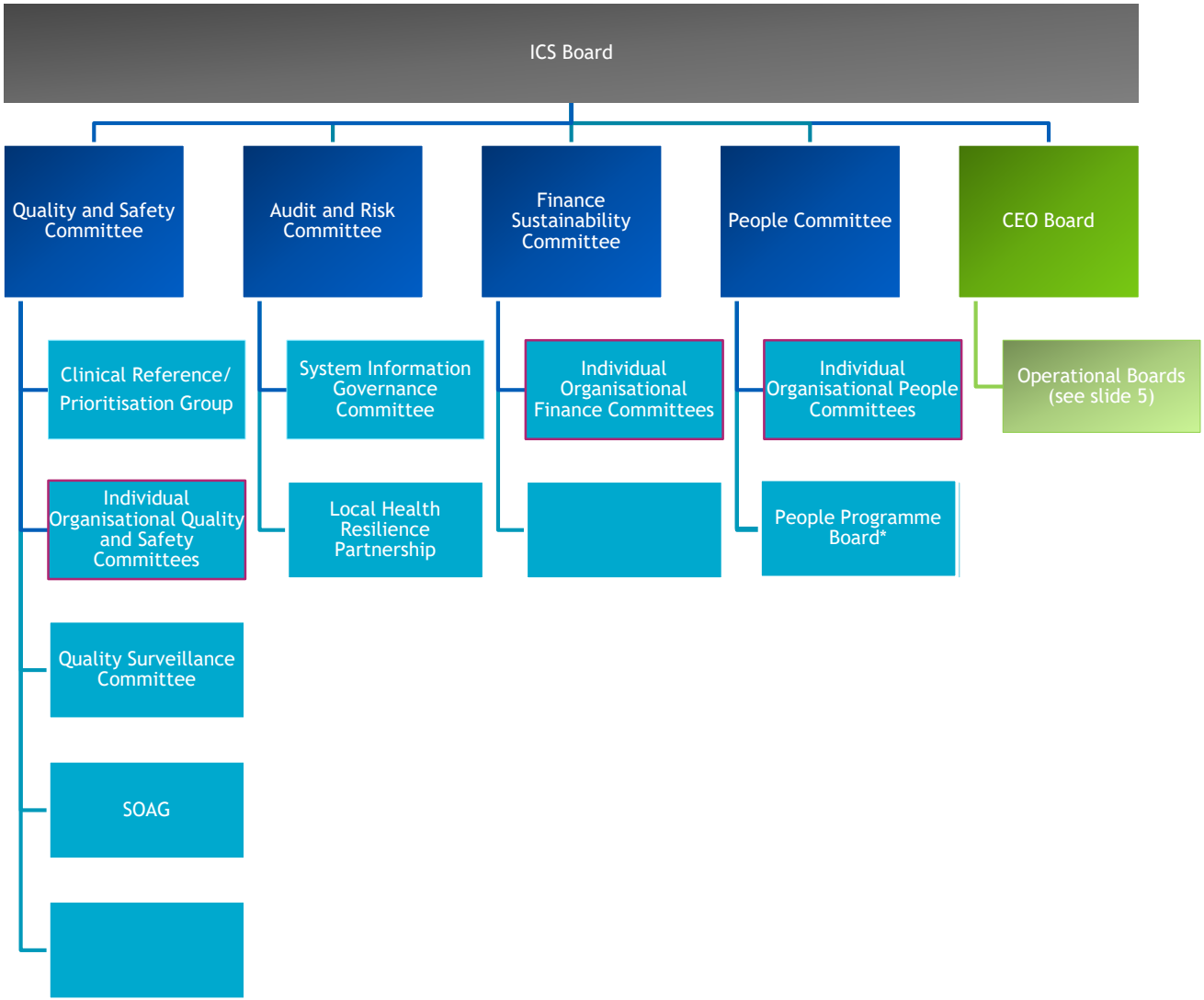
- **Leadership & Governance**
  We recognise that how we deliver and make decisions needs strengthening throughout and therefore we will review and revise our ICS Governance arrangements with a particular emphasis on place, neighbourhood and provider collaborative arrangements by 1st April 2021.

- **Enhanced engagement and accountability**
  We will increase our engagement, involvement and communication with stakeholders, politicians and the public and develop a plan for this by March 2021. This will include ways of making the ICS more accountable to the citizens of Shropshire, Telford and Wrekin including committing to an annual report by September 2021 and starting to hold ICS Board meetings in public.

