NHS
Shropshire
Clinical Commissioning Group
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A G E N D A

The meeting is to be held in public to enable the public to observe the decision making process.

Meeting Title	Governing Body Meeting	Date	Wednesday 11 March 2020
Chair	Dr Julian Povey	Time	1.00pm
Minute Taker	Mrs Sandra Stackhouse	Venue / Location	Room SGH026, The University Centre, Guildhall, Frankwell, Shrewsbury, SY3 8HQ

RESOLVE: ***A private Governing Body meeting will precede this where it will be resolved that representatives of the press and other members of the public be excluded having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960).***

Dr Julian Povey, Chair

Reference	Agenda Item	Presenter	Time	Paper
GB-2020-03.025	**Apologies**	**Julian Povey**	***1.00***	*verbal*
GB-2020-03.026	**Members' Declaration of Interests**	**Julian Povey**	***1.00***	*verbal*
GB-2020-03.027	**Introductory Comments from the Chair**	**Julian Povey**	***1.05***	*verbal*
GB-2020-03.028	**Minutes of Previous Meeting** Meeting held on 15 January 2020	**Julian Povey**	***1.10***	*enclosure*
GB-2020-03.029	**Matters Arising**	**Julian Povey**	***1.15***	*enclosure*
GB-2020-03.030	**Questions from Members of the Public** Questions from members of the public will be accepted in writing 48 hours prior to the meeting and should be submitted by 12.00 noon **Monday 9 March** to: Dr Julian Povey, Clinical Chair, Shropshire CCG, Somerby Suite, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL or via email: SHRCCG.govbody@nhs.net Guidelines on submitting questions can be found at: **http://www.shropshireccg.nhs.uk/get-involved/meetings-and-events/governing-body-meetings/**	**Julian Povey**	***1.20***	*verbal*
GB-2020-03.031	**Clinical and Financial Reports** Finance, Contracting Report incl. Quality, Innovation, Productivity & Prevention (QIPP) schemes	**Claire Skidmore**	***1.25***	*enclosure*
GB-2020-03.032	**Corporate Performance Reports** Performance and Quality Report	**Chris Morris/ Julie Davies**	***1.40***	*enclosure*

GB-2020-03.033	SaTH Quality and CQC Update	**Chris Morris**	***2.00***	*enclosure*
GB-2020-03.034	Update on Transforming Midwifery Care	**Fiona Ellis**	***2.15***	*enclosure*
BREAK			***2.30***	
	Governance & Engagement			
GB-2020-03.035	CCG Strategic Priorities Update	**David Evans**	***2.45***	*enclosure*
GB-2020-03.036	Single Strategic Commissioner Update	**Alison Smith**	***2.55***	*enclosure*
GB-2020-03.037	Emergency Preparedness, Resilience & Response	**Sam Tilley**	***3.10***	*enclosure*
GB-2020-03.038	Audit Committee – 26 February (summary)	**Keith Timmis**	***3.20***	*enclosure*
	For Information Only/Exception Reporting		***3.25***	
GB-2020-03.039	Clinical Commissioning Committee – 20 November, 22 January	**Sarah Porter**		*enclosure*
GB-2020-03.040	Finance & Performance Committee – 27 November, 9 January, 29 January	**Kevin Morris**		*enclosure*
GB-2020-03.041	Primary Care Commissioning Committee – 4 December	**Colin Stanford**		*enclosure*
GB-2020-03.042	Quality Committee – 27 November	**Meredith Vivian**		*enclosure*
GB-2020-03.043	System A&E Delivery Board – 19 November	**Julie Davies**		*enclosure*
GB-2020-03.044	North Locality Board – 28 November, 23 January	**Mike Matthee**		*enclosure*
GB-2020-03.045	Shrewsbury & Atcham Locality Board – 21 November, 16 January	**Deborah Shepherd**		*enclosure*
GB-2020-03.046	South Locality Board – 6 November	**Matthew Bird**		*enclosure*
GB-2020-03.047	**Any Other Business**	**Julian Povey**	***3.30***	*verbal*
	Date of Next Meeting • Wednesday 13 May 2020 - time and venue to be confirmed			
	A hearing loop system can be made available, upon prior request, to members of the public with hearing difficulties. Please contact the CCG at least 48 hours prior to the meeting at: SHRCCG.govbody@nhs.net			

Dr Julian Povey
Clinical Chair

David Evans
Accountable Officer

Shropshire Clinical Commissioning Group

MINUTES OF THE SHROPSHIRE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING

HELD IN THE LAKESIDE SUITE, ALBRIGHTON HALL HOTEL, ELLESMERE ROAD, ALBRIGHTON, SHREWSBURY, SY4 3AG

AT 1.00 PM ON WEDNESDAY 15 JANUARY 2020

Present

Dr Julian Povey	CCG Chair
Mr David Evans	Accountable Officer
Dr Finola Lynch	Deputy Clinical Chair
Mrs Claire Skidmore	Executive Director of Finance for Shropshire and Telford & Wrekin CCGs
Dr Jessica Sokolov	Executive Director of Transformation for Shropshire and Telford & Wrekin CCGs
Dr Stephen James	GP Governing Body Member & Clinical Director
Dr John Pepper	GP Governing Body Member & Clinical Director
Mr Kevin Morris	GP Practice Governing Body Member
Dr Deborah Shepherd	Locality Chair, Shrewsbury & Atcham Locality Board
Dr Matthew Bird	Locality Chair, South Locality Board
Dr Michael Matthee	Joint Locality Chair, North Locality Board
Dr Priya George	GP Governing Body Member & Clinical Director
Dr Alan Leaman	Secondary Care Member
Dr Julie Davies	Director of Performance for Shropshire and Telford & Wrekin CCGs
Mrs Christine Morris	Chief Nurse for Shropshire and Telford & Wrekin CCGs
Miss Alison Smith	Director of Corporate Affairs for Shropshire and Telford & Wrekin CCGs
Mrs Sam Tilley	Director of Planning for Shropshire and Telford & Wrekin CCGs
Mrs Nicky Wilde	Director of Primary Care
Mr Keith Timmis	Lay Member – Governance and Audit (Vice Chair)
Mrs Sarah Porter	Lay Member – Transformation
Mr Meredith Vivian	Lay Member – Patient and Public Involvement

In Attendance

Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire – Observer
Ms Jo Robbins	Consultant in Public Health – Observer
Dr Edwin Borman	Director of Clinical Effectiveness, SaTH *[Item No: GB-2020-01.013 only]*
Mrs Sandra Stackhouse	Corporate Services Officer – Minute Taker

1.1 Dr Povey welcomed members, observers and the public to the Shropshire Clinical Commissioning Group (CCG) Governing Body meeting being held in public.

Minute No. GB-2020-01.001 - Apologies

2.1 Apologies were noted from:

- Mr David Stout — Interim Transformation Director
- Mrs Gail Fortes-Mayer — Director of Contracting and Planning
- Dr Colin Stanford — Lay Member
- Ms Rachel Robinson — Director of Public Health, Shropshire Council

Minute No. GB-2020-01.002 - Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the Governing Body Register of Interests and was available to view on the CCG's website at:
http://www.shropshireccg.nhs.uk/about-us/conflicts-of-interest/
However, Members were asked to confirm any additional conflicts of interest that they had relating to the agenda items and these were noted as follows:

The following GP Governing Body Members declared a potential conflict of interest under the rules of the CCG's Constitution for the discussion under agenda item: GB-2020-01.011: Single Strategic Commissioner for Shropshire Telford and Wrekin Update Report:

- Dr Povey, Dr Shepherd, Dr Pepper, Dr Lynch, Mr Morris, Dr Bird, Dr Matthee, Dr George.

The following declarations were also noted:

- Miss Smith declared that she was the new Director of Corporate Affairs for Shropshire and Telford and Wrekin CCGs.
- Mr Evans declared that he was the Accountable Officer for Shropshire and Telford and Wrekin CCGs.
- Mrs Skidmore declared that she was the new Executive Director of Finance for Shropshire and Telford and Wrekin CCGs.
- Dr Sokolov declared that she was the new Executive Director of Transformation for both Shropshire and Telford and Wrekin CCG.
- Dr Davies declared that she was the new Director of Performance for Shropshire and Telford & Wrekin CCGs.
- Mrs Tilley declared that she was the new Director of Planning for Shropshire and Telford and Wrekin CCGs.

3.2 There were no other additional conflicts of interest declared.

Minute No. GB-2020-01.003 - Introductory Comments from the Chair

4.1 Those present were reminded that the meeting was being live streamed, which would be available to view on YouTube. Should there be any technical difficulties with the Wi-Fi signal connection affecting the streaming process, a recording of the meeting would be uploaded onto the CCG's website as soon as possible following the meeting.

Minute No. GB-2020-01.004 – Minutes of the Previous Meeting – 13 November 2019

5.1 The minutes of the previous meeting held on 13 November 2019 were presented and approved as a true and an accurate record of the meeting following one amendment: page 1, paragraph 2.1: amend the transposition of Mr Vivian's name.

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the minutes of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 13 November 2019.

ACTION: Mrs Stackhouse to make the agreed amendment to the minutes as noted in paragraph 5.1 above.

Minute No. GB-2020-01.005 – Matters Arising from the Minutes of the Previous Meeting

6.1 It was noted that the actions from the previous meetings had been completed or included on the agenda. The following updates on the matters arising were noted as follows:

a) GB-2019-07.097 – Ambulance Demand Deep Dive – Progress Update

Dr Povey noted that Mrs Fortes-Mayer had held discussions with Stafford and Surrounds, and Herefordshire and Worcestershire CCGs to agree what rural parts of the region required in terms of performance delivery targets and to develop community alternatives with the support of the ambulance service. It was understood that Mrs Fortes-Mayer had written to the Regional Commissioner regarding the outcome and setting out the position for local rural systems and would report back to the Governing Body. Mr Evans reported that he was aware the action had been completed but would obtain a progress update from Mrs Fortes-Mayer and would bring back to the next meeting.

ACTION: Mr Evans to obtain an update for the next meeting from Mrs Fortes-Mayer on the work in progress with other regional commissioners regarding the WMAS contract and what rural parts of the region had agreed they required to achieve performance delivery targets and to develop community healthcare.

Minute No. GB-2020-01.006 – Public Questions

7.1 Dr Povey advised the meeting that a number of written questions had been received from the public, which would not be read out at the meeting but hard copies of the questions and the CCG's responses had been provided at the meeting. These would also be attached to the draft minutes in readiness for the next meeting and would be available on the CCG's website.

CLINICAL AND FINANCE REPORTS

Minute No. GB-2020-01.007 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

8.1 Mrs Skidmore presented the report which outlined the CCG's financial position at 30 November 2019 (Month 8), the key points of which to note were as follows:

- The CCG was showing a year to date overspend of £13.9m against the submitted plan.
- The forecast risk adjusted financial position indicated that the CCG would end the financial year with a significant deficit with a total risk-adjusted position as reported at Month 8 of a deficit in year of £44.9m.
- The CCG has experienced adverse movements in the forecast position between month 7 and 8, particularly in: the overall Continuing Healthcare (CHC) position; and in the overall community position (due to hospice charges and over-performance in Community Health and Eye Care (CHEC) and Wye Valley contracts).
- However, improvements in the forecast of approximately £1.3m have succeeded in offsetting the adverse movement as listed in the report.
- Unfortunately, the savings achieved are just holding the forecast position and preventing it from worsening.
- The key drivers of the overspend continue in an over performance in acute services, which was discussed further under the item: GB-2020-01-009: Performance and Quality Report.
- The significant overspend on Individual Care costs continued in Month 8 with further increases contributing to a net £0.8m deterioration in the risk adjusted forecast, mainly due to adult joint funding costs.
- Current forecasts against the overall QIPP plan suggested an outturn of £16.3m (82% delivery) with £0.7m of this flagged as 'at risk'. Although £0.25m has been included as a potential mitigation to this as further Individual Commissioning savings were being ratified. The CCG was working hard to manage its portfolio of QIPP projects but it needed to be realistic about the level of delivery it can achieve so late in the financial year. However, the CCG was still forecasting to deliver a significant sum in QIPP savings of approximately £16m, which was consistent with the last two financial years.
- The CCG continued to work with regional partners to discuss the financial position and at the next Governing Body meeting, the Month 9 position figures would be presented where the CCG would have finalised a re-forecast for the end of year.
- The CCG was focussing its energies on the development of the plan for the next financial year and to ensure that this was aligned with the CCG's operational plans and the financial plans within the system. There were scheduled conversations, particularly at the Finance and Performance Committee over the next two months, and reports would be brought back to the Governing Body as they developed.

8.2 Dr Pepper thanked Mrs Skidmore for the report and commented that it was clearly presented. Dr Pepper raised a query regarding the table on page 4, which presented the forecast variance and the variance year to date. It was noted that some areas, such as acute services, would have a greater spend burden so a move from variance would have a greater impact on the overall deficit. Dr Pepper suggested it might be helpful if within those tables was also presented the percentage against their best set level, for example, acute services was currently on 5.8%, but Individual Commissioning was approximately 17%. Mrs Skidmore agreed for this to be shown in future reports.

8.3 Mr Vivian referred to the £16m QIPP savings that the CCG was hoping to achieve and agreed that it must be more difficult to achieve the same savings each year. Mr Vivian hoped that the staff would be thanked for their work on identifying and achieving those savings. The CCG also needed to be increasingly realistic about the QIPP savings for future years because these were becoming increasingly difficult to achieve.

8.4 Mr Vivian also referred to the £0.8m deterioration in the CHC position, with most due to adult joint funding costs with the locality authority. Mr Vivian asked if it was known whether the local authority was also experiencing similar difficulties in terms of the deterioration around those costs.

8.5 Mrs Skidmore confirmed that the increased pressure around costs was being felt across the system. Telford and Wrekin CCG was experiencing similar issues with the Local Authority also. The individual care section included CHC but it was also the broader remit around individual cases, which also included mental health. The financial pressures ran across a number of those areas and there had been not only a growth in patient numbers but also a growth in package costs. Work was being undertaken to understand the reasons for this, including working with the Locality Authority and looking at price management.

8.6 Dr Shepherd referred to paragraph 13 and the West Midlands Ambulance Service (WMAS) contract and said she had been surprised to note the large difference that at Month 8, WMAS had a year to date overspend of £241K and a forecast overspend of £549K.

8.7 Mrs Skidmore explained that there was an element of seasonality in the profiling with the plan for the ambulance activity and so the additional activity over the winter period was expected. It appeared that there was over-performance against plan, but after comparing the monthly actual figures to the planned figures, it had not moved from the planned variation.

8.8 Dr Povey raised a point about the out of area contracts and demand management. Referring to a note contained in paragraph 15, Dr Povey considered that letters to out of area providers, requesting them to reduce their activity levels, was not a robust process. Dr Povey asked if the contracts with the main out of area providers were managed on a robust enough manner.

8.9 Mrs Skidmore explained that for each of the main providers there was generally a lead commissioner allocated. For example, Shropshire CCG was the lead commissioner for The Shrewsbury and Telford Hospital NHS Trust (SaTH) and there were smaller value contracts that formed part of the lead commissioner arrangements. The CCGs who had smaller value contracts tended to abide by the policies that were within those contracts. Using the Wye Valley contract as an example, there was a lead commissioner for Wye Valley and Shropshire CCG was a co-commissioner on that contract, who would then expect that lead commissioner to act on Shropshire CCG's behalf in contract discussions. With those providers who are in close proximity where the CCG is experiencing a significant overspend, the contracts team spend more time with the lead commissioner themselves to work through the recovery plans and also do attend contract meetings.

8.10 Dr Davies added that there were some underlying issues that were driving that out of area pressures not least consistent pressures within the local hospitals. There had been a number of ambulances diverted to other Trusts, particularly to New Cross Hospital, Wolverhampton and to University Hospital North Midlands (UHNM), which was driving some of the non-elective activity. Particularly in Wye Valley, it was one patient that was very complex and had a long length of stay. This would mean that sometimes there were operational issues that would take the CCG outside of the process.

8.11 Dr Povey referred to planning for next year's finances, and sought clarification on the process followed for issues that arose that were not included in the plan. For example, included in the Primary Care Network (PCN) specification there was a need to move towards using dry powder inhalers rather than meter dose inhalers. It was understood this was a large cost pressure for the CCG and Dr Povey asked how the issues that were not on the spectrum were built into the finance plan.

8.12 Mrs Skidmore explained that as part of the CCG's overarching model for planning and budget setting purposes, it would apply all of the things that were expected every year in the finance plan. The Finance Team did not do that in isolation but would take those initial draft plans out into different areas of the CCG and discuss with the budget managers about what other drivers of spend there might be that the CCG was not aware of. For areas like the PCN, there was a pressure that goes into prescribing, and Mrs Skidmore would expect the prescribing heads of service to be discussing with the CCG's management accountants to help the CCG to create an estimate to build into that financial model. The CCG did not at this point plan for anything like that whether there would be additional money or not but tended to work on the previous assumption that there would not be. .

8.13 Dr Povey referred to the system working and the risks to the QIPPs which may overlap with the internal cost improvement and asked if the system had a place for this in the plan.

8.14 The internal process described in paragraph 8.12 dovetailed with the broader system plan and the challenge of ensuring that any savings are not counted multiple times within the system was quite difficult. There was a really well developed network of Directors of Finance and deputies for the Sustainability and Transformation Partnership (STP) that meets to collectively construct the financial models and align local plans to ensure there is no double-counting of items. Work was on-going to collectively build a project plan, a business case and a delivery model rather than trying to build different pieces of work that did not align. It was explained that the CCG would not have the totality of its QIPP programme being reliant on system partners. The CCG would be accountable for the delivery of those projects.

<u>RESOLVE</u>: The Governing Body NOTED:

- ***The financial position at Month 8***
- ***The financial challenge for 2019/20 and work to prepare for a formal reforecast at Month 9.***

ACTION: Mrs Skidmore to arrange for the tables showing the forecast variance year to include percentage figures against the best set level.

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2020-01.008 – Governing Body Assurance Framework (GBAF)

9.1 Mrs Tilley presented the GBAF report, which was considered self-explanatory, and highlighted particular points as follows:

- Work was now underway for the creation of the new single strategic commissioner, which would be discussed in more detail later in the meeting. This would be looking at how the two CCGs' GBAFs could be brought together and as a result of this the CCG had started to look at that alignment. The finance risk of this change had been amended in both CCGs' GBAFs to better reflect the joint position across the two CCGs in relation to the financial position.
- Mrs Tilley reiterated to the Governing Body to consider the risks as it considered its business throughout the meeting.

9.2 Mr Timmis agreed with Mrs Tilley's point about ensuring that there was a link with Telford and Wrekin CCG's financial position. Shropshire CCG was required to ensure that it was clear there was still a legal responsibility for its accounts and therefore needed to be clear about its financial position for the auditors who would be asking for information that would be definitive just for Shropshire.

9.3 Mrs Tilley confirmed that Shropshire CCG and Telford and Wrekin CCG would continue to report and identify their accounting as separate organisations whilst they remained separate statutory bodies. The work was focussing on aligning the risks where possible, however, in the action element of the assurance framework, the two organisations would have individual responses in terms of how they would be mitigating the risks where there was a difference of approach based on the differences of the two CCGs. The CCGs were mindful of reporting as two separate statutory organisations and would look to align as far as they practically could. There would be two separate documents but would be made the same where they could.

9.4 Dr Povey referred to the Finance Risk and the Action GC4 in the report, which stated that the Financial Recovery plan developed would be submitted to NHSE/I as part of the application to amend the forecast at Q3. Within those actions it had talked about those actions had already been taken and Dr Povey asked if this could be explained further.

9.5 Mrs Skidmore confirmed that in terms of the risk framework, this was designed to give assurance to the Governing Body that all steps had been taken to control or mitigate the risks. A lot of the conversations that had taken place at recent Finance and Performance Committee meetings had been focussed on the control element and whether everything had been done to try and restrict that expenditure and to have an effective financial recovery plan.

9.6 Ms Cawley pointed out that there was a Healthwatch Telford and Wrekin and was reassured to see the inclusion of the role that Healthwatch Shropshire played at present with Shropshire CCG. Ms Cawley believed that Healthwatch Telford and Wrekin operated slightly differently and suggested that going forward the two Healthwatch organisations and the two CCGs could meet and discuss further joined up working.

9.7 Mr Evans thanked Ms Cawley for raising this point and agreed it was certainly part of the work that was required with bringing the two CCGs together and to ensure that they worked with both Healthwatch organisations because they did work differently.

RESOLVE: The Governing Body:

- ***RECEIVED the detail of the GBAF risks and highlighted any updates required.***
- ***CONSIDERED the risks highlighted in the GBAF as it conducts its business.***
- ***SUPPORTED the interim amendment to the Finance risk (Risk No 1).***

Minute No. GB-2020-01.009 – Performance and Quality Report

10.1 Dr Davies presented the Performance and Quality Report, which contained updates on the CCG's performance against all its key performance and quality indicators for Months 7 and 8 where available for 2019/20. The key standards that were not met year to date for the CCG were in the following areas:

62 day Referral to Treatment (RTT)

2wk wait (Breast)
2wk wait from GP referral
31 day where subsequent treatment is surgery
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT

10.2 It was reported that there had been an improvement in the two week cancer performance following the issues around radiology capacity having been addressed. Unfortunately SaTH now had some long term sickness issues with surgeons, which would result in the position not being maintained. This had had an impact on the 62 day RTT and also on the 31 day RTT where the treatment was surgery. The 31 day RTT target was improving and, although this would be affected by the long-term sickness for the 2 week RTT, it was anticipated this would not affect the 31 day RTT for the full year.

10.3 It had been confirmed that the second robotic machine at the University Hospital of North Midlands (UNHM) would go live in February. There was a Shrewsbury and Telford consultant who was trained to use that which would help increase not only capacity for the local system but also for Shropshire patients.

10.4 Urology remained a significant challenge and the overall 62 day performance target was dependent on the CCG achieving that target.

10.5 Elective care and 18 week target continued to be challenging as both the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH)' day surgery units were being used as escalation capacity. Despite the significant pressures over the winter to date, SaTH had maintained all clinically urgent and cancer treatment. The additional Vanguard Unit that SaTH had been able to secure had also supported that delivery but there continued to be significant delays for routine surgery and the long waiting times had increased. The CCG was maintaining the zero waits over 52 weeks, which in some cases relied on individual patient management of pathways and was being continued.

10.6 Urgent care – A&E performance had deteriorated. Since the last meeting, two assurance meetings had taken place with NHSE/I and it had been acknowledged that there was a significant amount of work being carried out and that there were areas that showed really good practice, particularly around the management of the back door and delayed transfers of care. Dr Davies thanked local authority colleagues and the CCG's front line staff who supported SaTH on a daily basis in what was a very emotionally and challenging role.

10.7 Activity in terms of attendances and admissions had shown a slight decrease over the Christmas period compared to the same period last year. The period up to and since Christmas continued to be above plan. The local system was continuing to focus on demand management and the social care element. The admission avoidance scheme for the Shrewsbury and Atcham locality had gone live in January and work continued with Shropshire Community Health Trust (SCHT) to roll out a 24/7 service from the beginning of April.

10.8 The Governing Body was informed that, as a result of the pressures, there had been a significant increase in the 12 hour trolley waits. Mrs Morris referred to the report which highlighted that in November there had been 61 over 12 hour trolley waits reported; in December 348; and in January to date, there had been 226. It was acknowledged that these were really large numbers that on-one would wish for any patient, however, activity was a particular challenge nationally.

10.9 Mrs Morris explained that SaTH was required to undertake a harm assessment of patients waiting over 12 hours and it was the CCG's responsibility to collect the completed harm proformas and to ensure that any actions required of SaTH had been put in place. It was reported that whilst SaTH tried to cope with the large volumes of patients waiting, there was a time lapse in completion of the harm proforma checklists. The CCG was working with SaTH to produce an assessment of any potential harm that may have come to a patient as a result of the long wait, which would include reviewing patients' records from the time they entered SaTH to the time of discharge.

10.10 The Quality Team was in daily contact with SaTH and the Quality Leads have made daily visits to the Emergency Departments (EDs) when there has been continued high escalation to talk to patients and relatives and to ensure that appropriate checks have been made. Staff were also consulted to ensure staff well-being was being maintained. Feedback was passed to SaTH so that it can be acted upon to improve learning. It was noted that the long waits in the EDs were as a result of flow issues throughout the hospitals.

10.11 Workforce – There remained considerable workforce challenges. SaTH has undertaken some international recruitment and have recruited 186 registered nurses. A focus group was also looking at retention as well as recruitment of new staff.

10.12 Ms Porter expressed concern over the numbers of 12 hour breaches and said that whilst the harm proformas were being completed by SaTH, Ms Porter sought assurance that patients were receiving the basic nursing care during the long waits.

10.13 Mrs Morris confirmed that the Quality Team would check and expect the patients to be given drinks, food, and were being properly assessed for pressure-relieving mattresses if their skin was prone to breakdown or at risk of breakdown. The CCG was aware that sometimes the team did need to remind staff to ensure patients were offered drinks, however, there had been positive feedback received from staff and patients that all patients' basic needs were being met albeit not in the best environment.

10.14 Dr Leaman asked whether the CCG was reducing the number of patients being admitted to hospital from nursing homes because they were seen as complex patients.

10.15 Mrs Morris replied that there were a number of schemes in place. Dr Davies further explained that feedback had been given to the A&E Delivery Group from the Telford Care Home multi-disciplinary team that had been in place at PRH, which had shown that this had not reduced admissions but had shown a slight increase. More work was underway on anticipating and taking intervention early before the patient gets too unwell to facilitate a shorter length of stay. A report was due in February from a deep dive that was currently being undertaken comparing those Shropshire care homes that have low rates of admissions to those who have higher rates to understand the variation. It was highlighted that the number of admissions from care homes was a very small percentage of the overall number of admissions. Whilst the CCG was focused on this it needed to prioritise its efforts proportionately to the impact that it would have for the front door of the hospital.

10.16 Dr Lynch commented that there appeared to be a contradictory view in that there was obviously an increase in demand in the EDs at all times but even if the demand decreased there were still long waits occurring when there was a decision to admit the patient and the CCG was starting to see an increase in length of stays on the wards. It was suggested that there may be an issue with decision-making in all departments that required review to assess whether the patients admitted were at the level of acuity to be admitted. This cohort of patients may be lower in number but would have an impact on the system. Dr Lynch impressed that it was a system issue, not just SaTH's issue, and the benefit of working together as a system was to try and transform services. Without having access to the relevant information to understand the issues Dr Lynch could not see how the system could transform its services for the future.

10.17 Dr Sokolov responded by saying that the Governing Body needed to be mindful that it had two roles: to help facilitate the local health system with the development of schemes that would help manage demand and to help improve the system flow. This was a role that was taken very seriously and the Governing Body was trying to fulfil this as best it could and there was more work required.

10.18 The Governing Body's second role was an assurance role. There was a responsibility within SaTH as the provider to manage their own processes and performance. The Risk Summit update was due and the CCG took part in meetings but it was felt important to reflect that the CCG needed to ensure that it was fulfilling both roles and not neglecting one role in favour of the other. Reference was made to the monthly Safety Oversight and Assurance Group (SOAG) meetings, established and chaired by NHSE/I, which had been set up in response to the Care Quality Commission (CQC) findings, and was intended to be a system level discussion of how improvements can be made.

10.19 Dr Lynch said that she did not wish to abdicate SaTH of their responsibility to review internally to understand the issues but noted that the report presented did not include mention of SCHT which was key to the transformation of services that would be needed and asked why SCHT had not been included in the report.

10.20 Dr Davies explained that SCHT had been referenced in the area of the report, which covered the admission avoidance scheme. It was reported that the previous report had covered the quality issues within SCHT but there had been no variances to report this month in relation to SCHT.

10.21 Dr Povey referred to the SOAG meetings and the Care Quality Commission (CQC) report to SaTH and the CCG's role in that. It was understood that on the CQC's first visit to SaTH some concerns had been reported, which were being addressed through SaTH's action plan. The CCG had sought assurance that SaTH was addressing those concerns but when CQC conducted a second visit, they had found similar concerns to the ones that had been reported previously. Dr Povey asked what the thoughts were about

this issue when the CCG had been under the impression that the issues identified would be looked at and improved.

10.22 Mrs Morris advised that Mr Evans had written to the regulators who chaired the meeting following receipt of the CQC's most recent breach letter. The CCG had attended the SOAG meetings as members of the assurance group and had also been visiting SaTH to test out their improvement plan and found that in some cases improvements had been put in place but not in others. The CCG had fed back to SaTH when it found areas where improvements had not been in place. Mr Evans' letter had asked about how the CCG and SaTH could work better together to ensure that the assurances that were given were robust and appropriate assurances. Following this, the Risk Summit was held where a number of actions were identified for system partners, with a follow-up meeting to review the impact of those actions. A meeting with NHSE/I and CQC was planned in early February with the new Trust Chief Executive to look at how the CCG and SaTH were working together and how appropriate assurances were being obtained and sustained. It was understood that all the actions were in place but had not been embedded and tested to ensure that they were having the impact required.

10.23 Dr Povey asked to what extent would the CCG take SaTH's assurance that the actions were in place and to what extent would the CCG check the actions were being carried out. It was understood that the checking of actions was in place but this was normally done by the provider who would then provide assurance to the commissioner.

10.24 Mrs Morris requested the Governing Body to bear in mind that the CCG did not have the resources that the CQC had to conduct an in-depth investigation. The CCG had been conducting the visits and SaTH had been held to account through the Clinical Quality Review meetings (CQRM), which had proved a challenge. There had been a change of membership and some lines of work had not been carried through within the conversations with SaTH, which would be discussed at the SOAG meeting. As a commissioner, the CCG accepted the assurance from SaTH but the CCG had been questioning whether it was reassurance or robust assurance.

10.25 Dr Matthee highlighted that the ED staff were human and should not be blamed for the issues but needed support as much as possible. However, the patients waiting were human also and it was not a good experience for them. Dr Matthee reiterated his message that the abnormal should not be made normal. A lot of the issues were as a result of the process. There was also an impact if there were long waits in the EDs for General Practice with patients' health declining and trying to manage patients at home when it was considered inappropriate. The CCG was advised not to just focus on patients admitted from nursing homes because they normally received visits from GPs but also to consider the cohort of vulnerable patients who lived at home alone who were not known to services.

10.26 Mr Timmis agreed that the numbers quoted were of great concern and beyond anything he had experienced in over five years working for the CCG. Mr Timmis referred to the report and the risks of SaTH's position of being under 'special measures' and asked if there was a timescale for improvement when the figures had deteriorated to such a large extent. Mr Timmis understood that it was not entirely the CCG's role but it did commission the services, which Mr Timmis regarded as completely untenable.

10.27 Mr Evans asked the Governing Body to bear in mind that this was a complex issue with no easy solutions. SATH had significant staffing challenges, particularly around consultants, middle-grade doctors and nursing workforce, which made the organisation quite fragile in terms of those services. The system needed to work hard to support SaTH. As an organisation which was reliant to some extent on temporary staff, in order to avoid risks, there was a likelihood for patients presenting in EDs to be admitted in this system than it might be in an ED in a more stable system. It was a significant part of the reason why the CCG needed to work harder with system partners to do everything it could to prevent admission and attendance at the ED.

10.28 There was an acknowledgement that there had been successful system working undertaken around the back door, and with local authority partners and SCHT to discharge patients as soon as possible. The introduction of the pathway zero had had a major impact on the ability to discharge patients early with patients not needing further care. Attention should now concentrate on demand, which was the reason why the emphasis of the A&E Delivery Group and the A&E Delivery Board had changed in recent weeks to deal with those issues. The system needed to try and ensure patients received the most appropriate care and to stop deteriorating to an extent that they need admitting because otherwise this would result in long waits for patients, which was the present position and that was not good care for patients.

10.29 Dr Shepherd considered that if the CCG was to address demand then community resources needed to be effectively supported and developed because community and primary care was already at maximum levels albeit was not in the same performance category. The staff working in the community and in

primary care also needed to be commended for the work they were already undertaking as well as any additional work they were asked to do.

10.30 Dr Shepherd also referred to the high numbers of trolley waits and highlighted that the harm that patients might experience was not always easily measureable. A checklist may be completed to state that they had recovered and had received their treatment but the psychological impact of a patient who had experienced a long wait was hard to measure. Dr Shepherd agreed with Dr Matthee's comment that this did have the potential to impact on a patient's future treatment. A further question was put forward about if a patient was admitted because they required specialist care or investigational treatment and did experience a long trolley wait, what measures were in place to ensure they received their treatment.

10.31 Mrs Morris confirmed that the patients waiting on the trolleys would have already been seen and would have a treatment plan put in place and would be receiving their medications, pressure care and any other treatments they required and this was tested through the CCG visits also.

10.32 Dr James said that he fully accepted and understood the reasons about the complexity of the situation, however, the CCG did not have the full information to understand the reasons for the high level of 12 hour trolley waits and without that information how would the Governing Body be fully assured.

10.33 Dr Davies suggested that this would need to be discussed at the A&E Delivery Group meeting because it involved system wide information. It was agreed that Dr Davies would further discuss with Dr Sokolov and Mrs Morris what further information was required to develop a fuller picture of the demand issues, which could be taken to the A&E Delivery Board, and then reported back to the Governing Body.

10.34 Dr Pepper recognised that it was a complex area to analyse and understand. It was pointed out that the numbers of patients presenting in the EDs was not the sole determinant and Dr Pepper sought comments about what was being seen in terms of performance of the acute presentation and management of patients even before the point a decision to admit was made.

10.35 Mrs Morris described the process from when patients arrived at the ED when they should be triaged within 15 minutes but it was a challenge that SaTH rarely achieved that standard. Once individuals were directed through the department and it was appropriate that they were there for attendance then the wait could be a long time dependent on the queue, which could be 5-8 hours. This was a concern because this wait time did not include the time spent before the decision to admit.

10.36 In terms of the patients' clinical management, they would have been triaged and there was medical staff in the department, which may have a reduced level of substantive consultants but SaTH did have locum consultants in the department that were acting up at that level. SaTH do have high volumes of nurses and the CCG checked on a daily basis the completion and the fill rate for their nurses. On occasions serious incidents had been reported, which showed that there had been a delay in the management of a specific case, which would get fully investigated by the Trust. There were waits at each stage and these should be monitored and audited by SaTH. The issues were discussed on a weekly basis, and were discussed at the Clinical Quality Review meeting (CQRM) but it was not the standard that it should be.

10.37 Mr Vivian asked if the measurement of harm of a patient who had waited in excess of 12 hours on a trolley in an environment that was daunting, included areas such as a patient feeling anxious, worried or frightened and asked to what extent was their dignity compromised.

10.38 Mr Vivian also noted that there had been numerous groups, boards and committees that had been working on the demand issues and asked if these were seen as helpful interventions. It was considered that the response to the issues should be rational, measured and efficient in its own right and it felt that the situation was possibly being exacerbated by a disordered system pursuing the same cause. Mr Vivian pointed out that the winter period did have its challenges every year and wondered whether this activity was being carried out at the wrong time.

10.39 Mrs Morris confirmed that the harm proforma did not assess a sample of full impact and this was seen as a key issue. Where required, patients were transferred on to beds with appropriate pressure relieving mattresses. The harm proforma included questions asking if there was any skin damage or was care delivered in accordance with plan but did not include the psychological impact. The CCG team, when conducting their visits, did talk to patients and their families about their experience and asked what the CCG could do to feed back to SaTH so that they were aware of the human factors.

10.40 Dr Povey expressed his concerns and agreed that the issues were not only as a result of an increase in demand but a combination of demand, capacity and workforce. There had been a year on year rise in activity but compared with the Christmas period last year, there had been fewer admissions, fewer A&E attendances but far higher numbers of 12 hour breaches. The input of the national clinically-led

Emergency Care Intensive Support Team ECIST working in SaTH had also not seen a sustained improvement in activity and performance.

10.41 Dr Povey agreed with Dr Matthee's comments that staff who worked in the hospital and in the system were working very hard but suggested this needed to be balanced with the fact that there was potential harm to patients. The CCG had been told by NHSE/I that it needed to provide assurance and so would need to look at the two reviews by West Midlands Quality Research, and the Quality Team had reported back very positively, but there was something that was not happening as a system.

10.42 Dr Povey offered to write, on behalf of the Governing Body, to Sir Neil McKay, Chair of the STP, to ask what further steps could be taken as a system to try and improve patient experience, performance of the hospital and also the working lives of staff. It was considered that the single ED was required in order to attract and maintain high quality staff and services for Shropshire patients.

10.43 Dr Povey queried whether it was still the national requirement for the CCG to report monthly around defined RTT figures including the total waiting lists. Dr Davies explained that there was a requirement to report this information annually. The CCG would have a better view of the position in February and Dr Davies would provide an update to the March Governing Body meeting.

10.44 Mr Vivian referred to the performance of the GP Learning Disability Register and that the CCG had been positioned within the top quartile nationally on this measure. Mr Vivian queried the CCG's performance against itself rather than other CCGs to see whether the CCG was performing better or worse. Dr Davies offered to bring back an update on this to the next meeting.

10.45 The Governing Body agreed that it could not provide its assurance and, therefore, agreed the revision of the actions required by Governing Body Members, which were: 'The Governing Body was asked to NOTE the contents of the report and SOUGHT assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.' Dr Davies would ensure circulation of the revised recommendation.

RESOLVE: The Governing Body NOTED the content of the report and SOUGHT assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.

ACTIONS: Dr Davies to further discuss with Dr Sokolov and Mrs Morris what further information was required to develop a fuller picture, which could be taken to the A&E Delivery Board, and then reported back to the Governing Body.

Dr Povey to write to Sir Neil McKay to ask what further steps could be taken as a system to try and improve patient experience, improved performance of the hospital, and to improve the working lives of staff.

Dr Davies to bring back a report for the March meeting on defined RTT figures, including the total waiting list.

Dr Davies to present an update on the CCG's performance of the GP Learning Disability Register measure against itself.

Dr Davies to arrange circulation of the revised recommendation for the Governing Body to seek assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.

Minute No. GB-2020-01.010 – Shropshire CCG Strategic Priorities Update

11.1 Mr Evans referred to the set of strategic priorities that had been agreed at the Governing Body's August meeting and presented the update paper which now outlined the performance indicators against each of the key priorities and progress against those. Mr Evans explained that he had not planned to go through each priority in detail and opened the discussion for questions.

11.2 Mr Timmis made reference to planned care and enquired about the current state of procurement activity and contractual arrangements with the alliance agreement to provide MSK services.

11.3 Dr Davies reported that a formal response had been received from the providers confirming their agreement to an alliance, which had sought both CCGs' contribution to that alliance. A response had been agreed at the CCGs' Joint Executive Team meeting on 13 January confirming that the CCGs would form part of an alliance with the three providers: The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH), SCHT and SaTH to deliver the new model of care for integrated provision of MSK services

across the county. There were still a number of agreements and plans to finalise by the end of January before the alliance agreement was finalised at the end of February. Work was in progress and Dr Davies would provide an update on the key elements at the March meeting.

11.4 Mr Evans confirmed that a paper on priorities in mental health and learning disabilities standard investment had been discussed at the Joint Executive Team meeting on 13 January. It had been agreed that patients who present in crisis would be the top priority for new money received from the mental health investment standard and an update would be brought back to the next meeting.

11.5 Dr Povey requested further information about the work of the West Midlands Cancer Alliance and the integrated pathology network. Mr Evans believed that the work was looking at developing digitalising pathology services across the West Midlands into the centres but explained that this did not necessarily mean that pathology services would be run by the centres. Mr Evans would obtain a progress update from Mrs Fortes-Mayer on this and would bring back to the next meeting.

RESOLVE: The Governing Body NOTED the progress against the CCG's strategic priorities including the inclusion of a single high level KPI for each priority.

ACTIONS: Dr Davies to update the Governing Body on the progress of work resulting from the alliance agreement with providers for the new model of care for integrated provision of MSK services across Shropshire, Telford & Wrekin.

Dr Davies to update the Governing Body on work on mental health and learning disabilities investment and improved service for those patients who present in crisis.

Mr Evans to obtain an update from Mrs Fortes-Mayer on the West Midlands Cancer Alliance work on digitalising pathology services across the West Midlands.

GOVERNANCE & ENGAGEMENT

Minute No. GB-2020-01.011 – Single Strategic Commissioner for Shropshire and Telford and Wrekin Update Report

12.1 Miss Smith presented the update report on the Single Strategic Commissioner for Shropshire and Telford and Wrekin, which included an overview of the programme to date, and highlighted the following key points:

- The Governing Body to note the new revised application date for creating a single strategic commissioner across Shropshire Telford and Wrekin, which had been agreed with NHSE/I, was 30 April 2020, and the reviewed timeline that the CCG would be working to.
- The new director appointments for shared directors between Shropshire CCG and Telford and Wrekin CCG.
- The alternative proposal for aligning the existing governance structures between NHS Shropshire CCG and NHS Telford and Wrekin CCG. Reference was made to the paper presented to the November meeting, which had suggested that the CCGs would form committees in common and a joint committee for commissioning to help align the governance structures of both CCGs. It was explained that since that discussion, NHSE/I had suggested alternative options, which were now being utilised by other CCGs across the country. The outcome of the discussions with NHSE, as detailed in the report, were that:
  - The CCGs must determine whether they wished to share a constitution so as to remain two statutory bodies in the interim period leading up to April 2021, when it was expected the new CCG would be created, which would have a shared constitution with a shared governance structure, shared financial instruction sheet and shared scheme of delegation.
  - The shared constitution of both CCGs to then have the ability to create a committee in common for the Governing Body meeting and shared Governing Body members. It was highlighted that this was a different proposal than that presented to the November meeting and would also impact on Governing Body Members' appointments and terms of contracts. This would also mean that all Governing Body members, apart from those who have joint appointments, would have a conflict of interest, which had already been noted at the commencement of the meeting under declarations of interest.
  - The report was not for an approval process; it was for noting by the Governing Body. The actual decision to follow the new process would be made by the two respective memberships when they would be presented with a new shared constitution.
  - There were clear merits in moving to a shared constitution and aligning the governance processes, which were set out in the report. Members of staff who were to soon go through the management

of change themselves would be following one set of rules, processes and policies. It would also mean that both CCGs would potentially be able to make the 20% savings in running costs requested by NHSE/I.

- There were some proposed amendments to the current constitution, as detailed in the report, which needed to be approved in terms of reflecting the new director structure, voting rights and other respective committees. The Governing Body was asked to ratify those changes, which would be forwarded to NHSE/for further ratification in the next week.

12.2 Dr Pepper commented that he welcomed any steps that could be taken to streamline the CCG's processes and make them more impactful given the challenge in the system and it would be good to have these arrangements in place as soon as possible. It was felt that it was a difficult paper and Dr Pepper congratulated the executives who joined the board of both CCGs. However, Dr Pepper also recognised that there were those members who had done a large amount of work for both CCGs for many years and recognised the impact and importance of their work.

12.3 Dr Shepherd felt that it was quite a difficult paper to comment on because of the conflicts of interest. Dr Shepherd considered the proposal was a good idea and it was in line with the regional plan of having trying to form a single organisation from April 2021. It was appreciated that there were a lot of details to be worked through, for example, Shropshire CCG Lay Members did not align with Telford and Wrekin CCG's Lay Members. Dr Shepherd expressed a slight concern about the pace of change and the tight timescale to enact the changes in what was a time of great change already. It was felt that the CCG might made decisions too quickly and would be difficult to change if needed.

12.4 Dr Shepherd further suggested changes in the titles of the Director of Performance and Service Redesign and the Director of Primary Care, which were listed, but were no longer included in the new structure.

12.5 Miss Smith acknowledged this was a good point and explained that the changes reflected the present time but clearly there was a transitional period for the directors and some directors were still working in their previous roles. It was, therefore, anticipated that further changes would need to be made following the restructure to titles of Directors currently stated in the Constitution. The Governing Body was asked to approve the changes to the Constitution.

12.6 Dr Povey further explained that, for example, the terms of reference of the Primary Care Commissioning Committee, in which the Director of Primary Care was a voting member of that Committee, had been retained as a voting member in the interim whilst also changing the roles of the new directors.

12.7 Dr Povey reported that the CCGs' Chairs, the Accountable Officer and the CCGs' governance leads had held detailed conversations with NHSE/I about the challenges around the initial plan, which had been to move to a single CCG in April with a joint management team which would present challenges in terms of governance. There was a miss-alignment of committees, which could result in the management team working in two different ways. An interim step had been discussed but it was agreed it was better to align the two CCGs' Governing Body Boards, and having shared executives, Lay Members and a shared Secondary Care Doctor, to allow consistency, which had been supported by NHSE/I. It was agreed that the speed of change was an issue but the current plan was to enact the changes by May-July, which was at a slower pace than the initial plan discussed with NHSE/I and was to take into account the contractual and legal requirements around the process of change. The CCG was utilising the skills and experience of NHSE/I appointees to look at the three particular areas CCGs were required to look at when joining together, which were around: Workforce, the Constitution and Strategy. By following this process, the CCG would ensure there was a balance between enabling staff to carry out their role and also allow the membership and organisational structure to be a reflection of discussions.

RESOLVE: ***THE GOVERNING BODY:***

- ***NOTED the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin.***
- ***NOTED and provided feedback on the new advice from NHSE regarding how a shared Constitution could be adopted by both NHS Telford and Wrekin CCG and NHS Shropshire CCG, to allow governance structures to be shared, but still retaining a single Constitution for both CCGs.***
- ***NOTED that amendments required to the CCG's Constitution to facilitate the described alignment of decision making between NHS Telford and Wrekin CCG and NHS Shropshire CCG would need to be presented to the membership of both CCGs for approval.***
- ***APPROVED the proposed changes to the current CCG Constitution as set out in section 4 of the report and outlined in detail in Appendix 1 with regard to amending the composition and titles of executive voting and non-voting members of the Governing Body to reflect the newly created Executive structure.***

Minute No. GB-2020-01.012 – Emergency Preparedness, Resilience and Response Annual Assessment

13.1 Mrs Tilley presented the outcome of the CCG's 2019/20 annual EPRR assessment, which had achieved the rating of 'Full Compliance' and therefore continued the rating received in 2018/19. It was pointed out that this did not mean that there was no further work to do going forward and the CCG would continue to build on the improvements that it had made to its emergency planning processes over the last two years.

13.2 Reference was made to the enclosed letter from NHSE which contained a suggestion for the CCG to include a wider group of on-call directors in emergency planning exercises, which was being considered for implementation.

13.3 Dr Povey said that it was pleasing to see that the CCG had been rated as 'fully compliant' by NHSE. However, it was pointed out that there had been recommendations made for the CCG to 'consider better attendance at exercises for all on call staff to enable staff to consolidate EPRR training during live events'. It was understood that staff did take part in the activities but there was potential for better attendance.

13.4 Dr Leaman congratulated Mrs Tilley on the rating achievement and referred to the rota list of contacts that was shared with the hospital. Dr Leaman asked how the CCG ensured that the staff on duty could be contacted on the telephone contact details given and what should the hospital do if they could not contact the staff member on duty.

13.5 Mrs Tilley explained that there was a three-month rota that was prepared and shared with the hospital team who managed the on-call system. SaTH therefore had sight of all the contact details and was responsible for co-ordinating calls that were received which required an emergency out of hours response. SaTH was aware that if there was an issue it needed to report that to Mrs Tilley so that any issues could be addressed. Mrs Tilley reported that it was extremely rare for staff not to be able to contact the person on call. The CCG conducted annual training and refresher training for on-call directors so they were very clear about their responsibilities. The CCG also carried out exercises and tests, for example, a communications test exercise was planned. There was therefore a lot of checks in place to ensure the systems were operating properly. The CCG was in regular contact with NHSE/I who shared their expertise on learning from other areas around improvements to systems. Mrs Tilley was also in regular contact with other emergency planning leads across the system to ensure the CCG's systems were up-to-date.

13.6 Dr Povey voiced concern that the CCG's current on call system was purely dependent on directors. It had been noted that other organisations' on call rotas consisted of a tiered approach that did not rely on just directors being on call. It was highlighted that the directors had important roles during the day and some of the issues did not always require a director to solve. Dr Povey asked if there was an opportunity when forming the new CCG to address this and to review whether there was a better way of utilising key members of staff.

13.7 It was pointed out by Mrs Tilley that most organisations that operated a 2 tier approach that had a manager on call system backed up by a director on call tended to be larger organisations than the CCGs and therefore had a larger pool of staff to draw from. However, the Executive Team had committed to review who participates in the on-call rota because the number of directors had decreased. Therefore, this would definitely be an issue that would be addressed when going through the process of creating the new single CCG. In addition, there was the resource and the expertise of Mrs Tilley, as the Emergency Planning Lead, who was available as a point of contact during the day.

RESOLVE: THE GOVERNING BODY:

- ***NOTED the content of the report, in particular the continued rating of Full Compliance; and***
- ***SUPPORTED an on-going programme of EPRR work to ensure the Full Compliance rating can be maintained.***

Minute No. GB-2020-01.013 – SaTH Mortality

14.1 Dr Povey welcomed Dr Edwin Borman, Director of Clinical Effectiveness, SaTH who attended to give a presentation on SaTH Mortality, electronic copies of which had been previously circulated.

14.2 By way of introduction, Dr Borman explained that one of the things from a healthcare perspective which was particularly important about death was that it was a very discrete measurable and it was also very important that we do learn from the deaths of our patients. One of the ways in which to recognise the life and then the passing of a person was to review people's deaths so that lessons can be learnt from them in order to do better for others. Members were informed that the slides shown would present a lot of data,

metrics and information but each of these had stories behind them. Dr Borman proceeded to talk through the presentation slides highlighting key points, which covered the following areas:

CHKS Dashboard: October 2018-September 2019
5 year Risk Adjusted Mortality Index SPC: currently 88.1
Risk Adjusted Mortality Index (RAMI) 2018 monthly Peer comparison
5 year Hospital Standardised Mortality Ratio (HSMR) SPC – currently 89.22
HSMR monthly Peer comparison
5 year Summary Hospital-Level Mortality Index (SHMI) SPC – currently 101.46
SHMI monthly Peer comparison
Acute cerebrovascular disease HSMR has improved
Trauma Research Network (TARN) Rate of survival: 1 April 2019-31 July 2019 - The excess rates of survival are as expected and the data can be viewed with confidence:

- Royal Shrewsbury Hospital – the survivor/death ratio is 0.86
- Princess Royal Hospital – the survivor/death ratio is 1.18

At PRH ... NHFD 30 day Mortality has improved since 2018 but shows a slight increase above peer in Q2
At RSH ... NHFD 30 day Mortality has improved since 2018 and currently is below peer comparator

14.3 It was explained that SaTH receives data on a quarterly and annual basis from the Comparative Health Knowledge System (CHKS). It was noted that other than a very small number of exceptions, SaTH was placed on the correct side of the peer comparator and national comparator performance. The important message was that mortality at SaTH had consistently for the last five years been either at or below peer comparators across multiple indices.

14.4 SaTH looked for specific indicators that suggested that individual Health Resource Groups (HRGs)/Diagnosis Related Groups (DRGs)/or clinical complex areas potentially might become outliers. SaTH did have a potential alert for patients with acute cerebrovascular disease, as shown on the chart presented, and was placed beyond the funnel plot. That had now come back in within the funnel plot and SaTH had carried out a detailed review of patients within this group of clinical conditions and had produced a detailed report. When looked into further with the provision of externally validated confirmation of the explanation, the cause had been as a result of a coding issue linked to how SaTH provided end of life care for patients who have had a significant acute cerebrovascular episode. It was explained that some Trusts had palliative care consultants who provide end of life care. SaTH had a combination of palliative care consultants and the end of life team and people who have been trained by both. The coding difference had been found to be the cause, which had been validated by the University Hospitals Birmingham.

14.5 SaTH collectively with RSH's Trauma Unit was part of The Trauma Audit and Research Network (TARN) and receives reports from TARN that provide information on trauma patients. It was emphasised that given Shropshire's population, trauma did not necessarily mean motor vehicle accidents and major trauma. The typical type of trauma for SaTH patients presenting in its EDs and the Trauma Unit involved elderly patients who have had a fall. This was significant for patients who particularly have co-morbidities which could generate injuries and the combination of both could lead to death.

14.6 Referring to the data which was confirmed as accurate, Dr Borman demonstrated that there was a very small improvement in outcome. What the data showed was that for Shropshire patients, having the types of trauma that are counted by TARN, there might be a very small net survivor increase but it was not statistically significant nor was Shropshire an outlier.

14.7 Reference was made to the mortality alert for 2017 at The Princess Royal Hospital, Telford, as a result of the work of the National Hip Fracture Database, which had been flagged for SaTH that it had an alert. SaTH had carried out a detailed mortality review and had invited an external independent review to check the work that had been carried out, which had already identified some important elements. These were: (1) the average time for patients to go through to theatre at PRH because of theatre availability took longer than at The Royal Shrewsbury Hospital, Shrewsbury, which may have an influence and an adverse effect on mortality; (2) the limited number of geriatricians to review patients; and (3) the time patients spend in the ED department and the extent to which they are appropriately resuscitated and cared for in the ED; and the time from there to transfer to an appropriate orthopaedic bed was of increasing concern, therefore, more work was being done in that regard.

14.8 Lessons learnt from a mortality outlier alert for RSH during the years 2015 and 2016 had led to improvements in the time for patients taken to theatre but had not been 100 per cent resolved. There was geriatrician availability at RSH but it was more challenging at PRH, which was largely on the basis of a national shortage of geriatricians.

14.9 Two further pieces of work that was being undertaken by SaTH were: (1) as part of the thematic review SaTH was undertaking, it had been agreed that given there was a much higher presentation of patients at the ED and the long 12 hour breaches, SaTH had initiated a mortality review of patients who had attended the ED; and (2) SaTH would be contributing to a system-wide review of SIs and mortality related cases.

14.10 Dr Leaman commented that he had been particularly impressed by the completeness of the data submitted to TARN, as this involved a lot of work; however, he had been disappointed that there had not been any maternity data included in the report and enquired about the numbers of stillbirths.

14.11 Dr Borman's response was that he did not have the definitive numbers to hand but understood that there would be a separate report on maternity mortality, however, he would be happy to include the figures in future reports/presentations. From Dr Borman's recollection, for the most recent completed year, which was 2018, in terms of the Embrace collective figures as described, the number of still births was 14 and for perinatal mortality cases, the number was 7. This, therefore, showed there was a reduction in still births compared with preceding years. It was explained that the measurement depended on the period and which data was being consulted upon. The data presented was from Sept 2018-Sept 2019 and the numbers were going to be different. It was, therefore, really important to have multiple perspectives on this to see the accuracy of all the figures.

14.12 Dr Leaman asked how these numbers reflected over time. Dr Borman reported that over time there had been a gradual reduction in the number because there had been more stillbirths the year before. From Dr Borman's recollection of the number had been 27 stillbirths and 4 perinatal mortality. There had been a variation because partly those numbers were small but typically it had been found that the combination of stillbirths and neo-natal deaths had been around 20-27 cases overall as a general trend.

14.13 In order to gain a better understanding of the Risk Adjusted Mortality Index (RAMI) graphs presented that showed the seasonal variation, Dr Sokolov said that she understood that there were more cases of flu and respiratory conditions in winter time, but asked if the variation was entirely due to that or was there an element of relativity; and would the aspiration over time lead to see a plan to address the variation.

14.14 Dr Borman referred back to the data contained in slide 3 of the presentation. SaTH had looked into this area in more detail and had found that it was respiratory conditions that were contributing to that increase in deaths. Using the slides, Dr Borman demonstrated the comparison with peer organisations that it was the national type of seasonal variation, which tended to be elderly patients who have co-morbidities. A review had been carried out into these areas and SaTH had not been able to find a way as yet to identify specific factors that would change this position

14.15 Dr Sokolov noted the population update presented that suggested that SaTH was within the norm for its mortality indicators but asked how this information was triangulated with the CQC findings and with the repeated occurrences of serious incidents (SIs) reported, which meant that regardless of whether or not SaTH was within the norm, there was avoidable harm that needed to be reduced.

14.16 Dr Borman agreed with this point and confirmed that in his role of Director for Clinical Effectiveness the brief had been to look more broadly at what could be learnt from individual cases that can be applied more generally. The work of the dementia team was important and SaTH was now reviewing the SIs to identify links in themes, which had already been carried out in complaints. It was more difficult in these cases but there had been some elements picked up. Dr Borman was worried about the increasing stay of patients in the EDs and the extent to which that increase in demand has led to crowding in the EDs hence it was more difficult for the staff. However good the staff were and do their best for the individual patients it was really difficult when there were more than 100 patients in each of the EDs at any one time. There had been a fundamental change, which needed an understanding that it was not going to have an appreciable change in the mortality of patients, particularly with elderly patients who are more susceptible.

14.17 Ms Robbins commented that she had found the presentation on the population data really interesting but asked about data use internally. Ms Robbins wondered with some of the changes that had been referenced whether SaTH was following weekly activity data in response to those changes, which would give a different picture to a population number and demographic.

14.18 Dr Borman replied that he was not sure how widely the data was circulated but he received the data for the acute pathway on a daily basis. This information showed the whole range of demand and capacity information within the system, which included ambulance conveyancing to presentation in the ED.

14.19 Ms Robbins explained that her point was more about if the change was made in terms of an intervention or something had changed and asked would the information be available about that change and the suspected cause.

14.20 Dr Borman replied that this was left to the analysis of the staff who received the information. It was confirmed that discussions took place within the Executive Team and there were regular conversations with the Chief Operating Officer about what was making certain changes occur. SaTH had looked actively at the conveyance rates from WMAS and the conversion rate of ambulance presentations and walk in patients to admissions are carefully considered. It was confirmed that SaTH had tracked carefully whether those patients who do have a decision to be admitted, how rapidly they are brought in, which was why Dr Borman was concerned that that time had increase significantly, which did carry clinical risk.

14.21 Mr Vivian commented that the data collection and understanding was extremely sophisticated and asked how readily was it being used across the organisation in terms of a cultural organisational adoption model.

14.22 Dr Borman agreed that the crucial question was how to drive performance improvement on the basis of the data provided. In the first instance an invitation was extended to Members of the Governing Body, which a number of partner organisations had already accepted, which was to attend one of SaTH's Mortality Committee meetings where attendees can assure themselves that there was a robust process in place.

14.23 Dr Povey thanked Dr Borman for attending the meeting and considered that it was really positive that SaTH had initiated the mortality review in the ED; and also that SaTH was participating in the Niche review into the SI process and the system mortality review.

RESOLVE: THE GOVERNING BODY NOTED the content of the presentation.

Minute No. GB-2020-01.14 – Audit Committee – 30 October (summary)

15.1 Mr Timmis presented the Audit Committee summary report, which was taken as read, and highlighted the following key points:

- Mr Timmis had hoped to be able to report this month on the mental health investments standard. Apologies were extended to the Governing Body but there had been delays caused by NHSE/I nationally. Mr Timmis reported that he was not expecting any significant issues to raise with Members but expected to report back to the next meeting.
- Lay Members appreciated all the work that the Executives had been doing but it had been noted that there had been an increase in late Board/Committee papers received and they had asked if this could be addressed. As a governance issue it would be appreciated if papers could be received to allow sufficient time to consider the information before the meeting.

RESOLVE: THE GOVERNING BODY NOTED the content of the report.

ACTIONS: Report on Mental Health Investments Standard to be included on next agenda.

The Executive Team was asked to consider the Lay Members' request to receive more timely Governing Body/Committee meeting papers to allow sufficient time to consider the information presented before the meeting.

Minute No. GB-2020-01.015 – Healthwatch Shropshire Report

16.1 Ms Cawley presented the Healthwatch Shropshire (HWS) report, which she assumed Members had read, and highlighted the following points:

- HWS had now published its End of Life report on its website, which had been shared with a number of providers and the CCG for comment before publication. This was normally something HWS would do later in the review because it was not always clear from the comments received when experiences have happened so it was an opportunity to inform the public what was the current situation within the services. Unfortunately, by the time that HWS had published the report, comments had only been received from the Severn Hospice and the CCG. It was unfortunate that comments had not been received from either SaTH or SCHT but if comments were later received, the report would be amended to include those comments.

- HWS had arranged its annual event to take place on 4 March. The reason for the delay was mainly due to holding the event in the period before Christmas would not have been a good time for voluntary

and community sector involvement. HWS requested CCG representation at its event, which would be illustrating to the public how social care and the third sector work together to support their health and wellbeing with an emphasis on self-care and prevention. HWS also welcomed offers to speak to the CCG about how it would like HWS to communicate to the public.

- Ms Cawley also reiterated that as the CCG moved towards becoming a single strategic commissioning organisation, HWS was very open to evolving in the way that it worked with the CCG. The Governing Body was reminded that HWS was there to help the CCG communicate with the public and for the public to communicate with the CCG.

16.2 Mrs Wilde requested if the report that HWS was preparing on Access to Primary Care could be shared with the Primary Care Commissioning Committee (PCCC) when complete so that this could be included in the work covered in the CCG's annual report. Ms Cawley agreed that it had been the plan to do this and asked if HWS could receive the CCG's help in setting the context and with the writing of the report.

ACTION: The CCG to contact HWS to arrange CCG representation at their event on 4 March and to discuss the process on how to communicate with the public.

The CCG to contact HWS re. providing support with writing their report on Access to Primary Care.

RESOLVE: THE GOVERNING BODY NOTED the content of the report.

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute Nos. GB-2020-01.016 to GB-2020-01.023

17.1 The following minutes of the Governing Body Committees were received and noted for information only:

- Clinical Commissioning Committee – 16 October 2019
- Finance & Performance Committee – 30 October 2019
- Primary Care Commissioning Committee – 2 October 2019
- Quality Committee – 30 October 2019
- System A&E Delivery Board – 22 October 2019
- North Locality Board – 26 September 2019
- Shrewsbury & Atcham Locality Board – 19 September 2019
- South Locality Board – 4 September 2019.

17.2 Ms Porter asked Members to note a point of clarity on the summary page for the October meeting of the Clinical Commissioning Committee (CCC) where it stated that the CCG was discussing a new joint policy with Telford and Wrekin CCG. Once finalised this would be presented to CCC for approval before being brought back to the next Governing Body meeting.

17.3 Dr Povey referred to the minutes of the A&E Delivery Board and discussions around Babylon Health being part of a potential solution. Mrs Wilde confirmed that this had been considered along with other similar approaches for electronic means to communicate with GP practices but it had not been approved. It was pointed out that this had been included in the public questions received for the Governing Body meeting and any digital solution would need to be able to fully integrate with the systems in operation across the CCGs.

RESOLVE: THE GOVERNING BODY RECEIVED AND NOTED the minutes as presented above.

Minute No. GB-2020-01.024 – Any Other Business

18.1 There were no further items raised.

DATE OF NEXT MEETING

Dr Povey officially closed the meeting at 3.45pm and confirmed that the next scheduled Governing Body that was open to the public is:

- Wednesday 11 March 2020 – venue to be confirmed.

SIGNED …….. DATE ……

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 15 JANUARY 2020

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2020-01.004 – Minutes of Previous Meeting	Mrs Stackhouse to make the agreed amendment to the draft minutes as noted in paragraph 5.1.	Mrs Sandra Stackhouse	Complete	16.01.20
GB-2020-01.005 – Matters Arising [GB-2019-07.097 – Ambulance Demand Deep Dive – Progress Update]	Mr Evans to obtain a progress update from Mrs Fortes-Mayer on the discussions with Stafford and Surrounds CCG and Hereford and Worcestershire CCG regarding the CCGs' rural requirements of the WMAS contract and feed back to the Governing Body.	Mr David Evans	Next meeting – 11.03.20	
GB-2020-01.009 – Performance and Quality Report	Dr Davies to further discuss with Dr Sokolov and Mrs Morris what further information was required to develop a fuller picture of the demand and issues, which could be taken to the A&E Delivery Board, and then reported back to the Governing Body.	Dr Julie Davies / Dr Jessica Sokolov / Mrs Christine Morris	Next meeting – 11.03.20	
	Dr Povey to write to Sir Neil McKay to seek what further steps could be taken as a system to try and improve patient experience, improved performance of the hospital and to improve the working lives of staff.	Dr Julian Povey / Mr Dave Evans	As soon as possible	
	Dr Davies to bring back a report to the March meeting on defined RTT figures, including the total waiting lists.	Dr Julie Davies	Complete	Included in the Performance report.
	Dr Davies to present an update on the CCG's measurement of performance of the GP Learning Disability Register against itself.	Dr Julie Davies	Complete	Included in the Performance report.

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
	Dr Davies to arrange the circulation of the revised recommendation for the Governing Body to seek assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.	Dr Julie Davies	Next meeting – 11.03.20	Complete
GB-2020-01.010 – CCG Strategic Priorities	Dr Davies to update the Governing Body on the progress of work resulting from the alliance agreement with providers for the new model of care for integrated provision of MSK services across Shropshire, Telford & Wrekin.	Dr Julie Davies	11.03.20	Verbal update at the meeting
	Dr Davies to update the Governing Body on the work on the Mental Health and Learning Disabilities investment standard and improved service for those patients who present in crisis.	Dr Julie Davies	11.03.20	To be brought to the May meeting as financial allocations have not been confirmed to finalise the plan.
	Mr Evans to obtain an update from Mrs Fortes-Mayer on the West Midlands Cancer Alliance work on digitalising pathology services across the West Midlands.	Mr David Evans	Next meeting – 11.03.20	Complete
GB-2020-01.014 – Audit Committee – 30 October (summary)	The Executive Team was asked to consider the Lay Members' request for them to receive timelier Governing Body/Committee meeting papers to allow sufficient time to consider the information presented before the meeting.	ALL	With immediate effect / on-going	
GB-2020-01.015 – Healthwatch Shropshire Report	The CCG to contact Healthwatch Shropshire to arrange support for HWS with writing their report on Access to Primary Care.	The CCG	As soon as possible	

NHS
Shropshire
Clinical Commissioning Group

Submitted Questions by Members of the Public
for the Governing Body meeting 15 January 2020

Name Date & Time		Submitted Questions	CCG Summary Response
Gill George	1	Our CCGs worked together on a review of SaTH's maternity services in 2013 and concluded, *'This review provides assurances that the maternity services are safe and of a good standard'.* In fact MBRRACE audits in 2013, 2014, 2015 and 2016 showed a trust with high perinatal mortality rates. When did the CCG become aware of high mortality rates in the maternity service?	The first MBRRACE report published in December 2015, which presented 2013 data, was received by CQRM in February 2016.
		Did the two CCGs discuss this, or agree a joint approach?	The CCGs agreed a joint approach through the monthly CQRMs, which are a joint contractual meeting.
		Was the CCG board fully aware of the problems?	Through CCG Boards and associated sub-committees the CCGs have been kept informed regularly of the position in relation to stillbirths and neonatal deaths. Until the Ockenden review is complete, we cannot comment on whether the information received and acted upon by the CCGs reflects the full position.
		Did the board discuss mortality in the maternity service?	Yes. The Board discussed mortality in the maternity service on several occasions dating back to 2013 including in relation to information presented by the Quality Assurance Panel and through the Performance Report.
		What steps did the CCG take to challenge SaTH's poor performance?	As well as action taken through the CQRM meetings, the CCGs commissioned specific reviews to look into this in more detail dating back to 2013 onwards. In addition to the planned quality assurance visits, this also included additional reviews of specific serious incidents as well as broader reviews into the quality of the

Name Date & Time	Submitted Questions	CCG Summary Response
	Is it the CCG's view that it responded effectively to maternity service problems that posed a risk to patients?	maternity service at SaTH. The CCGs established a maternity specific CQRM in 2017 in order to ensure specific focus on this service area. More recently, the CCGs have initiated a refreshed quality assurance process for maternity services. We cannot comment on this, until the Ockenden review is complete. ***Dr Jessica Sokolov, Medical Director***
	2 At the November 2019 SaTH board meeting, the board nodded through a paper that identified Future Fit 'gaps' that included the clinical strategy, financial modelling, workforce modelling and whether or not the out-of-hospital programme would deliver required support. Currently we have soaring demand, a hospital that cannot cope (despite heroic efforts by staff), laughably poor estimates from SaTH on future bed requirements, and a capital cost that has – behind closed doors – escalated by 60%. Is it really a system priority to spend £498m on new hospital buildings? Why? Is it time to consider an alternative whole system solution that invests heavily in out-of-hospital solutions to meet patient needs and reduce demand?	The basis for clinical and financial sustainability of acute services remains that doing nothing is not an option and threatens the viability of the Trust to deliver services. The CCG is committed to investing in community services with the Care Closer to home programme. ***Mr David Evans, Accountable Officer***
	3 There are references in the notes of the 22nd October A&E Delivery Board to considering the use of Babylon Health as part of the Winter Plan. The minutes of the PCCC on 2nd October show the CCG has given consideration to using LIVI, a digital health solution, to provide weekend and bank holiday GP appointments. Have either of these options been taken forward? Are they still under consideration? Have these options been discussed with the CCG's members?	Telford and Wrekin CCG (TWCCG) worked with local GP colleagues to develop a locally provided appointment service for weekends and bank holidays over the Christmas and New Year period. From when this started over the Christmas period, the GPs feel that they have avoided attendances to ED by providing this service, therefore TWCCG have commissioned this service for a further 4 weeks in January. The evaluation of this project will be undertaken and presented to the A&E Delivery Group at the end of January. ***Mrs Claire Old, Urgent Care Director, Shropshire, Telford and Wrekin***

Name Date & Time	Submitted Questions	CCG Summary Response
		LIVI along with other digital solutions are being reviewed to assess the suitability. Video consultations will be part of the primary care offer moving forward and therefore as a health system the procurement of suitable platforms need to be reviewed. As part of the wider urgent care offer, how this service is procured is an important consideration and GP member practices will be fully engaged in the specification and platform of choice. Any digital solution will need to be able to fully integrate across the systems in operation across the CCGs. ***Mrs Gail Fortes-Mayer, Director of Contracting and Planning***
	4 There are several references in the papers to CHEC, 'Community Health and Eye Care Ltd'. There are evidently concerns around over-performance (possibly arising from data validation issues) and a reference to a poor relationship between SaTH and CHEC. A local ophthalmologist has told me of his view that the service is useless and a waste of NHS money. Minutes of the North Locality Board of 26th September record: *MECS/CHEC and Ophthalmology - Elaine Ashley advised that it was taking CHEC (Community Health and Eye Care Limited) about 16 weeks to complete an assessment for cataracts before being referred to RAS (Referral Assessment Service). Also referrals were being sent back to the GP to refer on to ophthalmology; it was confirmed that this shouldn't be happening. Dr Catherine Rogers advised that there was a significant event at her practice with a patient that should have been referred on immediately. The patient was seen by the CHEC service who stated the patient needed an urgent same day referral but this information was sent by email to the practice rather than CHEC making the urgent acute referral. Michele Matthee advised that her practice had a two week referral sent back. There was general agreement that the letters sent back from the service were not good quality with one line of information.* Concerns were also noted by the South Locality Board. Is it appropriate for CHEC to be sent '2 week referrals'? How does it benefit patients to have a 16 week wait for a cataract assessment, to then be	No it is not appropriate for CHEC to be sent 2 week wait referrals. CHEC are not commissioned to see cancer patients or wet AMD patients. The CCG were unaware of a 16 week wait for pre-cataract assessment. The CCG will raise this with CHEC and can look at it in more detail if the patient consents to have their information shared with us. The CCG investigates all incidents raised and the outcomes have been addressed with both SaTH and CHEC. CHEC should not be charging patients directly for any services. The CCG will raise this with CHEC to seek further assurance that this is indeed the case. The CCG recommissioned the same services however the contractual arrangement is different i.e. CHEC hold the contract and sub-contract services to our local optometry practices – the services commissioned are exactly the same as

Name Date & Time	Submitted Questions	CCG Summary Response
	referred to ophthalmology where most of this work will be repeated? What steps have been taken by the CCG to tackle concerns raised by GPs, especially where patient harm might result? Are patients charged by CHEC participants for any services (e.g. for retinal imaging)? A question raised before – but why did the CCG not carry out any public consultation or engagement before changing this service?	before. The CCG is working hard with CHEC & SaTH to help resolve the issues patients, commissioners and providers are having with the optometry and ophthalmology services currently being delivered. ***Dr Julie Davies, Director of Performance and Delivery*** Validation procedures are in place. A clinical review of the service will be undertaken to address the interdependencies between service providers. Commissioners endeavour to reduce duplication in service provision to ensure speedy access to services for patients. ***Mrs Gail Fortes-Mayer, Director of Contracting and Planning***
	5 Public Health Director Rachel Robinson attended the North Locality Board in September and commented that *'The figures across the STP (Sustainability and Transformation Partnership) show that the area has one of the worst life expectancy rates for people with mental health in the UK and there were poor outcomes and lower spend; all which needed to be addressed'.* Arguably, all of which go together. What are the CCG's plans to address these issues?	The STP MH Chapter within our Long Term Plan recognises the historical under-investment in mental health services and the fact that the performance of the CCG is in the bottom percentile when compared to other CCGs and that the STP as a whole is 42/43 when compared nationally to its mental health spend. In relation to life expectancy, the MH Chapter also recognises these figures, which is identified as a health inequality. The CCGs have set out a plan to address the issues raised through: 1 Prioritising the system issues to ensure there is a balance between preventative self-help and speedy access to services at place for when people most need them. This includes establishing crisis cafes, strengthening links with the police and working with colleagues in SATH to develop hospital avoidance schemes 2 Ensuring that the ambitions of the national mental health plan are reflected locally so that the focus on integration between health and care, between physical and mental and between secondary and primary care is

Name Date & Time	Submitted Questions	CCG Summary Response
		developed for people of all ages. ***Dr Julie Davies, Director of Performance and Delivery***
	6 Two months ago, I asked when the Shropdoc 'six month review' would be made public, along with any subsequent actions by the CCG, ShropComm or Shropdoc. I was told *'The CCG has indeed considered the review and its recommendations and has written formally to ShropComm on the matter. It is awaiting a response. The review and subsequent actions can be made public once a response is received and agreed.'* This has now presumably taken place. Can this information therefore be placed in the public domain (including ShropComm's response)?	(It should be noted that the provider is Shropshire Community Health Trust (SCHT) and the review has been undertaken in accordance with the terms of the contract agreement.) The review of SCHT has been undertaken. Following the delay in response from SCHT, the final outputs of the review of the service remain available to the public. ***Mrs Gail Fortes-Mayer, Director of Contracting and Planning***
	7 Is the Decommissioning/Disinvestment policy in the public domain? If not, can it be made available via the CCG's website?	Shropshire CCG does not have a current policy and is developing a joint decommissioning/ disinvestment policy with TW+CCG. This will go through appropriate sign off and be available via the website in due course. ***Dr Julie Davies, Director of Performance and Delivery***
	8 The 16th October CCC minutes suggest ShropComm is or was struggling to provide the expected level of service around Care Closer to Home pilots. Can you provide an update?	Case manager posts are now all covered. The case management pilots are provided mostly from within existing resources, but as we are seeing evidence of unmet need identified through these pilots, we are exploring with SCHT what additional resource within community teams may be required to best deliver the model. Some additional funding has already been made available to support this and a business case is currently being finalised to expand this service. The admission avoidance pilot in the Shrewsbury area is entirely additional resource, both the social care and health. ***Dr Julie Davies, Director of Performance and Delivery***
	9 The minutes of the Finance and Performance Committee of 30th October	The CCG continues to work on refining its Long

Name Date & Time		Submitted Questions	CCG Summary Response
		record, *'The new trajectory shows the CCG still in deficit at the end of the period and also pushes the system harder and faster which will prove particularly challenging as this will be looking at 7.5% QIPP savings for next year which feels unachievable. NHSE felt that these figures were reasonable. It will be key to keep the Committee up to date.'* Is there an update on this? Will the CCG be attempting QIPP savings of 7.5% in the coming financial year?	Term Financial Plan and we are anticipating further discussion with NHSEI about financial planning trajectories for both the CCG and the broader system. At this time we cannot say what percentage of savings will be finalised in our plans as this figure will not be confirmed until such time as income and expenditure plans and financial trajectories are agreed. ***Mrs Claire Skidmore, Chief Finance Officer***
Pete Gillard	1	The capital cost of Future Fit was to be £312m and has now increased to £498m. This leaves a shortfall of £186m. There is a further capital shortfall of £100m arising from the recent government decision to not proceed with Regional Health Infrastructure Companies as an additional source of capital above direct investment through the Treasury. It has been stated publicly that the Treasury had not committed to directly provide all the capital required for Future Fit. Has the CCG been informed how SaTH intends to source this additional capital? What does the CCG believe are the consequences if the additional capital is not available? What does the CCG believe are the consequences of the increased revenue costs of servicing increased capital loans?	The CCG has been assured that the clinical model can be delivered within the £312m. Any additional requirement for capital would have to be agreed with the CCG and NHSE/I. The cost of any additional capital requirement would have to be factored into the OBC and would have to be considered within the overall finance plan for the system that has been submitted as part of the system Long Term Plan. ***Mr David Evans, Accountable Officer***

Name Date & Time	Submitted Questions	CCG Summary Response
	2 The SOC records an estimated annual recurrent deficit now standing at £25.4 million (Figure 12). The SOC also reports an intention in the revised Future Fit financial plan to replace that deficit with a recurrent surplus of £1.935 million (page 2). The hugely increased cost of Future Fit means the likely cost of servicing the capital has risen to around £17.4 million per annum. An objective of Future Fit is therefore that SaTH will reduce its current levels of day-to-day expenditure by around £44.7 million per annum, based on the financial information in the SOC. On 2018/19 figures, this would be around 11.5% of SaTH's operating expenses. We're likely to be looking at a reduction of over 10% going forward. Does the CCG believe that's consistent with safe patient care, given soaring demand in Shropshire, Telford and Wrekin?	The CCG is continuing to develop its Care Closer to Home model of care. This will enable more patients to be treated within their own home or within another care setting, and will alleviate demand in the acute sector. ***Mr David Evans, Accountable Officer***
	3 SaTH's emergency admissions have risen by almost 60% since 2013/14 when detailed work on Future Fit began (a comparison of Quarter 3 data, from 10,459 to 16,588). In particular, though, there is an increase of 27.3% comparing emergency admissions in 2016/17 Quarter 3 and 2019/20 Quarter 3. A comparison of 2017/18 Quarter 3 data and 2019/20 data shows a 26.5% increase in emergency admissions. The leaked SOC suggests that updated modelling shows bed requirements are *'not significantly different to previous assumptions made in 2016/17 or 2017/18'.* Does the CCG believe this is credible? If you do, what is your evidence base? If not, will you insist that required bed numbers are revalidated, preferably external to SaTH? (This is a trust that on December 2019 data is now the worst in the country on 12 hour trolley waits. SaTH leaders have	

Name Date & Time	Submitted Questions	CCG Summary Response
	made exceptionally poor judgements on bed numbers in the past). The original estimate in Future Fit modelling was that there would be 37,620 emergency admissions in 2018/19 (*Modelling the Activity Implications of the Future Fit Clinical Model, Summary report for Programme Board*, December 2014, para 3.4). The actual figure for 2018/19 was 57,093, almost 52% above the original estimate. What steps have the CCG taken to ensure that the capacity modelling underlying the latest SOC reflects this 50% increase in the original estimate both in terms of physical capacity and staffing? Does the CCG believe that the financial modelling used to inform the short list through the evaluation process can still be considered viable? When will the CCG publish any revised modelling figures, that were not available during the consultation period, so that the public view the modelling assumptions side by side with the current SOC?	All modelling assumptions will have to be reviewed as part of the development of the Outline Business Case (OBC). ***Mr David Evans, Accountable Officer***
	4 SaTH's response to rising costs has been to opt for a phased approach, with six phases. Work on PRH does not feature until Phase 4, while work on the PRH UCC/ A&E Local does not begin until Phase 6. Have you discussed with SaTH the likelihood of significant investment in PRH not taking place? What are the potential consequences for patients?	There have been no detailed discussions on the phasing of work at this stage. There will be potential advantages and disadvantages of various phasing options should the business case be approved and commenced on that basis. ***Mr David Evans, Accountable Officer***
	5 When will you publish the Hospital Transformation Programme SOC?	The document that was leaked is a draft. ***Mr David Evans, Accountable Officer***

NHS
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Agenda item: GB-2020-03.031
Shropshire CCG Governance Board meeting: 11.03.2020

Title of the report:	Financial Position Month 10, 2019/20
Responsible Director:	Claire Skidmore – Chief Finance Officer
Author of the report:	Laura Clare - Deputy Chief Finance Officer
Presenter:	Claire Skidmore – Chief Finance Officer

Purpose of the report:

The purpose of this report is to articulate the current financial position and to highlight any financial or contractual risks.

At Month 10 the CCG is showing a year to date overspend of £20.5m against the submitted plan. In line with the NHSE/I process to amend the forecast at the end of a quarter, the CCG submitted an application at Q3 and is now forecasting a £47.3m deficit. This position has been discussed and agreed with NHSE/I and signed off by the CCG AO, CFO, CCG chair, Audit Committee chair and STP finance lead who have all been engaged throughout the process. The forecast is unchanged at Month 10.

Although the forecast has not changed, there have been movements in expenditure categories during Month 10 as set out below:

	SCCG £'000
Month 9 Forecast	**47,263**
Adverse Moves	
Deterioration in out of area acute contracts	171
Deterioration in Individual Commissioning/Mental Health	156
Mitigations	
Improved forecast on primary care (prescribing and co commissioning)	196
Improved forecast on community/other	131
Month 10 Forecast	**47,263**

During Month 10, the overall forecast position has remained static although we continue to manage risk within the Individual Commissioning and Out of Area acute contract lines. Year end agreements have been reached with both main acute providers (Shrewsbury and Telford Hospitals and Robert Jones and Agnes Hunt) providing a level of financial certainty for all parties and the health system as a whole.

A level of expenditure for the likely cost of change as the CCG moves to become a strategic

commissioning organisation has also been included in the position.

During the month, financial recovery plan actions have continued to deliver improvements against the position (shown in the summary above under mitigations)

Current forecasts against the overall QIPP plan would suggest an outturn of £16.4m (83% delivery) with £0.8m of this flagged as net risk. The majority of QIPP risk has now been removed from the financial position due to the year end agreements made with the acute trusts. However, risk remains in areas such as Individual Commissioning. QIPP will continue to be pursued and monitored robustly.

The CCG continues to pursue actions within the financial recovery plan including increased grip and control but it is now unlikely that those actions will deliver further benefits within the financial year. The CCG also continues to work with the system to pursue savings opportunities and transformational change to allow efficiencies to be delivered in 2020/21 and beyond.

Any cost impact of Brexit is not incorporated into our position at this stage as it is impossible to quantify at this point.

Work to prepare for the production of the 2019/20 year end accounts is underway and updates will be brought to future meetings. As part of this each governing body member is asked to:

- Declare that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.
- Accept that the CCG is operating as a going concern.
- Accept that disclosures around pensions and salaries will occur for each governing board member.

Actions required by Finance and Performance Committee Members:

The Committee is asked to:

- **Note** the financial position at Month 10.
- Make the **declarations** noted in the Executive Summary above in support of the annual accounts process.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No

6	Risk to financial and clinical sustainability *If yes how will this be mitigated* The CCG has now revised its forecast and will breach the agreed control total and the statutory duty to break even. There is now a risk that the underlying position of the CCG deteriorates further which will impact on the CCG's ability to recover financially over future years.	Yes

Tables included in this report:

Graphs included in this report:

Schedules appended to this report:

Appendix	**Content**
Appendix A	A1 Acute Services A2 Non Acute Services A3 Other A4 Running Costs A5 Better Care Fund A6 QIPP A7 Allocations A8 Statement of Financial Position A9 Annual Accounts Process
Appendix B	B1 Financial Summary Position B2 QIPP Detail B3 Allocations B4 Category Run Rate Analysis

NHS Shropshire CCG

CCG Governance Board - 11th March 2020

Financial Position Month 10 - 2019/20

Financial Performance Dashboard

1. The CCG's overall performance at 2019/20 Month 10 against key financial objectives is shown below:

Table 1: Performance Against Key Financial Objectives

Target/ Duty	Target	RAG
Control Total Deficit	£12.3m deficit	R
Performance against submitted plan	YTD- £20.5m above planned deficit	R
Cash	1.25% monthly drawdown	G
Better Payment Practice (App B-7)	>=95%	G

Summary Financial Position

2. At month 10 the CCG is showing a year to date deficit of £20.5 million. Further detail is provided at Appendix A.

3. The CCG formally amended its forecast at Month 9 to a deficit of £47.3m. This represents a variance from plan of £24.4m. This was agreed with NHSE/I and signed off by CCG Board and Committee members. The Month 10 position is consistent with this forecast.

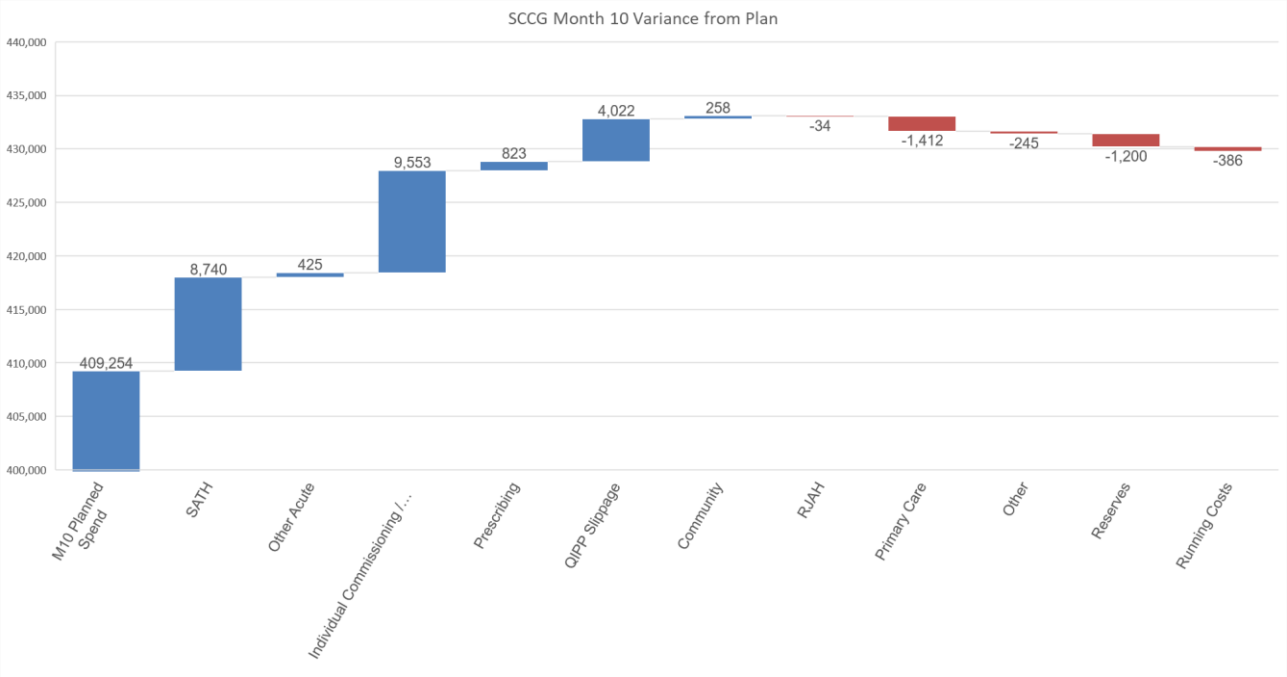
4. The table below outlines the financial position at Month 10 and further detail is provided at Appendix B-1.

Table 2: Summary Financial Position at Month 10

	2019/20 Budget	Forecast Outturn	Forecast Variance		Budget Year to Date	Actual Year to Date	Variance year to date	
	£000	£000	£000	%	£000	£000	£000	%
Total Resource Limit	**475,194**	**475,194**	**0**	**0%**	**390,209**	**390,209**	**0**	**0%**
Acute Services	233,649	250,277	16,628	7%	194,171	207,242	13,071	7%
Community Health Service	49,900	50,220	320	1%	41,302	41,722	420	1%
Individual Commissioning	35,432	43,961	8,529	24%	29,527	36,347	6,820	23%
Mental Health Services	43,178	46,278	3,100	7%	35,823	38,506	2,684	7%
Primary Care Services	63,459	64,363	904	1%	52,521	52,810	289	1%
Other	19,381	15,226	(4,155)	-21%	12,863	11,419	(1,444)	-11%
Running Costs	6,946	7,359	413	6%	5,844	5,788	(55)	-1%
Co-Commissioning	46,104	44,773	(1,331)	-3%	37,204	35,965	(1,239)	-3%
Total Expenditure	**498,049**	**522,457**	**24,408**	**5%**	**409,254**	**429,799**	**20,545**	**5%**
Deficit/(Surplus)	**22,855**	**47,263**	**24,408**		**19,045**	**39,590**	**20,545**	

Year to Date

Figure 1: Year to Date Variance from Plan at Month 10



5. The bridge diagram above shows the difference between planned expenditure of £409.3m at Month 10 and reported actual expenditure of £429.8m.

6. When the resulting £39.6m deficit is compared to the planned deficit for month 10 (£19.1m) this shows a £20.5m YTD variance.

Contract Position Summary

7. Month 9 SUS data is now available and Month 10 contract positions have been calculated on this basis. Appendix A shows the detail around each of the contracts below.

SATH- Shrewsbury and Telford Hospital

8. During Month 9 a year end agreement was reached between the CCG and Shrewsbury and Telford Hospitals NHS Trust providing a level of financial certainty for all parties and the health system as a whole.

9. The Month 10 position for SATH therefore shows the year to date overspend of £9.5m (some of which is shown in QIPP slippage in Figure 1) and a forecast outturn of £12.1m overspend.

10. The year end agreement has now mitigated against any further risk in this financial year in relation to things that impact on acute activity at our main provider trust (such as QIPP scheme under delivery). Further detail is provided in Appendix A.

11. Contract negotiations for 20/21 are well underway with the Trust and CCG working together to develop the activity and finance schedule and understand the reasons for any variances. Further work and agreement around affordability will be required before the final contract form can be agreed. Directors of Finance have agreed to pursue a block contract form with a view to working together on a more refined approach for future years.

RJAH- Robert Jones and Agnes Hunt

12. During Month 9 a year end agreement was also reached with Robert Jones and Agnes Hunt Orthopaedic Hospital.

13. The RJAH contract is over performing by £0.85m year to date with a forecast outturn of £1m overspend.

14. Contract negotiations for 20/21 are progressing and an operational group for the MSK alliance agreement is meeting weekly with a target of incorporating the Alliance agreement into the main contract before the sign off date in March.

WMAS- West Midlands Ambulance Contract

15. The Month 10 position at WMAS is a year to date overspend of £396k and a forecast overspend of £571k. Activity in December remains high at 6.65% above plan, an increase from the 6.06% reported in November. The over performance year to date now stands at 5.68%. Our forecast outturn position assumes a maintained level of over performance given the increased activity predicted for winter.

Betsi Cadwaladr University Health Board

16. During Month 10 the forecast expenditure against this contract has increased due to an increase in elective activity.

Out of Area Acute Contracts

17. Out of Area Acute Contracts continue to overheat at month 10. The main providers with over performance at Month 10 are University Hospital North Midlands (UHNM), Wye Valley and Royal Wolverhampton Hospitals. The majority of the overspends at these trusts is in Emergency activity.

18. Letters have been sent to out of area providers from the contracting team to request that activity is brought back in line with plan.

Community

19. During Month 10 the overall community expenditure forecast has reduced slightly due to improvements in both the St Michaels Dermatology contract and the Powys community services contract.

20. Community services have a current YTD overspend of £420k (some of which is shown in QIPP slippage in Figure 1) and are forecast to overspend by £320k. Prior year costs are built into the YTD position. The overspend is due in part to

unachieved QIPP of £175k within the Shropshire Community Contract, Hospice at Home additional costs of £350k and over-performance for Wye Valley Trust of £240k due to long stay patients in rehab beds. These cost pressures have been offset with slippage on investment for Care Closer to Home.

21. Actions have been taken to mitigate overspends for ophthalmology, dermatology and pain management contracts including formal challenges to the providers, activity query notices and re-negotiation of local prices in the contracts.

22. Contract negotiations are underway with Shropshire Community Trust and weekly meetings are taking place. Discussions are ongoing in relation to delivery of the QIPP target built into the plan and how we can work in partnership to realise the savings required.

Individual Commissioning

23. Appendix A outlines the current position on Individual Commissioning (Continuing healthcare/complex care including mental health) which shows a YTD overall position of £9.3m overspend and a forecast outturn of £11.2m overspend.

24. At Month 10 the position has held fairly steady with a slight (£46k) deterioration in the forecast. There has been a reduction in the forecast QIPP delivery in month by £211k due to staffing capacity issues delaying the patient review process.

25. The remaining increase is due to a slight increase in new ratifications.

Forecast Outturn

26. The forecast financial position has remained static since Month 10 at a total deficit of £47.3m and a variance from plan of £24.4m.

27. Within this position are key adverse movements that have been offset with other improvements/benefits. The key movements in month are shown below and further detail is provided in Appendix A.

Table 3: Month 10 Forecast Position Movements

	£ m
Month 9 FOT variance to plan	**47.26**
Adverse Movements:	
Out of Area Acute forecast deterioration	0.17
Individual Commissioning/Mental Health Deterioration	0.16
Favourable Movements:	
Primary Care improved forecast	0.20

Other/Community improved forecast	0.13
Month 10 FOT variance to plan	**47.26**

28. During Month 10 the forecast position on out of area acute contracts has deteriorated by £471k. The main reasons for this are adverse movements in forecasts for University Hospital North Midlands (UHNM) due to critical care and emergency activity and Wye Valley Trust long stay patients. At Month 9 an estimate of £300k additional cost in this area had been built into the forecast, this has now been completely used by the movement at Month 10 which therefore creates risk to the position in this area.

29. The Individual Commissioning/Mental Health forecast deteriorated slightly in month due to new ratifications in Individual Commissioning and increased Psychiatric Intensive Care Unit (PICU) expenditure at Midlands Partnership Foundation Trust (MPFT). At Month 9 £700k of additional assumed spend was built into the forecast position. At Month 10 we have offset one third of this additional assumed spend against the year to date position leaving a balance of £467k. There is an assumption built into the forecast that £837k of QIPP will be delivered between now and the end of the year based on the assessment of the IC team. If the QIPP does not deliver this would consume the balance remaining and risk an increase to the forecast if additional costs exceed this. Risk therefore remains high in this area in relation to delivery of recovery actions and the potential for additional high cost patients to be chargeable to the CCG.

30. The Primary Care budgets forecast improved in month. The main drivers of the reduction include an improved GP prescribing position and an improved Primary care co commissioning position due to related reduced dispensing expenditure.

31. There were also a number of very small improvements on forecasts across a number of budget lines in community and other including improved forecasts on the St Michaels dermatology contract and the Powys community services contract.

QIPP Summary

32. Current forecasts against the overall QIPP plan would suggest an outturn of £16.4m (83% delivery) with £1.0m of this flagged as ‘at risk’. Though £0.2m has been included as a potential mitigation to this as the Individual Commissioning team are putting steps in place to offset the risk to the QIPP delivery.

33. A year end agreement with both SATH and RJAH has helped to secure QIPP forecast financial positions. Teams continue to pursue projects during 2019/20 to ensure outcomes are being delivered and QIPP baselines are clear for 2020/21 and beyond.

34. Focus continues on the Pipeline of schemes for 2020/21. The PMO are working with leads across both CCGs to develop plans whilst keeping abreast of projects that are in progress across the STP through cluster workstreams.

35. The current pipeline of schemes across the two CCGs for 2020/21 holds a level of risk in its identified schemes as well as £6.4m of savings requirement that, to date, has no formal plans attributed to it. The PMO are actively encouraging and supporting work to finalise operational plans and delivery trajectories for projects in order that confidence in delivery of values can be increased.

QIPP RISK

36. Where variance from plan is found in actuals or forecast for year end this is incorporated into the finance position and associated QIPP reporting. In addition to this, schemes are risk assessed during the month. Where further risk is identified this is captured in the CCG's reported risk position. The level of risk applied at month 10 has been summarised in Table 4.

Table 4: QIPP Risk

Net Planned Savings £000's	Forecast Delivery £000's	Risk of Delivery £000's	Mitigation £'000's	Risk Adjusted Position £000's
£19,815	£16,378	£990	£200	£15,588

37. The PMO, in collaboration with executive leads and project managers, have identified four schemes as deemed to be carrying a risk that the figures reported in the overall position may not be achievable. These are shown in Table 5.

Table 5: QIPP schemes with risk

Scheme Name	Net Planned Savings £000's	Forecast Delivery(net) £000's	Confidence of Delivery £000's	Risk of Delivery £000's
HISU	£120	£120	£80	£40
CCtH – Admission Avoidance	£1,900	£500	£150	£350
CCtH – Demonstrator Sites	£1000	£654	£254	£400
Individual Commissioning	£2784	£3023	£2823	£200
Total Risk				**£990**

Underlying Financial Position

38. The underlying position at Month 10 is shown below. The table shows an underlying deficit of £47.8m due to non recurrent benefits in the position in year.

Table 6: Underlying Position at Month 10

Month 10:		
	£'000	
Month 10 Forecast Position in ledger	47,263	Deficit
Non Recurrent Items in Position:		
ACUTE	193	
MENTAL HEALTH	- 282	
COMMUNITY	- 594	
PRIMARY CARE	1,298	
CONTINUING HEALTHCARE	- 83	
OTHER	303	
RUNNING COSTS	- 291	
Underlying Position at Month 10	47,807	Deficit

Run Rate

39. Appendix B-4 shows the run rate analysis by category of spend. Expenditure does not occur in a linear way and therefore the finance team maintain oversight to ensure that forecasts are reasonable.

40. At Month 10 the CCG is showing a spend position that is £20.5m above the year to date plan. This is after taking account of the benefits realised in Months 7 to 10 which amount to £2.7m. (£2.4m reported last month for Month 7, 8 and 9 and £0.3m outlined in Table 3).

41. The current risk adjusted run rate of expenditure against plan has therefore reduced from an average of £2.3m a month to £2m a month due to the actions taken above.

42. If this rate of overspend continued to the end of the year on a straight line basis the CCG would be £24.6m away from the target. The current forecast is £24.4m away due to some prior year costs included in the year to date position.

Recovery Action and Oversight of the Reported Position

43. The CCG continues to pursue actions within the financial recovery plan including increased grip and control but it is now unlikely that those actions will deliver further benefits within the financial year. The CCG is working with the system to pursue savings opportunities and transformational change to allow efficiencies to be delivered in 2020/21 and beyond.

44. Any cost impact of EU exit is not incorporated into our risk position at this stage as it is impossible to quantify at this point.

45. The CCG is not currently eligible for Commissioner Sustainability Funding (CSF) as it did not submit a financial plan that meets the NHSE/I required control total.

46. The CCG started the financial year with a cumulative deficit carried forward from 2018/19 of £76.6m, the revised formal forecast of £47.3m in year deficit will now take the CCG cumulative position to a £123.9m deficit.

Annual Accounts

47. Appendix A-9 details the declarations that need to be made by the CCG Governing Body as part of the 2019/20 Annual Accounts Process.

2020/21 Financial Plan

48. At the January Finance and Performance Committee meeting a paper was presented to show the latest financial plan figures for 20/21. At the point in time there was a £3.1m difference to the January STP submission due to additional cost pressures and the movement in the 2019/20 forecast outturn.

49. Since then the plan has continued to be updated for recent discussions with providers and the latest planning guidance received. This work continues to show a deteriorating position due to additional cost pressures in the form of additional tariff impact, growth over and above the STP agreed 2.8% and issues with 'aspirational' STP QIPP targets not being sufficiently worked up and therefore not recognised within contracts.

50. On 11th March, Julian Kelly (NHSEI National Director of Finance) will be visiting the system to go through the financial plan and will be testing that the plan is realistic but stretching.

51. The focus will be very much on a system level plan and therefore we are in discussions with providers to attempt to secure block contracts for 2020/21. Work is currently ongoing to fully triangulate the financial positions and costs pressures arising between the commissioner and providers.

52. Given the discussions that will be happening with regulators over the coming weeks it was recommended to Finance and Performance Committee that the committee deferred governing body sign off of budgets for a month.

53. It is hoped that a paper will be presented to Finance and Performance Committee in March with the final financial plan and corresponding budgets to be signed off at the CCG Governing Body meeting in April.

Conclusion

54. As described above, at Month 10 the CCG has maintained the forecast position of a £47.3m in year deficit and £24.4m variance from plan/control total.

55. Management effort is focused on delivering actions that underpin the financial trajectories to the end of the year. Particular scrutiny remains in the areas of Emergency activity avoidance, Individual Commissioning and QIPP progress.

The year end agreements with providers allow attention to turn to next year's contracts and development of QIPP plans.

56. The CCG recognises that the poor financial outturn of this year directly impacts on the underlying position moving into future years and the CCG financial recovery plan will need to address this.

1. Appendix A

NHS
Shropshire
Clinical Commissioning Group

Contents page

A-1 Acute Services

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
SaTH	147,576	159,708	12,132	123,275	132,732	9,456
RJAH	32,673	33,679	1,006	27,047	27,896	848
WMAS	14,616	15,187	571	12,201	12,596	396
NCAs & Other	38,784	41,703	2,919	31,648	34,018	2,371
Total Acute Services	**233,649**	**250,277**	**16,628**	**194,171**	**207,242**	**13,070**

KEY MESSAGES

At Month 10 the CCG is currently reporting a year to date over performance of £13.1m. This is primarily being driven by SaTH and Out of Area (OOA) providers.

As described last month , year end agreements have been reached with the two main acute providers, SaTH and RJaH.

The agreement with SaTH is for a total value of £159.7m which includes readmissions reinvestment and delivery of Care Closer to Home QIPP. This has therefore mitigated the financial risk with the CC2H QIPP in this financial year as well as removed the risk of further overperformance within the main contract.

In order to provide support to RJAH , the CCG has agreed to adjust the CCG element of the MSK QIPP risk share to 78% from 50%.

The Other Acute Contracts have seen several contracts move materially during Month 10. The main one being UHNM which has moved by just over £200k, with Wye Valley also moving by £180k.

The WMAS contract has remained broadly inline with the previous month's forecast with activity being similar to previous months.

A-1a SaTH

NHS Shropshire Clinical Commissioning Group

Shrewsbury and Telford Hospital Trust

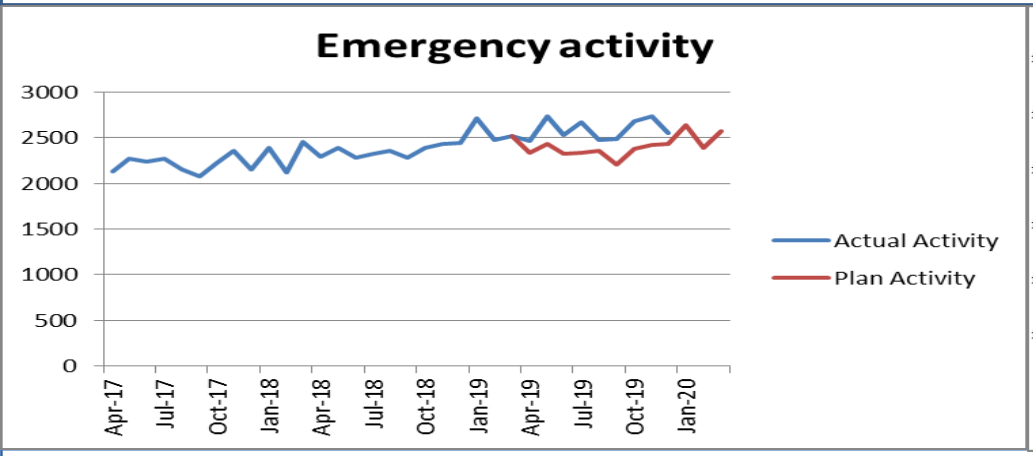
Shropshire CCG Position at Month 10 - Finance (Per Month 9 SATH Monitoring)

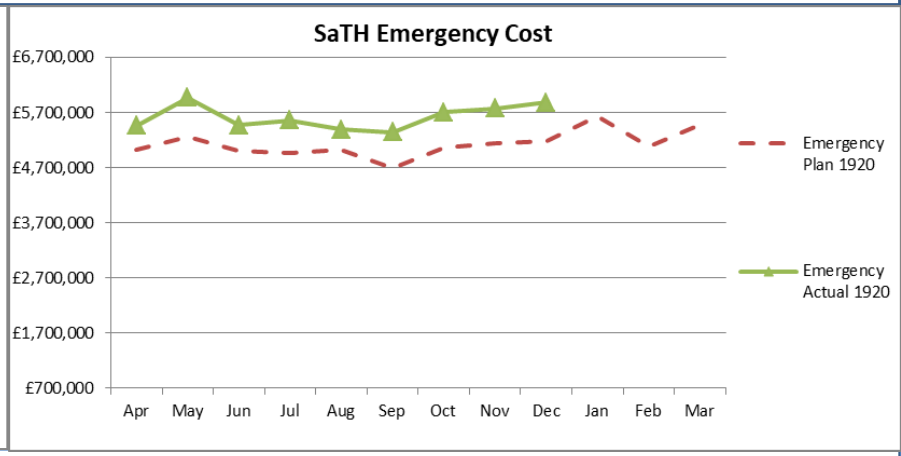
	Ytd Plan v Actual (£)				FOT 2019-20 Plan v Actual (£)			
POD	**Ytd Cost Plan £**	**Ytd Cost Actual £**	**Ytd Cost Variance £**	**Cost Variance as % of Total Cost Variance**	**2019-20 Cost Plan £**	**2019-20 Cost FOT £**	**FOT Cost Variance £**	**FOT percentage Variance above Plan**
Day Case	13,543,177	13,770,987	227,810	1.7%	16,284,975	16,639,228	354,253	2.2%
Elective	5,778,857	6,176,198	397,341	6.9%	6,847,723	7,415,108	567,385	8.3%
Emergency	51,016,794	56,857,075	5,840,281	11.4%	61,576,687	68,867,278	7,290,591	11.8%
Non Elective Other	5,270,368	5,197,703	(72,665)	(1.4%)	6,371,825	6,283,945	(87,880)	(1.4%)
CDU Adjustment	0	(429,981)	(429,981)	0.0%	0	(519,050)	(519,050)	0.0%
Critical Care	2,295,736	2,600,648	304,912	13.3%	2,745,861	3,210,525	464,664	16.9%
Outpatient Firsts	8,122,445	8,623,746	501,301	6.2%	9,731,420	10,332,170	600,750	6.2%
Outpatient Follow Ups	6,357,608	6,409,902	52,294	0.8%	7,631,711	7,694,498	62,787	0.8%
Outpatient Procedures	5,974,450	5,878,012	(96,438)	(1.6%)	7,114,656	6,999,883	(114,773)	(1.6%)
Accident and Emergency	8,694,287	9,393,051	698,764	8.0%	10,424,707	11,332,294	907,587	8.7%
Non PBR Variable	18,963,670	18,639,428	(324,242)	(1.7%)	22,813,286	22,438,690	(374,596)	(1.6%)
Non PBR Block	1,359,120	1,376,379	17,259	1.3%	1,630,944	1,651,712	20,768	1.3%
CQUIN	1,482,350	1,563,115	80,765	5.4%	1,778,820	1,875,739	96,919	5.4%
Blended Payment Rebate	0	(3,963,645)	(3,963,645)	0.0%	0	(4,784,699)	(4,784,699)	0.0%
MRET/Readmissions	(4,347,500)	0	4,347,500	(100.0%)	(5,217,000)	0	5,217,000	(100.0%)
Total	**124,511,362**	**132,092,618**	**7,581,256**	**6.1%**	**149,735,615**	**159,437,322**	**9,701,707**	**6.5%**
Prisoners	130,720	89,685	(41,035)		156,585	107,622	(48,963)	
Agreed Principles	0	(33,706)	(33,706)		0	(50,558)	(50,558)	
Penalties	0	(31,499)	(31,499)		0	(31,499)	(31,499)	
Year End Deal	0	0	0		0	362,428	362,428	
Readmissions Reinvestment	300,215	300,215	0		360,259	360,259	0	
CC2H QIPP	(2,711,111)	(288,743)	2,422,368		(3,900,000)	(1,154,972)	2,745,028	
Service Developments	539,635	84,583	(455,053)		647,561	101,499	(546,062)	
Audiology AQP	480,772	479,916	(856)		575,899	575,899	0	
Total Over/(Under) performance	**123,274,790**	**132,693,069**	**9,418,279**	**7.6%**	**147,575,919**	**159,708,000**	**12,132,081**	**8.2%**

A Year End agreement has been reached between the respective organisations.

A-1a SaTH

NHS Shropshire Clinical Commissioning Group





SaTH Emergency Activity

December was the lowest over-performing month to date being only 3.3% over plan compared to a year to date over-performance of 7.3%. However within the Emergency POD there are several HRG subchapters that are showing significant over and underperformance.

HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Respiratory System Procedures and Disorders	2,350	2,737	387	16.5%	6,580,341	7,977,846	1,397,505	21.2%
Cardiac Disorders	2,335	2,734	399	17.1%	3,553,104	4,316,115	763,011	21.5%
Nervous System Procedures and Disorders	1,216	1,344	128	10.5%	2,934,591	3,614,521	679,930	23.2%
Skin Disorders	415	531	116	27.8%	976,455	1,353,426	376,971	38.6%
Metabolic Disorders	194	281	87	44.6%	444,933	702,659	257,726	57.9%
Renal Procedures and Disorders	994	1,096	102	10.3%	3,255,059	3,495,754	240,695	7.4%
Digestive System Disorders	1,968	2,189	221	11.2%	3,148,558	3,389,012	240,454	7.6%

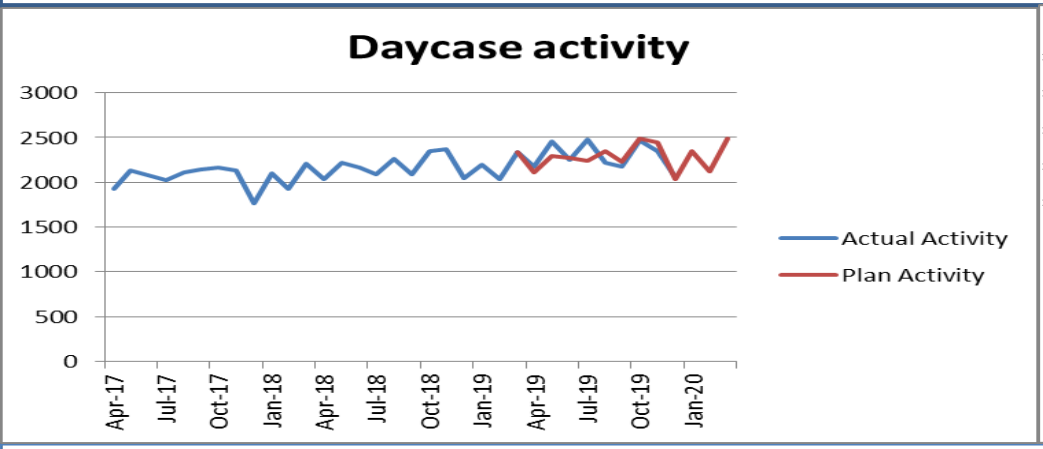
There are however several subchapters where activity is currently below plan, the main drivers of these are Orthopaedic Non-Trauma Procedures, Paediatric Respiratory Disorders and Haematological Procedures and Disorders.

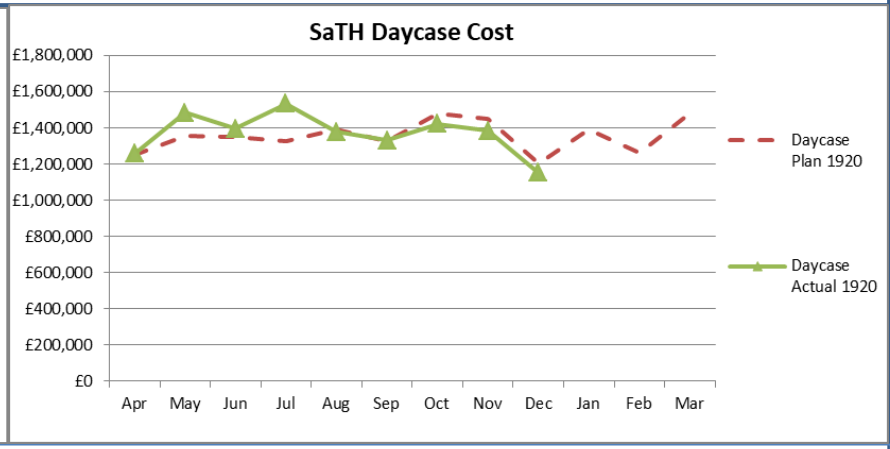
HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Orthopaedic Non-Trauma Procedures	112	96	-16	-14%	563,994	457,774	-106,220	-19%
Paediatric Respiratory Disorders	739	611	-128	-17%	617,079	488,051	-129,028	-21%
Haematological Procedures and Disorders	273	261	-12	-4%	1,069,625	924,319	-145,306	-14%

Additional detail around the emergency care overspend across both CCGs is provided at Appendix C.

A-1a SaTH

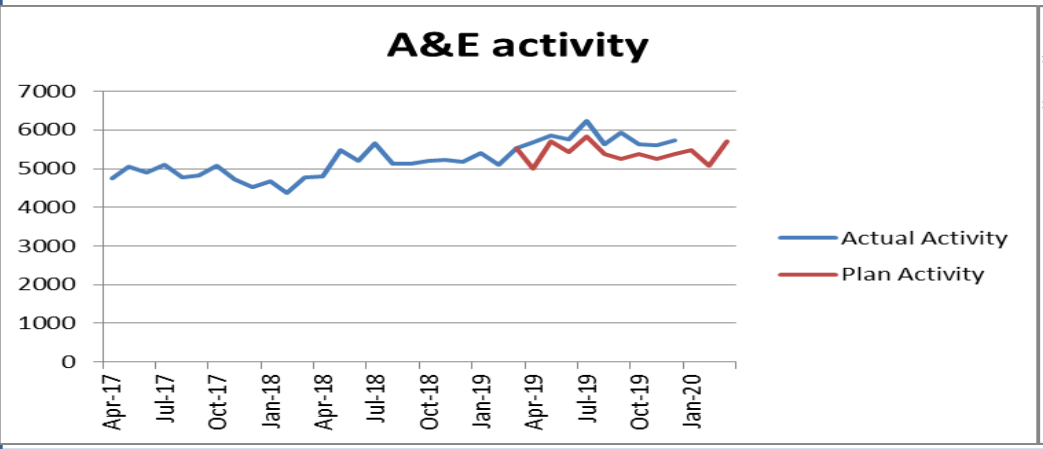
NHS Shropshire Clinical Commissioning Group

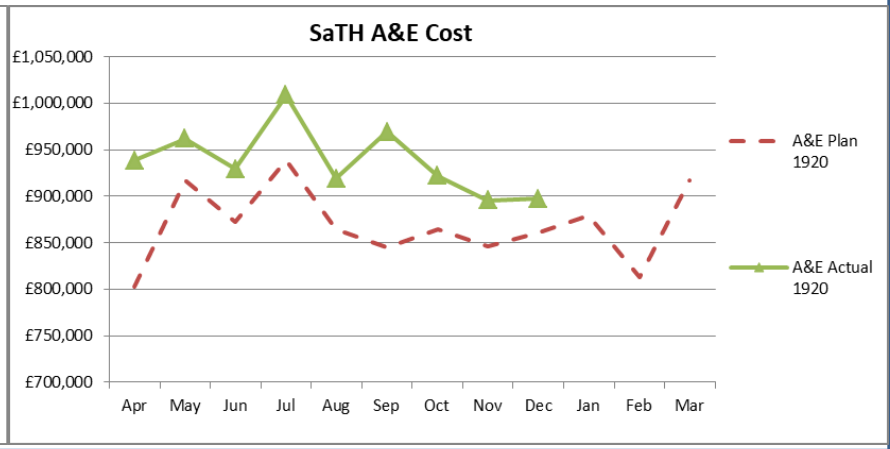




SaTH Daycase Activity

In December we saw a small over performance of 1.2% bringing the YTD over performance to 0.9%. The main drivers of this in terms of Speciality are Gastroenterology and Gynaecology. We have however seen significant under performance within the Vascular Surgery and Upper Gastrointestinal Surgery specialities.



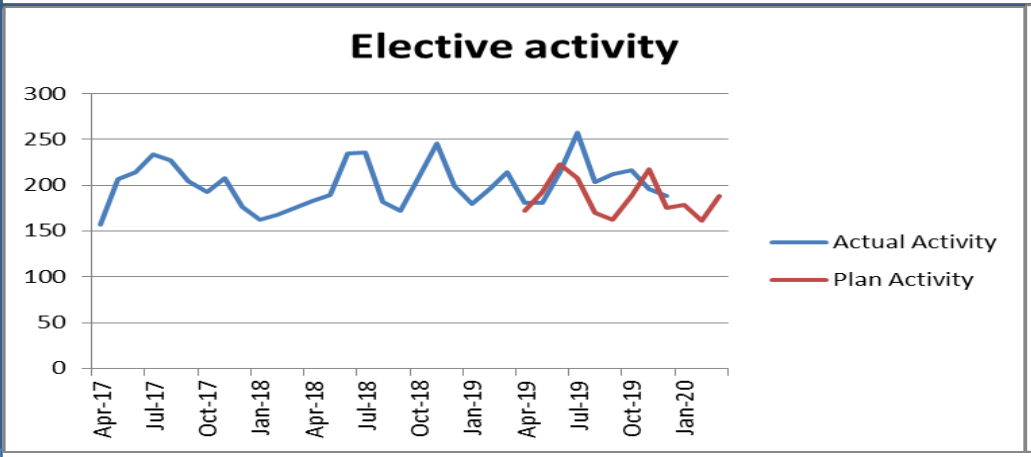


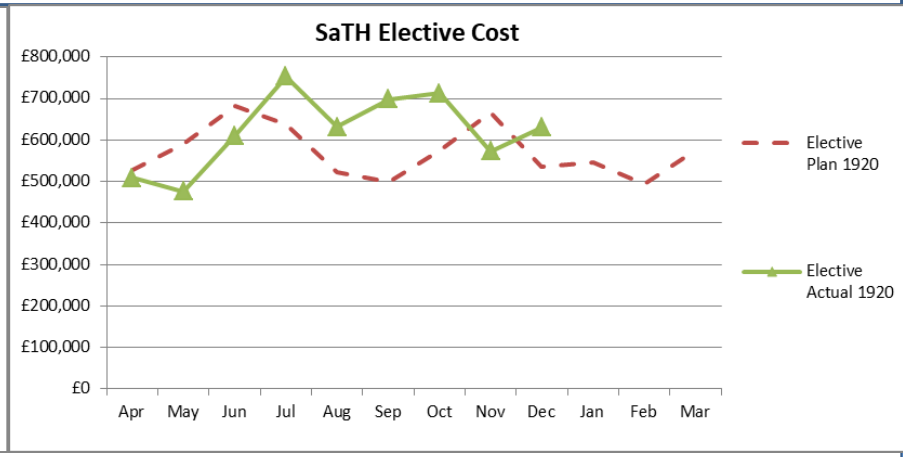
SaTH A&E Activity

In December we have seen over performance in relation to A&E of 6.6%, this has brought the YTD position to 7.2% above plan. The main drivers here are the category 1 and 2 HRGs.

A-1a SaTH

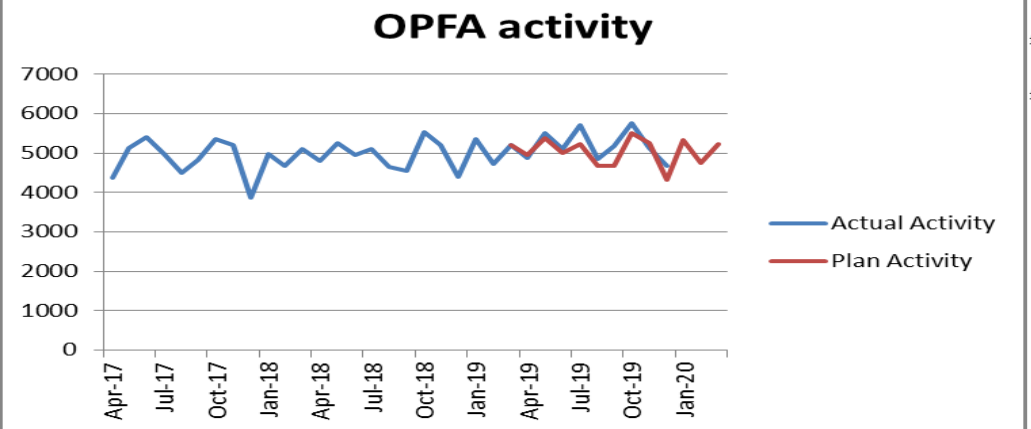
NHS Shropshire Clinical Commissioning Group

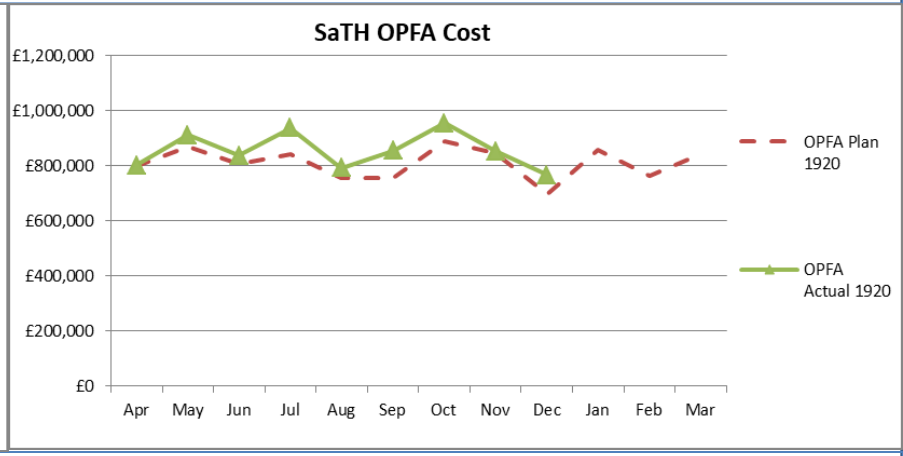




SaTH Elective Activity

In December activity was over plan by 7.7% bringing the YTD to 9.2% and finance 6.8% over. The main drivers of this over performance are *Orthopaedic Non-Trauma Procedures* and *Ear, Nose, Mouth, Throat and Neck Procedures*





SaTH OPFA Activity

OPFA has seen activity over perform in December by 8.3% and YTD over performance is 4% for activity and 6.2% for finance. The main drivers here are Ophthalmology and Trauma and Orthopaedics.

A-1b RJAH

NHS Shropshire Clinical Commissioning Group

Robert Jones and Agnes Hunt Hospital Trust

Shropshire CCG Position at Month 10 - Finance (Per Month 9 RJAH Monitoring)

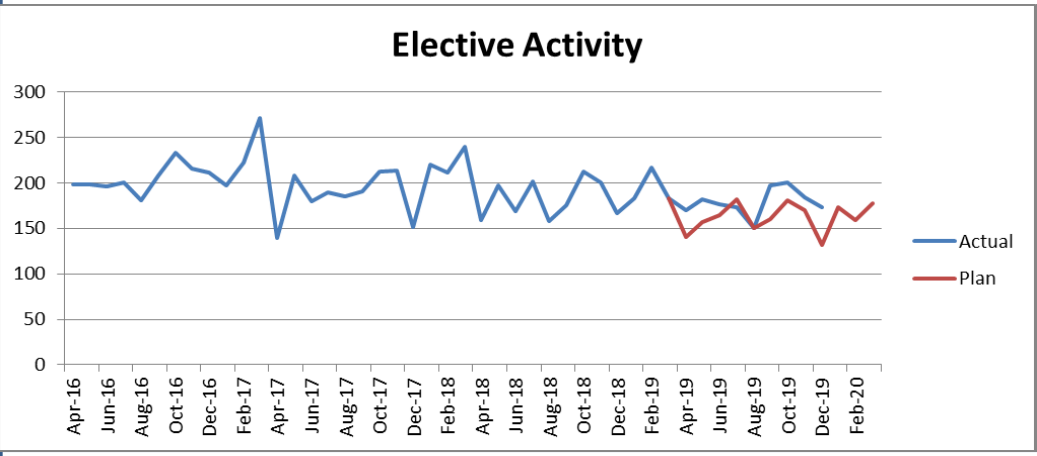
	Ytd Plan v Actual (£)				FOT 2019-20 Plan v Actual (£)			
POD	**Ytd Cost Plan £**	**Ytd Cost Actual £**	**Ytd Cost Variance £**	**Cost Variance as % of Total Cost Variance**	**2019-20 Cost Plan £**	**2019-20 Cost FOT £**	**FOT Cost Variance £**	**FOT percentage Variance above Plan**
Day Case	4,261,373	4,296,925	35,552	0.8%	5,149,986	5,192,951	42,965	0.8%
Elective	9,051,806	10,203,709	1,151,903	12.7%	10,939,355	12,331,461	1,392,106	12.7%
Non Elective Other	880,215	1,036,262	156,047	17.7%	1,063,764	1,252,351	188,587	17.7%
Regular Admissions	467,148	533,447	66,299	14.2%	564,562	644,686	80,124	14.2%
Outpatient Firsts	2,043,618	2,047,048	3,430	0.2%	2,469,768	2,473,913	4,145	0.2%
Outpatient Follow Ups	3,188,954	3,061,101	(127,853)	(4.0%)	3,853,938	3,699,424	(154,514)	(4.0%)
Outpatient Procedures	954,236	941,628	(12,608)	(1.3%)	1,153,220	1,137,983	(15,237)	(1.3%)
Non PBR Variable	3,510,945	3,886,429	375,485	10.7%	4,228,852	4,681,115	452,263	10.7%
Non PBR Block	2,378,282	2,255,311	(122,971)	(5.2%)	2,874,219	2,725,605	(148,614)	(5.2%)
CQUIN	310,855	319,378	8,522	2.7%	375,677	385,976	10,300	2.7%
Total	**27,047,432**	**28,581,237**	**1,533,805**	**5.7%**	**32,673,340**	**34,525,464**	**1,852,124**	**5.7%**
Riskshare	0	(554,709)	(554,709)		0	(439,612)	(439,612)	
Challenges	0	(26,430)	(26,430)		0	(35,240)	(35,240)	
Drug Legacy	0	(40,000)	(40,000)		0	(40,000)	(40,000)	
Non Elective Normalisation	0	0	0		0	0	0	
CQUIN Adjustment	0	(64,329)	0		0	(77,195)	(77,195)	
YE Deal	0	0	0		0	(254,417)	(254,417)	
Total position	**27,047,432**	**27,895,769**	**912,666**	**3.4%**	**32,673,340**	**33,679,000**	**1,005,660**	**3.1%**

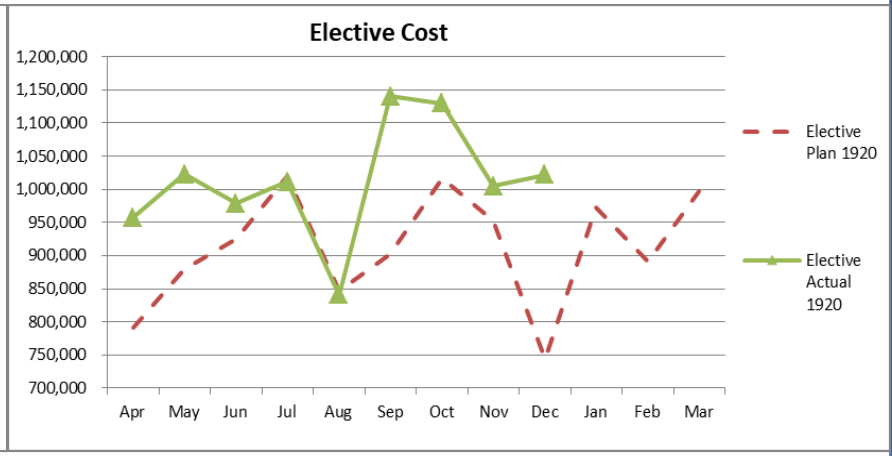
A Year End agreement has now been reached between the respective organisations.

A-1b RJAH

NHS Shropshire Clinical Commissioning Group

ELECTIVE POD





RJaH Elective Activity

In November we have seen continued over performance in relation to the Elective POD with December being £278k over plan. Year to date activity is 11.6% above plan and financially we are 12.7% over plan.

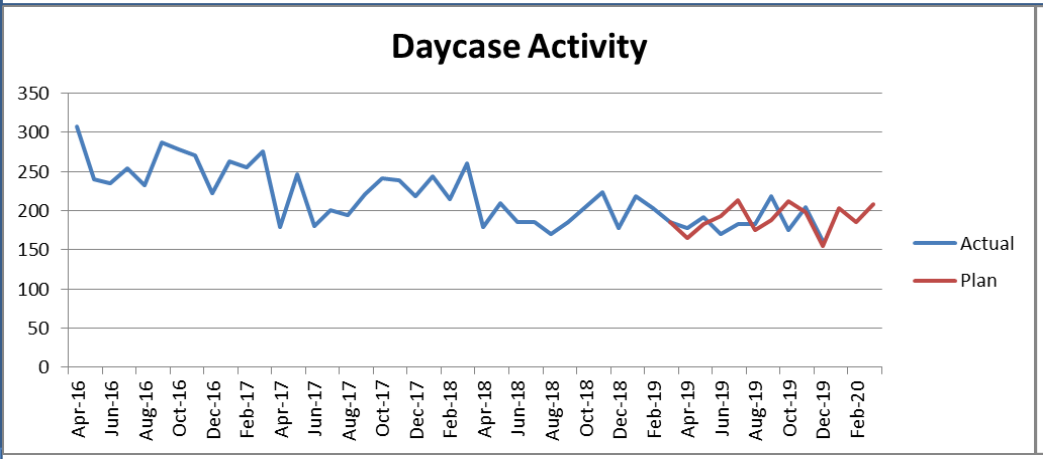
The main drivers of the over performance are Orthopaedic Non- Trauma Procedures however there is also significant over performance in relation to Spinal Procedures. As in previous months the main driver is activity relating to hips however we have also seen a significant over performance in December relating to Knee replacements as shown below where it compares the variance to plan (negative being over performance.

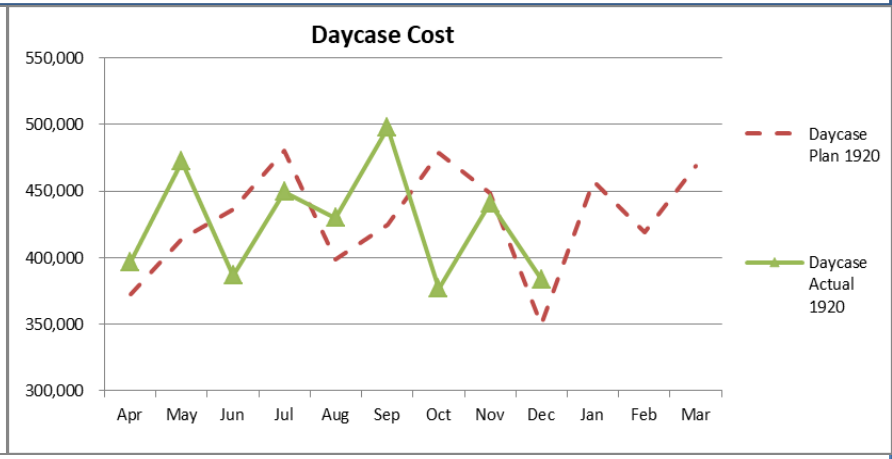
Commissioner	Month 1 - 8 average	Month 9
Arthroscopy Procedures	£455	-£6,014
Hip Replacements and Revisions	-£102,806	-£117,102
Knee Replacements and Revisions	£12,222	-£184,534
Primary Posterior Decompression of Lumbar Spine	-£25,053	-£3,860
Surgery for Shoulder Lesions	£21,735	-£33,475

Commissioner	Month 1 - 8 average	Month 9
Arthroscopy Procedures	- 0.8	- 4.0
Hip Replacements and Revisions	- 14.4	- 16.0
Knee Replacements and Revisions	- 0.4	- 29.0
Primary Posterior Decompression of Lumbar Spine	- 4.9	- 2.0
Surgery for Shoulder Lesions	5.3	- 7.0

A-1b RJAH

NHS Shropshire Clinical Commissioning Group





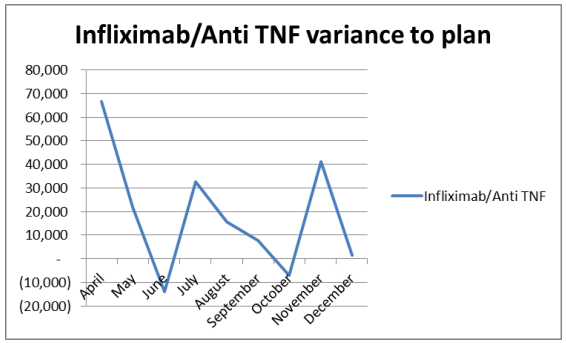
RJaH Daycase Activity

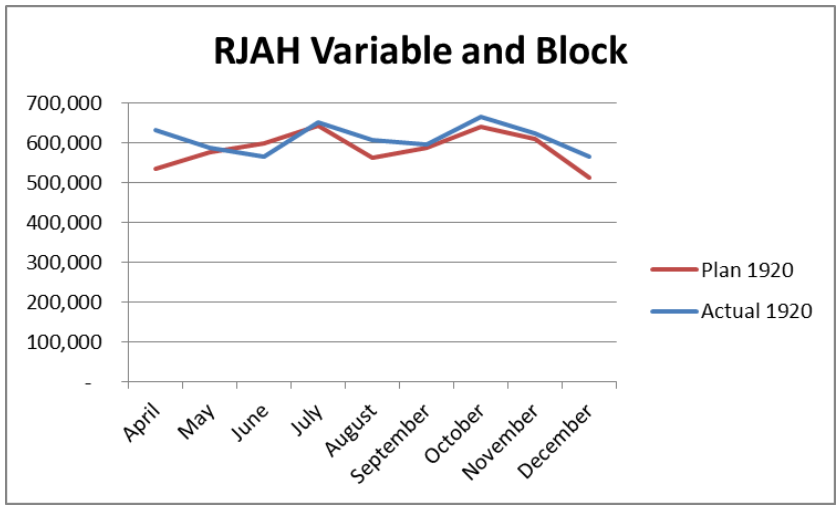
Within the Daycase POD we saw a small over performance of £34k in December. YTD activity is just below plan for activity and finance is £31k over.

The main drivers financially for this over performance are Spinal Procedures and Orthopaedic Trauma Procedures with Multiple Trauma and Orthopaedic Disorders being under plan.

RJaH Others

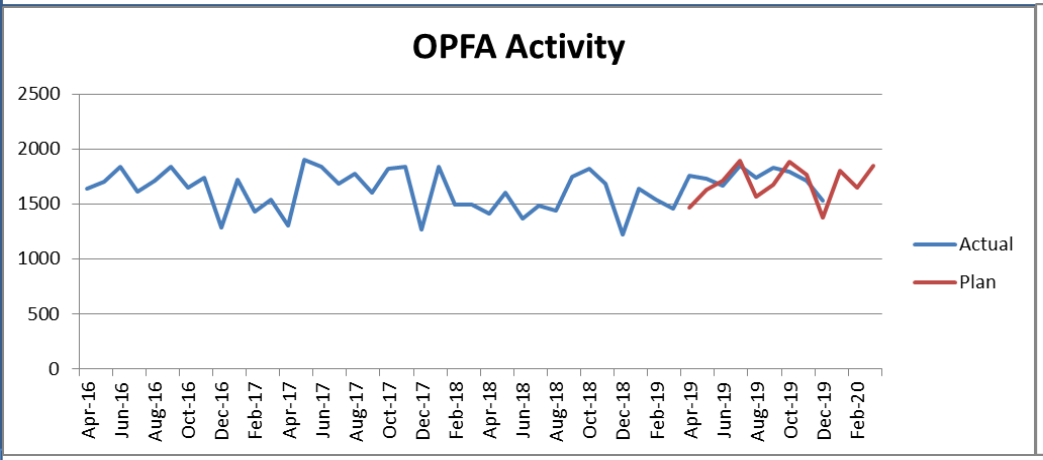
Within the 'other's the main over performance relates to the Inflixamab/Anti TNF drugs. Whilst it is an area that can show fluctuation due to the nature of the service we did see a significant spike in April which we believe relates, at least in part to 18/19.

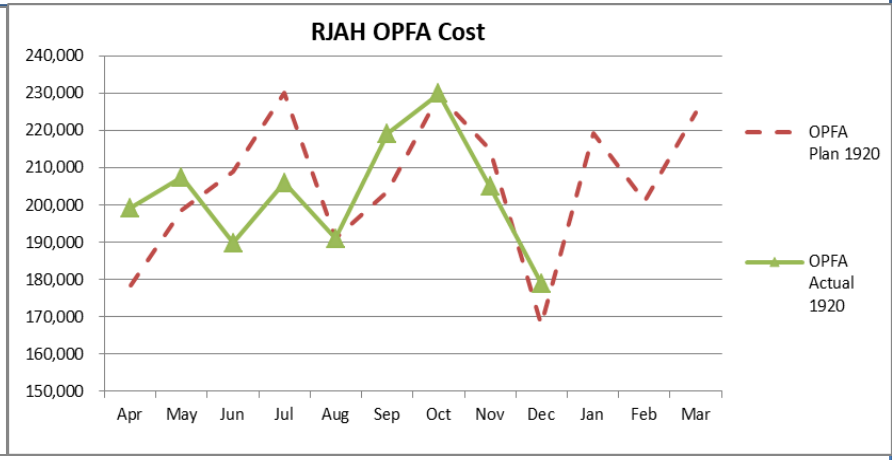




A-1b RJAH

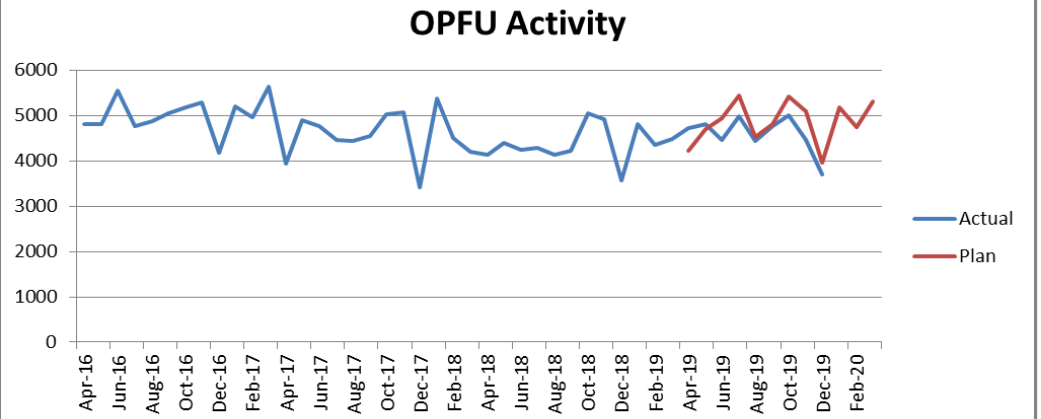
NHS Shropshire Clinical Commissioning Group

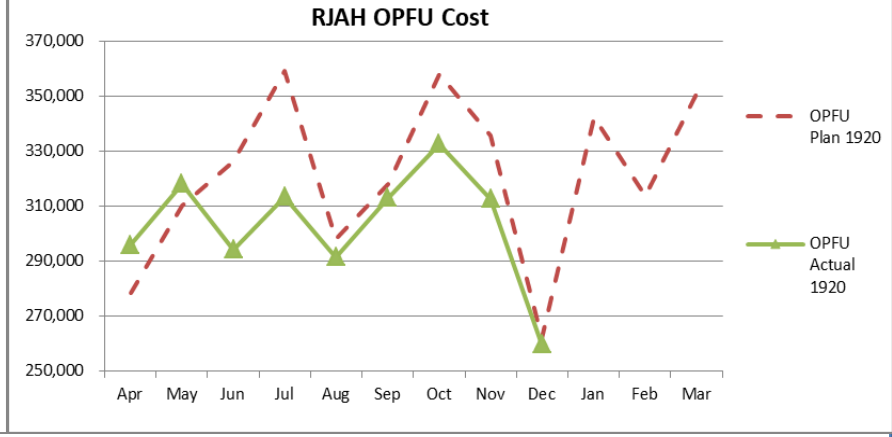




RJaH OPFA Activity

Within the Outpatient First Attendances we are 4.3% over in terms of activity YTD however we saw significant over performance in December with activity being 11% over. The main activity drivers are First Attendances in T&O and Occupational therapy attendances, Physiotherapy as well as DEXA scans.



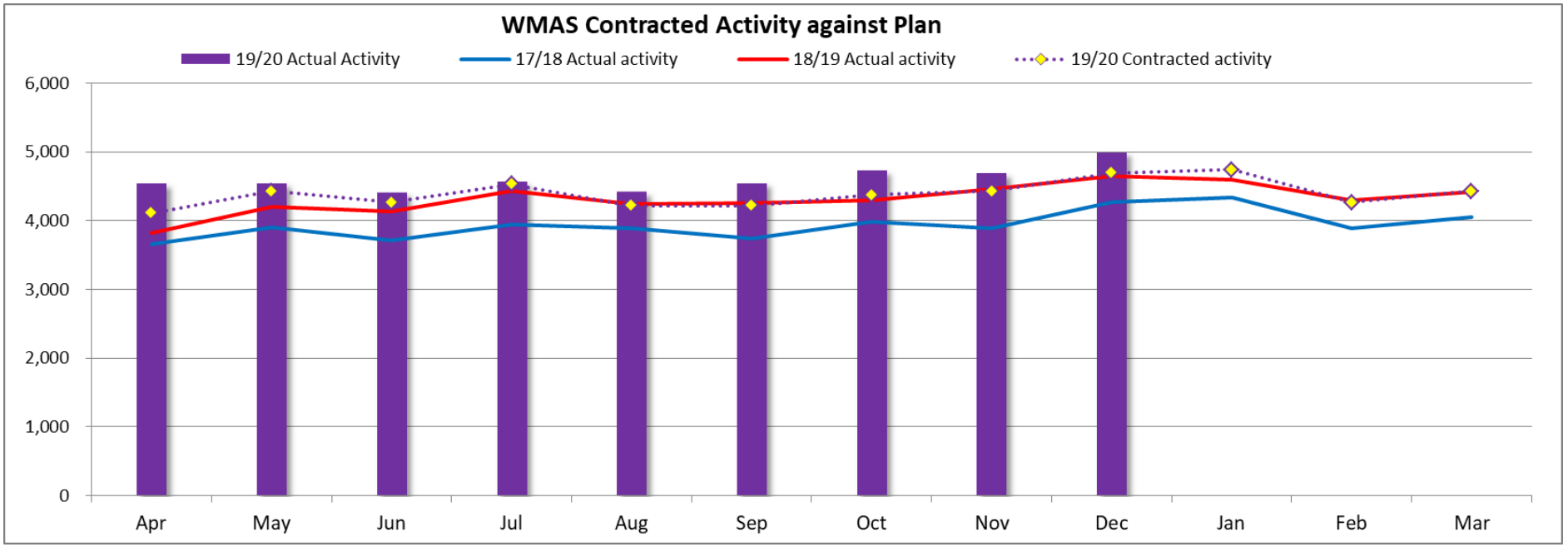


RJaH OPFU Activity

Within the Outpatient Follow Ups we are currently under performing by just under 4.1% for activity and £114k in relation to the finance. The main drivers of this under performance are Consultant led follow ups however activity is over performing in follow ups relating to DMARDS and occupational therapy.

A-1c West Midlands Ambulance

NHS Shropshire Clinical Commissioning Group



Month 10 Shropshire

M10		M12	
11,877,484	M10 Plan	14,227,706	M12 Plan
594,979	OP M9 + M10 Exp	789,832	FOT OP
95,190	HandChanges	135,190	HandChanges
27,658	Non Comp	33,190	Non Comp
12,595,311	**M10 Position**	**15,185,918**	**M12 Position**
1,021	Prior Year	1,021	Prior Year
41,285	CAS (SWBCCG)	41,285	CAS (SWBCCG)
12,637,616	**M10 Position Final**	**15,228,223**	**M12 Position Final**
		14,656,991	Annual Plan
		571,232	**Variance**
		(4,985)	**FOT Movement**

WMAS Activity 2019/2020

Activity in December continues to be high at 6.65% above plan, an increase from the 6.06% reported in November. The over performance year to date now stands at 5.68%. Our forecast outturn position assumes a higher level of 6.25% given the increased activity predicted for winter.

With the NHS111 service now being undertaken by WMAS all category 3 and 4 calls are now to be triaged from November onwards resulting in a potential reduction in conveyances however it is currently too early to predict the impact of this on the activity and finance and we have not seen any reduction to date.

A-1d NCA and Others

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
Other Acute Contracts	31,283	33,402	2,119	25,384	27,171	1,787
Acute NCA's	3,741	4,500	759	3,121	3,724	604
Acute Special Placements	22	22	0	18	17	(1)
Winter Resilience	2,030	1,928	(102)	1,695	1,695	0
Future Fit	230	187	(43)	192	158	(34)
STP	175	398	223	146	251	106
Acute services - Other	168	189	21	147	157	9
High Cost Drugs	533	469	(64)	444	388	(56)
Acute Services Team	602	608	6	502	457	(44)
NCA & Others	**38,784**	**41,703**	**2,919**	**31,648**	**34,018**	**2,371**

The main driver of the over-performance, both Year to Date (YTD) and Forecast Outturn remains 'Other Acute Contracts'.

<u>The variances in this area are as follows:</u>

University Hospitals of North Midlands Trust - Forecasting an overspend against contract of £1,374k, an adverse movement of £218k from last month. The variance primarily relates to over performing emergency activity £535k as well as a small number of high cost long stay critical care patients (£327k in excess of plan).

Royal Wolverhampton Trust - Forecasting an overspend against contract of £752k, including an over performance in emergency activity £346k and daycase/elective activity £261k.

Wye Valley Trust – Forecasting an overspend against contract of £507k due to over performances within emergency activity £344k and accident and emergency attendances £95k.

Dudley Group Foundation Trust – Forecasting an overspend against contract of £219k due to emergency activity over-performance of £70k and critical care of £53k.

Worcester Royal – Forecasting an underspend against contract of £188k due to daycase/elective activity under performance of £68k and critical care of £44k.

Betsi Cadwaladr University Health Board – Care of the Elderly activity has increased within the contract resulting in an increased FOT of £113k

QIPP Slippage in the **VBC/MSK** expected savings of £250k and £231k respectively are factored into the out of county trusts expenditure positions.

The prior year non recurrent benefit following the 'Balance Sheet' review undertaken in the last quarter has been finalised, as stated previously at £536k.

Appendix B shows overall activity trends by point of delivery and a breakdown of other acute contracts.

A-2 Non Acute Services

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
Community	49,900	50,220	320	41,302	41,722	420
Mental Health	43,178	46,278	3,100	35,823	38,506	2,684
Individual Commissioning	35,432	43,961	8,529	29,527	36,347	6,820
Primary Care	63,459	64,363	904	52,521	52,810	289
Total Non Acute Services	**191,969**	**204,822**	**12,853**	**159,172**	**169,384**	**10,212**

Key Messages

- The Non Acute Services position at Month 10 shows a £10.2m YTD overspend and £12.9m forecast overspend. The majority of the overspend relates to significant over performance in terms of both activity and cost in relation to IC – under both the core IC budget line and Mental Health (£2.8m of the £3.1m MH overspend relates to IC). Further information on the overspend and mitigating actions is provided on the IC slide.
- Information regarding the Shropshire Community Health NHS Trust (SCHT) and Midlands Partnership NHS Foundation Trust (MPFT) contracts are provided on the following slides. The SCHT position shows £267k overspent year to date and £304k forecast overspend. This is due to non-achievement of QIPP and over performance in MIU activity. The MPFT position is a year to date overspend of £497k and forecast overspend of £597k mainly due to Psychiatric Intensive Care Unit (PICU) over performance.
- Community services is forecast to overspend by £320k. This is due to unachieved QIPP of £175k, Hospice at Home additional costs of £350k and over-performance for Wye Valley Trust of £240k (due to having long stay patients in Rehab beds activity). The forecast position also includes overspends for Ophthalmology of £364k, and Dermatology £192k, less slippage on investment for Care Closer to Home/Other of £1.0m. Prior year expenditure is factored into the year to date position. The Ophthalmology revised position includes a £36k credit received relating to the first half of the year challenges. Dermatology over performance has been investigated and a full report is awaited for discussion at the Contract Assurance group.
- The CCG is planning to meet the Mental Health Investment Standard in 2019/20 which means that Mental Health spend will have increased in line (or more) with CCG allocation growth.
- A breakdown of the primary care position is provided at A-2d; the majority of the overspend relates to GP prescribing.

A-2a Shropshire Community Trust

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000		Forecast Outturn £'000	Forecast Variance £'000		Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000
Main Contract	40,553		40,857	304		33,794	34,069	275
Out of Hours	3,150		3,150	0		2,625	2,617	-8
Total SCHT	**43,703**		**44,007**	**304**		**36,419**	**36,686**	**267**

The YTD position for the Main Contract is £275k overspent, £129k of which is contract over-performance and £146k non-achievement of QIPP (50% of target to reflect the Risk share built into contract). The forecast is £304k overspend, (£175k QIPP). Trends in activity will be monitored over the coming months through the Contract Review Meetings (CRMs). The position includes a reduction for APCS Dermatology services which ceased in September. The CCG is currently awaiting the contract variation for this to be signed by the Trust.

A summary of the activity performance to December is shown in the table opposite. Year to date and forecast overspends are based on current over-performance at Month 9. MIU activity is estimated to be £123k over and inpatient activity paid at national tariff is also over-performing slightly. These overspends are partly abated by Outpatient underperformance of £42k. Community Equipment and Continence lines are under-performing against plan as well as compared to last year, however these are part of the block contract so would not result in a financial impact.

The contract includes a £350k QIPP target which is forecast not to achieve so the agreed risk share has been enacted via a contract variation. The provider is disputing the service lines that this has been allocated against and this has been escalated for Exec discussion. Contract meetings continue to progress QIPP opportunities for schemes along with meetings planned to discuss next year's contract.

There is a separate contract for Out of Hours which is at an agreed fixed value and therefore is reported as breakeven.

Summary		M9 Activity Plan	M9 Activity Actual	M9 Variance
Hospital				
	Imaging	6636	7103	467
	Inpatients	1383	1355	(28)
	MIU	20279	21084	805
	Outpatients	9482	8716	(766)
Community				
	Community	270,105	281,531	11,426
	Equipment	149,896	120,991	(28,905)

A-2b Midlands Partnership Foundation Trust

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000
Main Contract	30,439	30,987	548	25,366	25,822	456
0-25 Emotional Health & Wellbeing	2,965	3,014	49	2,395	2,436	41
Total MPFT	**33,404**	**34,001**	**597**	**27,761**	**28,258**	**497**

The MPFT (Main Contract) forecast overspend of £548k has deteriorated from £418k last month and relates to Psychiatric Intensive Care Unit (PICU) over performance. Further information has been requested from the trust for planning purposes e.g. estimated discharge dates. In a broader context the CCG has agreed a Remedial Action Plan (RAP) with the trust that reviews the utilisation of PICU and acute beds, both within the trust and private providers. Initial actions are to reduce out of area private bed use, and to develop the local rehab pathway: to make sure patients are cared for in the right place, for the shortest time possible.

The latest monitoring (month 9) for the MPFT Main Contract shows an over performance of £411k, which is £456k extrapolated to month 10. The contract is subject to caps/ collars and marginal rates which effectively make it a block contract except for Psychiatric Intensive Care Unit (PICU) activity.

The 0-25 EHWS YTD and forecast overspend of £49k relates to agreed inflation (£24k); and a non recurrent cost pressure of £25k relating to Autism Spectrum Disorder (ASD) waiting times as reported previously.

The 0-25 EHWS position has improved by £51k which reflects agreement to the CCGs' final offer to resolve the inflationary dispute.

Summary	M9 Activity Plan	M9 Activity Actual	M9 Variance
MH PbR Admitted Care	16,395	15,368	(1,027)
MH PbR Non Admitted Care	975,029	1,290,623	315,594
MH Non PbR	26,071	22,588	(3,483)
Specialist and Family Care	2,410	1,483	(927)
LD Services	5,706	6,159	453

The activity under the main contract is above plan as at month 9 (December). The over performance against PbR Non Admitted Care is mainly due to dementia activity which is being addressed through the Dementia Tariff Subgroup. Changes have been implemented since last August and have started to have a gradual impact but it is not currently enough to meet the reduced Dementia plan.

A-2c Individual Commissioning

NHS Shropshire Clinical Commissioning Group

At Month 10 the position across both core IC and Mental Health shows a YTD overspend of £9.25m and a forecast overspend of £11.22m. The forecast includes an assumption to over deliver against the QIPP target by a total of £239K which is a reduction from M09 of £211k.

Cost centre	Cost Centre Description	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Forecast Outturn	Forecast Variance
368522	Learning Difficulties S117	£506,924	£422,437	£870,941	£448,505	£1,029,680	£522,756
368541	Mental Health Collaborative Comn	£825,350	£687,792	£399,020	£(288,772)	£458,041	£(367,310)
368557	Mental Health S117	£5,092,738	£4,243,948	£6,125,043	£1,881,095	£7,202,880	£2,110,142
368561	Mental Health Specialist Services	£170,323	£141,936	£571,366	£429,431	£690,697	£520,374
	Mental Health	**£6,595,335**	**£5,496,112**	**£7,966,371**	**£2,470,259**	**£9,381,297**	**£2,785,963**
368682	IC Adult Fully Funded	£17,531,784	£14,609,820	£17,356,901	£2,747,081	£20,684,812	£3,153,028
368683	IC Adult Fully Funded PHB	£1,437,207	£1,197,673	£1,377,221	£179,548	£1,658,432	£221,225
368684	Adult Joint Funded	£5,116,873	£4,264,061	£8,304,294	£4,040,233	£10,634,499	£5,517,625
368685	Adult Joint Funded PHB	£0	£0	£52,810	£52,810	£62,980	£62,980
368687	Children's Joint Funded	£2,072,441	£1,727,034	£2,375,794	£648,760	£2,780,562	£708,121
368688	Children's Joint Funded PHB	£201,402	£167,835	£343,947	£176,113	£424,135	£222,734
368691	FNC	£7,939,684	£6,616,403	£5,521,300	£(1,095,103)	£6,488,686	£(1,450,998)
368796	Reablement	£523,567	£436,306	£469,479	£33,173	£525,043	£1,476
	Other CHC	**£34,822,957**	**£29,019,131**	**£35,801,746**	**£6,782,615**	**£43,259,149**	**£8,436,192**
	Grand Total	**£41,418,292**	**£34,515,243**	**£43,768,117**	**£9,252,874**	**£52,640,446**	**£11,222,154**

Note that the total costs for Other CHC differ from those shown for Individual Commissioning on slide A-2. This is due to the inclusion of Reablement costs in the table above which are shown within Other costs on slide A-3. In addition, the figures above exclude costs in relation to Individual Commissioning staffing costs.

A-2c Individual Commissioning

NHS Shropshire Clinical Commissioning Group

The forecast has deteriorated overall by approximately £0.046M when compared to last months risk adjusted position. The main drivers of the change in reported over spend include:

1. There has been an increase in new ratifications.

2. The over spend assumes that the IC team will over perform against their budgeted QIPP target of £2.78M for the year by £239K which is a decrease compared to last month of £211k. This is due to the fact that staffing capacity issues have meant a delay in reviews taking place and so the estimate has been decreased accordingly.

3. The reduced forecast in terms of QIPP delivery has been offset in month by use of assumed additional required funding included in the forecast . At Month 9 £700k was included in the forecast given recent patterns of activity and the potential for additional high cost patients. One third of this sum has now been used leaving a balance for the last two months of £467k.

It is important to also note that:

a) The current forecast assumes QIPP delivery in the last two months of the year to a total value of £837k. If this QIPP does not deliver this would significantly exceed the funds set aside.

b) Further, a financial review exercise has also been commissioned from Liaison. Liaison have now produced a set of initial findings and these are currently under review but we do not expect the findings to materially change the forecast.

A-2d Primary Care Services

NHS Shropshire Clinical Commissioning Group

Key Messages:

Primary Care Delegated Commissioning

The CCG submitted a delegated commissioning expenditure plan that is £1.5m higher than the ring fenced allocation. However, the current forecast is reduced to £0.2m higher than allocation due to the non recurrent underspend projected of £1,331k.

At Month 10, the YTD underspend related to :

- Enhanced Services £478k (£333k regarding the PCN Pharmacy Posts, where recruitment has been slower than plan) the balance linked to Minor Surgery / Learning Dis
- Premises underspend of £479k (£361k Rates rebate,£59k Practice Closure).
- GP GMS savings of £154k, linked to PMS savings, offset by increased costs linked to list size recalculations as at Sep19/Dec19.
- Other GP Services £117k mainly P/Y Locum savings.
- G.P.APMS savings £109k related to the Practice closure.
- These overall savings have been partly offset by an overspend on Dispensing of £93k although this has reduced since last months forecast.

The forecast position reflects YTD savings regarding the full year impacts of the PCN Pharmacy Posts, and current year PMS noted above and also cost/savings relating to the closure of the Whitehall practice in Sept19.

Prescribing

The forecast position has improved by £151k since last month, with the cost pressure reflective of CATM price increases. The YTD position also includes the £250k benefit b/f from 18/19.

Primary Care Other

The main variances in this section are as follows:

- An overspend in Central Drugs which reflects the General Prescribing pattern,
- The Prescribing Incentives saving relates to the 18/19 scheme, (all payments have now been made).
- Savings in CHAS both current and forecast relating to the spend YTD that now reflects the new scheme in 19/20 that has generated savings against the old scheme.
- Underspend in P.C. Team relating to vacancies
- A forecast overspend in P.C IT which reflects an unexpected hardware commitment later in the year.

Primary Care Delegated Commissioning	Opening Budget 19/20	Annual Budget	M10 YTD Budget	M10 YTD Actual	M10 YTD Variance	Forecast Outturn	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
General Practice - GMS	29,237	28,692	23,910	23,756	(154)	28,526	(166)
General Practice - PMS	375	375	313	313	0	375	0
General Practice - APMS	1,216	1,216	1,013	904	(109)	1,060	(156)
Enhanced Services	1,782	2,368	1,901	1,423	(478)	1,819	(549)
QOF	4,439	4,439	2,589	2,605	16	4,456	17
Premises cost reimbursements	5,420	5,420	4,600	4,121	(479)	4,911	(509)
Dispensing	2,508	2,508	1,968	2,061	93	2,662	154
Other - GP Services	1,071	1,071	898	782	(116)	949	(122)
Net Reserves	56	15	12	0	(12)	15	0
Co Commissioning Total	**46,104**	**46,104**	**37,204**	**35,965**	**(1,239)**	**44,773**	**(1,331)**

Other Primary Care Commissioning							
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Prescribing	49,603	48,859	40,671	41,134	463	49,839	980
Out Of Hours	3,150	3,150	2,625	2,625	0	3,150	0
Enhanced Services	2,696	5,640	4,466	4,466	0	5,590	(50)
Primary Care Other							
- Central Drugs	1,257	1,257	1,047	1,131	84	1,349	92
- Oxygen	605	605	504	499	(5)	589	(16)
- Primary Care Comm Schemes	1,414	54	45	45	0	54	0
- Hospice Drugs	75	75	62	61	(1)	75	0
- Prescribing Incentives	315	315	263	208	(55)	260	(55)
- Care Home Advanced Scheme	230	230	192	167	(25)	200	(30)
- Primary Care Team	1,935	2,039	1,680	1,508	(172)	1,885	(154)
- Primary Care IT	978	1,235	966	966	0	1,372	137
- Primary Care Reserves	242	0	0	0	0	0	0
Primary Care Other Total	**7,051**	**5,810**	**4,759**	**4,585**	**(174)**	**5,784**	**(26)**
Total Other P.C.Commissioning	**62,500**	**63,459**	**52,521**	**52,810**	**289**	**64,363**	**904**
GRAND TOTAL	**108,604**	**109,563**	**89,725**	**88,775**	**(951)**	**109,136**	**(427)**

A-3 Other

NHS Shropshire Clinical Commissioning Group

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000
Patient Transport	3,301	3,130	(171)	2,751	2,543	(208)
NHS 111	1,173	1,236	63	970	1,005	35
Referral Assessment Service Team	423	385	(38)	352	325	(27)
Community & Care Co-ordinators	370	370	0	308	308	0
NHS Property Services	225	196	(29)	187	163	(24)
Better Care Fund	7,779	7,779	0	6,483	6,483	0
Reablement	524	525	1	436	469	33
Cost of Change	0	0	0	0	0	0
Other	211	158	(53)	176	122	(53)
Commissioning Reserve	3,271	1,447	(1,824)	1,200	0	(1,200)
0.5% Contingency	2,104	0	(2,104)	0	0	0
Other Total	**19,381**	**15,226**	**(4,155)**	**12,863**	**11,419**	**(1,444)**

Key Messages

- The overall position on 'other' is a £1.4m underspend year to date and a forecast underspend of £4.2m. This underspend position is due to the release of £2.1m contingency and other reserves in Month 12.
- The underspend on Patient Transport reflects reduced activity levels against the budgeted level, following robust activity validation checks and appropriate recharges to other NHS bodies.

A-4 Running Cost Allowance

NHS Shropshire Clinical Commissioning Group

Key Messages

- The CCG has a separate allocation for the running costs of the organisation (non clinical posts/support), which equates to £6.6m.
- At Month 10 running costs are underspent Year to Date by £55k due to non recurrent Pay and Non-pay savings.
- The forecast position is overspent by £449k due to 'Single Organisation' costs which are forecast to hit the latter part of the year, offset by savings due to grip and control actions, i.e. a reduction in non-discretionary spend as a result of the implementation of the expenditure controls.
- For 2020/21 the CCG will have a much lower running cost budget of £5,835k and we are working on plans with Telford and Wrekin CCG in order to address this reduction.

	2019/20 Budget £'000	Forecast Outturn £'000	Forecast Variance £'000	Budget Year to Date £'000	Actual Year to Date £'000	Variance Year to Date £'000	Net Risk	Risk Adjusted Forecast Variance £'000
Corporate Costs	3,692	3,772	80	3,076	3,093	17	0	80
Service Planning	767	842	75	639	707	68	0	75
Commissioning & Contracting	777	593	(184)	647	494	(153)	0	(184)
Strategy & Service Redesign	395	372	(23)	329	311	(18)	0	(23)
Finance	1,098	1,020	(78)	971	894	(77)	0	(78)
Governance	200	193	(7)	167	160	(7)	0	(7)
Nursing & Quality	149	162	13	124	129	5	0	13
Corporate Reserves	93	225	132	(73)	0	73	0	132
Cost of Change	0	441	441	0	0		0	441
Running Costs QIPP	(225)	(225)	0	(38)	0	38	0	0
Running Cost Total	**6,946**	**7,395**	**449**	**5,844**	**5,788**	**(55)**	**0**	**449**

Cost of Agency/Interim Staff	Forecast Outturn £'000	%	Actual Year to Date £'000	%
Programme Costs	629	69%	551	69%
Running Costs	280	31%	248	31%
Total	909		798	

There are 9 interim staff in post as at month 10. The forecast outturn assumes this will reduce to 6 from 01.03.20: 2 re Commissioning and 4 re CHC.

A-5 Better Care Fund (BCF)

NHS Shropshire Clinical Commissioning Group

Summary Statement	Annual Budget £	Year to Date Budget £	Year to Date Expenditure £	Year to Date Variance £	Year end Forecast Expenditure £	Year end Forecast Variance £
Prevention Programme						
Care Navigation / Co Ordination	1,185,828	988,190	993,073	4,883	1,185,828	-
Total Prevention Programme	**1,185,828**	**988,190**	**993,073**	**4,883**	**1,185,828**	-
Admissions Avoidance						
Assistive Technologies	1,613,090	1,344,242	1,344,242	-	1,613,090	-
Care Navigation / Co Ordination	649,175	540,979	540,979	-	649,175	-
Enablers for Intergration	3,666,234	3,055,195	3,055,195	-	3,666,234	-
Healthcare services to Care Homess	230,000	191,667	166,667	- 25,000	200,000	- 30,000
Intermediate Care Services	3,171,187	2,642,656	2,715,383	72,727	3,201,187	30,000
Personailised Healthcare at Home	331,501	276,251	221,467	- 54,784	331,501	-
Total Admissions Avoidance	**9,661,187**	**8,050,989**	**8,043,933**	**- 7,056**	**9,661,187**	-
Early Supportive Discharge						
Integrated Care Plannning	2,992,005	2,493,338	2,493,338	-	2,992,005	-
Total Early Supportive Discharge	**2,992,005**	**2,493,338**	**2,493,338**	**-**	**2,992,005**	-
Other						
SCCG funded LA expenditure	7,779,300	6,482,750	6,482,750	-	7,779,300	-
LA Funding expenditure	9,235,247	7,696,039	7,696,039	-	9,235,247	-
i BCF	10,120,779	8,433,983	8,433,983	-	10,120,779	-
Total Early Supportive Discharge	**27,135,326**	**22,612,772**	**22,612,772**	**-**	**27,135,326**	**-**
Grand Total:	**40,974,346**	**34,145,288**	**34,143,115**	**(2,173)**	**40,974,346**	**-**

Funding Breakdown:	£
CCG Funded - Minimum	13,839,020
LA Funded via CCG	7,779,300
	21,618,320
Additional LA Funding, seperately allocated to the funds above	
LA Contribution	9,235,247
i BCF	10,120,779
	19,356,026
Total Joint CCG / LA Fund	40,974,346

Note

The budget figures are in line with 19/20 Joint SCCG/Local Authority BCF Template Submitted in September 19 to NHSE.

It is currently considered that the allocation will be spent in full and the forecast position reflects this.

A-6 QIPP Position

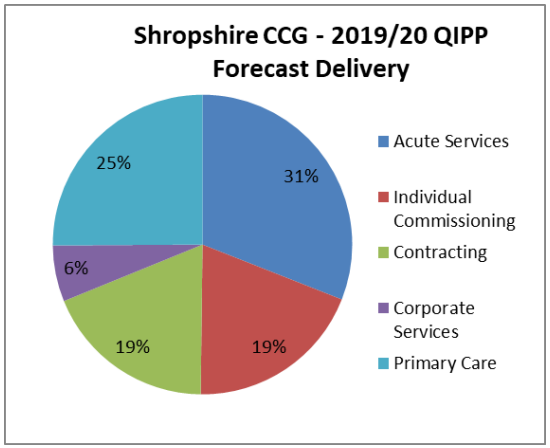
NHS Shropshire Clinical Commissioning Group

	2019/20 Plan			Month 10 YTD				Forecast					
QIPP Position M10	**Gross**	**Investment**	**Net**	**Plan**	**Actual**	**Variance**		**Forecast**	**Variance from Plan**	**%Variance from Plan**	**Risk**	**Mitigation**	**Adjusted Net Risk**
Category of Spend	£000's	£000's	£000's	£000's	£000's	£000's	% Achieved	£000's	£000's	%			
Acute Services	10,959	1,773	9,186	7,384	3,024	-4,360	41%	5,048	-4,138	55%	790		4,258
Individual Commissioning	2,871	87	2,784	2,259	2,318	59	103%	3,023	239	109%	200	200	3,023
Contracting	3,138	0	3,138	2,615	2,615	0	100%	3,138	0	100%			3,138
Corporate Services	1,000	0	1,000	832	501	-331	60%	1,018	18	102%			1,018
Primary Care	4,397	691	3,706	3,059	3,738	679	122%	4,151	445	112%			4,151
Total	**22,365**	**2,550**	**19,815**	**16,150**	**12,197**	**-3,953**	**76%**	**16,378**	**-3,436**	**83%**	**990**	**200**	**15,588**

The information above details the 2019/20 QIPP Plan and position as at Month 10. The CCG is forecasting to deliver £16.4m of QIPP against a target of £19.8m (83%).

Key messages

- QIPP is forecast to deliver **£16.4m** by the end of the year which is -**£3.4m** below plan
- There is a further risk of £1m set against the forecast delivery together with a mitigation of £0.2m which brings an adjusted net Risk position **of £15.6m**
- This represents a similar forecast position to Month 9.
- The main risk of delivery sits within the Care Closer to Home Programme and CHC Schemes.
- Regular meetings continue to be held led by Executive leads to provide scrutiny and Challenge
- Milestones and KPI's are being monitored by the PMO to ensure issues are escalated to the QIPP Programme Board



A- 7 Allocations

NHS Shropshire Clinical Commissioning Group

The CCG allocations at Month 10 are shown below:

	Recurrent £000	Non Recurrent £000	Total £000
Cumulative Allocations to Month 9	466,654	7,031	473,685
Month 10 allocation adjustments:			
Mental Health Winter Funds		100	100
FTA payments 19/20 in year Q1&2		113	113
HSCN CCG Corporate Connections costs		9	9
Primary Care HSCN transitional relief for move to fair share allocations in 2019/20		23	23
Digital Transformation - DFPC		800	800
Safeguarding - Programmes for STP/ICS		10	10
Safeguarding - Training		6	6
LD Accelerated Discharge Support		7	7
CYP Green Paper MHST Wave 2 commencing 19/20		51	51
Winter Pressure Volunteering Programme - SHREWSBURY AND TELFORD HOSPITAL NHS TRUST		25	25
HSCN migration support funding		29	29
6.3% pension uplift 1920		336	336
Total In-Year Resources 2019/20	466,654	8,540	475,194
Return of Cumulative Deficit		(76,726)	(76,726)
Total Cumulative Resources 2019/20	466,654	(68,186)	398,468

Appendix B-3 provides further detail of the allocations received in year.

A-8 Statement of Financial Position

NHS Shropshire Clinical Commissioning Group

The table below illustrates the CCGs Statement of Financial Position or Balance Sheet at month 10.

	DEC-19	JAN-20	Movement
PPE	0	0	0
Accumulated Depreciation	0	0	0
Net PPE	0	0	0
Intangible Assets	0	0	0
Intangible Assets Depreciation	0	0	0
Net Intangible Assets	0	0	0
Investment Property	0	0	0
Non-Current Assets Held for Sale	0	0	0
Non-Current Financial Assets	0	0	0
Other Receivables Non-Current	0	0	0
Total Other Non-Current Assets	0	0	0
Non-Current Assets	0	0	0
Cash	48,674	189,607	140,933
Accounts Receivable	3,545,945	2,912,342	(633,603)
Inventory	0	0	0
Investments	0	0	0
Other Current Assets	3,594,619	3,101,949	(492,670)
Current Assets	3,594,619	3,101,949	(492,670)
TOTAL ASSETS	3,594,619	3,101,949	(492,670)
Accounts Payable	43,551,399	46,235,605	2,684,206
Accrued Liabilities	211,143	211,143	0
Short Term Borrowing	0	0	0
Current Liabilities	43,762,541	46,446,748	2,684,207
Non-Current Payables	0	0	0
Non-Current Borrowing	0	0	0
Other Liabilities	0	0	0
Long Term Liabilities	0	0	0
General Fund	0	0	0
Share Capital	0	0	0
Revaluation Reserve	0	0	0
Donated Assets Reserve	0	0	0
Government Grants Reserve	0	0	0
Other Reserves	0	0	0
Retained Earnings incl. In Year	(40,167,923)	(43,344,799)	(3,176,876)
Total Taxpayers Equity	(40,167,923)	(43,344,799)	(3,176,876)
TOTAL EQUITY + LIABILITIES	3,594,619	3,101,949	(492,670)

A-9 Annual Accounts Process

NHS
Shropshire
Clinical Commissioning Group

- As part of the accounts process each governing body member must:

- Declare that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

- Accept that the CCG is operating as a going concern.

- Accept that disclosures around pensions and salaries will occur for each governing board member.

Appendix B-1
Shropshire CCG
2019/20 Financial Summary Position as at Month 10

	2019/20			2019/20			2019/20	
	Recurrent Budget	Non Recurrent Budget	Annual Budget	Budget Year to Date - month 10	Actual Year to Date - month 10	Variance Year to Date - month 10	Forecast Outturn	Outturn Variance
	£000	£000	£000	£000	£000	£000	£000	£000
RESOURCES								
Programme Allocation	415,129	8,540	423,669	348,630	348,630	0	423,669	0
Deficit Brought Forward		(76,726)	(76,726)	(63,938)	(63,938)	0	(76,726)	0
Co-Commissioning Allocation	44,570		44,570	35,735	35,735	0	44,570	0
Running Costs Allocation	6,955		6,955	5,844	5,844	0	6,955	0
Total resource limit	**466,654**	**(68,186)**	**398,468**	**326,271**	**326,271**	**0**	**398,468**	**0**
EXPENDITURE								
Acute Services								
Shrewsbury and Telford Hospitals NHS Trust	147,576		147,576	123,275	132,732	9,457	159,708	12,132
Robert Jones and Agnes Hunt FT	32,673		32,673	27,047	27,896	848	33,679	1,006
West Midlands Ambulance Service Contract	14,616		14,616	12,201	12,596	396	15,187	571
Other Acute Contracts	29,562	1,721	31,283	25,384	27,171	1,787	33,402	2,119
Acute NCA's	3,741		3,741	3,121	3,724	604	4,500	759
Acute Special Placements	22		22	18	17	(1)	22	0
Winter Resilience	2,030		2,030	1,695	1,695	0	1,928	(102)
Future Fit	230		230	192	158	(34)	187	(43)
STP	175		175	146	251	106	398	223
Acute services - Other	168		168	147	157	9	189	21
High Cost Drugs	533		533	444	388	(56)	469	(64)
Acute Services Team	586	16	602	502	457	(44)	608	6
Acute Reserves	0		0	0	0	0	0	0
Acute Services Total	**231,912**	**1,737**	**233,649**	**194,171**	**207,242**	**13,071**	**250,277**	**16,628**
Community Health Services								
Shropshire Community Trust	40,553		40,553	33,794	34,069	275	40,857	304
Other Community Services	6,721	314	7,035	5,582	5,499	(83)	6,741	(294)
Palliative Care	2,312		2,312	1,926	2,154	227	2,622	310
Care closer to home reserve	0		0	0	0	0	0	0
Community Health Services Total	**49,586**	**314**	**49,900**	**41,302**	**41,722**	**420**	**50,220**	**320**
Individual Commissioning								
Complex Care	26,360	0	26,360	21,966	29,811	7,845	36,245	9,885
Funded Nursing Care	7,939	0	7,939	6,616	5,521	(1,095)	6,489	(1,450)
Complex Care Team	1,133	0	1,133	944	1,014	70	1,227	94
Continuing Care Reserves	0	0	0	0	0	0	0	0
Individual Commissioning Total	**35,432**	**0**	**35,432**	**29,527**	**36,347**	**6,820**	**43,961**	**8,529**
Mental Health Services								
Midland Partnership FT	33,314	91	33,405	27,761	28,259	497	34,001	596
Other NHS Mental Health Contracts	(424)	0	(424)	(353)	(476)	(123)	(568)	(144)
Mental Health NCA's	1,253	0	1,253	1,044	911	(133)	1,093	(160)
Mental Health - Other	1,814	536	2,350	1,875	1,846	(28)	2,371	21
Mental Health - TCP	(1)	0	(1)	(0)	0	0	0	1
S117 Placements	6,595	0	6,595	5,496	7,966	2,470	9,381	2,786
Mental Health Reserves	0	0	0	0	0	0	0	0
Mental Health Services Total	**42,551**	**627**	**43,178**	**35,823**	**38,506**	**2,684**	**46,278**	**3,100**
Primary Care Services								
Prescribing	48,824	35	48,859	40,671	41,134	463	49,839	980
Central Drugs	1,257	0	1,257	1,047	1,131	84	1,349	92
Oxygen	605	0	605	504	499	(5)	589	(16)
Enhanced Services	2,763	2,877	5,640	4,466	4,466	(0)	5,590	(50)
Out Of Hours	3,150	0	3,150	2,625	2,625	0	3,150	0
Primary Care Commissioning Schemes (Dermatology)	54	0	54	45	45	0	54	0
Hospice Drugs	75	0	75	62	61	(2)	75	0
Prescribing Incentives	315	0	315	263	207	(55)	260	(55)
Care Home Advanced Scheme	230	0	230	192	167	(25)	200	(30)
Primary Care Team	1,986	53	2,039	1,680	1,508	(171)	1,885	(154)
Primary Care IT	1,157	78	1,235	966	966	(0)	1,372	137
Primary Care Reserves	0	0	0	0	0	0	0	0
Primary Care Services Total	**60,416**	**3,043**	**63,459**	**52,521**	**52,810**	**289**	**64,363**	**904**
Other								
Patient Transport	3,301	0	3,301	2,751	2,543	(208)	3,130	(171)
NHS 111	1,173	0	1,173	970	1,005	35	1,236	63
Referral Assessment Service Team	423	0	423	352	325	(27)	385	(38)
Community & Care Co-ordinators	370	0	370	308	308	0	370	0
NHS Property Services	225	0	225	187	163	(24)	196	(29)
Better Care Fund	7,779	0	7,779	6,483	6,483	0	7,779	0
Reablement	524	0	524	436	469	33	525	1
Cost of Change	0	0	0	0	0	0	0	0
Other	211	0	211	176	122	(53)	158	(53)
Other Total	**14,006**	**0**	**14,006**	**11,664**	**11,419**	**(245)**	**13,779**	**(227)**
Reserves								
Commissioning Reserve	668	2,603	3,271	1,200	0	(1,200)	1,447	(1,824)
0.5% Contingency	2,104	0	2,104	0	0	0	0	(2,104)
Reserves Total	**2,772**	**2,603**	**5,375**	**1,200**	**0**	**(1,200)**	**1,447**	**(3,928)**
Running Costs								
Corporate Costs	3,692	0	3,692	3,076	3,093	17	3,772	80
Service Planning	767	0	767	639	707	68	842	75
Commissioning & Contracting	777	0	777	647	494	(153)	593	(184)
Strategy & Service Redesign	395	0	395	329	311	(18)	372	(23)
Finance	762	336	1,098	971	894	(77)	1,020	(78)
Governance	200	0	200	167	160	(7)	193	(7)
Nursing & Quality	149	0	149	124	129	5	162	13
Cost of Change	0	0	0	0	0	0	405	405
Corporate Reserves	**(132)**	**0**	**(132)**	**(110)**	**0**	**110**	**0**	**132**
Running Cost Total	6,610	336	6,946	5,844	5,788	(55)	7,359	413
Co-Commissioning	45,873	0	45,873	37,012	35,965	(1,047)	44,758	(1,115)
Co-Commissioning Reserves	**231**	**0**	**231**	**192**	**0**	**(192)**	**15**	**(216)**
Co Commissioning Total	46,104	0	46,104	37,204	35,965	(1,239)	44,773	(1,331)
Total Expenditure	**489,389**	**8,660**	**498,049**	**409,254**	**429,799**	**20,545**	**522,457**	**24,408**
Budget (Surplus)/Deficit	22,735	76,846	99,581	82,983	103,528	20,545	123,989	24,408
	22,735	76,846	99,581	82,983	103,528	20,545	123,989	24,408
Total Resource Limit	**466,654**	**(68,186)**	**398,468**	**326,271**	**326,271**	**0**	**398,468**	**0**
Total Expenditure	**489,389**	**8,660**	**498,049**	**409,254**	**429,799**	**20,545**	**522,457**	**24,408**
Budget (Surplus)/Deficit	22,735	76,846	99,581	82,983	103,528	20,545	123,989	24,408
Deficit Brought Forward			**(76,726)**	**(63,938)**	**(63,938)**		**(76,726)**	**0**
In Year (Surplus)/Deficit			22855	19045.03267	39589.78848	20544.75581	47263	24408

Appendix B-2
Shropshire CCG
2019/20 QIPP Month 10

QIPP Month 10 Position

		Plan			Month 10 YTD			Forecast M10		Risk			M9 Forecast			
Budget Area	QIPP Scheme	Gross Savings	Investment	Net Savings	M10 YTD Plan	M10 YTD Actual	M10 Variance	Forecast Delivery M10	Variance from Plan M10	Risk	Mitigation	Risk Adjusted Position	Forecast Delivery M9	Risk	Mitigation	Net Risk
Acute Services	Additional VBC	250	0	250	208	415	206	415	165			415	415			
	Autism and Aspergers Provision	20	0	20	10	0	-10	0	-20			0	0			
	Category 1 PLCV Activity	35	0	35	29	38	9	41	6			41	37			
	COPD Admissions	656	0	656	510	0	-510	0	-656			0	0			
	Dermatology Commissioning Options	42	0	42	35	35	0	42	0			42	42			
	Ex-Tel (Investment)		133	-133	-103	0	103	0	133			0	0			
	Ex-Tel (SaTH)	764	0	764	594	0	-594	0	-764			0	0			
	Fracture Liasion Service	115	220	-105	-88	-40	47	-75	30			-75	-17			
	Frailty front door	420	420	0	0	150	150	150	150			150	0			
	Heart Failure	374	0	374	291	64	-227	128	-247			128	128			
	HISU	120	0	120	93	14	-79	120	0	40		80	120	40		
	Home Oxygen Assessment and Review Service	51	0	51	40	24	-16	35	-16			35	40			
	MSK Service Redesign EL other	232	0	232	194	97	-97	136	-97			136	136			
	MSK Service Redesign DC Other	44	0	44	36	18	-18	26	-18			26	26			
	MSK Service Redesign DC RJAH	305	0	305	254	25	-228	25	-279			25	25			
	MSK Service Redesign DC SaTH	94	0	94	78	47	-31	47	-47			47	47			
	MSK Service Redesign EL RJAH	2,043	0	2,043	1,702	1,120	-582	1,529	-514			1,529	1,529			
	MSK Service Redesign EL SaTH	255	0	255	213	104	-109	104	-152			104	104			
	MSK Service Redesign OPFA RJAH	98	0	98	82	15	-66	30	-68			30	1			
	MSK Service Redesign OPFU RJAH	22	0	22	18	66	47	91	69			91	50			
	RTT Relaxed Target	770	0	770	640	642	2	770	0			770	770			
	SCHT (Contract 1) inc APCS	350	0	350	292	105	-187	175	-175			175	175			
	Shropshire Care Closer to Home (Admissions Avoidance)	2,900	0	2,900	2,256	0	-2,256	500	-2,400	350		150	500	250		
	Shropshire Care Closer to Home (Demonstrator Sites)	1,000	0	1,000	778	0	-778	654	-346	400		254	654	500		
	Shropshire Care Closer to Home (Investment)	0	1,000	-1,000	-778	-24	754	-27	973			-27	-27			
	Commissioning Stretch	0	0	0	0	0	0	0	0			0	0			
	Big 6 Paediatrics	0	0	0	0	70	0	73	73			73	75			
	Dermatolgoy APCS	0	0	0		40	40	61	61			61	61			
	Total	10,959	1,773	9,186	7,384	3,024	-4,430	5,048	-4,138	790	0	4,258	4,890	790	0	0
Individual Commissioning	CHC AQP	329	0	329	263	0	-263	0	-329			-200	0			
	CHC Stretch Target	1,000		1,000	800	0	-800	0	-1,000			0	23			
	Childrens Placements	500	0	500	400	205	-195	500	0	200	200	500	500		200	
	Collaborative Commissioning	300	0	300	250	0	-250	0	-300			0	0			
	Review Programme	452	0	452	377	1,530	1,154	1,793	1,341			1,793	1,645			
	Mental Health Out of Area (Commissioning / Cygnet)	290	87	203	169	582	413	730	527			930	866			
		2,871	87	2,784	2,259	2,318	59	3,023	239	200	200	3,023	3,034	0	200	0
Contracting Services	Mental Health Rebasing of the Contract	600	0	600	500	500	0	600	0			600	600			
	OOH Service	757	0	757	631	631	0	757	0			757	757			
	RJAH Contract	852	0	852	710	710	0	852	0			852	852			
	SaTH Contract	623	0	623	519	519	0	623	0			623	623			
	SCHT (Contract 2)	306	0	306	255	255	0	306	0			306	306			
	Total	3,138	0	3,138	2,615	2,615	0	3,138	0	0	0	3,138	3,138	0	0	0
Corporate	Running Costs Review in year	225	0	225	187	243	56	243	18			243	244			
	Running Costs Review towards 20%	775	0	775	645	258	-387	775	0			775	775			
		1,000	0	1,000	832	501	-331	1,018	18	0	0	1,018	1,019	0	0	0
Primary Care Services	Appliances (Stoma)	40	22	18	15	39	24	40	22			40	36			
	Appliances (Wound)	180	0	180	150	0	-150	20	-160			20	40	40		
	Biosimilars (RJAH)	431	0	431	359	307	-52	350	-81			350	350			
	Biosimilars (SaTH)	386	0	386	322	637	315	720	334			720	720			
	Biosimilars (Other)					38	38	38	38			38	31			
	Biosimilars (Credits)					15	15	15	15			15	28			
	Care Home Prescribing	440	24	416	347	399	52	416	0			416	416			
	Co-Commissioning Efficiences	216	0	216	180	180	0	216	0			216	216			
	Diabetes	150	47	103	86	88	3	103	0			103	103			
	DOLVs	100		100	83	111	27	120	20			120	120			
	Drug Switches	300		300	250	296	46	300	0			300	300			
	Prescribing Stretch Target	133	0	133	111	0	-111	0	-133			0	0			
	Prescription Ordering Direct (POD)	1,030	578	452	377	904	527	982	530			982	982			
	Respiratory	220	20	200	167	144	-22	200	0			200	200			
	Scriptswitch	500	0	500	417	569	152	600	100			600	600			
	Self-Care (OTC)	100		100	80	10	-70	30	-70			30	80			
	Self-Care (OTC) NHSE Stretch	170	0	170	116	0	-116	0	-170			0	0			
	Total	4,397	691	3,706	3,059	3,738	679	4,151	445	0		4,151	4,222	40	0	0
Grand Total		22,365	2,550	19,815	16,150	12,197	-4,022	16,378	-3,436	990	200	15,588	16,303	830	200	15,673

Appendix B-3
Shropshire CCG
Allocations 2019/20

Full list of current allocations and adjustments at Month 10

	Month	Programme		Admin		Delegated Co-Commissioning		Total		
		R	NR	R	NR	R	NR	R	NR	Total
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Baseline Allocation M01	1	415,448		6,610		44,570		**466,628**	**0**	**466,628**
Return of Cummulative Deficit	2		-76,726					**0**	**-76,726**	**-76,726**
Month 12 IR changes	3	16						**16**	**0**	**16**
Excess Treatment Costs	3		-19					**0**	**-19**	**-19**
Community transformation TCP 19/20 funding	3		32					**0**	**32**	**32**
IPS Wave 1 (Year 2) Transformation funding (Q1 & Q2)	3		145					**0**	**145**	**145**
GPFV - GP Retention - STP Funding	3		108					**0**	**108**	**108**
GPFV - Practice Resilience - STP Funding	3		68					**0**	**68**	**68**
GPFV - Reception & Clerical - STP Funding	3		84					**0**	**84**	**84**
GPFV - Online Consultation - STP Funding	3		136					**0**	**136**	**136**
GPFV - Primary Care Networks - STP Funding	3		374					**0**	**374**	**374**
Improving Access Allocations 19/20 from National Programme	3		1,807					**0**	**1,807**	**1,807**
MOCH 2019 Q1 and Q2	3		35					**0**	**35**	**35**
Phase 2 - Cancer Alliance Funding	3		213					**0**	**213**	**213**
2019/20 IR - PELs Changes	3	15						**15**	**0**	**15**
19/20 upfront FTA proposal - Shropshire TCP	4		1,260					**0**	**1,260**	**1,260**
Offender Health secondary care allocation - 1st tranche	4		78					**0**	**78**	**78**
GPFV - STP Funding - Workforce Training Hubs	4		85					**0**	**85**	**85**
GPFV - STP Funding - Fellowships Core Offer	4		77					**0**	**77**	**77**
GPFV - STP Funding - Fellowships Aspiring Leaders	4		98					**0**	**98**	**98**
2019/20 Armed Forces CCG OOH allocation	5		23					**0**	**23**	**23**
Q1 West Midlands Cancer Alliance Allocation	6		120					**0**	**120**	**120**
Q2 West Midlands Cancer Alliance Allocation	7		120					**0**	**120**	**120**
IPS Wave 1 transformation funding	7		73					**0**	**73**	**73**
Enhanced GP IT infrastructure and resilience arrangements	7		78					**0**	**78**	**78**
IR Exercise	7	-3						**-3**	**0**	**-3**
Transfer of TCP funds to Telford CCG	8		-1,080					**0**	**-1,080**	**-1,080**
Transfer of Early Discharge funds to Telford CCG	8		-32					**0**	**-32**	**-32**
Cancer Alliance Q3	8		120					**0**	**120**	**120**
Charge Exempt Overseas Visitor (CEOV) Adjustments	8		871					**0**	**871**	**871**
UEC FUNDING	8		194					**0**	**194**	**194**
Winter Funding	8		773					**0**	**773**	**773**
Q2 Flash Glucose sensor reimbursement	9		35					**0**	**35**	**35**
National Diabetes Prevention Programme - 2nd payment	9		20					**0**	**20**	**20**
Learning Disability Mortality Review Programme (LeDeR)	9		15					**0**	**15**	**15**
Additional Winter Elective funding - Urology at SaTH	9		100					**0**	**100**	**100**
Additional Winter Elective funding - General surgery at SaTH	9		200					**0**	**200**	**200**
Additional Winter Elective funding - Oral at SaTH	9		75					**0**	**75**	**75**
Pharmacy Integration MOCH Q3 payment	9		18					**0**	**18**	**18**
IPS Wave 1 Transformational Funding Q4	9		72					**0**	**72**	**72**
TCP LD transformation funding	9		260					**0**	**260**	**260**
IR Changes	9	-2						**-2**	**0**	**-2**
Mental Health Winter Funds	10		100					**0**	**100**	**100**
FTA payments 19/20 in year Q1&2	10		113					**0**	**113**	**113**
HSCN CCG Corporate Connections costs	10		9					**0**	**9**	**9**
Primary Care HSCN transitional relief for move to fair share allocations in 2019/20	10		23					**0**	**23**	**23**
Digital Transformation - DFPC	10		800					**0**	**800**	**800**
Safeguarding - Programmes for STP/ICS	10		10					**0**	**10**	**10**
Safeguarding - Training	10		6					**0**	**6**	**6**
LD Accelerated Discharge Support	10		7					**0**	**7**	**7**
CYP Green Paper MHST Wave 2 commencing 19/20	10		51					**0**	**51**	**51**
Winter Pressure Volunteering Programme - SHREWSBURY AND TELFORD HOSPITAL NHS T	10		25					**0**	**25**	**25**
HSCN migration support funding	10		29					**0**	**29**	**29**
6.3% pension uplift 1920	10		336					**0**	**336**	**336**
		415,474	**(68,186)**	**6,610**	**0**	**44,570**	**0**	**466,654**	**(68,186)**	**398,468**

Appendix B-4
Category Run Rate Analysis

	M10 YTD Variance from plan	FOT variance from plan on straight line basis	Current FOT variance at Month 10	Difference in FOT	Main reasons for difference
	£'000	£'000	£'000	£'000	
Acute	13,071	15,685	16,628	943	The main drivers of this variance are as follows Sath - £0.7m - This is driven by the phasing of the plan (back ended for emergency activity for winter), £0.4m is also related to phasing of YE deal. WMAS - £0.1m - We are expecting increased activity in Q4 in terms of conveyances as well as in an increase in handover charges.
Community	420	504	320	(184)	Key areas: IPMS and CHEC prior year costs totalling reduce run rate by £290k; Hospice costs up to January only thereby reducing run rate var by £70k, APCS Derm from SCHT contract ceased service so run rate reduces by £30k; Continence credits from CHC £33k reduce run rate; Admission Avoidance costs from January less prev CCTH FOT increased run rate £187k
Individual Commissioning	6,820	8,184	8,529	345	Forecast based on known info on packages of care from Broadcare and includes assumption around QIPP delivery in latter part of year. Significant prior year impact included in YTD position.
Mental Health	2,684	3,221	3,100	(121)	£179k favourable relates to Individual Commissioning; £59k adverse relates to costs to reduce children's ASD waiting times profiled later in the year
Primary Care	289	347	904	557	YTD position includes prior year Prescribing benefit, and also Primary Care Team savings reduce towards the final months of this year, plus additional P.C.IT costs expected in final months of year, re Forecast
Other	(1,444)	(1,733)	(4,155)	(2,422)	£2m contingency phased into M12, offset by £1.5m expenditure against reserves assumed in mth12. £1.2m reserves utilised in YTD position, (straight line utilisation would be £2.7m).
Running Costs	(55)	(66)	413	479	One organisation' costs built into latter part of year
Co Commissioning	(1,239)	(1,487)	(1,331)	156	YTD position, includes Prior year savings and also one off Rate rebate receipts.
TOTAL	**20,546**	**24,655**	**24,408**	**(247)**	

	M10 YTD Expenditure	FOT expenditure on straight line basis	Current 'most likely' FOT at Month 10	Difference in FOT	Main reasons for difference
	£'000	£'000	£'000	£'000	
Acute	207,242	248,690	250,277	1,587	The main drivers of this variance are as follows Sath - £0.5m - This is primarily driven by the phasing of the Emergency POD (£0.6m) RJAH - £0.2m - This is driven by the phasing of the contract as it is slightly back ended Other Acute Contracts £0.7m - The main driver of this is the Winter Funding held in reserve and not within the YTD actuals.
Community	41,722	50,066	50,220	154	Key areas: IPMS and CHEC prior year costs totalling reduce run rate by £290k; Hospice costs up to January only thereby reducing run rate var by £70k, APCS Derm from SCHT contract ceased service so run rate reduces by £30k; Continence credits from CHC £33k reduce run rate; Admission Avoidance costs from January less prev CCTH FOT increased run rate £187k
Individual Commissioning	36,347	43,616	43,961	345	Forecast based on known info on packages of care from Broadcare and includes assumption around QIPP delivery in latter part of year. Significant prior year impact included in YTD position.
Mental Health	38,506	46,207	46,278	71	£179k favourable relates to Individual Commissioning as above; £191k adverse relates to additional spend phased in latter months due to the commencement of new services funded by national transformation funding; also £59k Children's ASD waiting times as above.
Primary Care	52,810	63,372	64,363	991	YTD position includes prior year Prescribing benefit, and also Primary Care Team savings reduce towards the final months of this year, plus added P.C.IT costs increase in final two months, as per FOT position.
Other	11,419	13,703	15,226	1,523	£1.5m expenditure against reserves assumed in mth12
Running Costs	5,788	6,946	7,359	413	'One organisation' costs built into latter part of year
Co Commissioning	35,965	43,158	44,773	1,615	QOF payments built into latter part of year
TOTAL	**429,799**	**515,759**	**522,457**	**6,698**	

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.032
Shropshire CCG Governing Body meeting: 11.03.2020

Title of the report:	Governing Body SCCG Performance & Quality Report 2019/20
Responsible Director:	Julie Davies, Director of Performance Chris Morris, Chief Nurse
Author of the report:	Charles Millar, Head of Planning, Performance and Contracting Joe Allan, Head of Quality
Presenter:	Julie Davies, Director of Performance

Purpose of the report:

To update the governing body on the CCGs key quality and performance matters for 2019/20 against the key performance & quality indicators that the CCG is held accountable for with NHS England. This overview provides assurance on performance achievement against targets/standards at CCG, the quality of our commissioned services at provider level as appropriate, and the delivery and contractual actions in place to address areas of poor performance & quality.

Key issues or points to note:

The attached report is our integrated quality and performance reporting for the CCG and sets out Shropshire CCG's performance against all its key performance & quality indicators for Month 9 and 10 where available for 2019/20.

They key standards that were not met YTD for SCCG are :-
62 day RTT
2wk wait (Breast)
2wk wait from GP referral
31 day where subsequent treatment is surgery
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT
Diagnostic waits
52wk waits.

The 2wk Breast Symptoms was achieved in December the first time this year and is a direct result of the successful delivery of the improvement plans. Both 2wk targets are now expected to be met for the year end. The 62day RTT is still not achieving and the overall trajectory for the recovery of 85% 62day RTT target submitted to NHSE/I is

based on the ongoing impact of Urology. Ongoing clearing of the backlog will keep this measure below target for the foreseeable future. Further improvement remains dependent on the wider joint working with UHNM and the region on Urology. The overall position on cancer is improving and the improvements linked to cancer alliance work and optimized pathways is now having a positive impact on the cancer care delivered in Shropshire. Bi -weekly calls remain in place with NHSE to also monitor delivery against these plans and provide support as required. The CCGs overall cancer performance is also affected by out of county providers and this is continually progressed through the corresponding lead commissioners via our contract team with support as required from NHSI & NHSE.

The increased IAPT access target run rate of 22% in place for 2019/20 has slipped in Nov and December and the mental trust has been asked to investigate the variation in the delivery of this target and to improve its consistency for the remainder of the year. Following the themed review of serious incidents presented by MPFT at the December CQRM and the further statistical analysis undertaken including triangulation with the related issues in Staffordshire it was agreed at January 2020 that recent levels are not statistically significant to previous year's levels.

A&E performance has remained in the mid sixties since September. Demand for Shropshire remains above plan YTD and ambulance conveyances are still increasing locally at a faster rate than elsewhere in the region. However demand in January was below plan for the first time this year. The dedicated ambulance working group has now been re-established to focus specifically on reducing conveyances and ambulance handover delays. Workforce levels and increases in demand are the main issues although middle grade workforce is showing some signs of improvement but slowly and not in time to have a material impact during winter. There continued to be a significant increase in 12hr trolley waits in December and January but the level has reduced in February. These are being reported up through NHSE/I and the harm pro-formas are being received. In addition desk top reviews of patient records have been introduced to assess any delayed harm experienced during their hospital stay as a result of extended trolley waits. The Quality team continues to make daily visits to both sites while they are at heightened escalation levels to ensure care of patients on trolleys is being maintained at the highest levels. A separate paper is on the agenda for the governing body which covers the findings of the recent CQC unannounced visit and resulting risk summit.

Both > 1hr and >30mins ambulance handover delays peaked in December and have come back down in January. This as described above will be one of the priorities to improve as part of the local ambulance working group.

The CCG has continued to fail the RTT target YTD as a result of emergency pressures at SaTH and ongoing escalation into both sites Day Surgery Units. In addition the non admitted performance is now being impacted by the reduction in waiting list clinics being delivered due to the consultant pension tax issue. An options papers is currently being prepared by SaTH for the recovery of 18wks and this will be considered by an extraordinary planned care working group in mid March to inform planning submissions for 20/21.

The CCG had its first over 52 wk waiter reported at the end of December at an out of area Trust in Hampshire. The patient was treated in January. This continues to be monitored weekly by the CCG for its patients across all providers to continue to minimize any >52 wk breaches.

The 99% Diagnostics wait target was also breached in November and December due to report issues within echocardiography and increases in demand generated from ED. Finally there have been positive improvements noted in patients experience in maternity services following recent CQC visits.
Actions required by Governing Body Members: The Governing Body is asked to NOTE the contents of the report and sought assurance from the CCG actions contained within it to ensure patients' safety and compliance with quality care.

Monitoring form
Agenda Item: GB-2020-03.032

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	~~Yes~~/ No
2	Health inequalities The action taken by the CCG to deliver all its constitutional targets will address any health inequalities currently present in the areas the performance targets are not being met.	Yes/ ~~No~~
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	~~Yes~~/ No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	~~Yes~~/ No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	~~Yes~~/ No
6	Risk to financial and clinical sustainability The CCG would fail to get its full Quality Premium Payment if it fails any of its key performance premium indicators.	Yes/ ~~No~~

GOVERNING BODY

PERFORMANCE AND QUALITY REPORT

February 2020

1 INTRODUCTION

1.1 This performance and quality report provides an overview of the key performance indicators (KPIs) that the CCG is held accountable for with NHS England during 2019/20. Many of these are part of the CCG's NHS Oversight Framework (NHS OF) for 2019/20.

1.2 The monthly data reported is for December 2019 and January 2020 where data is available.

1.3 Some of the CCG NHS Oversight Framework indicators have been updated where new data has been made available.

1.4 The oversight provides assurance on performance achievement against targets/standards at CCG level and the delivery of actions in place to mitigate.

1.5 The narrative includes details of the reasons for non-achievement of the standards and the actions in place to mitigate the risks.

1.6 Where key standards were not achieved in 2018/19, trajectories have been set as part of the Sustainability & Transformation Fund (STF), in the 2019/20 planning round. For Robert Jones & Agnes Hunt Hospital and Shrewsbury & Telford Hospital Trust, these included;

- A&E 4 Hour Wait
- 18 Weeks RTT Incompletes
- Cancer 62 days wait

2 EXECUTIVE SUMMARY –

Shropshire CCG	No of Indicators	GREEN		RED	
		Current Month	Previous Month	Current Month	Previous Month
Cancer	8	4	2	4	6
Elective Access	3	0	1	3	2
Urgent & Emergency Care	12	2	1	10	11
Mental Health	6	5	5	1	1
Learning Disability	2	n/a	n/a	n/a	n/a
Maternity	4	n/a	n/a	n/a	n/a
Dementia	1	1	1	0	0
Primary Medical Care and Elective Access	4	0	0	4	4
NHS Continuing Healthcare	2	1	2	1	0

3 CANCER

3.1 As at October 2019, performance for the cancer indicators is as follows:

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Cancer	Cancer Diagnosed at Early Stage - % of cancers diagnosed at Stage 1 & 2	2016	50.6% (CCG) 52.6% (England)		2017 49.2% (England 522%)												
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2017/18	83.5%	85%	71.4%	76.6%	73.2%	70.5%	68.5%	66.0%	75.2%	74.7%	79.4%				72.9%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2017/18	88.6%	90%	95.7%	76.5%	66.7%	100.0%	96.2%	90.0%	89.5%	72.7%	88.2%				87.8%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2018/19	87.5%	No National Standard	89.2%	84.9%	81.5%	83.0%	92.7%	85.7%	83.9%	84.1%	86.7%				85.6%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for suspected cancer	2017/18	93.0%	93%	81.8%	80.0%	82.2%	81.2%	86.4%	91.6%	93.0%	90.6%	92.0%				86.6%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2017/18	91.5%	93%	31.6%	12.7%	18.2%	14.7%	50.5%	80.9%	95.1%	89.5%	93.2%				47.8%
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2017/18	99.0%	96%	96.9%	97.6%	96.2%	97.2%	97.9%	96.0%	97.4%	94.7%	98.3%				96.9%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2017/18	97.3%	94%	100.0%	74.2%	95.6%	83.6%	87.9%	90.0%	92.5%	88.9%	87.0%				87.8%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is anti cancer drug regimen	2017/18	99.9%	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2017/18	99.3%	94%	100.0%	100.0%	100.0%	96.9%	98.0%	93.5%	98.4%	100.0%	98.1%				98.2%
	One-year survival for all cancer				2017 72.7% National 73.3%												
	Cancer patient experience of responses, which were positive to the question "Overall, how would you rate your care?"	2017	8.9 (CCG)		2018 8.8 (CCG)												

Cancer:	
Key Performance Headlines Risks and Issues	**Actions to Address**
Performance on 14 day Breast has achieved target for the second time this financial year 93.2% the 14 day urgent standard was not achieved 92% just falling short of achieving target (93%). 62 day wait performance also improved during the month to 79.4% which is the second highest level of achievement in the current year. Staffing capacity remains a concern for Urology, Haematology and ENT 31 day standards performance also declined for surgery in the last couple of months. For drug and radiotherapy treatment, the standards were achieved. The cancer dashboard also details 3 further indicators, which are all reported on an annual basis. The indicators are; diagnosis at early stage 1&2 which has fallen to 49.2% , one year survival which has increased to 72.7% and cancer patient experience which remains at 8.8. Baselines and the latest position are shown. The patient experience RAG rating is based on a survey where patients are rating their care (excellent or very good).	Cancer performance generally has improved in the last few months, notably in the 2 week wait standards as a result of additional capacity becoming available and process improvements Performance in a number of tumour sites including UGI has improved significantly. Improvement plans are in place for all tumour sites but problems still exist in Urology in relation to capacity and demand. The Urology position is impacting on the 62 day performance standard which is also being impacted by clearance of previous backlogs. Improvements continue to be seen in the percentage of patients offered an appointment within 7 days of referral and SaTH continue to work with ECIST on pathway improvements. As improvements begin to be seen in the 14 day and 31 day standards this will, in time, be expected to filter through to improvements in the 62 day standard performance. Two additional Lung consultants are now in post. As staffing levels improve, processes such as the 83 day review of long wait cases are being re-introduced.

	SaTH continues to work with the Cancer Alliance to implement improvements to meet the faster diagnosis standards for which prelim=nary shadow data shows encouraging performance levels.
Key Quality Risks and Issues	
12 104+ day breaches were reported in December 2019 across urology, head & neck, upper GI, colorectal, lung and breast. Causes of the delay in the main include patient choice, workforce and delayed diagnostics / pathways.	Harm proformas completed on each patient indicated no harm identified. A thematic review of cancer breaches was presented by cancer lead nurse to CQRM in December 2019 with a further update provided at CQRM in January 2020 which confirmed the majority of long waits are due to the consultant workforce capacity issues in Urology.

3.2 The performance at SaTH by tumour site for December 2019 is detailed below compared with the national average where possible. At tumour level, local numbers are small in comparison to national values and consequently more prone to the variability inherent with rates based on small numbers. Significant work is being progressed with the Cancer Alliance on tumour pathways for Lung, Breast, Upper GI and Colorectal as part of the move towards adoption of national optimal pathways.

Dec-19	2 week performance			62 day performance		
Tumour Site	SaTH	National	Comparison	SaTH	National	Comparison
Breast	91.2%	89.5%	Better	88.9%	91.2%	Worse
Childrens cancer	100.0%	94.3%	Better			
Gynaecological	93.0%	95.0%	Worse			
Haematological	94.4%	96.5%	Worse			
Head & Neck	97.3%	95.8%	Similar			
LGI	98.3%	86.6%	Better	78.6%	66.7%	Better
Lung	41.7%	95.2%	Worse	50.0%	68.0%	Worse
Skin	88.3%	93.8%	Worse	95.1%	92.6%	Better
Testicular	100%	97.3%	Better			
UGI	89.1%	91.4%	Worse			
Urological	98.4%	93.9%	Better	72.7%	75.0%	Worse

Empty cells indicate where data is not reported

4 MENTAL HEALTH

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG/SSSFT)	2018/19	16.4%	22%	1.5%	1.5%	1.8%	2.3%	1.70%	1.8%	1.9%	1.7%	1.5%				15.7%
	IAPT Recovery Rate (CCG/MPFT)	2018/19	53.8%	50%	57.9%	55.9%	50.6%	52.4%	52.3%	51.6%	51.1%	55.1%	50.4%				53.0%
	75% of people with relevant conditions to access talking therapies in 6 weeks (CCG/MPFT)	2018/19	95.4%	75%	95.9%	97.9%	95.6%	97.2%	99.5%	95.7%	94.3%	95.4%	96.2%				96.4%
	95% of people with relevant conditions to access talking therapies in 18 weeks (CCG/MPFT)	2018/19	98.8%	95%	100.0%	99.5%	98.3%	99.6%	100%	99.1%	99.1%	99.2%	98.7%				99.3%
	50% of people experiencing first episode of psychosis to access treatment within 2 weeks	2018/19		56%	100.0%	75.0%	-	50.0%	100.0%	66.7%	100.0%	100.0%	75.0%				80.6%
	Out of Area placements for acute mental health inpatient care - transformation				166	176	191	90									623
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric patient care	2018/19		95%	99.1%			95.3%			96.1%						97.2%

Mental Health:	
Key Performance Headlines Risks and Issues	**Actions to Address**
IAPT performance was reported at 1.5% in December. Although the monthly performance was below target, the CCG is ahead of plan at the end of Q3 and the provider expects to meet the yearend target. The recovery rate target of 50% has been achieved consistently through the year.	MPFT has been asked to look into the variation in delivery of the IAPT access target and to improve its consistency. The CCG has already invested additional funds into the service in the current year with a view to easing the step up to the 25% target for the 20/21 financial year.

As at Q3, 2019/20, 96.1% patients on CPA were followed up within 7days against the 95% standard. As at the end of October the CCG is achieving 75% against a target of 56% for EIP. The numbers of cases each month is small, so month on month percentage achievement is subject to variability due to small numbers.	
Progress continues to be made with implementing the agreed Improvement plan for the Under 25 services and fortnightly reporting against this continues to be in place.	The ability to recruit staff to maintain the current improvements seen in the KPIs is still seen as the main risk to the service delivery.
Key Quality Risks and Issues	
MPFT reported 9 serious incidents in December 2020. 7 were unexpected deaths (3 in the community, 3 recently discharged from service and 1 expected suicide).	The annual SI report was shared at CQRM on 31st January 2020 and the learning identified will be monitored through the CQRM. Statistical analysis (including triangulation with Staffordshire) also confirmed that current levels of SIS are not statistically significantly different to previous years.

5 LEARNING DISABILITIES (LD) Dementia and Maternity

5.1 There are two indicators relating to LD, which are reported annually. For maternity, three out of the four maternity indicator positions are reported annually. There are three indicators in the dashboard, with data now populated. These show the CCG in the middle range of the national distribution.

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Learning Disability	Proportion of people with a learning disability on the GP register receiving an annual health check	2017/18	51.4% (England)		52.68% (2018/19: CCG)												
	Completeness of the GP learning disability register	2017/18	0.49% (England)		0.52% (2018/19: CCG)												
Maternity	Maternal smoking at delivery	Q3 2019/20	10.4% (England)		11.0%			10.1%			11.0%						
	Neonatal mortality and still births per 1,000 population	2015	4.64		4.3 (2017: CCG)												
	Women's experience of maternity services	2017	88		81 (2018: CCG)												
	Choices in Maternity Services	2017	66.2%		67.6% (2018 CCG)												
Dementia	Maintain a minimum of two thirds diagnosis rates for people with dementia	2018/19		67%	**71.0%**	**71.0%**	**71.2%**	**70.8%**	**71.1%**	**71.0%**	**70.6%**	**70.5%**	**71.0%**	**69.8%**			69.8%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2018/19	78.0% (England)		79.31% (2018/19: CCG)												

Learning Disabilities:	
Key Performance Headlines Risks and Issues	**Actions to Address**

Completeness of the GP Learning Disability Register – the CCG performs better than the England average but its performance has deteriorated over the past two years from its highest value of 65% in 16/17.	This is being discussed with primary care colleagues as an improvement plan will be required for 20/21.
Maternity Maternal smoking at time of delivery is reported on a quarterly basis. Q3 2019/20(11.0%) showed an increase against Q2 performance (10.1%). Preliminary recent data for Perinatal Mortality shows a slight improvement in the level, reversing the slight trend seen in the most recent published metric	The level is slightly better than the average rate for England as a whole. The Improving Births programme is targeting initiatives to improve the CCG's position relative to other parts of England.
Dementia diagnosis continues to perform above the national standard, January 2020 achievement was 69.8% The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months, was 79.31% for Shropshire CCG, with the England average being 78.0% (2018/19).	The CCG is the best performing in its peer group of most similar CCGs The CCG is in the top quartile nationally.
Key Quality Risk and Issues	
The ASD and ADHD waiting lists remain a concern. The Mental Health Wellbeing provider commissioned to address the back log of 12months + waiting list continue to work closely with MPFT, and the teams are positively working towards the 6 month trajectory.	Plans for those waiting under 12 months and a clear neurodevelopmental pathway is still in development and work is taking place across the wider health care and education system to achieve a multidisciplinary approach to neurological development support. It is acknowledge that this work requires some pace in order to implement a pathway that address the current waits and improves outcomes for CYP.
CQC inspected maternity services during the visits in April 2019 and November 2019. SaTH are expecting the CQC report in February 2020.	CQC acknowledged the delay in publishing findings from visit undertaken in April 2019 and recognised that improvements had been made and these improvements

	were observed during the visit in November 2019. SaTH has introduced a number of measures to support staff, including offering psychological support. CCG unannounced quality visit to maternity in February 2020 that reported positive patient experiences.

6 URGENT AND EMERGENCY CARE -

6.1 A&E Performance and Ambulance Handover Delays

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Urgent and Emergency Care	Achievement of milestones in the delivery of an integrated urgent care service				6	6	6	6	6	6	6	6	6	6	6		
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 2018/19	2074 (England)		Q1 2019/20 845			Q2 2019/20 965									
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (SaTH)	2017/18	71.0%	95%	68.2%	73.0%	71.1%	73.2%	73.4%	65.9%	64.4%	65.6%	60.5%	65.0%			68.1%
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (SaTH)	2017/18	62	Zero Tolerance	15	0	0	1	1	1	44	61	348	411			882
	Ambulance Handover time - Number of handover delays of >30 minutes (RSH + PRH)	2017/18	8997	Zero Tolerance	806	627	629	608	571	813	897	991	1118	770			7830
	Ambulance Handover time - Number of handover delays of > 1 hour (RSH + PRH)	2017/18	2562	Zero Tolerance	349	132	122	89	115	155	219	341	605	232			2359

URGENT AND EMERGENCY CARE:

Key Performance Headlines Risks and Issues	Actions to Address
The SaTH A&E 4 Hour Wait target has not been achieved and is reported as 60.5 in December and 65.0% in January. This is below the target trajectory.	The action plan agreed through the A&E Delivery Board has identified 6 key action areas: • Ambulance Demand • Frailty • ED Systems & Processes • Same Day Emergency Care • Home First – Pathway Zero • Integrated Discharge Management

	These areas have been reviewed at a workshop in February to identify which should be continued and which need replaced by an alternate approach
Workforce limitations continue to be the key problem for SaTH.	Recruitment of middle grade medical staff is starting to be translated into actual capacity and this is expected to continue to improve through to June. Significant concern remains around availability of consultant cover with a high proportion of capacity being provided through bank and agency routes. Recruitment efforts continue to gain consultant cover and there is possibility of 2 additional consultants from late summer. Nursing recruitment is progressing and is expected to show some further increases in capacity by the end of the financial year.
Numbers of Super Stranded patients (>21days LOS) remains problematic at SaTH.	Performance relating to Delayed Discharges and the contribution from local authorities and the SCHT remains amongst the best in England. Community based alternatives have been switched from IV Therapy in the Community to focus more on Stroke patients and Fractured Neck of Femur rehabilitation Joint processes to achieve targeted numbers of Complex discharges continue to operate reasonably effectively. Home First and Pathway 0 is operational on both sites with promising early indications and, crucially, no indication of re-admissions for patients going through these pathways.
Reported Ambulance handover delays (over 60mins) have improved in January from the December numbers but are still amongst the highest in the Midlands. Walk In demand continues to show a downward trend from the peak levels seen in July 2019 whilst ambulance demand has decreased to	Ambulance handover improvement plans are in place between SaTH and WMAS and the AEDG has re-established the Ambulance subgroup with a remit to explore options for reducing conveyances and handover delays. The CCG has met with WMAS at executive level to identify further opportunities for reducing conveyances to ED. SaTH continue to with

levels equivalent to those seen in the summer. Same Day Emergency Care is operating at both sites but is being hampered by the impact of winter bed overspill (particularly at RSH). Challenges remain in being able to operate it 7 days per week, largely through staffing and capacity constraints	WMAS to improve handover processes. Options to reduce the frequency of high rates of ambulance arrivals has been identified as a priority work area for the local WMAS lead. ED Processes are being reviewed in light of CQC recommendations with a focus on enhancing streaming. Additional specialist mental health staff are being recruited for A&E liaison and the Alcohol Liaison service is being restored at PRH. Work is also being undertaken to develop alternatives to ED conveyance for patients with identified MH issues
Key Quality Risk and Issues	
CQC placed SaTH into special measures following their inspection in November 2018. Further CQC inspections took place in April 2019 and November 2019 to review maternity services and urgent and emergency care. CQC imposed the powers of Section 31 of the Health and Social Care Act (2008) as they are concerned that patients will or may be exposed to risk of harm. In total there are currently 21 conditions in place. CQC identified the following issues of concern: • Managing the deteriorating patient and sepsis • Triage of children with ED • Basic nursing care being delivered by ED staff • Children leaving ED before being seen • Restraint of patients not in line with guidance	SaTH has been in special measures since September 2018 and is struggling to deliver safe and effective care and treatment. The conditions in place are not driving the required improvement at SaTH and as a result NHSE/I has held three Risk Summits (December 2019, January and February 2020). The Risk Summits identified a number of actions for all partners and stakeholders to consider / implement to support SaTH and CQC will continue to inspect, and or take necessary action, as required, should sufficient improvements not be clearly evidenced. CQC actions are presented to the System Oversight and Assurance Group (SOAG) and to the CQRM each month. CCG continue to chair the weekly 'Safe Today' call with SaTH and partners to discuss and manage the risks within ED. CCG quality assurance visits to SaTH continue, including unannounced

• Lack of mental health risk assessments A number of other concerns were identified across the organisation relating to documentation, incomplete risk assessments and governance.	visits. QA visit to ED took place over weekend of 22nd & 23rd February 2020 which identified ongoing issues around documentation and appropriate clinical assessment not completed.
Workforce limitations continue to be the key problem for SaTH, with the level of nursing vacancies remaining a significant concern.	The Trust reported a successful recruitment campaign in India with the appointment of 186 registered nurses (cohorts arriving each month in Shropshire). The Trust anticipates double staffing during the induction / competency phase until overseas recruited nurses have NMC registration in place. CQC raised further concerns about the low numbers of paediatric trained nurses within ED. SaTH have developed an action plan to cover each shift with appropriate levels of paediatric trained nurses or trained nurses with advanced skills in paediatric nursing. Medical staff recruitment and retention remains a significant risk to the Trust. Vacancies advertised are receiving little or no interest. Agency usage remains a significant number of the consultant workforce, in particular, within ED. SaTH director of workforce updates CQRM each month.
There were 850 12 hour trolley waits reported in A&E at SaTH in Q3 for 2019/20. The increased number being reported due to demand and capacity issues.	The CCG is supporting SaTH with a 'desktop' exercise to review patient records following a 12-hour trolley wait. The findings of the review have been escalated to SaTH executives, NHSE/I and CQC. This exercise is ongoing each week throughout February and March 2020.

6.2 Ambulance Response Times, Crew Clear and Delayed transfers of care

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Urgent and Emergency Care	Category 1 (mm:ss): 90th Percentile	WMAS	11:47	15mins	11:39	11:51	11:56	12:00	11:39	12:10	12:13	12:15	12:15	12:03			11:55
		SCCG	20:26		20:16	19:46	23:25	22:52	20:38	21:00	22:43	22:50	21:29	23:29			21:41
	Category 2 (mm:ss): 90th Percentile	WMAS	22:12	36mins	22:22	21:31	23:57	23:44	23:06	24:10	25:21	27:06	28:09	22:45			00:20
		SCCG	33:29		34:51	32:21	36:54	37:08	39:09	39:38	38:10	41:54	45:09	38:07			38:33
	Category 3 (mm:ss): 90th Percentile	WMAS	76:14	90mins	78:47	69:49	99:36	109:47	88:08	109:15	121:43	136:52	144:05	71:44			103:40
		SCCG	71:19		81:14	71:59	95:54	106:25	89:30	134:01	129:48	149:01	168:15	87:00			110:58
	Category 4 (hh:mm:ss) : 90th Percentile	WMAS	120:23	180mins	115:46	104:08	141:26	185:42	127:18	175:44	178:49	198:23	193:27	114:58			150:28
		SCCG	101:36		122:44	111:52	163:58	144:28	90:49	165:10	175:21	180:56	209:21	108:49			142:25
	Crew Clear delays of > 30 minutes (RSH + PRH)	2018/19	709	Zero Tolerance	40	12	12	13	9	14	13	15	13				141
	Crew Clear delays of >1 hour (RSH + PRH)	2018/19	15	Zero Tolerance	3	0	0	0	0	1	2	2	0				8
	Delayed Transfers of care attributable to the NHS (LA)	2017/18	3381	Reduction 2016/17 Outturn	274	281	223	281	284	324	571	647	560				3445
	DTOC Rate (SaTH)			3.5%	1.3%	0.8%	1.5%	1.7%	1.1%	1.6%	1.7%	2.4%	1.2%				1.2%
	DTOC Rate (RJAH)			3.5%	6.4%	3.4%	4.4%	6.4%	4.0%	4.9%	5.9%	6.0%	5.8%				5.8%
	Population use of hospital beds following emergency admission	Q2 2018/19	500.5 (England)		Q1 2019/20 799			Q2 2019/20 815									

Ambulance Response Times, Crew Clear and Delayed transfers of care

Key Performance Headlines Risks and Issues	Actions to Address
The CCG achieved the standards for the Category 3 & 4 calls in January but, failed the standards for categories 1 and 2 calls. Ambulance demand has increased steadily through the year but shows indications of flattening out in the December and January data.	Performance issues are raised regularly with the Regional lead commissioner The lead commissioner is planning reduced demand from the 20/21 year based on the joint running of the 999 and

	NHS 111 services by WMAS
DTOC (SaTH) – In December 2019, the number of delayed days was 1.2% of patients delayed. This is ahead of the 3.5% target at SaTH. The RJAH deteriorated to 5.8%, though this figure includes complex spinal patients. At SCHT, the December value deteriorated to 7.5%. The SaTH values are amongst the best performers in England	The CCG works closely with all local providers and local authorities to ensure discharges are made in as timely a manner as possible.
Key Quality Risk and Issues	
Delayed discharges, in particular, for spinal patients remain an issue at RJAH as many patients are requiring transfer out of area.	RJAH is currently working closely with NHS England Specialised Commissioning to improve the discharge process for spinal patients and new ways of working to be introduced from January 2020. CQRM discussions in February 2020 demonstrated an improvement in delayed discharges.

7 Primary Medical Care, Community Services and Elective Access

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Primary Medical Care	Patient Experience of GP Services	2019	82.9% England	87.99%													
	Last time you had a general practice appointment, how good was the healthcare professional at giving you enough time	2018 GP Patient Survey	87% England (Good)	91% Good													
	Last time you had a general practice appointment, how good was the healthcare professional at listening to you		89% England (Good)	92% Good													
	Last time you had a general practice appointment, how good was the healthcare professional at treating you with care and concern		87% England (Good)	92% Good													
	How would you describe your experience of your GP Practice		84% England (Good)	89% Good													
	Overall, how would you describe your experience of making an appointment?		69% England (Good)	76% Good													
	Were you satisfied with the type of appointment offered?		94% England (Good)	96% Good													
	Primary care access - proportion of population benefitting from extended access services	Oct-18	98.4% (England)		50%	49%	49%	51%	51%	51%	100%	100%	100%	100%	100%	100%	
	Primary care workforce	Mar 2019	1.06 (England)	1.21 (March 2019)													
	Count of total investment in primary care transformation made by CCGs compared with £3 head commitment made in the General Practice Forward View	Qtr 2 2018	Green (England)	Green													

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Elective Access	RTT - incompletes (CCG)	2018/19	91.0%	92%	89.7%	90.2%	89.9%	89.4%	88.7%	89.2%	88.5%	87.9%	87.3%				89.0%
	RTT - incompletes (SaTH)	2018/19	92.3%	92%	87.5%	87.8%	87.0%	86.0%	85.8%	86.1%	85.0%	83.9%	82.8%				85.7%
	RTT - incompletes (RJAH)	2018/19	89.8%	92%	87.5%	87.2%	86.6%	85.1%	83.6%	88.5%	88.0%	82.1%	82.2%				85.9%
	No. of 52 Week Waiters (CCG)	2018/19	56	Zero Tolerance	0	0	0	0	0	0	0	0	1				1
	Diagnostic Test Waiting Time < 6 weeks (CCG)	2018/19	0.9%	1%	1.2%	1.3%	0.9%	1.7%	2.3%	2.7%	0.9%	1.1%	1.5%				1.5%
	Diagnostic Test Waiting Time < 6 weeks (SaTH)	2018/19	0.3%	1%	0.8%	0.7%	0.5%	1.2%	2.4%	2.7%	0.6%	1.6%	1.4%				1.3%
	Diagnostic Test Waiting Time < 6 weeks (RJAH)	2018/19	1.0%	1%	2.4%	2.9%	1.7%	1.5%	1.2%	1.1%	0.1%	0.1%	2.0%				1.4%
	Cancelled Operations - no. of patients re-admitted within 28 days (SaTH)	2018/19	5	Zero Tolerance	2			1			2						5
	Cancelled Operations - no. of patients re-admitted within 28 days (RJAH)	2018/19	1	Zero Tolerance	0			0			0						0

Primary Medical Care, Community Services and Elective Access	
Key Performance Headlines Risks and Issues	**Actions to Address**
Access to, and satisfaction with, Primary care services continues to be rated highly by Shropshire patients and compares well with the overall England position. Comparing the CCG with others in nationally published data, continues to show the Shropshire practices, in general, are rated at the positive end of the national spectrum on almost all available measures. Practices that show as outliers against these measures are supported by the Primary Care Team, via their Locality Managers, to work on improving access, quality and patient satisfaction.	Extended access at weekends and evenings was introduced from the 1st of October 2018 and continues to run smoothly. Additional extended hours are also being delivered via the Primary Care Networks.
The CCG failed to achieve the RTT 18 week performance (incompletes) in December (88.5%). The CCG failed to achieve the Diagnostics Wait target in Nov and Dec.	Winter overspill, increased cancer referrals and reduction in outpatient capacity are impacting on performance. These issues are expected to remain through February and March. Data validation issues were encountered in SaTH relating to Echocardiography which impacted the performance. In addition, increased demand from A&E is impacting on capacity particularly for CT and MRI. Actions to identify the key drivers of this demand and options to deal with it are being agreed with SaTH
SaTH failed to achieve their overall RTT target in December at 87.3%. This is largely due to the overspill from emergency cases limiting elective capacity and capacity limitations in	Additional bed capacity for the winter months is planned at SaTH to protect some elective capacity though this may not become fully operational until later in the winter.

outpatients.	Additional sessions are enabled where possible to recover performance but are subject to continued revisions due to on-going escalation into the Day Surgery Units at both acute sites
At the end of December there were 1 x 52 week waiters reported for the CCG. The patient has been seen and treated in January at Hampshire Health Trust.	The CCG actively manages the position with long waiters.
CCGs are also monitored on the overall numbers on the Incomplete Waits list to remain at the March 2019 level. This has increased at the end of December to 21,703 against a target of 19,284. The rate of increase in these numbers has slowed considerably in the last couple of months. At SaTH, numbers waiting for all commissioners increased by just over 400 to the end of December to 19,759 and is 9% above target. The numbers of English patients waiting at RJAH in December was 7062 which is 5.65% above target. The total has decreased by 57 from the previous month. Performance against the 99% standard for waiting time for a Diagnostic Test was failed by the CCG in December with a level of 88.5%.	The CCG works with providers to ensure recorded numbers are as accurate as possible. The impact of some providers commencing to submit RTT data for the first time in April has lessened. .
Cancelled Operations –SaTH failed the target in Q3, SaTH reported 2 cancelled operations.	Any patient safety issues relating to cancelled operations are managed through the contractual quality processes**.**
Key Quality Risk and Issues	

Primary care quality dashboard development.	The CCG is working with business intelligence to develop a primary care quality dashboard. The dashboard will aim to identify areas of good practice and areas for improvement whilst triangulating with patient experience and performance matrix. The first draft will be presented in February 2020.
Shropshire and Telford and Wrekin have been accepted to be part of the first Midlands Region Frailty Collaborative programme. The programme will take place over the next 4 months and will be intense in order to be ready to support winter pressures.	The Frailty Collaborative working group has been formed with representation across commissioners and providers. Project implementation and delivery will be supported by the Emergency Care Intensive support team.
There are currently no care homes under level 4 scrutiny.	Ongoing monitoring and information sharing across multiagency organisations continues (both nursing and residential care). Shropshire and Telford information sharing meeting held in January 2020 with no home have been identified further escalation. CCG continue to undertake quality assurance visits to care homes and triangulate findings with CQC and HealthWatch.

8 NHS Continuing Health Care and HCAIs

NHS Continuing Healthcare	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	Qtr 1 2019	6.54% (England)		1.6%			0.0%									

Additional Indicators Requiring Focus	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
	Healthcare acquired infection (HCAI) measure (MRSA)	2017/18	3	0	0	0	0	0	0	0	0	1	0	0			1
	Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)	2017/18	46	43	3	5	8	5	2	6	3	4	6	6			48

9 Recommendation

The Governing Body is asked to NOTE the contents of the report and the CCG actions contained within it to ensure patients' safety and compliance with quality care.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.033
Shropshire CCG Governing Body meeting: 11.03.2020

Title of the report:	**Shrewsbury and Telford Hospitals NHS Trust Quality & CQC Update Report**
Responsible Director:	**Mrs Christine Morris, Executive Director of Quality / Maggie Bayley, Interim Executive Director of Quality**
Author of the report:	**Mrs Christine Morris, Executive Director of Quality / Maggie Bayley, Interim Executive Director of Quality**
Presenter:	**Mrs Christine Morris, Executive Director of Quality / Maggie Bayley, Interim Executive Director of Quality**

Purpose of the report:

This paper aims to update the Board on the actions identified at the three risk summits held relating to quality and safety at Shrewsbury and Telford Hospitals NHS Trust (SaTH). Risk summits were held on 13th December 2019 and 21st January 2020 following the CQC inspection in November 2019 and the imposition of section 31 breach notifications.

Key issues or points to note:

A further inspection of the two emergency departments was carried out on 17th and 18th February 2020 which resulted in further Section 31 breach notices. To this end another risk summit was called on 25th February 2020 chaired by NHSEI Regional Medical Director. Further actions were identified and the group will reconvene in 4 weeks.

The CQC confirmed there are currently 21 conditions on the Trust's registration in place.

It is expected that the CQC inspection report will be with the Trust in the next few weeks prior to its publication.

Improvement plan updates recognise there is much work to be done to build robust sustainable assurances relating to patient safety and workforce.

The next meeting of the Safety oversight and assurance group in March will be last of this forum as the System Improvement Board will commence in April 2020.

Actions required by Governing Body Members:

The Governing Body is asked to:

- Review the content of the report and identify further assurances that may be required.

CCG GOVERNANCE BOARD EXECUTIVE SUMMARY SHEET – PART ONE	
DATE:	10th and 11th March 2020
TITLE OF PAPER:	Shrewsbury & Telford Hospitals NHS Trust Quality & CQC Update Report
EXECUTIVE RESPONSIBLE: **Contact Details:**	Mrs Chris Morris, Executive Director of Quality christine.morris19@nhs.net 01952580334 Maggie Bayley, Interim Executive Director of Quality Maggie.bayley@nhs.net
CG OBJECTIVE:	To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes, based upon best available evidence.

☐	For Information	☐	For decision	x	For performance monitoring

EXECUTIVE SUMMARY	This paper aims to update the Board on the actions identified at the three risk summits held relating to quality and safety at Shrewsbury and Telford Hospitals NHS Trust (SaTH). Risk summits were held on 13th December 2019 and 21st January 2020 following the CQC inspection in November 2019 and the imposition of section 31 breach notifications. A further inspection of the two emergency departments was carried out on 17th and 18th February 2020 which resulted in further Section 31 breach notices. To this end another risk summit was called on 25th February 2020 chaired by NHSEI Regional Medical Director. Further actions were identified and the group will reconvene in 4 weeks. The CQC confirmed there are currently 21 conditions on the Trust's registration in place. It is expected that the CQC inspection report will be with the Trust in the next few weeks prior to its publication. Improvement plan updates recognise there is much work to be done to build robust sustainable assurances relating to patient safety and workforce. The next meeting of the Safety oversight and assurance group in March will be last of this forum as the System Improvement Board will commence in April 2020.
FINANCIAL IMPLICATIONS:	There are no direct financial implications within this paper
EQUALITY & INCLUSION	There are no specific issues related to equality and inclusion

	detailed within this paper.
PATIENT & PUBLIC ENGAGEMENT:	Both Shropshire and Telford & Wrekin Healthwatch Chairs are members of the group.
CONFLICTS OF INTEREST:	None evident related to this area.
RISKS/OPPORTUNITIES:	The quality of services provided by SATH to both Shropshire and Telford & Wrekin residents is listed as risk within the CCGs risk register.
RECOMMENDATIONS:	The Governance Board is asked to: • Review the content of the report and identify further assurances that may be required

The CCG Governing Bodies 10TH and 11th March 2020
SATH Quality & CQC Update Report

1.0 Aim

This paper aims to update the Governance Board in relation to quality and safety at Shrewsbury and Telford Hospitals NHS Trust (SaTH) following Care Quality Commissions inspections in November 2019 and February 2020.

2.0 Background

SaTH was rated inadequate by Care Quality Commission (CQC) following an inspection in September 2018 and prior to the CQC report publication NHS Improvement placed the Trust into special measures. An improvement plan was put in place and monitored via the NHSEI led Safety Oversight and Assurance Group. There has been senior CCG attendance at this meeting throughout the past year.

CQC inspected the Trust again in April 2019 to review Maternity and carried out a full inspection in November 2019. The report of this will be with the Trust in the near future for accuracy checking and then publication. Following the February 2020 inspections of the two emergency departments the Trust was notified of addition regulatory breaches of Section 31 of the Health and Social Care Act 2008

3.0 Section 31 breaches

Section 31 allows the CQC to serve a Notice of Decision upon a provider if it has reasonable cause to believe that, unless it acts any person will or may be exposed to the risk of harm. Such a notice would suspend a provider's registration for a period of time, or impose, vary or remove conditions on your registration with immediate effect. The CQC is considering action including but not limited to:

- Imposing a condition on the trust's registration which limits the operating hours of the emergency department service at one or both locations.
- Imposing a condition on the provider's registration which limits, or totally stops the conveyance of children to Princess Royal Hospital, except in life threatening scenarios.
- Imposing a condition on the provider's registration which restricts the number of ambulances conveyed to the emergency department at one or both locations.

A presentation was shared with board members in a confidential session on 10th and 11th December 2019 just after the CQC notified the CCGs of a Section 31 notification being issued placing conditions in the Trust registration. This focussed on the following areas:

- Deteriorating patient & management of patients with signs of sepsis
- Care of patients with mental health and compliance with the Mental Capacity Act
- Application of Mental Capacity Act & DOLS

Further breach notifications were received in February 2020 related to what the inspectors described as poor care within the two emergency departments. The CQC have reported there are now 21 conditions in place in relation to the Trust

The Trust public board meeting in February received a briefing on the issues identified by the CQC.

https://www.sath.nhs.uk/wp-content/uploads/2020/02/10-CQC-Update.pdf

5.0 NHSE/I Roundtable

A system level roundtable executive meeting was held on 4 February 2020. The Roundtable event identified work streams across the health economy to support SaTH and the development of a system improvement board to drive and monitor quality improvement. This will supersede the Safety Oversight and Assurance Group (SOAG) that has been in place since November 2018 and will commence in April 2020.

6.0 SOAG 18th February 2020

Key points

The following points were raised at the February 2020 SOAG meeting:

- Emergency Department Consultants - 4 substantive in post supplemented by locum workforce – mitigating actions in place
- Therapy workforce is reported to be challenging across the Trust and this is under review
- Sepsis screening and time of antibiotic treatment initiation was discussed as requiring improvement.
- A review of how risk management is strengthened from floor to the Board is to be discussed at a future meeting along with assurances to partners as to how actions are signed off as completed within the trusts improvement plan
- The Trust is developing a single improvement plan to ensure impact can be measured.
- The next meeting in March will be last of this forum as the System Improvement Board will commence in April 2020.

The CCGs Executive Director of Quality and Head of Quality carried out unannounced visits to both emergency departments on the weekend of 22nd and 23rd February to test if the immediate actions put in place by the Trust were being enacted to manage patient safety, privacy and dignity. The outcome of this was that paediatric nurse cover was not in place at PRH and the audit outcomes from records reviewed continued to align with the CQCs previous findings.

Conclusion

The CCGs need to continue to work closely with the Trust, regulators both NHSEI and CQC, along with Helathwatches in the monitoring of actions and improvement plans, testing compliance in real time as well as through contractual routes to ensure the required improvements are progressed and sustained.

Chris Morris
Executive Director of Quality

Maggie Bayley
Interim Executive Director of Quality
3rd March 2020

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.034
Shropshire CCG Governing Body meeting: 11.03.2020

Title of the report:	**Maternity Update**
Responsible Director:	**Christine Morris, Executive Nurse**
Author of the report:	**Fiona Ellis, Local Maternity System Programme Manager**
Presenter:	**Fiona Ellis, Local Maternity System Programme Manager**

Purpose of the report:

To provide the Governing Body with a Maternity Update.

Key issues or points to note:

There is currently significant public attention, including in the local and national media, in relation to maternity services in Shropshire, Telford and Wrekin. This report summarises the current position in relation to:

Ockenden Review
The CCG has not seen the leaked report or any other reports in relation to the Ockenden review findings. Therefore, whilst it is not possible to monitor specific actions in relation to specific findings at this stage, the CCG continue to work closely with SaTH to ensure that progress is made in areas that have been identified through local assurance processes as requiring improvement.

Transforming Midwifery Care
NHS E/I regional team have submitted the proposals for approval by a national panel. The NHS E/I national panel have not yet discussed the proposals. Consultation on the new model cannot commence until approval is given by NHSE/I.

Local Maternity System
The LMS is on track to deliver the projected improvements against most indicators. The rate of stillbirths and neonatal deaths at SaTH continues to reduce. The LMS has funded three additional senior midwives within SaTH to lead on the implementation of key service and pathway changes in relation to Continuity of Carer, Postnatal Care and Antenatal Care pathways.

CCG Assurance Processes
The CCG works closely with a number of health partners, including SaTH, CQC, NHSE/I and patient groups to triangulate information relating to the quality and safety of maternity services provided by SaTH in order to gain assurance in relation to the quality and safety of maternity services. In addition, the CCG has secured the support from an experienced midwife to provide expert advice across the CCGs quality assurance processes for maternity services.

Actions required by Governing Body Members:

The Governing Body is asked to:

- Note the content of this report and to receive further updates at future Governing Body meetings.

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

CLINICAL COMMISSIONING GOVERNANCE BOARD
EXECUTIVE SUMMARY SHEET

DATE:	10 March 2020
TITLE OF PAPER:	Maternity Update
EXECUTIVE RESPONSIBLE: **Contact Details:**	Chris Morris, Executive Nurse Ext: Email: christine.morris19@nhs.net
AUTHOR (if different from above) **Contact Details:**	Fiona Ellis, Local Maternity System Programme Manager Ext: Email: fiona.ellis3@nhs.net
CCG OBJECTIVE:	
[X] For Information [ ] For decision [ ] For performance monitoring	
EXECUTIVE SUMMARY	There is currently significant public attention, including in the local and national media, in relation to maternity services in Shropshire, Telford and Wrekin. This report summarises the current position in relation to: Ockenden Review The CCG has not seen the leaked report or any other reports in relation to the Ockenden review findings. Therefore, whilst it is not possible to monitor specific actions in relation to specific findings at this stage, the CCG continue to work closely with SaTH to ensure that progress is made in areas that have been identified through local assurance processes as requiring improvement. Transforming Midwifery Care NHS E/I regional team have submitted the proposals for approval by a national panel. The NHS E/I national panel have not yet discussed the proposals. Consultation on the new model cannot commence until approval is given by NHS E/I. Local Maternity System The LMS is on track to deliver the projected improvements against most indicators. The rate of stillbirths and neonatal deaths at SaTH continues to reduce. The LMS has funded three additional senior midwives within SaTH to lead on the implementation of key service and pathway changes in relation to Continuity of Carer, Postnatal Care and Antenatal Care pathways. CCG Assurance Processes The CCG works closely with a number of health partners, including SaTH, CQC, NHSE/I and patient groups to triangulate information relating to the quality and safety of maternity services provided by SaTH in order to gain assurance in relation to the quality and safety of maternity services. In addition, the CCG has secured the support from an experienced midwife to provide expert advice across the CCGs quality assurance processes for maternity services.

FINANCIAL IMPLICATIONS:	There is a nationally set tariff for maternity care however it is known that this does not fully cover all maternity costs. The Local Maternity System is allocated funding from NHS E/I to deliver the transformation agenda.
EQUALITY & INCLUSION:	Impact assessments are undertaken where required.
PATIENT & PUBLIC ENGAGEMENT:	The Maternity Voices Partnership pro-actively involves women and their families as well as staff in the development and delivery of service transformation. Public Consultation can be undertaken in relation to the Transforming Midwifery Care Proposals following NHS E/I approval. Meanwhile, engagement activity continues with seldom heard groups in relation to Transforming Midwifery Care.
LEGAL IMPACT:	There is potential for challenge if the system does not engage appropriately with the population on service changes.
CONFLICTS OF INTEREST:	None
RISKS/OPPORTUNITIES:	This report demonstrates the opportunities being taken to improve maternity services. There is a risk that service changes/pace of change will be challenged due to resource capacity within the system.
RECOMMENDATIONS:	The Board is asked to note the content of this report and to receive further updates at future Boards.

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

CLINICAL COMMISSIONING GOVERNANCE BOARD
10 March 2020

Maternity Update

1.0 Introduction

There is currently significant public attention, including in the local and national media, in relation to maternity services in Shropshire, Telford and Wrekin. The CCGs are working with SaTH and others to transform maternity services through the Local Maternity System and other related activity.

This paper provides a summary of the status of key programmes of work relating to maternity services in Shropshire, Telford and Wrekin. It summarises the current position in relation to:

- Ockenden Review
- Transforming Midwifery Care
- Local Maternity System
- CCG Assurance Processes

2.0 Ockenden Review

The Ockenden review refers to the review being led by midwife Donna Ockenden following a request in 2017 from the Secretary of State for Health and Social Care for a review to be undertaken in relation to the number of stillbirths and neonatal deaths at Shrewsbury and Telford Hospital Trust. This review started in 2017 with a remit to review 23 deaths at the Trust. It is reported that the review is now considering in the region of 900 cases dating back up to 40 years. It has not yet been confirmed when the Ockenden Review will publish the findings. However, it is thought that a report on the findings may be published in October 2020.

A leak of an update paper from the Ockenden review was reported by local and national media. The media reported that the leaked update identifies the following issues:

- A long-term lack of informed consent for mothers choosing to deliver their babies in midwifery-led units – where risks can be higher if problems occur – which “continues to the present day”
- A long-term lack of transparency, honesty and communication with families when things go wrong. This supported a culture that was “disrespectful” to families who had been “damaged” as a result
- Failure to recognise serious incidents. Many families who had undergone horrific experiences were told they were the only ones and lessons would be learnt. The report said: “It is clear this is not correct”

- A long-term failure to involve families in investigations that were often poor and described as “extremely brief” and “overly defensive of staff”
- A lack of kindness and respect to parents and families with multiple examples of deceased babies given the wrong names in writing or referred to as “it”
- Not sharing learning, meaning “repeated mistakes that are often similar from case to case”. Failure to learn was present from the earliest case of a neonatal death in 1979 to cases occurring at the end of 2017
- A lack of support for families who have “experienced significant loss and tragedy”
- A long-standing culture at the trust “that is toxic to improvement effort”

Any families contacting the CCG in relation to this are being advised to contact the review team directly (maternityreview@donnaockenden.com *or 01243 786993)*

More recently, Jeremy Hunt (the previous Secretary of State who instigated the review) made a public plea to Matt Hancock, the Secretary of State for Health and Social Care to ensure progress is made against a specific set of requirements in relation to service improvements at SaTH.

The CCG has not seen the leaked report or any other reports in relation to the Ockenden review findings. Therefore, whilst it is not possible to monitor specific actions in relation to specific findings at this stage, the CCG continue to work closely with SaTH to ensure that progress is made in areas that have been identified through local assurance processes as requiring improvement.

3.0 Transforming Midwifery Care

Transforming Midwifery Care (TMC) refers to the CCG-led review which commenced in 2017 in relation to midwife-led care in Shropshire, Telford and Wrekin. A proposed new model of care has been developed and is subject to NHS E/I Assurance Processes. The proposals have been approved locally by the CCGs and supported by SaTH. The Joint Health Overview and Scrutiny Committee have also indicated their support for consulting on the proposed new model of care. The West Midlands Clinical Senate have endorsed the proposals and the NHS E/I regional team have submitted the proposals for approval by a national panel. The NHS E/I national panel have not yet discussed the proposals. Consultation on the new model cannot commence until approval is given by NHS E/I.

The review found that the current model of service delivery is inequitable. The current model of midwifery care also does not include maternity hubs (a requirement of Better Births) and does not support a more flexible staffing model required to deliver continuity of carer in line with national targets. The delay in consulting on the proposed new model of care is hindering progress in relation to ensuring better, more equitable access to care and is also contributing to delay in delivery of some wider Local Maternity System targets.

4.0 Local Maternity System

The Local Maternity System (LMS) has been established to deliver the requirements of the 2016 national review of maternity services (Better Births). Every area in England has a LMS. Local Maternity Systems are required to deliver the following improvements:

- A 50% reduction (from 2010 levels) in Stillbirth, Neonatal Death and Brain Injury by 2025
- Enable most women to receive continuity of carer by 2021
- Enable all women to have a personalised maternity care plan by 2021
- Enable all women to have a choice of three different types of birth setting by 2021
- Increase the proportion of women giving birth in midwifery settings (with an ambition for this to be above 30%)
- Improve access to perinatal mental health services

The Long Term Plan also identified additional improvements to be delivered through the LMS, including:

- Improvements in postnatal care (particularly in relation to improved access to postnatal physiotherapy to reduce incontinence and pro-lapse)
- By 2024, 75% women from BAME communities and a similar percentage from the most deprived groups will receive continuity of carer throughout antenatal, birth and postnatal care.
- Specialist smoking support to help women quit.

The local transformation trajectories against the Better Births priorities are provided in the table below.

KLOE	2019/20 Target	2020/21 Target	2021/22 Target
Stillbirths	3.2/1000 (16)	3/1000 (15)	2.8/1000 (14)
Neonatal Deaths	1.2/1000 (6)	1/1000 (5)	1/1000 (5)
Brain Injury	1.8/1000 (9)	1.7/1000 (8)	1.5/1000 (7)
Personalised Care Plans	0	100%	100%
Three Places of Birth	100%	100%	100%
Continuity of Carer	20%	35%	51%
Births in Midwifery Settings	17%	20%	25%

The rate of stillbirths and neonatal deaths at SaTH continue to reduce. Through the LMS a number of programmes are in place to continue to reduce stillbirth, neonatal death and brain injury in line with the national requirements. This includes public awareness campaigns in relation to key risk factors such as smoking in pregnancy and reduced fetal movements, training for staff and utilising the expertise of others such as the West Midlands Clinical Network to ensure delivery of key initiatives such as the Saving Babies Lives Care Bundle[1].

The LMS has funded three additional senior midwives within SaTH to lead on the implementation of key service and pathway changes in relation to Continuity of Carer, Postnatal Care and Antenatal Care pathways. A transformation plan is in place for each of the three areas and delivery will be monitored through the LMS Programme Board.

The Maternity Voices Partnership continues to grow in moving towards co-production becoming 'business as usual'. There is currently an opportunity for people to apply to be Maternity Voices Partnership volunteers gathering valuable feedback from across the county as well as applications being invited for a service user chair and vice chair for the Maternity Voices Partnership. These new posts will be hosted by Healthwatch Telford and Wrekin on behalf of the Maternity Voices Partnership.

6.0 CCG Quality Assurance Processes

The CCG works closely with a number of health partners, including SaTH, CQC, NHSE/I and patient groups to triangulate information relating to the quality and safety of maternity services provided by SaTH in order to gain assurance in relation to the quality and safety of maternity services. In addition, the CCG has secured the support from an experienced midwife to provide expert advice across the CCGs quality assurance processes for maternity services.

A maternity focused clinical quality review meeting (CQRM) is held each month, chaired by the CCG executive nurse and attended by senior clinical staff from SaTH's maternity services team. The CCG also utilise the expertise of an external midwife in providing support and challenge to SaTH in relation to the quality and safety of the service provided, based on the information submitted to CQRM. This helps to ensure that appropriate evidence is provided where additional assurance is required.

The CCG also has in place a programme of Quality Assurance visits that take place throughout the year. Members of the CCG quality team, including the midwife advisor, visit each maternity setting over the course of a year. Each visit looks at a number of different factors including: Clinical effectiveness; Staff experience; Patient Safety and also incorporates a patient experience perspective through '15 steps to maternity' co-ordinated by the Maternity Voices Partnership. The findings from each Quality Assurance Visit are reported to CQRM and used to inform improvements accordingly.

[1] An NHS 'care bundle' is an action plan put together by experts and carried out on all patients who meet certain criteria. Care bundles are targeted on causes of death or ill-health and are designed to save lives. https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

The CCG attends monthly safety oversight assurance group (SOAG) meetings at SaTH that are chaired by the regional medical director for NHSE/I and health partners, including Health Watch. The SOAG is a forum for SaTH to present updates on actions and progress being made towards improvement. The SOAG also gives health partners the opportunity to raise concerns or seek further assurance.

The CCG investigate all serious incidents that are reported by SaTH in accordance with the NHS England (2015) Serious Incident Framework and the CCG will source the opinion of appropriate clinical experts. Action plans to address learning identified are monitored through the monthly clinical quality review meetings. The CCG quality assurance visits are used to ensure that the implementation of learning reported to CQRM is taking place in practice.

Should the CCG identify a particular concern, unannounced quality assurance visits can be undertaken at any time.

7.0 Recommendations

The Board is asked to note the content within this report and to receive further updates at future Boards.

Fiona Ellis
Local Maternity System Programme Manager

20 February 2020

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.035
Shropshire CCG Governing Body: 11.03.2020

Title of the report:	Shropshire CCG Strategic Priorities Update
Responsible Director:	David Evans – Accountable Officer
Author of the report:	Sam Tilley – Director of Planning
Presenter:	David Evans – Accountable Officer

Purpose of the report:
To update the Governing Body on progress in relation to the Strategic priorities for Shropshire CCG during 2019/20

Key issues or points to note:
In June 2019 Shropshire CCG's Governing Body undertook a development session focused on agreeing a set of strategic priorities for delivery during 2019/20. The priority areas set out below were selected from a longlist of options generated at the development session by Governing Body members and then put to a vote to create a shortlist.

- Development of a single strategic commissioning organisation across Shropshire, Telford & Wrekin
- Urgent & emergency care
- Primary Care
- Mental health & learning disabilities
- Planned Care
- Cancer

The short list was formally adopted by the Governing Body at its confidential meeting in August 2019 and it was agreed that regular updates would be brought back to each Governing body meeting to demonstrate progress in delivery. Further to this a high level Performance Indicator has been added to the update and the creation of more detailed performance indicators will form part of the work to create a single strategic commissioning organisation

Actions required by Governing Body Members:

The Governing Body is asked to:

- Note the progress against the CCG's strategic priorities including the inclusion of a single high level KPI for each priority

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of the effect upon these requirements*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the effect upon these requirements*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *If yes how will this be mitigated*	No

Shropshire CCG Strategic Priorities Update Tracker – January 2020 (updates shown in red)

Priority	Action	Update (as at 1 March 2020)
Development of a single strategic commissioning organisation across Shropshire, Telford & Wrekin We have recognised the importance of moving to a single strategic commissioning organisation across the STP area as a key means of delivering our overall ambitions, with an aim of achieving that by April 2020.	Develop a transformation plan to deliver a new CCG and ensure that we support staff through the change	Lead: David Evans Update provided as a separate item on the Governing Body Agenda
Urgent & emergency care We continue to face increasing pressures on the urgent & emergency care system. It is essential that we address these pressures through our care closer to home programme to improve the quality of care and to deliver commitments we have made as part of the Future Fit programme.	Support the system wide development of the co-ordination of a comprehensive community offer with an innovative integrated front door	Lead: Jess Sokolov With regard to the comprehensive community offer, case management data collated by the CCG BI team is demonstrating positive impact. The Case Management pilots will be rolled out in the first instance to 8 neighbouring practices, with an intention to roll out across the whole footprint by November. With regard to the integrated front door, Urgent Treatment Centres procurement has now moved to mobilisation. Urgent care "flow" ,including SDEC, has been identified as one of the system priorities for 20/21 and work is therefore underway to develop the specific implementation plans that support this
Primary Care GPs and practice teams provide vital services for patients. They are at the heart of our communities and we recognise the importance of having good access to the full range of primary care services, not only to a GP practice but to the full range of Primary Care Providers.	Use innovation and work in collaboration with NHS England as the commissioner of community pharmacy, dentistry and optometry to ensure improved patient access to all areas of primary care, which in turn will reduce the pressure on the wider health	Lead: Nicky Wilde commissioners for community pharmacy, dentistry and optometry to discuss potential collaboration in delivery of wider Primary Care Services A meeting with the Local Pharmaceutical Committee Chair has taken place specifically around the new Pharmacy contract to commence April 2020 and the links to the wider delivery of the Long Term Plan. Primary Care Commissioning Committee received a paper at the

		October 2019 meeting outlining the Governing Body priority to work closer with community Pharmacy, Optometry and Dentistry and similarities between the four contracts. A meeting has now been held with NHSE and representatives of all 4 Primary Care Contractors where 3 potential priority areas have been highlighted for further consideration. The areas are **diabetes**, **frailty** and **ophthalmology**. Post meeting, Shropshire CCG highlighted **minor ailments** as also being a priority and a request will be made at the next meeting to add this as the 4th priority. The group is also looking at how the digital agenda could be progressed, specifically around enabling optometry and dentistry to have access to the Summary Care Record. The next stage is for a workshop to be held to explore these 4 areas in greater detail, which will include the relevant lead commissioners for the areas highlighted. There has been attendance from NHSE/I at an STP clinical leaders forum to include all areas of Primary Care on 5 March 2020. The detailed workshop mentioned above has been delayed due to changes in the management structure at NHSE/I but plans are now in place to reinstate this workshop and to align it with STP work. KPI – to have agreed areas for closer working by the end of March 2020 which will improve access to primary care services. Once these areas are defined, measurable outputs will be put into place
Mental health & learning disabilities In line with delivering the mental health long term plan, we are committed to meeting the mental health investment standard.	Prioritise the management of mental health crisis and improve follow up for those who present in crisis	Lead: Julie Davies Further work has been done to map the required investment against the MH and LD priorities for the next 4yrs including Crisis for both adults and CYP – due to be presented to Joint Execs on 13th January- Paper for March delayed due to delay in confirming

		our financial allocations for 20/21 – delivery of this priority is directly linked to the additional financial investment received from the centre. KPI: To be confirmed following confirmation of allocation
Planned Care We have a wide programme of transformation of planned care services set out in the operating plan. Within that programme, one specific priority given the scale of the opportunity to deliver significant quality and value for money improvements is the transformation of MSK services (including the existing SOOs/TEMS services, pain management, rheumatology and metabolic bone disease).	Develop a single integrated model of care of MSK services across Shropshire, Telford & Wrekin that requires more integrated provision	Lead: Julie Davies This priority is being taken forward via the MSK Alliance Board which has replaced the MSK Transformation Board. The Alliance agreement is on track for agreement by the end of March. The new single model of care is now planned to be delivered across the county from the 1st September 2020. KPI: to be agreed by the MSK Alliance Board in March as part of the formal Alliance Agreement.
Cancer We recognise that there are particular challenges in delivering some cancer pathways in Shropshire, Telford & Wrekin given workforce issues for our local providers and access issues for our patients.	Work with providers to address access and workforce issues by developing wider alliances with bigger hospitals	Lead: Gail Fortes Mayer There is a signicint amount of work ongoing in Shropshire and Telford &Wrekin, through an integrated approach across the system, led by the commissioning SRO for Cancer, reporting into the Acute cluster of the STP. Challenged caner pathways have been identified and these are the focus for commissioners and providers. Significant progress has been made across the 4 challenged cancer sites, most notably Lung, where the system will be moving to “Straight to test” by Q3 20/21/ This pathway work entails, reviewing the pathways end to end to identify where the key blocks are to delivery. Once identified commissioners and providers are working as a system to remove these blocks. To ensure timely cancer pathway management.

		There are a number of key themes being required to support the development of timely cancer pathways notably, workforce and diagnostics. There is a dedicated cancer workforce group at an STP and wide (Staffordshire) level. Digital, workforce and support service clusters are all key enabler to delivery of the cancer agenda in STW. Cancer Commissioning SRO is engaged across these enabling groups. The Cancer Strategy Board has oversight of the cancer strategy, which is beng revised to take full account of the developing ICS. reviewing critical cancer pathways that require a networked service approach. Urology has been the first cancer pathway that this model has been explored with UHNM. NHS England & NHSI continues to support the network development of a strategic commissioning intention to developespecialised kidney, bladder and prostate cancer service specification published in 2019.r. The specification would appear to require significant reconfiguration of urological cancer services, potentially from seven centres to four in the West Midlands. The engagement event was held on 1st November to review all urology (including cancer) across the West Midlands, to deliver a sustainable model of care. Of importance, the engagement event proposed the following networked provision: • Black County and West Birmingham • Birmingham and Solihull • Shropshire &Telford / Staffordshire • Coventry & Warwickshire / Hereford & Worcester NHSEI administers a Urology Partnership Board; setting the

		strategic direction for the planning and delivery of General Urology and Urological Cancer services in the West Midlands is now in place. The first meeting was held on 11th December 2019 and the board has representation from STW. Its purpose is to define a commissioning framework which will set the perameters for local systems to implement and will oversee delivery of each network's plans. STW and Staffordshire are trail blazing this network development through the work undertaken to address the urological capacity in Shropshire. The STW STP is working as part of the West Midlands Cancer Alliance to progress work on networked diagnostics, Rapid Diagnostic Centres and technology driven solutions to ensure that if SaTH does not provide an enhanced level of care, STW patients have equitable access to such services. RDC: Shropshire will receive resource over the forthcoming 4 years to develop it RDC approach. The services believe that the wprk om pathways expedite the process. It is expected that the RDC approach is one that will continue to develop with an increase in the number of diagnostic pathways available and is alluded to as a priority in the Long-term Plan (LTP). All STPs have referred to this within the cancer element of their respective LTPs and STW have joined and will attend the steering group to support future RDC mobilisation. Digital Pathology: The West Midlands Cancer Alliance (WMCA) was successful with a transformation funding bid for 2018/19. The successful bid included the development of a West Midlands integrated pathology network where four tertiary centres would form a regional networked digitalised diagnostic service. Pathology services at the four tertiary centres will be defined as lead digital laboratories (LDLs).

		University Hospitals Birmingham Foundation Trust (UHBFT) are leading the procurement process on behalf of WMCA and its constituent members. The procurement process will enable a managed service agreement via a framework agreement (Queen Elizabeth Clinical Information Technology Framework). The invitation to tender was made available on 19 November 2019 and deadline for receipt of tenders is 6 January 2020. STW STP will have representation in the procurement evaluation process Evaluation of tender bids took place on 26th February 2020. As part of the WMCA, STP level early diagnosis and survival trajectories have been developed. The trajectories provide a basis on which to focus work programmes for cancer services across STW. The trajectories have been formally included in the STW Long Term Plan. As part of the WMCA, STP level early diagnosis and survival trajectories have been developed. These provide a basis on which to focus work programmes for cancer services across STW. KPI: The Acute Cluster deliverables for 2021 are – 62 days diagnosis and development of the RDC. The urology network partner for Shropshire and Telford & Wreking is Staffordhsire.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.036
Shropshire CCG Governing Body meeting: 11.03.2020

Title of the report:	**Single Strategic Commissioner for Shropshire & Telford & Wrekin – Update Report**
Responsible Director:	**David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Author of the report:	**Alison Smith, Director of Corporate Affairs, NHS Shropshire CCG and NHS Telford and Wrekin CCG**
Presenter:	**David Evans, Accountable Officer, Telford & Wrekin CCG**

Purpose of the report:

The purpose of this report is to provide:

1) an update on the application process for creating a single strategic commissioner across Shropshire and Telford and Wrekin; and

2) to outline additional changes required to the current CCG Constitution.

3) to seek support of the Governing Body to make a re-application to NHS England/Improvement for the two CCGs to be dissolved and a single CCG created across the whole footprint of Shropshire, Telford and Wrekin.

Key issues or points to note:

The additional changes proposed to the CCG's current Constitution, is to bring it in line with legal advice and best practice received from NHS England/NHS Improvement.

Actions required by Governing Body Members:

The Governing Body is asked to:

- Note the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin;
- Approve the proposed amendments to the CCG's current Constitution to ensure that the terms of reference for the Remuneration Committee meet recent legal advice and best practice; and

- Support the planned re-application to NHS England/Improvement on 30th April 2020 to create a single CCG across the footprint of Shropshire, Telford and Wrekin.

Monitoring form

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *Future working arrangements will impact on future resources required by the CCG's*	Yes
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *The CCGs have commissioned Equality Impact Assessments on both the workforce of both CCGs and of the populations the CCGs serve.*	Yes
4	Clinical engagement *Clinical engagement will be key in moving forward with and shaping future working arrangements*	Yes
5	Patient and public engagement *Public engagement forms part of the Communications and Engagement Plan for the programme.*	Yes
6	Risk to financial and clinical sustainability *Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forwards*	Yes

Single Strategic Commissioner for Shropshire & Telford & Wrekin – Update Report

David Evans, Accountable Officer, NHS Shropshire CCG and NHS Telford and Wrekin CCG

1.Introduction

1.1 At its meeting held on 14th May 2019, the Governing Body agreed to support the dissolution of both CCGs and the formation of a single strategic commissioning organisation for the Shropshire, Telford & Wrekin footprint. It also supported recruitment of a single Accountable Officer across both CCGs and the establishment of a single management team, whether an early application to NHS England for establishment of a single CCG was accepted or not.

1.2 On September 17th both CCG memberships supported this proposal and an application was formally made to NHS England/NHS Improvement on 30th September to dissolve the two existing CCGs with a view to creating a single CCG from April 2020.

1.3 An NHS England panel meeting was convened by the regional team to consider the application in more detail on 11th October 2019 with the outcome that the application was unsuccessful, mainly due to lack of time to develop some of the key evidence to a sufficient level, to satisfy the criteria used to judge the application by NHS England.

1.4 This report seeks to provide the Governing Body with a further update on progress in moving towards becoming a single strategic commissioner with NHS Telford and Wrekin CCG and for support in making a re-application to NHS England/Improvement on 30th April 2020.

1.5 The report also outlines some additional amendments required to the current CCG Constitution to align with recent legal advice provided by NHS England/NHS Improvement and best practice.

2. Report on progress of the programme

2.1 The NHS England/NHS Improvement have supported the CCGs to make a further application earlier than the normal deadline of September 2020, as they believe our application can be enhanced to meet the 10 application criteria in full, if we continue to work at pace. We have agreed with NHS England the following new timescale for re-application and the programme timelines have been amended accordingly:

- Final submission of revised application evidence - 30th April 2020

- Regional NHS England/NHS Improvement panel – early June 2020
- National NHS England/NHS Improvement Committee – July 2020
- Creation of a new single CCG – April 2021

2.2 As part of NHS England's commitment to supporting both CCGs through this process and acknowledging their feedback from the panel process, two national merger leads on Organisational Development/HR and Strategy have been asked by NHS England/NHS Improvement to provide support to the programme in relation to the next steps required on Organisational Development and further support on developing the Commissioning Strategy. The involvement of these national leads to date has resulted in the Commissioning Strategy being further enhanced with more detail on the approach the single CCG will take to utilising population health management, refining our proposed operating model and being clearer about what we will commission in the future and in what way. The Organisational Development plan has also been enhanced with a series of actions agreed to scope further pieces of work on clinical leadership, a Board Development programme, and a talent management process to include in the plan.

2.3 Public engagement on the proposal to create one single CCG across Shropshire, Telford and Wrekin was undertaken from late January to February 2020 with a public engagement launch event taking place on 24th January in Shrewsbury. In addition this was supplemented with a hard copy and online survey and pop ups at Oswestry Library, Darwin Shopping Centre Shrewsbury, Ludlow Library, Park Lane Centre Telford, Telford Shopping Centre and Tesco Supermarket Wellington. Feedback from the launch event has been shared with participants and all engagement feedback, whether through face to face discussions or via the survey is currently being collated to be presented in an Engagement Report which will form part of the application submission. We will also publish the Engagement Report on both CCGs websites and distribute to those that participated in the engagement exercise and expressed an interest in receiving the engagement output. At the time of writing this report overall feedback had not been collated, so a verbal update will be given at the meeting.

2.4 As previously stated, the management of change process to create one single staffing structure for senior managers and staff has started and has continued regardless of the delay in a successful application. A management of change process for existing Directors started in November and concluded in December 2019. Some of these roles were not appointed to so these vacancies have gone out to national advert and the recruitment process will run until middle to end of March.

2.5 The highest risks to the programme are currently; developing a financial plan that would meet the NHS England criteria for the application process and the delay in proceeding with the planned staff management of change process.

2.6 Work has continued to develop the financial plan for the new single CCG, however this has been challenging as much of the content and modelling is dependent on the parallel work to develop a sustainable financial plan to support the local Long Term Plan, which has not yet be approved by NHS England/Improvement. Discussions are currently taking place with NHS England/Improvement on a way forward to enable a finance plan to be submitted that will meet the application criteria.

2.7 Following the appointment of Executive Directors and Directors, staff structures have started to be developed to inform a staff management of change process that will incorporate a 30 days consultation period with staff. The initial timeline for this process to start had been towards the end of February, however this had been delayed due to the need to seek NHS England/Improvement support to undertake a mutually agreed resignation scheme prior to any management of change process beginning. This approval was provided at the end of week commencing 24th February and so the new timeline will mean that staff management of change consultation will start w/c 16th March.

2.8 Following the last Governing Body meeting in January, drafting of a new Constitution for the CCG that will align with a similarly drafted Constitution for Telford and Wrekin, has started with a view to sharing this with both memberships for feedback and discussion. A date for a joint membership meeting to be convened has been identified for 24th March with a view to a vote by both memberships on a draft Constitution being undertaken by the end of March. This will then begin a management of change process for existing Governing Body members during April, followed by recruitment and election of shared Governing Body members in May to July 2020, with a view to having newly appointed Governing bodies for both CCGs by the end of July.

2.9 Following the last Governing Body meeting in January when amendments to the current CCG Constitution were agreed to reflect the new director structure, this draft was shared with NHS England for ratification. However, initial feedback from NHS England highlighted that after reviewing the whole document, the current decision making powers vested in the Remuneration Committee are contrary to recently published guidance from NHS England. The guidance states that Remuneration Committees should only make recommendations to the Governing Body and not have delegated decision making on behalf of the Governing Body and that the Chair of Remuneration Committee should not be the Audit Committee Chair. On this basis NHS

England have requested the CCG considers amending the current Remuneration Committee terms of reference and references in the Constitution and scheme of Reservation and Delegation to reflect this recent guidance, prior to any ratification of the requested changes that have already been submitted by the CCG.

The areas of the Constitution that require further amendment are as follows and are detailed in appendix 1 attached to this report with changes highlighted in red text:

Page 33 section 6.10.4 – outline of the role of Remuneration Committee

Pages 76 – 80 – Scheme of Reservation and Delegation

Page 139 – Remuneration Committee Terms of Reference – amended the Chair to the Lay Member for Transformation from the Chair of Audit Committee.

3. Recommendations

The Governing Body is asked to:

- Note the actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin;

- Approve the proposed amendments to the CCG's Constitution to ensure that the terms of reference for the Remuneration Committee meet best practice; and

- Support the planned re-application to NHS England/Improvement on 30th April 2020 to create a single CCG across the footprint of Shropshire, Telford and Wrekin.

Appendix 1

Page 33 section 6.10.4

a) **Remuneration Committee** – the Remuneration Committee is accountable to the Group's Governing Body. This Committee shall make ~~determinations~~ recommendations about pay and remuneration for employees of the Group and other allowances for employees and for people who provide services to the Group, and on ~~determinations~~ recommendations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body will approve and keep under review the Terms of Reference for the Remuneration Committee, which includes information on the membership of the Remuneration Committee.

Page 76, 77 and 80 – Scheme of Reservation and Delegation

Policy Area	Decision/Duties	Reserved to the membership	Delegated to the Locality Committees	Reserved or delegated to Governing Body	Accountable Officer	Chief Finance Officer	Chair Person	Director of Corporate Affairs	~~Director of Contracting & Planning~~	Other Committee
	~~The Committee shall~~ make determinations about pay and remuneration for employees of the CCG having proper regard to the CCG's circumstances and for senior managers to the provisions of any national arrangements for such staff			X						~~Remuneration Committee~~
	~~The Committee shall~~ make determinations on any			X						~~Remuneration Committee~~

	proposed remuneration for individual Clinical Advisory Members for specific work in addition to their corporate CCG role, to ensure the individual is fairly rewarded for their individual contribution to the CCG while having proper regard to the CCG's circumstances and performance, and to the requirements of fair and open tendering or recruitment policies.									

	Approve proposals for the remuneration of directors and senior employees and those of the AO.			X						~~Remuneration Committee~~

Governing Body Remuneration Committee

Terms of Reference

Introduction

1. The Remuneration Committee (The Committee) is established in accordance with the Shropshire Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference (TOR) set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

Membership

2. The Committee membership shall consist of all the Governing Body Lay Members appointed by the CCG. The Committee shall be chaired by the Lay Member with the lead role in overseeing ~~governance~~ transformation issues; he or she will also chair the ~~Audit~~ Clinical Commissioning Committee.

3. In the event that the Chair cannot attend all or part of the meeting one of the other Lay Members shall act as Chair. All members have voting rights and a proposal shall be carried if there is majority agreement. In the event of a tied vote, the Chair shall have a casting vote.

4. The Accountable Officer shall attend meetings of the Committee in an advisory capacity and be present for all discussions other than those directly involving them. A duly appointed qualified Human Resources (HR) Adviser shall also attend all meetings and shall be present for all discussions.

5. For issues impacting the remuneration of the Accountable Officer they will be absented from that section of the meeting, and any proposals should be presented by the CCG Clinical Chair or CCG Deputy Clinical Chair in the absence of the former.

Secretary

6. Secretarial support shall be provided to support the Chair in the management of the Committee's business.

Quorum

7. The quorum shall be 2 Lay Members.

Remuneration of Lay Members

8. For any matters regarding the remuneration of Lay Members of the Governing Body the membership of the Committee shall be:

- CCG Clinical Chair
- Governing Body Secondary Care Member
- Accountable Officer

9. If the CCG Clinical Chair cannot attend then the CCG Deputy Clinical Chair shall deputise. The quoracy requirement for meetings held with this membership shall be that at least two members will be present, at least one of whom must be the CCG Clinical Chair or CCG Deputy Clinical Chair.

Frequency of Meetings

10. Meetings shall be held at least once a year and more frequently as required for the effective conduct of business.

Remit and Responsibilities of the Committee

11. The Committee shall make ~~determinations~~ recommendations about pay and remuneration for employees of the CCG, people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. In doing so the Committee will seek assurance from the Chief Finance Officer or Accountable Officer that ~~decisions~~ recommendations made by the Committee take into consideration the financial envelope within which the CCG is managed. This shall include:

a) ~~Determining~~Recommending the remuneration and conditions of service of the Executive team and any other managerial appointment that is not subject to the Agenda For Change framework.
b) Considering severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval as appropriate and making a recommendation to the Governing Body.

Relationship with the Governing Body

12. The Remuneration Committee is a committee of the Governing Body. The Chair shall report to the Governing Body at least annually on the proceedings of the Committee

and draw to the attention of the Governing Body any issues that require disclosure or executive action.

13. A summary of each Remuneration Committee meeting and the decisions made, should be presented to the following Governing Body meeting held in public.

Policy and Best Practice

14. The Committee shall apply best practice in conducting its business. For example, the Committee shall:

    a) Comply with disclosure requirements for remuneration.

    b) Where appropriate, seek independent advice about remuneration for individuals.

    c) Ensure that ~~decisions~~recommendations are based on clear and transparent criteria.

    d) Act in accordance with national guidelines and relevant codes of conduct and good governance practice.

15. The Committee shall have full authority to commission any reports or surveys it deems necessary to help it fulfill its remit.

Review

16. The Committee shall review its own performance, membership and Terms of Reference at least annually. Any change shall be ratified by the Governing Body.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.037
Shropshire CCG Governing Body: 11.03.2020

Title of the report:	Shropshire CCG Emergency Planning Resilience and Response Coronavirus Update
Responsible Director:	Sam Tilley – Director of Planning
Author of the report:	Sam Tilley – Director of Planning
Presenter:	Sam Tilley – Director of Planning

Purpose of the report:

To update the Governing Body on the current position in relation to the response to Coronavirus.

Key issues or points to note:

Coronavirus is a rapidly developing worldwide issue and this short report aims to assure the Governing Body in relation to the local preparations to respond this issue.

At the time of writing there are no confirmed cases of Coronavirus in Shropshire, Telford and Wrekin and the number of people presenting for testing remains low. The risk to the UK public is considered to be moderate and the infection and death rates for the virus appear to be broadly similar to seasonal flu currently.

Nationally we are working closely with NHS England, Public Health England and the Department of Health and Social Care who are monitoring the situation closely and providing us with up to date advice.

We are working locally with system partners to co-ordinate appropriate action and resources in line with national guidance and requirements to protect the public's health, and to plan and prepare for any changes in the situation, should they arise. This includes the mobilising of Shropshire Local Health Resilience Partnership to co-ordinate plans. System partners are in regular contact and take part in daily and weekly update meetings with local, regional and national colleagues.

NHS and Public Health England have provided advice and guidance on things people can do to protect themselves and their family as well as a range of guidance to support health professionals in both clinical and non-clinical settings.

In line with national requirements locally we have put in place Priority Assessment facilities at both Royal Shrewsbury Hospital and Princess Royal Hospital and a community and home testing service which will be operational from Friday 6 March 2020.

We continue to promote the national guidance in relation to hygiene awareness and that the route for support for individuals who are concerned that they may have contracted the virus being via 111.

The situation is being monitored very carefully and plans are being developed that will enable us to scale up our response should it become necessary.

Actions required by Governing Body Members:

The Governing Body is asked to:

- Note the content of the report and to support the ongoing programme of response.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *It may be necessary to draw more staff into the Coronavirus response* *Workforce levels may be affected if number of cases or suspected cases increase significantly*	Yes
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the effect upon these requirements*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *There may be a financial impact on the CCG if number of cases or suspected cases increase significantly*	Yes

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.038
Shropshire CCG Governing Body meeting: 11.03.2020

Title of the report:	Report from Audit Committee 26 February 2020
Responsible Director:	Alison Smith, Director of Corporate Affairs
Author of the report:	Keith Timmis, Lay Member – Governance & Audit
Presenter:	Keith Timmis, Lay Member – Governance & Audit

Purpose of the report: To highlight to the Governing Body key issues arising from the 26 February 2020 Audit Committee meeting and to agree any actions that result.

Key issues or points to note:

1. Internal Audit presented two reports of specific reviews. They give Significant Assurance on our contracting arrangements for Shrewsbury and Telford Hospitals NHS Trust and Midlands Partnership Foundation Trust. There is still work to complete on our arrangements for information governance before we complete our return at the end of the operational year.
2. The Mental Health Investment Standard report is still not available, pending a national decision on the release of the results of the work.
3. Counter Fraud reported on the completion of the National Fraud Initiative work. There are no unresolved issues and no instances of fraud have been identified.
4. The Committee discussed the arrangements for the preparation of the CCG annual report, accounts and, in particular, the content of the Annual Governance Statement.

Actions required by Governing Body Members:

- Note the content of the report.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	No
3	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
4	Clinical engagement *If yes, please provide details of the clinical engagement*	No
5	Patient and public engagement *If yes, please provide details of the patient and public engagement*	No
6	Risk to financial and clinical sustainability *If yes how will this be mitigated*	No

NHS Shropshire CCG Audit Committee Report 26 February 2020
Keith Timmis: Lay Member –Governance & Audit

Matters arising

1 Progress has been made on all outstanding actions from previous Committee meetings.

2 The Chief Finance Officer is waiting for a reply clarifying a query from the Audit Committee Chair on the information governance policy. The current wording suggests a role for the Audit Committee that is inconsistent with the requirements of the Audit Committee Handbook. Once this is resolved the IG policy will be signed off by the CFO and Chair of the Committee.

Governing Body Assurance Framework

3 We discussed the current version of the GBAF and suggested some relatively minor changes. Overall, the Committee is happy the GBAF covers the key risks and actions.

Annual Governance Statement

4 The Director of Corporate Affairs led the Committee through the processes for completing the AGS for 2019/20. Members considered the content in the initial draft and agreed to receive further updates as the process continues. The Committee will be taking a strong interest in the wording that covers the CCG's financial performance.

Internal audit

5 Internal audit reported there is still strong control of outstanding recommendations.

6 The Internal Audit reports on contracting arrangements for SaTH and MPFT concluded there is Significant Assurance for our arrangements. The Committee asked for an amendment to the CCG response to one recommendation. This was to make the response more closely relevant to the recommendation from IA and to have one CCG employee responsible for the implementation of the recommendation, rather than spreading responsibility across a range of people.

7 The draft IA plan for 2020/21 has been drafted to provide a close link with the Telford and Wrekin CCG plan. The Committee support this approach but asked a series of questions about the detailed coverage. We agreed to hold discussions outside the Committee to produce a revised version of the plan for approval at the April meeting. External Audit also raised questions about the level of days in the plan.

8 The work on our arrangements for the Data Security and Protection Toolkit identified the work that remains to be completed before final submission at the end of the operational year. Most of this depends on information required from the CSU. They are due to report to our CFO in early March. At the moment we expect to satisfactorily resolve all the outstanding points.

External audit

9 We are still waiting for approval from NHSEI to release the results of the special review of mental health expenditure. We are not expecting to have any issues of significance to report to the Governing Body.

10 The Committee considered the CCG accounting policies. Other than minor updates to reflect the latest national guidance there were few changes and the Committee was happy to approve the updated version. There was a discussion (as we had last year) about the most appropriate wording for the required disclosure on the "going concern" status of the CCG.

11 The arrangements for producing the annual accounts have been updated. The Committee had no concerns and noted the results of the "Month 9 exercise". There have been improvements to the agreement of balances process that should deal with the points raised by external audit in last year's accounts report.

12 The Committee approved the external audit plan for work on the 2019/20 accounts. We discussed Grant Thornton's work on the Value for Money Conclusion and outlined the Lay Members' views on the key issues around the CCG's financial position.

Counter Fraud

13 The Local Counter Fraud Specialist reported that all the remaining queries from the National Fraud Investigation data-matching exercise have been satisfactorily resolved.

14 The NHS Counter Fraud Authority has introduced the proposed new system of "fraud champions". This will be Laura Clare, the Deputy CFO. We will monitor the impact and value of this mandatory role.

Other matters

15 The Committee considered a report on the CCG arrangements for hospitality and the cases recorded to date. Our approach complies with national guidance but the policy will be reviewed as we work jointly with Telford and Wrekin CCG. The Committee asked for an update on arrangements at a future meeting.

16 For the last 18 months, the Committee has received regular reports on the business approval process for interim staff. This followed concerns from NHSEI about how consistently this was applied. The Committee noted the continued reduction in the number of interim staff and the much improved process. We therefore concluded that we no longer' need to receive regular reports.

Next meeting

17 The next Audit Committee is scheduled for 29 April 2020.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.039
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	20th November 2019
Chair:	Mrs Sarah Porter

Key issues or points to note:

- **SEND:** Statement of Intent approved
- **Children and Young People's Long Term Plan (LTP):** It is expected that this plan will be incorporated in the Mental Health LTP
  Refreshed plan approved
- **Non-Medical Referral to Radiology:** New protocol pilot approved
- **0-25 Bee-U action plan closure update:** The CCC received assurance that the recommendations were cleared and the action plan was now closed. The Share Care Agreement issue was now being led by Medicines Management directly and any future issues would now be monitored via the regular contracting process

Actions required by Governing Body Members:

- None

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN ROOM K2 AT 9.00AM ON WEDNESDAY 20 NOVEMBER 2019

Present:

Mrs Sarah Porter (Chair)	Lay Member for Transformation
Dr Deborah Shepherd	Shrewsbury & Atcham Locality Chair
Dr Katy Lewis	North Locality Chair
Dr Matthew Bird	South Locality Chair
Dr Alan Leaman	Secondary Care Consultant
Dr Jessica Sokolov	Medical Director
Mrs Chris Morris	Director of Nursing & Quality
Mr Kevin Morris	GP Practice Manager Board Representative
Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Mr David Stout	Interim Transformation Director
Dr Julie Davies	Director of Performance & Delivery
Dr John Pepper	GP Board Member
Dr Finola Lynch	GP Board Member
Dr Julian Povey	CCG Chair
Dr Steve James	GP Board Member
Mrs Faye Harrison	Personal Assistant (Minute taker)

In Attendance:

Cathy Davis	For Agenda Item CCC-19/11/125 GP Counselling – Lessons Learnt
Lisa Wicks/ Barry Reis-Seymour	For Agenda Item CCC-19/11/127 - Shropshire Care Closer to Home Update
Lynda Ferron/ Beth Emberton	For Agenda Item CCC-19/11/129 – MSK Services
Helen Bayley	For Agenda Item CCC-19/11/130 - SEND Update
Steve Trenchard	For Agenda Item CCC-19/11/131 – Children and Young People's LTP

Apologies:

Mrs Claire Skidmore	Chief Finance Officer
Dr Priya George	GP Board Member
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Nicky Wilde	Director of Primary Care

CCC-19/11/123 Apologies

Apologies were noted as above.

CCC-19/11/124 Members' Declarations of Interest

1.0 Mrs Porter requested that attendees declared any potential conflicts of interest regarding the Committee agenda.

1.1 Dr Pepper and Dr Povey both work at surgeries which are pilot sites for Phase 2 of the Shropshire Care Closer to Home initiative. It was agreed that as there were no decisions to be made and no financial gain both could remain to be present for any discussion.

1.2 There were no other declarations of interest.

CCC-19/11/125 Minutes/Actions of Previous Meeting 16.10.19 & Matters Arising

2.0 The minutes of the previous meeting were discussed and agreed as a true record.

2.1 The CCC Action Tracker was discussed and updated as appropriate; the following point was noted:

Data Sharing Agreements – *Dr James updated members that everyone is now signed up to the Data Sharing Gateway. Work is underway with regards to the Pharmacists within the Medicines Optimisation Team having access. There is a National Data Sharing Agreement coming out with regards to GP Connect and NHS 111.*

2.2 **CCC Working Group Update**

Dr Davies informed that an update would be brought in December around the Enhanced Care Home Framework. Falls Prevention, Bone Health Strategy, Dementia, Pain Services, Cardiology Pathways, X-Ray Non-Medical Referral to Radiology and Diabetic Foot Screening were also discussed at the Working Group along with Smoking and Weight Management. Timings to get papers ready are quite tight and will be brought to CCC in due course.

There are currently differences between Shropshire and Telford & Wrekin Prevention services which were discussed along with issues within Public Health and their budgeting which have been raised at the Health and Wellbeing Board. Public engagement is important to move forward however scrutiny at Working Group will be required. Decision making is currently limited due to Purdah although this will be over by the next meeting.

2.3 **GP Counselling – Lessons Learnt**

Cathy Davis attended the meeting for this item. She updated that currently the IAPT service is standardised with waiting times of 6 weeks for initial contact and telephone assessment. Following this material will be given to the patient to work through such as Silvercloud (online programme), they will then be added to the waiting list for face to face treatment should this be required; this should be within 18 weeks. Concern was raised that this waiting time is not currently being achieved. Further discussion was held around this issue and the difficulties involved.

9.30am David Stout joined the meeting

Dr Davies highlighted that there had been further investment into IAPT which had created extra capacity but that there are still issues around the accuracy of the figures. Future investment from the Mental Health Transformation Money will need to be prioritised. It was felt that priorities lie with Crisis and Children and Young People. The impact of Silvercloud will also need to be considered as well as the impact of the 6 month wait on the patients. It would be beneficial to look at the patient numbers and corresponding waiting times involved for each part of the service for full evaluation.

Action: Cathy Davis to complete this piece of work and bring back to CCC around February time

Communication with the GP Surgeries was also discussed and it was agreed that this is something that needs to be improved upon. It was suggested that communications could be validated by the Locality Chairs before being shared.

Action: GP Surgery Communications to be validated by the Locality Chairs before being shared

2.4 **ASD Assessment and Diagnosis**

Cathy Davis reported to members that a new waiting list initiative and sustainable solution is currently being developed and a model has been agreed in relation to this although Executive approval is awaited. Work is on going with both Local Authorities.

A Multi-Disciplinary Panel has been created in Telford with the whole system including education being involved in order to address the issues without the focus being on diagnosis. Assessments are carried out in term time only as panels can't be held without schools. Parents do not attend the panel. With regard to Shropshire it was agreed that any specific questions could be raised with Ms Davis following the meeting.

CCC-19/11/126 – 0-25 Action Plan Closure Update

3.0 This report was brought to the committee for members to note. Ms Davis reported that the changes had been made and the recommendations are now clearer. Clarification around children in Primary Care Health Checks was requested and this would be followed up after the meeting. Shared Care Agreements are currently not up to date and this will be picked up with Liz Walker. A updated will then be circulated.

Action: Mrs Davis to speak to Liz Walker around Shared Care Agreements and circulate an update.

Members noted all the recommendations in the paper.

CCC-19/11/127 - Shropshire Care Closer to Home Update
Outcome of SCCtH Phase 3 Impact Assessments
SCHT Workforce Issues – Delivery Case Management

4.0 Lisa Wicks and Barrie Reis-Seymour attended the meeting for this item. They updated that there are still staffing issues within the Frailty Intervention Team across both sites. A meeting with the Case Managers is taking place tomorrow and an update paper will be brought back to the next meeting detailing the early findings and options for roll out. It will need to be agreed whether the service is scaled up or left as it is. Admin support will be required so that clinicians are used more appropriately. Discussion was held around the current set of data as it is somewhat limited

4.1 The SCCtH Programme Board had requested an Impact Assessment on Phase 3 with all providers looking at the impact on existing services. There are system issues detailed in the paper and Ms Wicks requested steer from the committee as to whether they should continue without the Impact Assessment or whether this should be waited for. The lack of Impact Assessment has been escalated with the provider. It was agreed that SaTH would be the biggest beneficiary from this and therefore their asset was critical. Discussion was held around this issue and the system plan. Members agreed to proceed whilst the Impact Assessment was awaited from SaTH.

4.2 It was noted that no response had been received from Neil Nisbet following the Governing Body meeting. Dr Lynch agreed to chase this response up.

Action: Dr Lynch to chase up response from Neil Nisbet following the Governing Body Meeting

4.3 Workforce Issues with Case Managers and Health Assessments were discussed. It was highlighted that the initial scheme was a pilot and a lot of the Case Managers were seconded from other roles until March 2020 and are due to go back to their previous roles which will also have an impact.

Members noted the recommendation in the paper.

CCC-19/11/128 – Frailty Collaborative PDSA

5.0 Dr Lynch presented this paper for information. Clinicians, commissioners and representatives from all partnership organisations in Shropshire and Telford and Wrekin including the voluntary sector have been brought together under the Frailty Collaborative, which is a regional initiative started by Emergency Care Improvement Support Team (ECIST). This has created an opportunity to work more closely with colleagues and collaborators around frailty. It meets monthly, attends regional education and quality improvement meetings, and has been involved in several initiatives since its inception in July, including:

- Providing clinical leadership for a MacMillan bid for £500,000 for system education training around advanced care planning/non-palliative end of life (EoL) recognition. First round has been successful and further iteration of bid is now for £1 million
- A Winter Planning scheme for advanced care planning in SaTH, with £62,000 awarded to the trust to support a specialist doctor identifying and doing advanced care plans with patients who are extremely frail/potentially last year of life
- PDSA in a Telford care home working alongside Telford's care home multidisciplinary team to further support advanced care planning in care homes and recognition of last year of life

5.1 Dr Lynch confirmed that 'Frailty' is a clinical indicator and doesn't relate to the age of the person specifically. Each case is assessed on an individual basis. Discussion was held around this and the criteria involved along with the Rockwood Scoring System and how it worked. Further conversations could be held outside of the meeting around the issues raised.

CCC-19/11/129 – MSK Services

This item was discussed under confidential part of the meeting

CCC-19/11/130 - SEND Update

7.0 Helen Bayley attended the meeting for this agenda item. She informed members that the paper was an update from the last meeting in June and that there has been no inspection as yet however this is expected in the New Year and briefings will be sent out in due course detailing the key lines of enquiry. The SEND Strategic Board announced 3 new sub-groups and there will be Health representation at all 3. These will be aligned across Telford & Wrekin and Shropshire.

The Statement of Intent was approved by members.

CCC-19/11/131 – Children and Young People's LTP

8.0 Mr Trenchard attended the meeting for this agenda item and talked members through the updated plan highlighting the key changes. Some actions have been amended in line with the KLOE NHSE/I feedback although further update will be required and it is hoped this will be complete by the end of January. There is an ongoing issue around the system not being currently aligned and work is to going to resolve this. It is expected that moving forward the CYP LTP would be included in the MH Long Term Plan.

8.1 Mr Trenchard confirmed that the paper has had full involvement of various professionals including from local authority, public health and MPFT. However the finances have not been updated as yet to include the additional resources (mental health in schools teams and crisis or ADHD funding) and work is ongoing with the Finance Team. The report is still in draft format and is awaiting approval from Finance & Performance Committee around the Transformation monies.

8.2 It was confirmed that children are able to access on-line self-care tools and these will be communicated to children through schools and are available on BeeU website. Communication is still highlighted as a problem area. Use of other technology such as apps was discussed. All services will be available to Looked After Children.

The refreshed plan was approved by members with the caveat that the Executive Summary needed more detail as it didn't include all the headlines and it was also confirmed that the Stepped Model has now been agreed.

12.10pm David Stout left the meeting

CCC-19/11/132 – Non-Medical Referral to Radiology

9.0 Dr Deborah Shepherd gave a brief background to members highlighting the legal regulations. Approval was sought for a pilot scheme to be rolled out within a single practice and Dr Shepherd explained that the protocols were to support this. The clinical conditions and governance around this can be influenced currently. Brief discussion was held around this and the exclusions and inclusion which will be involved as well as how the pilot scheme would work and it was clarified that this was mainly to test the process and procedures. Which clinicians could refer to the service was also discussed. Members agreed this was a very positive piece of work.

Members noted the contents of the report and approved the new protocol pilot.

12.35pm Julie Davies left the meeting

CCC-19/11/133 – Any Other Business

10.0 There were no items of any other business.

Date of Next Meeting

The next meeting of the Clinical Commissioning Committee will be held on Wednesday 18 December 2019 at 9.00am in Meeting Room K2, William Farr House.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.039c
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	22nd January 2020
Chair:	Mrs Sarah Porter

Key issues or points to note:

- **Falls Prevention and Bone Health (ST&W):** Business Case approved
- **Back Pain Pathway:** Approved subject to final comments received from GPs
- **Mental Health Financial Long Term Plan :** Presented for information

Actions required by Governing Body Members:

- None

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN AO'S ROOM, SOMERBY SUITE AT 9.00AM ON WEDNESDAY 22 JANUARY 2020

Present:

Mrs Sarah Porter (Chair)	Lay Member for Transformation
Dr Deborah Shepherd	Shrewsbury & Atcham Locality Chair
Dr Katy Lewis	North Locality Chair
Dr Matthew Bird	South Locality Chair
Dr Alan Leaman	Secondary Care Consultant
Dr Jessica Sokolov	Medical Director
Mr Kevin Morris	GP Practice Manager Board Representative
Dr Julie Davies	Director of Performance & Delivery
Dr John Pepper	GP Board Member
Dr Finola Lynch	GP Board Member
Mrs Laura Clare	Deputy Chief Finance Officer
Dr Julian Povey	CCG Chair
Mrs Rachel Robinson	Shropshire County Council
Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Dr Priya George	GP Board Member
Mrs Sam Tilley	Director of Planning
Mrs Liz Walker	Head of Medicines Management
Mrs Trudy Attfield	Personal Assistant (Minute taker)

In Attendance:

Alison Massey	Agenda Item CCC-20/01/004 Falls Business Case & CCC-20/01/005 AF Business Case
Lisa Wicks/ Barrie Reis-Seymour	Agenda Item CCC-20/01/006 – Shropshire Care Closer to Home Admission avoidance update Roll out of Case Management – option appraisal
Rose Howard	Agenda Item CCC-20/01/007 Back Pain Pathway
Emma Pyrah	Agenda Item CCC-20/01/008Revised pre-hospital management of PE pathway
Cathy Davis	Agenda Item CCC-20/009 Mental Health Financial LTP (for information)

Apologies:

Mrs Claire Skidmore	Chief Finance Officer
Mr David Evans	Accountable Officer
Mrs Nicky Wilde	Director of Primary Care
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Chris Morris	Director of Nursing & Quality

CCC-20/01/001 Apologies - Apologies were noted as above.

CCC-20/01/002 Members' Declarations of Interest

1.1 Mrs Porter requested that attendees declared any potential conflicts of interest regarding the Committee agenda. .
Dr Bird advised that Albrighton Medical Practice was working as a pilot for the Care Closer to Home

CCC-20/01/003 Minutes of Previous Meetings/Matters Arising
Minutes 20 November 2019

- It was noted that under 'in attendance' it should have read Cathy Davis not Riley
- CCC-19/11/132 – Non Medical Referral to Radiology – Dr Shepherd advised that the third sentence should read .. that this was mainly to **test** the process not text.
- 8.1 It was agreed that Prof Trenchard should be changed to Mr Trenchard.

Minutes 18 December 2019 – Minutes were accepted as a true record.

The CCC Action Tracker was discussed and updated as appropriate.

CCC Working Group Update

2.1 Dr Sokolov updated members following the CCC Working Group meeting:

- Palpitations Pathway – developed by Shrewsbury Locality. It was agreed that this would be shared through Localities for information.
- VBC Policy – Following discussions a number of amendments were identified. It was agreed that amended document would be brought back to a future CCC with another piece alongside this in relation to the process.
- Pain Pathway – on agenda
- PE Pathway – on agenda

CCC-20/01/004 – Shropshire, Telford and Wrekin Falls Prevention and Bone Health – Business Case update

2.1 Mrs Massey asked CCC to review and approve the changes made following the December CCC meeting.

2.2 Mrs Clare highlighted that at the December meeting it was agreed that the paper needed to demonstrate the phasing of the investment and savings and acknowledged that there was a suggested trajectory in terms of percentages within paragraph 45 but thought that it would also be useful to incorporate a table which showed what this meant in terms of investment and savings for clarity. It was agreed that this could be inserted. It was agreed that revised document could be forwarded to members for information.

2.3 Mrs Robinson advised that the postural stability elevated programme funded by Public Health which was due to run out in June had been extended until April 2021.

Members gave final approval to the Business Case

CCC-20/01/005 – AF Business Case

3.1 The AF Business Case paper was presented for discussion only and Dr Davies explained that the paper could not currently demonstrate whether there would be financial pressure so would only be discussed clinically and the would be brought back to a future CCC.

3.2 Mrs Massey explained that the difficulty in terms of cost savings was that only activity that was happening in the acute sector could be counted, so financial savings within the original business case made assumptions around post discharge which was difficult to quantify. The aim was to now carry out work with the Finance and Medicines Management team to try and capture this in a more quantifiable way. She explained that the cost savings that could be counted was the reduction in stroke, acute aspect so would need to understand where the balance sat.

3.3 Following discussions, it was acknowledged that the business case was not intended to be a standalone piece of work. Dr Povey commented that he felt that the Pharmaceutical Industry Policy needed to be aligned across both CCGs and then could look how to address an AF Strategy. Mrs Tilley advised that there was currently a programme in place for aligning all policies. It was agreed that this policy needed to be made a priority going forward.

3.4 Dr Lewis expressed concerns with regard to monitoring as did not feel that this had not been taken into account as would have cost implications. She talked about usage of different types of medication and felt that if using the pharmaceutical industry that there would be cost and workforce issues for GPs. Mrs Walker agreed would take concerns back.

3.5 Dr Shepherd said when looking at the three elements, Detect, Protect and Perfect that the paper stated that it would not look at 'Perfect' as this involved secondary care and expressed that she felt that this was the important element to focus upon financially and clinically. Mrs Walker explained that it would be covering the Protect first to save putting any more pressure on practices and would then build and develop to do next piece of work. Dr Lewis felt that needed to look at this as a whole around detecting and monitoring. Mrs Walker explained that this would be covered within a different part of the pathway.

3.6 Dr Leaman asked about clarification with regard to costings for major bleeds and asked whether this included Epistaxis and pointed out that around 40% of patients on anticoagulants have an Epistaxis and required hospital assessment. Mrs Massey said costs were based on acute episodes and explained that this had been obtained from the Right care model. She agreed to check this.

It was agreed that Mrs Massey would feedback concerns/comments made to the working group

3.8 Dr Povey asked Mrs Walker to show/explain the different models in greater details when the paper was presented again. It was agreed that further discussion would now be held within the Working Group and would come back to CCC once finalised.

ACTION: Any further feedback to be fed back to Dr Davies or Dr Sokolov to enable them to take back through the Working Group

CCC-20/01/006 - Shropshire Care Closer to Home update

The Journey so Far

4.0 Ms Wicks gave brief update of the journey so far:

- Frailty – working well but still have some staffing issues which are being raised through the Working Contract group and A&E Delivery group. Dr Sokolov advised that a conversation had been held at the A&E Delivery group and concern raised, especially on the Telford site, around the staffing not functioning as it was intended even though there was significant resource. It was suggested that a whole review needed to be carried out to assess how much was being achieved from the model, how it was working and whether the resource was being best utilised.

- Case Management – Working towards the expansion model. The Memorandum of Understanding had been expanded to include SaTH and this would be signed off at the Programme Board.

- Phase 3 Impact Assessments – Still awaiting SaTH's Impact Assessment but had been assured that the Clinical Governance Lead would be signing this off this week so would then have a full impact assessment on the phase models. An update would be brought back to the March CCC outlining all the captured feedback.

- JSNA – Work continues

Admission Avoidance Update

5.0 Ms Wicks advised that the service went live but on a phased approach:
Phase 1 – non medical intervention (social care and domiciliary care) – went live 9th December
Phase 2 – full model with reduced nursing hours – 5th January 2020
Phase 3 – full model 24/7 – May 2020

5.1 Ms Wicks advised that data was being captured on a daily basis and that the latest figures showed that 32 referrals had taken place since the start of the service which meant that 81% had been supported to stay at home. The majority of the referrals had been from A&E but work was required with the Community Team to try and reach out to Shropdoc and GP Practices to ask them to also refer in.

5.2 The paper updated on progress in terms of contract value and steps taken. Ms Wicks advised that the service had gone out to procurement but they did not receive any bids, but now had been approached by the Council to support the system to take forward the work. Negotiations were taking place with Shropcom who had come forward to provide the nursing element and advised that costs were high because staffing was currently being provided by agency staffing whilst they recruit staff on a permanent basis. Ms Wicks highlighted that the contract value had changed with the cost pressure being offset by the winter monies received and said that if the Committee were happy to proceed she would work with the Finance team to ensure all waivers were in place. Mrs Clare said to note that the UEC transformation and the Winter Planning money was non-recurrent, a one off benefit.

5.4. Mr Vivien asked if there was a risk that demand would exceed supply. Ms Wicks confirmed that had carried out detailed modelling and knew what the total demand was that should go through the service and the amount of visits per day that the service could take and that Shropshire Council had carried out mapping in terms of their Social Care capacity so were confident that will be able to carry out 30/40 visits per day with the staffing in post over the 3 postcodes.

5.5 Dr Povey asked if referrals go through Community Coordination Centre (CCC) as this needed to be clear? Ms Wicks said that in the design it was detailed not to go through CCC but to take a call through the very senior advanced practitioner. Concerns were expressed and it was agreed that these would be fed back to establish whether this needed changing. Suggestions were made that would be helpful if could use both routes for referral.

It was noted that wording "One phone call/one email should read one phone call <u>or</u> one email."

CCC Members noted the progress update on the commissioning of the service and the revised total costs on the nursing element provided by Shropshire Community Trust and the revised financial and QIPP profiling

Roll out of Case Management – Option Appraisal

6.0 Ms Wicks advised that the Case Management sites had been rolled out in June for a period of 9 months. The demonstrator sites would conclude at the end of March unless a decision was made to resource sites to continue work. Because of delays the data captured had not been as detailed as would have hoped. There was now an opportunity to expand to another 8 sites to continue the evaluation and a precedent response had been received that this was felt as the right direction to take, as case studies had shown the impact that this had had on the prevention model. The Committee were asked to approve taking forward the expansion in two phases. Phase 1 would be to establish the Case Managers and admin along with some clinical assessment at the 16 practices. Ms Wicks would bring paper back to February CCC outlining staffing and resource requirements to take this up to align to PCNs.

Action: Ms Wicks to bring back Case Management Paper – Phase 1 around staffing and resource requirements

6.1 Discussions were held around data capturing and communication with regard to learning, feedback and primary care engagement. Ms Wicks advised that this was a pilot model and that it would note and capture the differences and monitor the impact and effectiveness of the variation. Dr Lynch said that this needed to articulate the intent for contracting and how this fit in with Primary Care Network (PCN) Direct Enhanced Services (DES), as a lot of the model was aligning with PCN DES. Dr Sokolov advised that this was referenced within the paper and said the team was currently working very closely with the Primary Care Team to try and understand and map this across.

6.2 Mr Vivien commented that need to make sure that the Telford provision was also being built in with regard to staffing and delivery and join up if available. Ms Wicks advised that she was working closely with Tracey Jones at Telford & Wrekin to ensure join up and had shared the Shropshire specification to enable the joining through the contract negotiation meetings and advised that they were looking to deploy the same case management model. Work would be carried out around admission avoidance working through all available options. Dr Sokolov assured members that even if things were carried out differently then would ensure that they were still measuring in the same way so that the learning could be brought together.

6.3 Discussions were held with regard to the choices of site. Ms Wicks advised that sites had been agreed following a workshop held which had included everybody who had been involved within the case management and had been identified because they could move at pace with regard to staffing ease and could neighbour up and obtain impact faster. It was noted that there was a need to target other sites but it was hoped to bring back the hub paper to the February/March CCC which would show the gap between step one and step two as being minimal. It was hoped by summer to target the whole of the County. Dr Lewis expressed concerns with regard to cross border working.

Members agreed all recommendations

CCC-20/01/007 – Back Pain Pathway

7.0 Mrs Howard-Jones presented the back pain/spinal pathway to seek approval for publication of the pathway onto the CCG website and roll out to Primary Care and Provider Trusts.

7.1 Dr Davies advised that an action from the Working Group was for Dr James to liaise with SaTH around wording under the headings - Emergency/24 hours and Urgent/2 weeks with regard to Major motor radiculopathy and significant neurological deficit. Dr Shepherd advised that these had been inserted by Yvonne Rimmer from the MSK team and highlighted that these conditions were hard to define but felt that they were in there as sometimes clinically the context was important, but felt that maybe major motor neurological deficit was more likely to be more urgent than major sensory to the patient. Following discussions it was felt that this could be left in as listed as gave scope for clinical interpretation. Dr Povey talked about the urgent 2 week heading and said that he was not aware of a pathway to refer urgently apart from the MG12 suspected cancer referrals so this would not be clear if left in place. Dr Lynch advised that it required clarity around 2 week terminology and suggested maybe changing name to Urgent/2 weeks.

7.2 Mrs Howard-Jones explained that the pathway was initially developed following an action from the RJAH Planned Care Working Group where they had raised a number of end to end concerns around not having a spinal pathway. The intention of the pathway was to explain the flow of the patient and was not the intention to address MRI capacity but to describe the process to enable clarity.

7.3 Dr Shepherd stated that if a clearly defined pathway could be agreed and adopted then the Provider could be held to account to follow it that this would then address any concerns. Dr Pepper talked about concerns/inconsistencies when phoning through to the Orthopaedic Teams at RJAH and also felt that it is was inappropriate to go through A&E as patients would have already been assessed by a GP. Dr Leaman said there was a need to amend wording in red box to read emergency referral would be to the Orthopaedics at SaTH via Care Coordination Centre (CCC). Dr Davies pointed out that need to approve/agree a pathway for commissioning then can take this forward with the Providers with regard to obtaining consistency across the two providers for delivering the pathway through the contract.

7.4 Discussions were held around the issue of a non-urgent pathway around diagnostics for Orthopaedics and the need to cross reference this within the new model of care

Action: It was agreed that Mrs Howard-Jones would work with Dr Sokolov to make amendments and incorporate comments made and send revision out to members for approval to enable this to be taken forward.

CCC-20/01/008 – Revised Pre-hospital Management of PE Pathway

8.0 Mrs Pyrah presented her report and asked members for approval of a change to the current pathway. She explained that the change was not about changing the treatment but around changing the location and timing and that the aim was to improve patient experience and reduce demand on acute beds.

8.1 Dr Pepper expressed that he felt wording should be changed to read "modified" PESI and explained that this was a different scoring system and would ensure clarity for GPs using it. Ms Pyrah agreed to take back to Dr Pringle to change wording to enable clear communication for GPs.

8.2 Dr Bird highlighted that it would be useful if we could consider the use of a quick acting oral anticoagulant instead having to use LMWH as this may avoid the need for patients to attend Shropdoc.

8.3 Dr Shepherd asked for clarity around what happed to patients after midday as would leave gap for patients who turned up in the afternoon. Ms Pyrah advised that this point had been raised through the CCC Working Group and it was agreed to complete the pre-hospital pathway first to avoid delay and then could work on the next stage.

8.4 Dr Sokolov advised that Telford & Wrekin had already approved this pathway and felt that a lot could be learnt about the demand and impact as the proposal was that Shropdoc would earmark 4 appointments per day, so would be able to see the uptake and then track the data across once the patient was admitted. This would be proof of concept and would be an opportunity to undertake learning because of the way that the monitoring was being structured.

8.5 Dr Povey expressed concerns with regard to the issue of PSI score and felt that they were not using the appropriate tool for the assessment of risk of a PE so felt that he could not give approval.

Action: It was agreed that the PE Pathway needed to be taken through CCC Working Group as needed further clarification/reference and brought back to CCC with final flowchart.

CCC-20/01/009 – Mental Health Financial Long Term Plan (for information)

9.0 Mrs Davis presented the Mental Health Financial Long Term Plan for information and members were asked to note the paper for information.

Members noted the paper

CCC-20/01/010 – Any Other Business

There were no further items for discussion

Date of Next Meeting
The next meeting of the Clinical Commissioning Committee would be held on Wednesday 19 February 2020 at 9.00am in Room K2, William Farr House.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.040
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Finance and Performance
Date of Meeting:	27/11/19 , 9/1/20 & 29/1
Chair:	Kevin Morris

Key issues or points to note:

- Pressure during the whole period on A & E has been highlighted
- Improvement in Cancer wait times continued during this time period
- Revised Finance figures looked at shows some slippage
- QIPP Pipeline for 20/21 is main priority. Extra resource to firm up proposals
- System need to work together to achieve the QIPP for next year

Actions required by Governing Body Members:

- To note

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE COMMITTEE HELD IN MEETING ROOM K2, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL ON WEDNESDAY 27 NOVEMBER 2019 AT 11.00AM

Present

Mrs Claire Skidmore	Chief Finance Officer
Mr Keith Timmis (Chair)	Lay Member – Governance & Audit
Dr Julie Davies	Director of Performance & Delivery
Mrs Laura Clare	Deputy Chief Finance Officer
Mr David Stout	Interim Transformation Director
Dr Michael Matthee	North Locality Chair
Ms Sarah Porter	Lay Member – Transformation
Ms Kate Owen	Head of PMO
Mr Meredith Vivian	Lay Member – Patient & Public Engagement

Apologies

Mr Kevin Morris (Chair)	GP Practice Board Representative
Mrs Gail Fortes-Mayer	Director of Contracting & Planning

In Attendance

Mr Tim Woodhead	Deputy Director of Finance, NHSE/I– North Midlands
Mrs Faye Harrison	Personal Assistant (minute taker)

Mr Tim Woodhead, Deputy Director of Finance from NHSE/I attended the meeting today due to the worrying financial position. Members introduced themselves around the table.

FPC-2019.11.118 - Apologies

1.1 Apologies were noted as above.

FPC-2019.11.119 - Members' Declaration of Interests

2.1 No declarations were raised.

FPC-2019.11.120 - Minutes of Previous Meeting held on 30 October 2019

3.1 It was confirmed that the additional paragraph which was circulated following the meeting had been added to the minutes and these were therefore agreed as being a true and accurate record of the Committee which was held on 30 October 2019.

FPC-2019.11.121 - Matters Arising/ Action Tracker

4.1 The Action Tracker was discussed and updated.

FPC-2019.11.122 - Quality, Innovation, Productivity & Prevention (QIPP) Report

5.1 Mrs Skidmore highlighted the Key Messages from the report to members. She clarified the risk adjusted position and it is currently hoped to deliver £15m. There are still some concerns around pace which will impact on delivery.

5.2 The CHC Portfolio has a reduced risk assessment with hope to deliver the full plan. Work is ongoing on the Month 8 figures before deciding whether to take out the risk adjustment. The Grip and Control Risk is being looked at with 2 separate areas to monitor. It was requested that if there is anything within the plan that won't deliver that the Committee be informed.

Action: If there is anything within CHC which is not likely to deliver Mrs Morris would be asked to inform the Committee

5.3 The pipeline schemes are being worked on for the Long Term Plan. Mr Woodhead commented that NHSE/I are assured on CHC processes and the actions being taken. There is some concern regarding the numbers and there needs to be a re-think on how this is presented to take account of the most likely savings and net cost of CHC. It will be key to look at the overall numbers for Month 8 and to keep the Committee updated. Mrs Skidmore reported that she is holding separate sessions with all the Directors over the next 2 weeks to try to identify any potential savings.

5.5 Regarding Care Closer to Home there is concern that some of the Providers are not being as supportive as they could be. There had been a good outcome from the recent workshop to support the position and a paper on Admissions Avoidance outlining the phasing will be going to the Joint Exec Meeting next week.

5.6 MSK was discussed briefly as there are currently 2 strands of work going on to push delivery on an operational level. The redesign of the MSK pathway has been through the Clinical Commissioning Committee and procurement is due to start shortly.

FPC-2019.11.123 – Proposed move to Single QIPP Programme Board

6.1 Members discussed the proposal to move to a single QIPP Programme Board which would mean the amalgamation of the Shropshire QIPP Programme Board and the Telford PMC meeting. Both meetings currently report to the relevant Finance Committee but have no decision making authority. Who would chair the meeting going forward was discussed and it was felt that a single rather than a joint chair would be required. With this amendment the proposal was agreed.

FPC-2019.11.124 – Complex Care Performance Dashboard Update

7.1 As the report was not available at the time of this meeting it was agreed to defer this until the next meeting.

FPC-2019.11.125 – STP Month 6 Finance Report (for information)

8.1 This report will be shared with the Committee on a monthly basis for information. A brief discussion was held regarding this report. Mrs Skidmore was happy to discuss the report in further detail outside the meeting if required.

Monthly Monitoring for Finance and Performance

FPC-2019.11.126 – Finance & Contracting Report

9.1 Mrs Skidmore reported that the Month 7 position is currently a significant way from the submitted plan and although this has not improved it has not got any worse. There has however, been a deterioration with the SaTH forecast across the board with a net deterioration with the individual commissioning position.

9.2 Work is ongoing around the recovery actions to re-assess the position. A significant grip and control exercise is also in use to identify any further savings which can be made. Liaison VAT is currently looking for any duplicate payments or VAT reclaims although no formal report is available as yet.

9.3 Mrs Skidmore further reported than an initial self-assessment on all of the 135 areas across both CCGs had been carried out and these had then been RAG rated. Areas included running costs, BCF, Mental Health, CHC, Prescribing, demand management, Governance and QIPP. NHSE/I have offered to carry out a peer review. It will be key to focus on the targets which can be achieved. An update on this piece of work would be brought to a future meeting.

Action: Mrs Skidmore to bring an update on self-assessment work to future meeting

9.4 Discussion was held around the Outpatient situation at RJAH and it was commented that clarity was required around the follow ups. Query was raised as to whether other CCGs commission services from SaTH and whether they have the same slippage issues as we do; brief discussion was held regarding this.

9.5 Concern was raised regarding the SaTH Cost Improvement Plan and the limited progress that had been made. It would be beneficial to know what the process would be to agree the budget for 2020/21 and what the timetable for this would be. Members were informed that at the monthly Joint Contract Meeting there was a presentation to support the discussion and how this would be delivered. It was agreed that this presentation timetable would need to be brought to the January meeting.

Action: Contract Presentation and Timetable for 2020/21 budget to be brought to January Meeting

9.6 Work on the Long Term Plan is ongoing although it has not been accepted as yet because of th gap on the financial position.

9.7 Concern was raised regarding the overspend at RJAH and it was commented that triangulation needed to be improved although currently the risk adjusted position matches RJAH report position at Month 7 which is a positive alignment. Further discussion was held regarding this along with winter pressures and ambulance demand.

9.8 Query was raised as to whether the External Auditors could be used to gain further understanding around creditors at Shropshire Council. Mrs Skidmore confirmed that there was a proposal being made to the Council for a quarterly reconciliation process to be put in place so that agreed values can be paid and disputes can be discussed. Good practice is now being put into place around cashflow.

9.9 The system wide LTP is still awaiting sign off and different options will need to be looked at before this goes ahead. The gap is approximately £50m for the whole system. Further advice from NHSE/I will be required.

FPC-2019.11.127 – Performance Report

10.1 Dr Davies began by drawing members' attention to the current ambulance situation as the category 3 standard has not been achieved. There has still been no response

from the Ambulance Service with regards to the half day summit. There are still potential issues around the system level operational work and it was suggested that the risk could be shared if some additional operational capacity is invested in.

10.2 Concern was raised around the recurrent theme of representation from West Midlands Ambulance Service not engaging or turning up to meetings. Mr Woodhead agreed to escalate the issue with NHSE/I. The Committee also discussed the state of A&E issues with reports of: 44 12 hour breaches; only 64% achievement of the four wait target; and fewer A&E consultants in December and beyond than the same period last year. The Committee questioned the acceptability of the current position and the potential for further and harmful deteriorations on the service provided.

Action: Mr Woodhead to escalate the Ambulance Service engagement issues to colleagues at NHSE/I

12.20pm David Stout left the meeting

10.3 There is continuing bed pressure at SaTH which is impacting on the RTT level and it is expected that recovery will take at least 12 months.

10.4 Regarding diagnostics RJAH have been achieving targets since October and it is hoped this will continue. There were issues around endoscopy at SaTH and although this has now been resolved the improvements are still awaited. Concern was raised about diagnostic performance in general. Demand and capacity planning needs to be taken into account moving forward and workforce issues need to be addressed as there is currently lack of consultants in A&E. Discussions around this are being held at the A&E Delivery Group.

10.5 Conversion rates were discussed and it was felt it would be beneficial to look at the individual circumstances of the patients. If front end capacity was increased this would make savings down the line however concern was raised regarding further investment into the service. Additional capacity and resolving workforce issues would be key to breaking the cycle to provide assurance that staff can be recruited.

10.6 Dr Davies further reported that 2 week cancer waits had now improved and it is hoped that the 14 day performance rates would improve by Quarter 3. The Urology Service had also shown an improvement.

FPC-2019.11.128 – Key Messages to the Governing Body

- Month 8 – reassess QIPP forecast in relation to CHC and Care Closer to Home and change the risk adjusted position.
- Process for 2020/21 budget
- LTP - £50m gap
- A&E concerns
- Improvements to cancer waits

Mr Woodhead commented that from an NHSE/I point of view they are looking for improvements and these are currently not happening. The Quarter 3 forecast needs to be challenging but realistic.

FPC-2019.11.129 - Any Other Business

11.1 Mr Vivian commented that he felt it was helpful to have NHSE/I presence at the meeting.

Date and Time of Next Meeting

Thursday 9 January 2020, 9am – 11am in Meeting Room B8, WFH
Dave Evans and Julian Povey have been invited to sign off the Q3 position.

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE COMMITTEE HELD IN MEETING ROOM B8, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL ON THURSDAY 9 JANUARY 2020 AT 9.00AM

Present

Mr Kevin Morris (Chair)	GP Practice Board Representative
Mrs Claire Skidmore	Chief Finance Officer
Mr Keith Timmis	Lay Member – Governance & Audit
Dr Julie Davies	Director of Performance & Delivery *(part)*
Mrs Laura Clare	Deputy Chief Finance Officer
Dr Michael Matthee	North Locality Chair
Ms Kate Owen	Head of PMO
Mr Meredith Vivian	Lay Member – Patient & Public Engagement

Apologies

Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Ms Sarah Porter	Lay Member – Transformation
Mr Tim Woodhead	Deputy Director of Finance, NHSE/I– North Midlands

In Attendance

Mr David Evans	Accountable Officer
Dr Julian Povey	Shropshire CCG Chair
Mr Geoff Braden	Lay Member, Telford & Wrekin CCG
Mrs Chris Morris	Executive Nurse *(for agenda item FPC-2019.12.135)*
Mrs Faye Harrison	Personal Assistant (minute taker)

Mr Morris informed members that the agenda would need to be moved around to accommodate the Q3 sign off for which Mr Evans and Dr Povey needed to be present. Members introduced themselves around the table.

FPC-2019.12.130 - Apologies

1.1 Apologies were noted as above.

FPC-2019.12.131 - Members' Declaration of Interests

2.1 No declarations were raised.

FPC-2019.12.139 – Quarter 3 Financial Position Sign Off

3.1 Mrs Skidmore gave handouts to members detailing the Quarter 3 Financial Position and talked through the spreadsheet. She reported that they have been given the opportunity to reset the forecast position and clearance from NHSE/I has been given on the agreed figure subject to commitment on achieving this.

3.2 Mrs Skidmore explained the spreadsheet to members. When the Month 8 position was reported there was combined deficit of £57.7m risk adjusted position. Both best case and worse case scenarios have been looked at and the level of risk involved.

An assessment into the cost of change has also been included. The agreed figure has now been signed off at £60.4m. The Shropshire figure was agreed at £7.3m.

3.3 Mrs Skidmore reported that the cost to the CCG would be included and the savings which need to be made. Also included would be an estimated cost of the reduction and combination of Governing Body and the estimated cost of staff MARS/redundancy. This is being looked at on a 50/50 level for Shropshire and Telford & Wrekin. The rationale for the figures is dependent on Management Team discussions. Some costs have already been factored in and the number can be refined so progress is made.

3.4 A Year End deal with SaTH will have a big impact on the current position and a deal has now been agreed which was better than planned for therefore the risk has been removed.

3.5 The biggest area of risk currently is on the Shropshire side to deliver £1m QIPP in the last 3 months of the year. There is a detailed set of figures in line with the action plan with additional money built in.

3.6 Discussion was held around the specific areas of issues regarding data accuracy from CHEC Eyecare provider and what could be done to resolve this. There are also problems with a complex patient within the Wye Valley Community Contract and the costs involved with this. It was agreed that this would be picked up with Julie Davies.

Action: Claire Skidmore to raise the issue of the Wye Valley patient with Julie Davies to see what can be done

3.7 Another adverse movement which has been built in to the reset position is around the Mental Health spend as there has been an increase in the Psychiatric Intensive Care Unit (PICU) spend.

3.8 Mrs Skidmore reported that a Year End deal with RJAH had also been secured and explained to members how this had been reached. ShropCom have offered support and the 50/50 split on MSK has been relaxed in order to recreate the estimate for Year End. NHSE/I have been involved.

3.9 A query was raised regarding the removal of QIPP risk that was specific to Telford and Mrs Clare explained that this was due to a technical adjustment.

3.10 Further discussion was held around the central monies and Mrs Skidmore confirmed that it had been verified with NHSE/I that this will not be clawed back. There has been some challenge around the Primary Care budget and extra narrative around timescales will be added it to explain this.

3.11 Mrs Skidmore reported that extra support was being from NHSE/I around the Grip and Control work. Although some areas were identified these would not have an impact until next financial year.

3.12 Mrs Skidmore confirmed to members that the numbers would now be fixed at regional level and could not be moved up or down. This would be closely monitored although there will be a degree of prudency in the numbers to allow for any slippage. However if the position worsens this would impact greatly on the creditability of the CCG. Mrs Skidmore provided assurance that she felt comfortable with the proposed number.

3.13 Following further discussion members of the committee agreed the proposal of the submission to NHSE/I to change the forecast although the correct communications would need to be lined up around this moving forward. The relevant documents were signed.

10am - Geoff Braden left the meeting

FPC-2019.12.132 - Minutes of Previous Meeting held on 27 November 2019

4.1 It was agreed that these minute were a true and accurate record of the Committee which was held on 27 November 2019.

4.2 Mr Morris informed members that it had been noted at the Audit Committee that the Month 7 Finance Report contained an error regarding the performance of the acute service directorate containing the wrong figures and the question was raised as to how this can be changed as the document had been published into the public domain. It was agreed to note that this had been discussed by members of this committee and that it was only the wording which was incorrect and not the actual figures.

FPC-2019.12.133 - Matters Arising/ Action Tracker

5.1 The Action Tracker was discussed and updated as appropriate

5.2 Update from Mr Woodhead was provided via email on the following action:
FPC-2019.11.127 – Performance Report Mr Woodhead to escalate the Ambulance Service engagement issues to colleagues at NHSE/I
"This is being managed by the Performance and Improvement Directorate (headed by Jeff Worrall) who are aware of both the general issues as well as the specific Shropshire issues and are working with the Trust to resolve these."

FPC-2019.12.134 - Quality, Innovation, Productivity & Prevention (QIPP) Report

6.1 Mrs Skidmore informed members that the Month 8 is reporting a delivery of £15.8m; there are no new areas of concern although the issues with Care Closer to Home are on going.

6.2 Brief discussion was held regarding the methodology and a proposed change to the pilot sites. More robust monitoring and looking at trends from previous years will be required to move this forward. The poor performance over the Christmas period was also discussed and it was though this relates to Trust issues rather than system wide problems.

6.3 Mrs Skidmore reported that the pipeline is a live document and the numbers in the models triangulate with the STP. The challenge moving forward is to get provider sign up to the numbers. The draft System Plan is hoped to deliver 3% QIPP target next year for both CCG's. The plan has been jointly developed to avoid duplication. Concern was raised around how 'limited' some of the schemes were.

10.20am - Julie Davies joined the meeting

6.4 Query was raised around whether a financial penalty would be offered to SaTH around Heart Failure and it was confirmed this had been included in the Year End deal. This will be reflected in the QIPP report.

6.5 The HISU work was discussed briefly as a different model had now been introduced due to staffing issues. This will be managed on the Directorate Risk Register and will be picked up jointly moving forward.

FPC-2019.12.135 – Complex Care Performance Dashboard Update

7.1 Mrs Chris Morris joined the meeting for this agenda item. Concern was raised by members around the succession planning for the service following Mrs Morris leaving the Organisation in March 2020. Discussions are on going around this within the CCG and with the Local Authority.

7.2 Mrs Morris talked through the key points of the dashboard explaining the narrative. She highlighted that priority at the moment was managing the money aspect of the service.

7.3 The backlog and long waits were still causing problems however a new interim Clinical Lead was now in place to help with this as well as the new Nurses who are now in post.

7.4 The vast majority of outstanding reviews currently relate to Funded Nursing Care and an escalation process is in place however the main focus is on Mental Health, Joint Funding and Children's Reviews as these are part of the QIPP. There are currently 2/3 of patients who have an outstanding review. Mrs Morris reiterated to members that it would take up to 2 years to recover the backlog.

FPC-2019.12.136 – STP Month 8 Finance Report (for information)

8.1 Mrs Skidmore informed the Committee that that this document would be circulated following the meeting.

Action: Mrs Skidmore to circulate the STP Month 8 Finance Report

Monthly Monitoring for Finance and Performance

FPC-2019.12.137 – Finance & Contracting Report

9.1 Mrs Skidmore highlighted that although the focus has been on Month 9 and the reforecast of the position she provided assurance that work as still been on going towards Year End and the Long Term Plan. A brief update will be brought to the January meeting regarding this.

9.2 Lessons learned would need to be included in the plan and budget going forward. Discussion was held around the longer term trends and impact on activity, individual commissioning and QIPP. Relevant data sets would need to be provided. Mrs Skidmore confirmed that the concerns, risks and mitigations would be reflected and built into the narrative.

10.55am – Dave Evans, Julian Povey and Chris Morris left the meeting

FPC-2019.12.138 – Performance Report

10.1 Dr Davies informed members that following all the issues with the Ambulance Service they now have a named contact for engagement and a meeting is being held

in the next 2 weeks to take actions forward. The priorities will be around reducing conveyances and ambulance handovers. The new admissions avoidance service went live on 4 January.

10.2 A 2 week trial of a new service between ShropDoc and the Ambulance Service began last week. This is to look at what intervention is required to avoid conveyance.

10.3 RTT has been suspended due to the winter pressures however SaTH are managing to maintain urgent and cancer but no routine surgeries. There is an expectation that this will take more than 12 months to recover.

10.4 RSH has been on level 4 repeatedly over the Christmas and New Year period and a Vanguard Unit has been brought in to maintain the urgent and cancer. A contributory factor has been the delayed opening of Ward 35 although it is hoped this will be complete by February. Dr Davies highlighted her concern regarding staffing as there is currently 2 full time equivalent Consultants less than this time last year.

10.5 With regards to Diagnostics there has been a reporting issue with echocardiology although this is an internal system problem.

10.6 The 2 week cancer performance recovered in October as the Improvement Plan was delivered and the Radiology capacity managed. However a consultant has now gone on long term sickness and locums are being sought in order to maintain performance.

10.7 Regarding Urology the 2nd robot at UHNM will go live in February and one of the SaTH Urologists has been trained to use this which should provide a positive impact for Shropshire patients.

10.8 Delayed Transfers of Care are being maintained with SaTH although there was a slight 'blip' with the Community Trust however there has been great effort to target the Community capacity.

10.9 Concern was raised about the lack of 111 data from the Ambulance Service; this has been escalated to the Regional Director.

10.10 Query was raised as to what more the committee could do to ensure the correct escalations and recommendations are made to the right people. It was felt that pathways needed to be made clear and assurance would be required from the Management Teams. It would be key to track any actions and keep a record. The A&E Improvement Plan would need further work to create impact. Concern was raised that poor performance is now normalised and the possibility of receiving reports from the Urgent Care Director was discussed.

FPC-2019.12.140 – Key Messages to the Governing Body

- CHC
- Pressure on A&E
- Revised figures for Finance
- Year End agreements

FPC-2019.12.141 - Any Other Business

11.1 There were no items of Any Other Business discussed.

Date and Time of Next Meeting

Wednesday 29 January 2020, 11am – 1pm in Meeting Room B8, WFH

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE COMMITTEE HELD IN MEETING ROOM B8, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL ON WEDNESDAY 29 JANAURY 2020 AT 11.00AM

Present

Mr Kevin Morris (Chair)	GP Practice Board Representative
Mrs Claire Skidmore	Executive Director of Finance
Mr Keith Timmis	Lay Member – Governance & Audit
Dr Julie Davies	Director of Performance
Dr Michael Matthee	North Locality Chair
Mr Meredith Vivian	Lay Member – Patient & Public Engagement
Ms Sarah Porter	Lay Member – Transformation

Apologies

Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Laura Clare	Deputy Chief Finance Officer
Ms Kate Owen	Head of PMO

In Attendance

Mrs Chris Morris	Executive Nurse *(for agenda item FPC-2020.01.007)*
Ms Kay Holland	Deputy Director of Contracting
Mrs Faye Harrison	Personal Assistant (minute taker)

FPC-2020.01.001 - Apologies

1.1 Apologies were noted as above.

FPC-2020.01.002 - Members' Declaration of Interests

2.1 It was noted that both Claire Skidmore and Julie Davies are Directors across both Shropshire CCG and Telford & Wrekin CCG. As it was felt that more clarity was required around this Mr Morris agreed that he would formally write to Dave Evans requesting this..

Action: Kevin Morris to formally write to Dave Evans around the new Director roles and how this affects the Committee going forward.

FPC-2020.01.003 - Minutes of Previous Meeting held on 9 January 2020

4.1 The following corrections were requested:

- Surname of Geoff Braden to be corrected
- Paragraph 3.2 – the Shropshire figure to be clarified as £7.3m
- Paragraph 3.4 – second sentence to be deleted.
- Paragraph 3.9 – amended to read '*A query was raised regarding the removal of QIPP risk that was specific to Telford'*
- Paragraph 6.1 – remove 'majority relating to MSK'

4.2 Once these amendments had been made the minutes were agreed as being a true and accurate record of the meeting held on 9 January 2020.

FPC-2020.01.004 - Matters Arising/ Action Tracker

5.1 The Action Tracker was discussed and updated as appropriate

FPC-2020.01.005 - Quality, Innovation, Productivity & Prevention (QIPP) Report

6.1 Mrs Skidmore informed the Committee that as at Month 9 reporting a forecast was put in to deliver £16.3m against the £19.8m target. A risk assessment around the delivery of the projects has been carried out however the risk of impact on the financial position has been lessened by the Year End deal being completed.

6.2 The forecast has not moved significantly and moving forward focus will be on the 2020/21 position and the pipeline. The pipeline concerns are being worked through at system level. There is still no agreed position with NHSE.

6.3 Mrs Skidmore highlighted some additional risk to the committee around lack of pace within the system. Discussion was held about how the gap was going to be bridged and how the actions will be mobilised in a united way. Improved leadership will be required along with key representation at meetings to take agreed actions forward.

11.30am – Chris Morris joined the meeting

6.4 The Outpatient issue at SaTH was discussed although this is currently considered a clinical problem and not a finance one. It will be important to learn from mistakes rather than repeating them.

6.5 Mrs Skidmore commented that additional delay to on going work could be down to the distraction from the current restructure although it is hoped this risk will be mitigated during the Management of Change process as the structure becomes clearer.

6.6 Care Closer to Home was discussed as it was felt that effective actions to make savings were not being upheld however Mrs Skidmore confirmed that the zero figure was down to a timing issue. Mr Timmis commented that he felt a lack of confidence around achieving the QIPP for this and that there was no evidence of the outcome or impact. Each delay is highlighting that delivery will be a challenge. He also felt that the pipeline scheme figure was particularly low and raised further concern around this. Members agreed that the pace needed to be improved. Suggestion was made that a prioritisation exercise should be carried out to complete actions and mitigate risk. It would be key to look at the bigger issues and the Senior Leadership Group would need to take responsibility in the delivery of the QIPP.

6.7 After lengthy discussion it was felt in order to take this forward a more formal discussion would be required. This would be added to the agenda for the Development Session for the Governing Body before being taken forward to a more formal discussion. It would be key to start with the STP priorities and look how these interrelate to the QIPP Plans and how will this be taken forward at a system level. Any feedback regarding these points should go to Claire Skidmore.

6.8 Mr Morris informed members that on a positive note Jon Cooke is dedicating his time to QIPP and the PMO. Mrs Skidmore confirmed that work on the RAG rating is on going.

FPC-2020.01.006 – STP Finance Report (for information)

7.1 This item was not discussed.

FPC-2020.01.007 – Complex Care Performance Dashboard Update

8.1 Mrs Chris Morris joined the meeting for this agenda item. She briefly talked through the dashboard with members highlighting the key areas.

8.2 The dashboard now shows the December figures which includes a 70% increase in fast track patients although the joint funded and children figures have reduced. Mrs Morris reported that reaching the 28 day target is still a challenge and reported that they are still quite a way away from this. A plan will need to be in place for the next financial year. Long standing figures have now reduced and processes are improving. The backlog of outstanding reviews is still being worked on as substantive posts have now been filled however there is still some staff sickness within the team and interim support around Mental Health is in place. There have been no complaints throughout December.

8.3 The legacy issues with the Local Authority continue although payments have been made there are still 16 cases being disputed. The possibility of the service moving over to the Local Authority was briefly discussed. A constructive meeting with Betsi Cadwalladr has taken place recently.

8.4 Risks around the lack of succession planning were discussed and it has been proposed that a Senior post to manage the service is required however the Management of Change process is causing a delay which was highlighted as a potential risk to the progression of the Improvement Plan.

8.5 Collaborative Commission was discussed as the Cabinet had recently voted not to proceed although work around this is still on going. Mrs Morris confirmed that the CHAT Tool is Continuing Healthcare assurance tool which is being used to submit compliance to NHSE.

12.05pm – Chris Morris left the meeting

FPC-2020.01.008 – Self Assessment Grip and Control Update

9.1 Mrs Skidmore informed members that work around Grip and Control is on going linking in with Rob Clarke from NHSE; further detail is awaited. Rightcare was discussed and meetings around this have been arranged.

9.2 It was felt that the Grip and Control process is reassuring and tackling the right areas although the BCF is considered to be a vulnerable area as targets are not being achieved. It was reported that the Local Authority is an area for potential savings which could be linked to the Community Trust however clarity around this is awaited.

9.3 There are 3 Mental Health Crisis provision areas to be considered and it is hoped to have results by the end of March. There is risk around the IBCF funding and a risk paper has been requested to take to the Joint Commissioning Group.

FPC-2020.01.009 – Contract Presentation and Timetable

10.1 Kay Holland attended the meeting to present this agenda item. She highlighted the key points in the presentation however there is still some information which needs to be included once it has been received.

10.2 Work is on going with the Trust to pull a baseline together. It will be key to refine and agree the methodology with a consistent approach.

10.3 The big 4 contracts are being looked at to concentrate on transformation change rather than transactional change in the next financial year. Work is on going on the contract negotiation period and NHSE require contracts to be signed by 27 March.

10.4 Ms Holland confirmed to members that performance management is still on going within the service and also some old contracts are being 'tweaked' as required to enable flow between the contracts. KPI's will need to be achievable and will also require flow.

10.5 Ms Holland further confirmed that the new contract with ShropCom is going ahead although changes can be made to this. This will be made clear within the terms and conditions of the contract. It will be critical to engage a Statement of Intent and Memorandum of Understanding between system partners to ensure that joint working is carried out in order to manage expectation. Focus is currently on agreeing 1 year contracts although the need to increase the length of these should be factored in. Time will be required to work towards the required improvements.

FPC-2020.01.010 – 2020/21 Finance Plan

11.1 Mrs Skidmore informed members that the Plan is currently a work in progress and has been presented to both Shropshire and Telford & Wrekin Committees. The previous plan was aligned to what was submitted through the STP and is incumbent on delivering 3% of the QIPP target. As time has moved on the focus is now on what needs to be realistically built into the model for 20/21 which has resulted in needing to deliver 4% QIPP instead of 3%.

11.2 Discussions are on going with system providers around the amount of growth which needs to be factored in however an agreement has not yet been reached.

11.3 As part of the work to get the Legal Directions stood down NHSE/I have requested the latest draft of the Finance Strategy to be signed off however conversations around the figures for this are on going therefore it is currently more of a position statement. The intention is still to bring a set of budgets to the next meeting which will then be shared with the Governing Body.

11.4 Concern was raised regarding the activity figures particularly at SaTH and discussions around this are also on going. It needs to be ensured that enough capacity is built into the contract and that it is made clear exactly what activity is being reported and referred to. What is causing the increase in activity was discussed further as this is something which may be raised in the future.

Monthly Monitoring for Finance and Performance

FPC-2020.01.011 – Finance & Contracting Report

12.1 As the position had only been discussed a couple of weeks ago at the delayed December meeting it was not necessary to discuss this further but Mrs Skidmore agreed to answer any specific questions members had.

12.2 The possible move from PbR for SaTH was discussed as it was felt this was quite late in the year for such a big strategic move and whether this should be delayed for another 12 months. As this is a live contract it is being explored whether a block arrangement can be added to create a position to lose the transactional elements to move forward.

12.3 Year End Agreements were briefly discussed and Mrs Skidmore confirmed these had taken place with the exception of MPFT and ShropCom and that she would share the letters with members.

Action: Mrs Harrison to share the Year End Agreement letters with members

12.4 Mr Timmis highlighted some conflicting information in the reports around accounts receivable and what is causing the problems. A new way to manage cashflow with the Local Authority is now being used and a quarterly reconciliation process is in place. Payment of 85% of the outstanding balance for this year has been authorised and will be completed next week.

FPC-2020.01.012 – Performance Report

13.1 Dr Davies began by informing members with regard to Ambulance performance there was a big increase in activity in December for both 111 and 999. The monthly Ambulance is being reinstated with representation from WMAS.

1pm – Keith Timmis left the meeting

13.2 RTT remains static due to winter pressures and it is felt that the backlog is not currently recoverable within a 12 month period. Echocardiography within diagnostic performance remains a concern and a Route Cause Analysis will be required to see what has happened as well as looking more closely at systems and processes.

13.3 With regards to A&E it was suggested that an Improvement Plan be used however the Board have declined this offer and have decided to focus on flow and admission avoidance. Numbers are now available for 111 however there is some nervousness around these and how they have been measured which may result in incorrect data. This is being tracked through the A&E Delivery Group.

13.4 There has been some improvement in the Cancer service however due to staff sickness this has not been as great as expected. Dr Davies will be asking the Trust to quantify the use of the robot at UHNM for Shropshire patients.

13.5 Following on from discussions at the previous meeting Dr Davies informed members that moving forward it would be critical to ensure that the actions are adequate enough to mitigate them therefore the recommendations in the report will be framed around this. As part of her new role Dr Davies is hoping to add some extra capacity to work on the performance recovery plan where there is currently limited resource. Members agreed with this way forward.

FPC-2020.01.013 – Key Messages to the Governing Body

- QIPP Pipeline for 20/21 is main priority. Extra resource to firm up proposals
- Board to look for further areas to develop for QIPP
- System need to work together to achieve the QIPP for next year
- Focus on performance report to be re-assessed by Dr Davies and monthly progress will be provided.

FPC-2020.01.014 - Any Other Business

11.1 There were no items of Any Other Business

Date and Time of Next Meeting

Wednesday 26 February 2020, 11am – 1pm in Meeting Room K2, WFH

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-03.041
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Primary Care Commissioning Committee
Date of Meeting:	4th December 2019
Chair:	Dr Colin Stanford

Key issues or points to note:

- Committee received a request and supporting information from Clive Medical Practice to close their branch surgery in Wem to centralise and improve services at the main surgery. Also taking into account that there is another GP Practice in Wem and the very small numbers of patients using the branch surgery. Committee supported the application with the proviso that checks are made with regard to the bus service between Wem and Clive and the Practice Manager was asked by committee to write to patients who had expressed concerns.

- Concerns were raised about cuts to Local Authority services such as smoking cessation and how they might have an impact on NHS plans to increase access to all areas of Primary Care including community pharmacy, dentistry and opticians.

- Primary Care Risk Register – committee noted that "the closure of Whitehall Medical Practice" remains on the register as several hundred patients had not yet transferred to an alternative practice. Previous concerns about the risk to neighbouring practices accepting large numbers of new patients had not materialised, mainly because of support provided by the CCG.

- The Chair expressed disappointment at the absence of updates from NHS England as none had been received for several months and felt that at least a written update should have been provided to keep committee members informed of changes occurring at NHS England.

Actions required by Governing Body Members:

- To note.

Shropshire Clinical Commissioning Group

MINUTES OF THE PRIMARY CARE COMMISSIONING COMMITTEE (PCCC) HELD IN ROOM K2, WILLIAM FARR HOUSE, SHREWSBURY AT 9.00 AM ON WEDNESDAY 4 DECEMBER 2019

Present

Dr Colin Stanford	External GP Member (Chair)
Mr Dave Evans	Joint Accountable Officer, Shropshire CCG and Telford & Wrekin CCG
Mr Meredith Vivian	Lay Member, Patient & Public Involvement
Mrs Christine Morris	Chief Nurse
Dr Deborah Shepherd	GP Member, Shrewsbury & Atcham Locality Chair
Mr Kevin Morris	Practice Member Representative
Mrs Sarah Porter	Lay Member, Shropshire CCG
Mr Keith Timmis	Lay Member, Performance
Mrs Sam Tilley	Director of Corporate Affairs (Part)
Dr Finola Lynch	GP Member (Part)
Mrs Nicky Wilde	Director of Primary Care, Shropshire CCG
Mrs Claire Skidmore	Chief Finance Officer, Shropshire CCG
Mr Steve Ellis	Head of Primary Care, Shropshire CCG
Dr Stephen James	GP Member
Ms Vanessa Barrett	Healthwatch Shropshire

Apologies

Mrs Amanda Alamanos	NHS England Primary Care Lead, Shropshire & Telford
Mrs Rebecca Woods	Head of Primary Care for Shropshire and Staffordshire, NHS England
Cllr. Lee Chapman	Shropshire Council
Dr Julian Povey	Clinical Chair, Shropshire CCG
Dr Jessica Sokolov	Medical Director

PCCC-2019-12.090 - Apologies

Apologies received were recorded as above.

PCCC-2019-12.091 - Members' Declaration of Interests

Dr Shepherd referred to the Agenda item relating to the Primary Care Strategy Report which referred to the GP Retention Fund. She advised that she is part of the Shropshire Sessional GP Network which was successful in bidding for money from that Fund. She advised Committee that she had absolutely no involvement in the bid that was submitted.

Mr Morris referred to the item on the Agenda relating to Clive Medical Practice – Branch Closure. He advised the Committee that he is part of the Primary Care Network of which Clive is a member and wished to highlight his involvement in this matter.

No further action was judged necessary in respect of these declarations.

PCCC-2019-12.092 – Minutes of Previous Part 1 Meeting held on 2 October 2019 and Matters Arising

The Minutes of the previous Part 1 meeting held on 2 October 2019 were agreed as an accurate record, provided the following amendment is made:-

Page 5: The final paragraph should read:-
"Mr Timmis referred to inaccurate information being given out by both the hospitals and local Opticians regarding Opticians who supply post-operative checks".

The Action Tracker was reviewed and updated as appropriate.

PCCC-2019-12.093 – Public Questions
No questions were received from members of the public.

PCCC-2019-12.094 – Clive Medical Practice - Branch Closure
Janet Gittins, Locality Manager (North) introduced Zoe Bishop, Practice Manager at Clive Medical Practice.

Ms Gittins advised Committee that an application notice had been received from Clive Medical Practice to close the Branch Surgery in Roden Grove, Wem. Committee were asked to note the contents of the report and make a decision on the application.

The Practice believe that by centralising services to their main site in Clive they will provide a better service for patients and will also offer more flexibility and efficiency with the GP service.

Patient comments and the Quality Impact Assessment have been taken into consideration. The overall impact is considered to be relatively minor because of the very low numbers of patients who are accessing that site, and because there is another option. When the results of the assessment were analysed, three main concerns from members of the public were identified. These were:-

- Transport to Clive
- Pressure on waiting time
- