NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CCG REPORT COVER SHEET

Meeting Title:	**Governing Body in Public**						**Date: 8 September 2020**
Report Title:	**Strategy & Planning Committee Overview Report**						**Agenda Item: 3.1**
Chief Officer:	Jan Thomas, Chief Officer						
Chair:	Julian Huppert, Lay Member and Chair of Strategy and Planning Committee						
Report Author:	Gemma Keats, Corporate Governance Administrator						
Document Status:	Final						
Report Summary:	This Report provides an overview of the latest meetings of the Strategy and Planning Committee held on 14 July 2020 and 11 August 2020.						
Report Purpose:	**For Assurance**	**x**	**For Decision**		**For Approval**		**For Recommendation**
Recommendation:	The Governing Body is asked to note the contents of the report. The Governing Body is asked to note the approved Committee minutes of the meeting held on 11 February 2020. The Governing Body is asked to endorse the Ethical Committees Terms of Reference attached as Appendix B						
Link to Corporate Objective:	**Objective 1 – Ensure clear patient voice in everything we do**						**X**
	Objective 2 – Deliver improvements that make best use of the public pound and save system 'cost'						**X**
	Objective 3 – Use data and information to prove everything						**X**
	Objective 4 – Deliver the prioritised performance standards						**X**
	Objective 5 – Deliver the 6 transformation programmes						**X**
	Objective 6 – Deliver the CCG Financial Plan						**X**
CAF (Strategic Risk) Reference	**Description of Risk**						**Current Risk Score**
CAF08	Risk to maintaining robust CCG Governance arrangements						8 (A)
NHSE CCG IAF Links	**IAF 1 Domain 1 - Better Health**				**X**		
	IAF 2 Domain 2 - Better Care				**X**		
	IAF 3 Domain 3 - Sustainability:				**X**		
	IAF 4 Domain 4 - Leadership				**X**		
Resource implications:	N/A						
Chief Officer/ SRO Sign Off:	Jan Thomas, Chief Officer						
Chief Finance Officer Sign Off: (if required)	N/A						
Legal implications including equality and diversity assessment:	N/A						
Conflicts of Interest	In line with the CCG's Conflicts of Interest Policy						
Report history:	Prepared for Governing Body on 8 September 2020						
Next steps:	Overview of Committee work for information / assurance.						

MEETING: GOVERNING BODY IN PUBLIC

AGENDA ITEM: 3.1 **SECTION:** STRATEGY

DATE: 8 SEPTEMBER 2020

TITLE: STRATEGY & PLANNING COMMITTEE OVERVIEW REPORT

FROM: JAN THOMAS, CHIEF OFFICER &
DR JULIAN HUPPERT, CCG LAY MEMBER & CHAIR OF COMMITTEE

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1 ISSUE

1.1 This paper presents a brief overview of the Strategy and Planning Committee (SPC) which met formally in July 2020. The COVID-19 pandemic saw a change to the CCG Business Cycle and therefore, the Governing Body has not received an update from the Committee since March 2020.

1.2 The minutes of the meeting held on 11 February 2020 are attached at Appendix A.

2 KEY POINTS

2.1 Topics for Review and Discussion

2.1.1 Health Inequalities Strategy

The Committee received the updated Health Inequalities Strategy and working Action Plan. The paper described how the impact of the COVID-19 pandemic will increase inequalities both directly through increased deaths and cases in the most deprived areas and indirectly through the impact on the economy and mental health. The increase is likely to continue further over the coming months and years. Progress is already being made within the CCG and the Cambridgeshire and Peterborough health care system to mitigate some of the impacts of COVID-19 on health inequalities, but further action is now needed to galvanize the momentum.

The Committee discussed the need for further work to build sustainable health inequalities infrastructure with the right data to support the system approach to inequalities to make positive change going forward. Discussion also covered whether enough is being done to address longstanding inequalities and whether the work being done is brave enough. Some bold targets or objectives could provide influence. The Committee talked about the link between addressing health inequalities and recovery, remembering a previous presentation from Sir Michael Marmot on the introduction of wellbeing cities. The CCG recognises health inequalities in the population across Cambridgeshire and Peterborough and how this differs in the widest sense between North and South. The Committee discussed the significant challenges and social determinants of health to ensure people do not become ill and there is work to be done to make the Health Inequalities Impact Assessment a live process that is meaningful so it can be used as a catalyst for change.