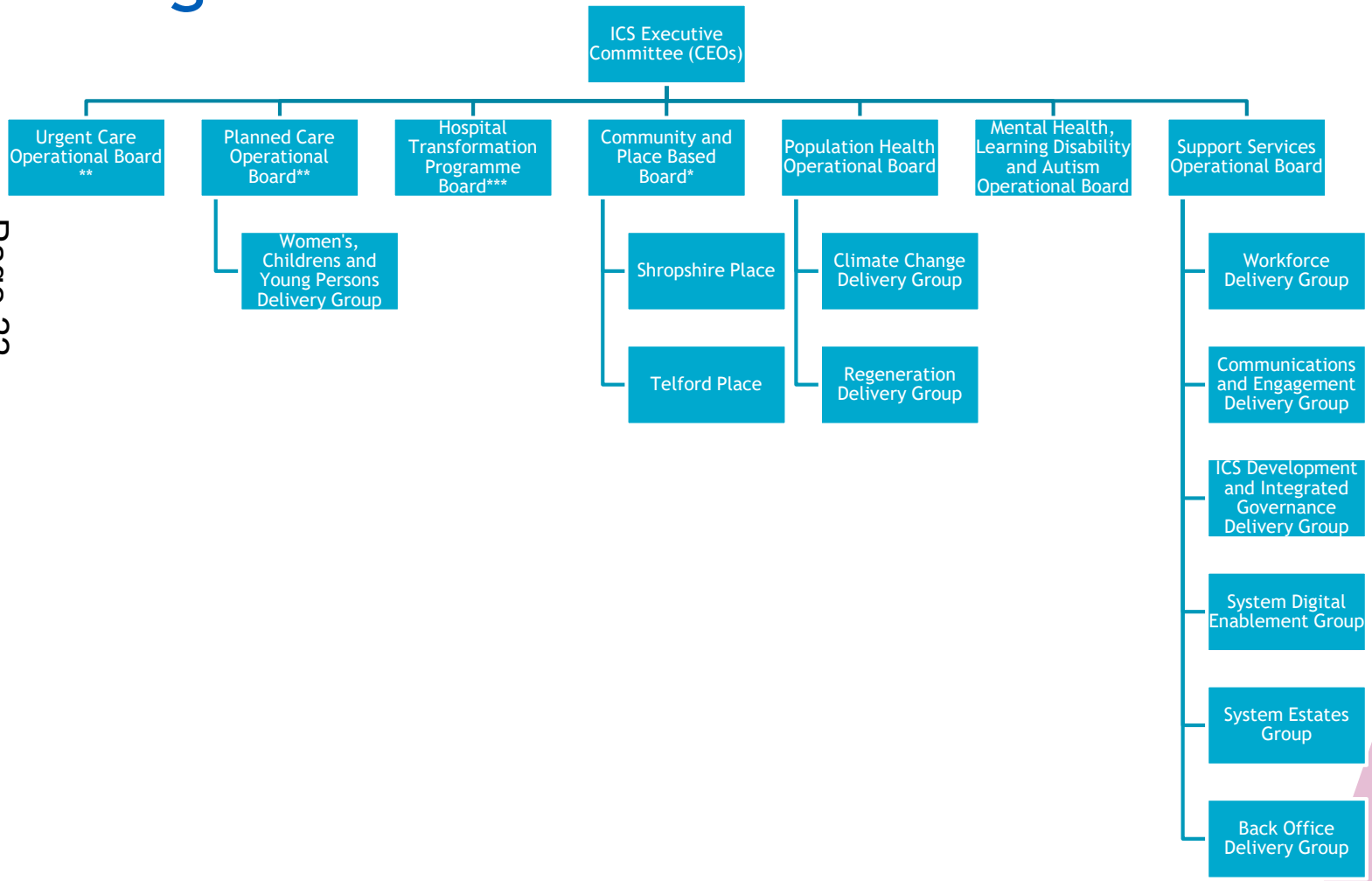
- **Creating system sustainability**
  Building upon the work included in our LTP, we will produce a sustainable ICS Financial Recovery plan by April 2021 alongside a System People Plan committing to recruiting and retaining the best people in a supportive working environment. This Pledge will ensure we have system wide arrangements agreed for financial control and future financial allocations.

- **Workforce**
  Making our system a great place to work by creating environments where people choose to work and thrive and by building system leadership and a flexible co-operative workforce.

STW ICS Sub-committee and Operational Meeting Framework – Proposed Assurance Structure



STW ICS Sub-committee and Operational Meeting Framework – Proposed Operational Meeting Structure



Indicative Timetable

By end Q1 2021/22

- Confirm senior appointment process and issue model constitution
  - National process
  - Local work

- Systems update SDPs and confirm:
  - Constituent partner organisations
  - Place based arrangements
  - System Transition Plan

By end Q2 2021/22

- Confirm Designate appointments to ICS Chair and Chief Executive roles (Accountable Officer/CFO)

- System confirm proposed arrangements for health and care partnership governance and board of the ICS NHS body

By end Q3 2021/22

- System confirm designate appointments to other ICS NHS Body senior executive leadership and ‘non-executive’ roles, including place level leaders

By end Q4 2021/22

- Systems confirm designate appointments to any remaining senior ICS roles
- Complete due diligence arrangements for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies
- Submit ICS NHS Body constitution for approval and agree ICS 'MOU' with NHSEI

1st April 2022

- Establish new ICS bodies with staff and property (assets and liabilities) transferred and boards in place