Paper ref:	TB (09/20) 009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	COVID-19 overview		
Sponsoring Executive	David Carruthers – Medical Director		
Report Author	David Carruthers – Medical Director		
Meeting	Quality and Safety Committee	Date	3rd September 2020

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

The report reflects on our current position in the Trust with respect to patient flows and current infection rate. A close watch is kept on community infection rate and age profile of those affected. Risk assessment and harm reviews are underway for long waits and progress on Gold work streams is summarised.

The phase 3 letter has been received and collaborative work across the BCWB system looks at how to progress more rapidly with diagnostic recovery. The initial data submission has been made to combine data across the system and we await feedback on that.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan		People Plan & Education Plan	
Quality Plan	X	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Q+S committee 08/20

4. Recommendation(s)

The Quality and Safety Committee is asked to:

a.	Note the progress in covid recovery and work streams at SWBH
b.	Discuss impact of system working and phase 3 letter and data submission
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	x						
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 3rd September 2020

COVID-19 overview

1. Introduction

1.1 The Paper outlines the Trust response to COVID-19 pandemic with an update on current data related to cases, swabbing, PPE, Risk assessment and recovery plan.

1.2 As of the 23rd August there were 12 patients who were COVID swab positive with no patients in intensive care unit. Cases are split across our sites either in covid specific ward areas (D17 – respiratory hub, or end of life care with many having been swab positive some weeks ago). At present the 7 day rolling average for new admissions or diagnosis (swab positive) is 1.2 with new admissions lower than those diagnosed on routine swabbing. We have had a small cluster of cases in medical staff members, re-enforcing the need for appropriate PPE and social distancing in clinical and non-clinical environments.

1.3 Admissions where possibility of covid is raised at initial presentation are a little lower this month (5-8 per site per day). However, when swabs and clinical assessment are negative these patients move to the lilac wards. Repeat swabbing of blue (every 5 days) and lilac (3 days) continues, hence the pick of positive mainly asymptomatic patients in these environments. Access to different swabbing process remains unchanged (low number of 2 hour but no current limit of 24 hour turnaround time for test once received).

1.4 New IPC guidance has been received and is currently being reviewed where there is further information of streaming patients into high, medium and low risk categories. This helps with defining care pathways for patients in the different streams and will need to be considered against the 3 pathways we currently have for admissions in the Trust. There is also a focus on PPE for staff, requirements for isolation/swabbing patients pre surgery and a discussion on AGP and risk based on the streaming of patients into the 3 groups above. The impact of the latter on how we might be able to progress with endoscopy and other AGP needs to be carefully considered and whether this will allow more rapid reduction of the backlog of diagnostics.

1.5 We are keeping a close eye on Community COVID-19 cases both in Sandwell and Birmingham but increased rates recently in the community (in a younger and low/asymptomatic group) isn't reflecting on increased work in wither primary or secondary care. However this increase in community cases delays any decision on re-

introducing visiting on a wide scale at present, but some relaxation of criteria for visiting certain groups of patients seems acceptable where their care will be improved by this. An effective track and trace system will need to be in place and IPC conditions closely considered within the wards to relatives can maintain social distancing from other patients, though PPE would be worn by visitors and time visiting limited.

1.6 Alignment of wards at each site have allowed Red AMU beds on each site and one ward at City for those swab positive patients requiring admission. Some side-rooms are available in specialist ward areas at Sandwell where clinical need for their underlying condition requires them to be in specialist areas (e.g. stroke). Other ward moves are still being considered to realign services and discussions continue with a view on future bed models at MMUH.

1.7 PPE provision still remains in a positive position and compliance with masks in clinical areas is generally good but reminders are needed particularly in hand cover and meetings where social distancing can't be maintained.

1.8 Working from home guidance has been extended to mid January while appropriate assessments are taken to define future models to make sure staff health and safety is maintained and areas consider the correct balance for staff to be WFH and in the office to maintain a working team, social distance rules and productivity.