The Committee supported the recommendations set out in the Strategy, which is on the September Governing Body agenda as a separate item.

2.1.2 **Obesity and Diabetes Inequalities – Next Steps**

The Committee received a paper on Obesity and Diabetes Inequalities Next Steps which was previously received by the Governing Body. Our Clinical Lead, Dr Jessica Randall-Carrick joined the meeting and talked about how the biggest thing that caused mortality is a raised BMI. Not only is there an increased risk for cancers, but also for COVID-19. This is a huge problem and the population is growing. To keep momentum, a coordinated systematic push to raise the obesity pandemic to the attention of the population is needed.

The Committee discussed food outlets and restaurants and that work will be done with shops and business owners on advertising healthier options, reducing portion sizes and ensuring a variety of foods is on offer. The Committee discussed the very low calorie diet and the need to look at how to sensibly put this to socio-economic families. The CCG will be talking to partners to support delivery of this programme which will see a pilot with 100 people to ensure great returns and savings in the longer term. The CCG will look at sponsorship options and also link in with other approaches already up and running to utilise the whole network of people out there in the community.

2.1.3 Other Issues

During the July meeting the Committee also considered:

- **Recovery and Restoration Update**
  The Committee received an update on Recovery and Restoration where there is increasing pressure to answer questions from the Region on in-hospital services, theatre productivity, diagnostic capacity and keeping people safe on waiting lists. The Committee agreed to hold a Planning Session in August to discuss Planning for 2021/22 in more detail.

- **Review of Strategy & Planning Committee Terms of Reference**
  The Committee reviewed its Terms of Reference as part of the regular annual process, which had been amended to reflect changes to the Chief Officer Team. The final version would be included within the Governance Handbook for future formal ratification by the Governing Body.

- **Ethical Committee Terms of Reference**
  The Committee received the Ethical Committee Terms of Reference which was a system wide group agreed by the Sustainability and Transformation Programme and the CCG. This was a group for advice rather than decision making and they were looking for people to join it, such as a GP representative. The Committee discussed its link to the Ethical Committee. The Term of Reference are attached as Appendix B for the Governing Body's endorsement.

- **CCG Assurance Framework & Risk Register**
  The Committee received the CCG Assurance Framework and Risk Register and discussed whether there was a need for any specific risks under the Committees ownership and that the Health Inequalities risk could be. Further discussions outside of the meeting will take place on this.

3 RECOMMENDATION

3.1 The Governing Body is asked to note the update from the latest meetings of the Strategy & Planning Committee.

3.2 The Governing Body is asked to note the approved minutes of the Strategy & Planning Committee meeting held on 11 February 2020 attached at Appendix A.

3.3 The Governing Body is asked to endorse the Ethical Committee Terms of Reference attached as Appendix B.

Author ***Gemma Keats***
Corporate Governance Administrator
21 August 2020

Appendix A – Minutes of Strategy & Planning Committee 11 February 2020
Appendix B – Peterborough and Cambridgeshire System-wide Ethical Committee Terms of Reference

Appendix A

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

MINUTES OF THE STRATEGY & PLANNING COMMITTEE HELD ON TUESDAY 11 FEBRUARY 2020 AT 2.00 PM IN THE CEDAR ROOM, LOCKTON HOUSE, CAMBRIDGE

Present:

Dr Julian Huppert, CCG Lay Member (Chair)
Jessica Bawden, Director of External Affairs & Policy
Dr Mark Brookes, GP Member
Dr Jane Collyer, GP Member
Sharon Fox, Associate Director Corporate Affairs (CCG Secretary)
Dr Fiona Head, Associate Director Clinical Outcomes, Population Health Strategy and Hosted Research
Dr Gary Howsam, CCG Chair
Louis Kamfer, Chief Finance Officer
Stephen Mitchell, CCG Lay Member
Dr Sripat Pai, GP Member
Dr Adnan Tariq, GP Member
Jan Thomas, Accountable Officer

In Attendance:

Dr Rozelle Kane, Clinical Lead for Digital & Innovation, STP
Gemma Keats, Corporate Governance Administrator, CCG
Matthew Smith, SRO, Urgent & Emergency Care
Sinem White, Hosted Research

1 Welcome and Introductions

Dr Julian Huppert, Chair welcomed everyone to the meeting and introductions were made round the table.

2 Apologies for Absence

Apologies for absence were received from Carol Anderson, Dr Liz Robin and Jane Webster.

3 Declarations of Interest

There were no declarations of interest related to the agenda.

4 Notification of Any Other Business

1. System by Default.

5 Minutes of the Last Meeting

The minutes of the last meeting were **agreed** as an accurate record.

6 Matters Arising

There were no Matters Arising.

7 Guest Speaker – Professor Martin Roland CBE, Emeritus Professor of Health Services Research, GP

The Chair welcomed Professor Martin Roland (Martin Roland) CBE to the meeting.

Martin Roland gave an overview of his experience, being trained in Oxford and spending the last 35 years as a GP. He advised that he was also a Professor of Health Services Research, at the applied end of research looking at how to measure quality care and improve it. Recent work had seen him being commissioned to look at the future of primary care which led to the GP Forward View. He went on to ask the Committee what the CCG's main achievements were over the last twelve months. The Committee discussed its achievements, including the establishment of Primary Care Networks with Clinical Directors in place and conversations were happening about the staff needed to take things forward. Members discussed the issues raised related to the specification, that it was an unaffordable ask and that GPs could be out of pocket. Martin Roland observed that networks, federations and groups started organically five or six years ago, and he thought this was about NHS England taking on a good idea and bureaucratising it. The Committee discussed that the CCG had underestimated the vulnerability of primary care in the patch and that a lot of time went into managing acute contracts. Most of the CCG's time was spent discussing secondary care, not leaving much time for everything else. Dr Gary Howsam commented that the Primary Care Commissioning Committee solely discussed primary care. Sharon Fox added that much of the Committee business and discussion was about transactional processes rather than strategy. Martin Roland commented on practice closures and asked how many had closed in the CCG area. Jessica Bawden advised that there had been two practice closures which were planned for some time. She added that there were five or six practices rated Inadequate by the Care Quality Commission and the status of these. Martin Roland referred to the Collings Report on the state of General Practice and quoted a British Medical Journal article he had written that 'if general practice fails the whole NHS fails'.

Martin Roland talked about integration and asked about the role of the STP. Jan Thomas advised that the STP was a partnership to get people who usually worked independently to try to work together, for example, social care, community, acute, primary care providers and Royal Papworth as a tertiary provider. The STP for this area was led by the Cambridge University Hospitals NHS Foundation Trust (CUHFT) Chief Executive and Chair. The Committee discussed the finances Cambridgeshire and Peterborough system, acknowledging that partners were beginning to share each other's financial issues which was not the case a few years ago. The Committee discussed the different contracts between the CCG and providers, such as Guaranteed Income Contracts, Payment by Results, Block Contracts and how many times organisations had switched between them. The Committee discussed the changing relationships between organisations and that the CCG assessed the financial opportunities to improve the position. Jan Thomas highlighted the ten key milestones system wanted to achieve which included agreeing financial limits and the Primary Care Budget. Martin Roland commented on potential changes to budgets in the future and the Committee discussed the need for commissioners in whatever form. Martin Roland said the CCG was responsible for allocating national funding. Jan Thomas commented that the reality was the weight of ensuring that acute trusts did not crash and burn. She said if the CCG did what it really wanted to do, there would be a very different financial plan. Jan Thomas

said the ability to change the landscape was a long way off and providers were finding it difficult to meet the £15m reduction the CCG had asked for. Martin Roland said this was often the case and acute trusts were powerful players.

Dr Rozelle Kane said she believed organisations could work as a system with cross organisation projects which could mean pooled budgets in future. The Committee discussed pooled budgets, what they could look like and the way acute care was contracted. Martin Roland moved on to talk about outpatients, referring to Tower Hamlets and how they were trying to reconstruct this to reduce outpatient appointments by 50% by using technology. The Committee noted that some of this work had already started locally in terms of some follow ups being done by phone.

Martin Roland commented on community teams and why community trusts needed to exist. He said he could not see the logic of self-standing community trusts that were horizontal with primary care. He asked about contracting in future and the services currently provided by Cambridge and Peterborough Foundation Trust. Members discussed how big primary care providers would need to be to take on more, such as district nursing for example. Jan Thomas commented on the model the CCG was starting to articulate and what the right geography looked like. She said there was also a review of what the CCG received from CPFT going on at same time. Jan Thomas said this was also about vertical integration and larger entities should hold the risk. Martin Roland asked about the financial risk. Jan Thomas said it was about having some of the scale to cope with volatility. For example, recruitment and other practical things such as how to map to Primary Care Networks (PCNs) and also looking at making PCNs bigger to do more. Martin Roland said there was no one size fits all in the NHS and structures needed to be aggregated to fit. Dr Rozelle Kane commented on GP trainees and social prescribing and where this sits. Dr Mark Brookes advised that there were 15 PCNs that were undertaking social prescribing and there was uncertainty about the service specifications.

Martin Roland referred to the new GP contract and how this will influence the PCNs in future, he asked what the role of the CCG would be. Dr Gary Howsam said culture change needed to be encouraged to ensure conversations on the GP contract were about things primary care could do. He said primary care needed to be less precious about what it held onto. It was important to ensure the primary care voice was always around the table. Dr Mark Brookes said it was as simple as not asking the PCNs to run before they could walk. He added that as progress was made, the attitude of primary care leaders needed to change as current leaders were stuck in the confrontational relationship that was there in the past. Matthew Smith commented that there was something about having a clear local vision, beyond the National blueprint. Dr Gary Howsam asked why the CCG had struggled in the past. Matthew Smith said it was about not fully appreciating the primary care position and that previously within Cambridgeshire and Peterborough, Local Commissioning Groups had been set up below the Governing Body and were dominated by primary care clinicians. Dr Gary Howsam asked whether there should be a CCG vision for primary care or if it should be primary care led. Matthew Smith said he did not see it as ‘them and us’. Dr Adnan Tariq commented that there was a time when primary care was suffering with a reduction in doctors, staff shortages and primary care felt it did not receive help at that time. He agreed with the need for a mantra for PCNs as this would help them to survive. He added that there was quite a big ask in terms of getting some things for free by primary care expanding its horizons. Dr Adnan Tariq commented on the need to fix and utilise the issues and said he thought

primary care could take on some function of community nursing but asked what elements. Martin Roland commented on leadership and that developing this in primary care was really important in terms of promoting the next generation of leaders.

Martin Roland talked about risk stratification and that on its own it doesn't do anything. In order to make improvements or reduce costs in future, risk stratification would initially increase costs and you could start to see benefits after 2 years. If the CCG was looking to see results any sooner, risk stratification was not the way to go. The Committee discussed case management and the benefits for patients in terms of outcomes and experience. Martin Roland said the likelihood was it would improve care for patients but would not reduce costs. Martin Roland commented on what continuity of care looked like in modern care.

The Chair thanked Martin Roland for attending the meeting.

Martin Roland left the meeting.

The Chair reflected on the guest speaker discussion and asked the Committee why the CCG could not ask these questions of ourselves. Jan Thomas said she found the discussion around the CCG's role for the PCNs interesting and the Development Fund and what the CCG would spend the money on if it was trusted to just get on with it. Dr Sripat Pai commented on the discussion on risk stratification and that he found this interesting. Dr Gary Howsam asked if there was a bigger 'so what' and whether the CCG should send its Commissioning Intentions to someone before they went to providers. The Chair advised that there would be no speaker at the next meeting and asked what the next meeting could bring. Dr Fiona Head commented on the future state of the system and that the Committee should write or draw the outcomes of these sessions after each meeting as a rolling document. Jan Thomas said she thought the Committee should be thinking about the three things the Committee should be doing and suggested having an open session to do this. It was agreed that Jan Thomas, Dr Gary Howsam and the GP Members (Dr Mark Brookes, Dr Jane Collyer, Dr Adnan Tariq and Dr Sripat Pai) should work up a list separately without conferring before the next meeting.

8 System by Default

Jan Thomas gave an update on System by Default after she had attended an event run by the Regional Team. She advised that discussion on this continue around who the system leader was that took overall accountability and the lead for system performance. There was concern this could undermine the good work already happening in terms of partnership working. Jan Thomas talked about the plans for an intensive support regime and there being one plan for the system. This would not take away organisational accountability. There was a group of people regionally/nationally that see things differently to us locally. there was no consensus yet on system by default and Jan Thomas agreed to keep the Committee informed. Jan Thomas advised that she also in conversation with local MPs around the system control total. The Committee **noted** the update.

9 Update on the NHS Operational Planning and Contracting Guidance 2020/21

The Committee received an update on NHSE/I Operational Planning & Contracting Guidance which outlined the timeline for a contribution to a system response which would come back to the next Committee meeting. The Guidance focussed on decreasing bed occupancy, carbon reduction and NHS Public Health Prevention.

The Chair commented that some of this was going to hit against there being no agreement with the STP in terms of the Governance. Sharon Fox advised that the revised Framework was awaited although she understood work was underway to address this. Jan Thomas commented on legal directions and understanding why the CCG was still under these. Dr Mark Brookes commented on the final annex which supported practices with long waits for appointments.

The Committee **noted** the update.

10 Date of the Next Meeting

The date of the next meeting was confirmed as Tuesday 10 March 2020 in the Cedar Room, Lockton House, Clarendon Road, Cambridge, CB2 8FH.

Author
Gemma Keats
Corporate Governance Administrator
11 February 2020

Appendix B

Peterborough and Cambridgeshire System-wide Ethical Committee

Terms of Reference

Purpose

The role of this committee is to provide ethical advice across the Cambridgeshire and Peterborough Health and Care system.

It will be a resource available to answer questions from system leaders, provider ethical committees, clinicians, patient groups and others, as well as considering ethical issue proactively. It will encourage consistency of ethical decision-making across the system. It is advisory, rather than having an executive, legal, or clinical role. Decision-makers retain responsibility for their final decisions.

Establishment and reporting

This Committee is created by and reports to both the STP Board and the CCG. Reports from the Committee should appear on the agendas of both organisations, with oral presentations from the Committee where appropriate.

Topics for discussion

Subjects can be raised with the Ethical Committee by the STP Board, CCG, Healthwatch, Health and Social Care Committees, Provider Trust Ethical Committees, the cross-system Clinical Advisory Group, patient groups, clinicians or others. The Ethical Committee would undertake to consider the questions promptly, normally at its next meeting; there would also be an emergency protocol where needed. The Ethical Committee will also decide its own subjects for discussion as appropriate; these may be ongoing issues or individual subjects.

Meetings

Meetings will take place monthly or as required if more frequent. They are expected to take place virtually by Zoom or equivalent, but may also take place in person. Where there are urgent matters, email discussion may be used.

Administration

Provision of agendas and record-keeping will be the responsibility of the CCG, currently by the CCG R&D team. The Committee will comply with the CCG Conflicts of Interest Policy through all aspects of its business, and keep a record of any conflicts of interest.

Reporting

Reports to the STP, CCG and other bodies will focus on conclusions and recommendations, rather than keeping a record of everything that was said. Reports will note that Membership of the Committee does not imply agreement with every recommendation, but Members are also free to ask for their dissent to be noted.

Membership

The initial membership will be as shown below. The Committee will appoint its own Chair and any other positions on an annual basis, with no time limit. It will also be able to co-opt members as needed. It would be expected to invite others to join meetings where they are particularly involved or have particular information to share. Members are present in their own capacities, and are not expected to represent their own organisations or professional interests, but to act in a system-wide way.

Dr Jag Ahluwalia, *Chief Clinical Officer, EAHSN and NED, Royal Papworth HFT*
Dr Stephen Barclay, *CCG & STP Clinical Lead for End of Life Care, GP*
Dr Colin Borland *Retired Consultant Physician and Geriatrician (Hinchingbrooke/NWAFT)*
Dr John Ford, *Public Health Registrar, C&P CCG*
Dr Zoë Fritz, *Consultant Physician in Acute Medicine, Addenbrooke's & Wellcome Fellow in Ethics and Society, CUH Ethics Committee*
Sarah Hamilton, *Head of Safeguarding People, C&P CCG*
Dr Suzanne Hamilton, *Deputy MD North West Anglia Foundation Trust and NWAFT Ethics Committee*
Dr Julian Huppert, *Deputy Chair, C&P CCG*
Dr Kathy Liddell, *Director Centre for Law, Medicine and Life Sciences, Faculty of Law, University of Cambridge*
Prof. Richard Holton, *Professor of Philosophy, University of Cambridge*
Prof. Peter Jones, *NED CPFT and CPFT Ethics Committee*
Val Moore, *Chair, Healthwatch and former Director, NICE*
Rev. Mark Stobart, *Lead Chaplain, Addenbrooke's*
Viv Shaw (Secretariat), *Head of R&D C&P CCG*

We would also like to identify one or two members from the care sector (perhaps one local authority and one from a care home), an additional GP and/or community nurse, an additional member from the North of the County, and an additional person from public health. We would also like to identify someone who works with children, and ideally a CFO from either a provider or the CCG who would like to be involved in these discussions. We are also keen to improve the ethnic diversity, so would ideally find at least one or two additional BAME members. Once the Committee is fully established, future appointments should be made based on open advertisement.

Review

These Terms of Reference will be reviewed on an annual basis. Any changes must be agreed by the CCG and STP. The Committee should also review at least annually the impact it is having.

Resources

In addition to contributions of time from the CCG for administration, other expenses up to a limit of £20,000 may be incurred, to compensate members for participating where there is no other source of funding, for meeting rooms and refreshments where needed, and other minor costs. The Committee shall try to minimise these costs.

Appendix – sample report

Report from C&P Covid 19 Ethical Committee 16.05.20
Dr Julian Huppert (Chair)

1. **Ethical considerations as we reopen NHS services over the coming months and years**

    - As we seek to reopen NHS services, there is likely to be significantly reduced capacity, perhaps as low as 25% of usual. This results from constraints on space to achieve appropriate distancing, and constraints on staff from distancing, the need to test patients and staff, PPE use (time to don/doff, availability, and constraints it imposes), and the need for staff to have some breaks from work. On the other hand, there is likely to be more demand for services, as a result of the reduced access over the previous months.

    - There is considerable work being done to consider operationally how to restore NHS services over the coming weeks, months and years. We felt that it was important that decisions about what is restored and how be done in the context of a clear ethical framework to underpin the difficult decisions that need to be made. We highlight many of the issues that need to be addressed below – this is a non-exhaustive list, and in no particular order.

    - ***Active decision-making***. We should not seek to return the pattern of provision to what it was, just because it is how things were done. We should not seek to maintain the new operating models, just because they are what we do now.

    - ***Value and impact***. When deciding which services to restore, there needs to be a clear consideration of what they achieve in terms of the value and impact they bring to promote health and reduce the burden of disease. This should include consideration of emergency need, avoiding irreversible harm to patients, as well as avoidable pain and suffering.

    - ***Evidence base and shared decision making***. Careful consideration should be made of the evidence base for interventions. In many cases, there is no evidence that particular interventions have a positive effect, and their re-adoption should be questioned. There will be a need to be open and honest with patients about these decisions. Personalised discussion about risks and benefits can increase patient agency, and often leads to less invasive treatment choices.

    - ***Redesign pathways for the new reality***. The optimal pathway for treatment under the new constraints is unlikely to be the same as the optimal one previously, for example as we try to avoid hospital and the risk of nosocomial Covid infection. These pathways all need to be reconsidered with reference to treatment success, speed, and number of patients able to benefit. In many situations, it may be ethical to provide a somewhat suboptimal treatment to many patients, than an optimal one to only a few.

    - ***Avoid over-investigation***. There is an understandable drive for many clinicians, particularly in teaching centres, to recommend more investigation than is actually merited by the current evidence. Some tests are worth doing; others are not, and can cause harm. This requires focused communication to clinicians, and there is a balance to strike between the benefits of standardisation and leaving appropriate flexibility for clinical judgement when appropriate.

- ***Refocus research.*** Over the next two years, the research agenda should shift to focus more on testing whether current practice actually works, and what interventions could be safely stopped, rather than testing out exciting new methods that may not be applicable at the moment. Making patient participation in research far more the norm across services would be helpful. There is an ethical duty to learn as much as we can from the constraints we are facing.

- ***Patient safety***. There needs to be continued focus on patient and staff safety, minimising the risk of nosocomial infection.

- ***System working***. There has been some admirable cross-sector working during this crisis, and it is an ethical imperative that this continues, so that the system response is coordinated as one geography to avoid silo working, and achieve a move towards true integrated care with shared purpose and accountability.

- ***Focus on staff wellbeing***. Staff have had to adapt rapidly to new ways of working, and in many cases taking on new roles, increased stress, and extended hours. Any future plans have to ensure that staff are supported and given time to recover, including allowing for holiday that many have been unable to take. Many staff will have taken on roles they were not used to or not specifically trained for; they will need support whether they return to their previous roles or remain in the new ones.

- ***Support primary care.*** There is a very real risk that a reduction in capacity in secondary care will simply shift the burden and risk on to primary care, who will have to cope with an increased number of people wanting and expecting treatment that is not available. Provision must be made to ensure that primary care is supported to do this.

- ***Reduce inequality***. We have frequently referred to Dr Julian Tudor-Hart's 'inverse care law', where more care is given to or sought by those in least need of it. It is an ethical imperative to focus on addressing this proactively when considering new services. There is a real opportunity to use this process to reduce existing health inequalities, rather than increase them.

- ***Public Health and prevention***. Since it is likely that less treatment will be possible, it becomes even more important than previously to focus on prevention and public health approaches, including public mental health. These approaches may not be subject to the same capacity constraints as treatment options, and there may be more public willingness to listen to these messages and act on them now than previously.

- ***Digital***. The last months have seen rapid introduction of digital and remote approaches for service delivery. Some of this is undoubtedly positive, but some may well have resulted in worse performance. There is a pressing need for evaluation of all of the digital delivery of service, so that informed decisions can be made as to what to keep and what to discard. This must also include considerations of whether some groups of people have been inadvertently excluded – for example, people from more disadvantaged backgrounds, older people, those with mental health issues or learning disability. Consideration should also be given to staff wellbeing in using digital tools; while there are some benefits, there are also downsides and risk of increased burnout. Lessons should be learned from areas around the world that use more digital techniques,

including rural Australia. There is an important distinction to be made between introducing digital services where none existed, and substitution of alternative provision.

- ***Building trust with patients***. It will be important to build trust with patients, who will see different NHS services to what existed before and they may have been expecting. This will be particularly challenging for patients who were already on a waiting list, and may either find that they waiting list is much longer than anticipated, or that the treatment they were offered has changed. Open and honest discussions will be essential, with increased clinical patient-centred conversations.

- ***Clarity of communications***. There is a risk that the public will be unclear what services are available to them, and what is the appropriate action to take in various circumstances. A carefully thought through and detailed approach to public communications will be essential, to encourage people to present only when appropriate, but to do so when it is appropriate.

- ***Deliberation***. A large number of crucial decisions will need to be made that will affect the public significantly. It will be very valuable to understand how the public think about the competing factors. We therefore recommend conducting a series of deliberative representative discussions, such as those convened by Healthwatch as part of the Big Conversation.

- ***Transparency***. There needs to be a high degree of transparency about what decisions are being made, by whom, and why. This is important legally and also a crucial part of trust-building.

- ***Accountability***. There needs to be clear accountability for decisions made and the reasons for them.

Membership (NB Membership should not be taken to mean agreement with every recommendation)

Dr Julian Huppert (Chair) *Deputy Chair, Cambridgeshire & Peterborough Clinical Commissioning Group*

Dr Jag Ahluwalia, *Chief Clinical Officer, EAHSN and NED, Royal Papworth HFT*

Dr Stephen Barclay, *CCG & STP Clinical Lead for End of Life Care*

Dr Colin Borland *Retired Consultant Physician and Geriatrician (Hinchingbrooke/NWAFT)*

Dr Zoë Fritz, *Consultant Physician in Acute Medicine, Addenbrooke's & Wellcome Fellow in Ethics and Society, CUH Ethics Committee*

Sarah Hamilton, *Head of Safeguarding People, C&P CCG*

Dr Suzanne Hamilton *Deputy MD North West Anglia Foundation Trust and NWAFT Ethics Committee*

Dr Kathy Liddell, *Director Centre for Law, Medicine and Life Sciences, Faculty of Law, University of Cambridge*

Prof. Richard Holton*, Professor of Philosophy, University of Cambridge*

Prof. Peter Jones *NED CPFT and CPFT Ethics Committee*

Val Moore *Chair, Healthwatch and former Director, NICE*

Viv Shaw (Secretariat), *Head of R&D C&P CCG*