2. Workstreams

2.1 The Exit plan continues to consider community and hospital infection rate as bed position is considered. At times admissions rates are back up to pre-covid levels and 2 streams in ED and AMU contribute to long waits in ED which are being actively managed. R rate in the Midlands is approaching 1 with local lockdown in both Sandwell and Birmingham having been talked about but not enacted. The majority of staff have had antibody testing but the significance of results still remains unclear apart from reflecting prevalence of infections within the tested environment. We have developed a system plan to step back up mitigations should we need to address a second wave balanced against the urgent need to recover services. The surge plan is being modified currently.

2.2 The recovery dashboard has been developed and demonstrates considerably delivery against both modelled and production plan activity. The Trust continues to ensure that all cases are clinically prioritised, now to a common theme to allow risk assessment, with all operations delivered where possible in order of clinical priority. Cancer services remain at the forefront of what we do and we have ensured that we have provision to deliver all aspects of our cancer pathways. Patients who miss 52 week wait, 62 and 104 day cancer treatment targets all have a harm review. Approaches to shorten the

endoscopy waiting list by both local and system activity are being undertaken. The new IPC guidance may help stream patients into low and higher risk groups to reduce the time in-between list cases.

2.3 The Risk and mitigations linked to Covid are consolidated in one risk register discussed at the Risk Management committee as well as Board, with a plan now to bring the covid risks into the overall risk register. We have created the information cell containing consumables, PPE, IT equipment and medications so that we have continual future sight of stock levels and can mitigate issues proactively. Risk scores are regularly reviewed with plans in place to review risk mitigations through RMC.

2.4 Psychological employee wellbeing is well developed with a focus on both work place related stress but also mental health assessment. We are still extremely aware of the PTSD effects of Covid on our staff groups and have ensured that high risk areas have been assessed. The support comes in 3 levels - Level 1 – REACT practitioners who are trained to have psychologically savvy conversations and raise issues across the workforce, Level 2 – A 30-strong team of Mental Health First Aiders had been recruited and trained in the first wave of an initiative which would eventually roll-out across the organisation. The March on Stress organisation had been assisting and Level 3 – TriM practitioners had been trained to make therapeutic, psychological interventions for the most traumatised. This process is supported by a pastoral lead. Staff risk assessments are now complete for the majority.

2.5 Communication with staff and the system remains paramount in our assurance and our ability to manage expectations. The weekly bulletin continues and wider communication to partners and GP's continues as we stand back up services and volumes of activity

2.6 Winter planning is to be discussed at CLE again this month allowing discussion on integration of covid and normal bed pressures to be undertaken. Emphasis on our flu campaign will be key as will community access and take up of vaccination.

3. System wide progress

3.1 Discussions continue via the BCWB Clinical Reference Group to develop effective system based working in areas of greatest challenge – this includes endoscopy, imaging and ophthalmology. Best practice approach has been proposed for endoscopy to get the right patients to be having the correct test with the aim of applying across all 4 organisations. A suitable model allowing sharing of staff, space or movement of patients is under review. We have expressed a wish to lead on the ophthalmology and imaging aspects which will feed into longer term vision for collaborative management in these

areas in the future. How the diagnostic aspects of these proposals will fit in with the national plans for community based rapid diagnostic hubs is unclear, but funding is available for this initiative. Our ICU lead is representative for the Black Country on a Birmingham and Black Country wide assessment of ICU capacity and service that is starting up.

3.2 The phase 3 letter focused on four broad areas summarised below and shown in annex 1. The implications and impact are being reviewed at a local and system level.

3.2.1 Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

- Restore full operation of all cancer services.
- Recover the maximum elective activity possible between now and winter, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.
- Restore service delivery in primary care and community services.
- Expand and improve mental health services and services for people with learning disability and/or autism

3.2.2 Preparation for winter alongside possible Covid resurgence.

- Continue to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave.
- Preparation for winter

3.2.3 Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

- Workforce
- Health inequalities and prevention.

3.2.4 Financial arrangements and system working

3.3 Our initial submission made to the BCWB STP who will start pulling together data on a system wide basis, with an initial submission date for 1st of September and final submission from the system due later in the month. The data submission focuses on activity based on last year's figures, showing projections for delivery over the rest of the year (RTT, referral received, outpatient, elective and non-elective performance, ED, diagnostic and cancer activity).

4. Recommendations

4.1 The Public Trust Board is asked to:

a. Note the progress in COVID recovery and work streams at SWBH
b. Discuss impact of system working and phase 3 letter and data submission

David Carruthers
Medical Director and acting CEO

August 26th 2020

Annex 1: phase 3 summary table

UI	Key action
A	**Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter**
A1	A1. Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:
A1.1	To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
A1.2	Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:
A1.2.1	Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
A1.2.2	Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
A1.2.3	Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
A1.2.4	Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
A1.2.5	Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.
A1.3	Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.
A2	Recover the maximum elective activity possible between now and winter, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals. Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:
A2.1	In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);
A2.2	This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
A2.3	100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
A2.4	Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.
A2.5	Elective waiting lists and performance should be managed at system as well as trust level to ensure equal patient access and effective use of facilities.
A2.6	Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by Covid receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change.
A2.7	Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.
A2.8	To further support the recovery and restoration of elective services, a modified national contract will be in place giving access to most independent hospital capacity until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held

	directly to account for delivering against them.
A2.9	In scheduling planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.
A2.10	Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical outpatient appointments where a clinically-appropriate and accessible alternative exists.
A3	**Restore service delivery in primary care and community services.**
A3.1	General practice, community and optometry services should restore activity to usual levels where clinically appropriate, and reach out proactively to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.
A3.2	In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood immunisations and cervical screening through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.
A3.3	GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes, and begin a programme of structured medication reviews.
A3.4	CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.
A3.5	Community health services crisis responsiveness should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need ongoing rehabilitation and other community health services. Community health teams should fully resume appropriate and safe home visiting care for all those vulnerable/shielding patients who need them.
A3.6	The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the discharge to assess processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.
A3.7	The Government has further decided that CCGs must resume NHS Continuing Healthcare assessments from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.
A4	**Expand and improve mental health services and services for people with learning disability and/or autism**
A4.1	Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.
A4.2	In addition, we will be asking systems to validate their existing LTP mental health service expansion trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
A4.2.1	IAPT services should fully resume

A4.2.2	the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
A4.2.3	maintain the growth in the number of children and young people accessing care
A4.2.4	proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
A4.2.5	ensure that local access to services is clearly advertised
A4.2.6	use £250 million of earmarked new capital to help eliminate mental health dormitory wards.
A4.3	In respect of support for people with a learning disability, autism or both:
A4.3.1	Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
A4.3.2	Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
A4.3.3	GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)
B	**Preparation for winter alongside possible Covid resurgence.**
B1	**Continue to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:**
B1.1	Continuing to follow PHE's guidance on defining and managing communicable disease outbreaks.
B1.2	Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS.
B1.3	Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising nosocomial infections across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.
B1.4	Ensuring NHS staff and patients have access to and use PPE in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.
B2	**Prepare for winter including by:**
B2.1	Sustaining current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.
B2.2	Deliver a very significantly expanded seasonal flu vaccination programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.
B2.3	Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed A&E capital to help offset physical constraints associated with social distancing requirements in Emergency Departments.
B2.4	Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.
B2.5	Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.
B2.6	Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3

	above).
C	**Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.**
C1	**Workforce**
C1.1	Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 (https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/) - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:
C1.2	Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
C1.3	Specific requirements to offer staff flexible working.
C1.4	Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
C1.5	New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
C1.6	Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
C1.7	Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.
C1.8	All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.
C2	**Health inequalities and prevention.**
C2.1	We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:
C2.3	Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.
C2.4	Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
C2.5	Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.
C2.6	Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

C2.7	Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.
D1	**Financial arrangements and system working**
D1.1	To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two. Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:
D1.2	Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.
D1.3	Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.
D1.4	Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.
D1.5	A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.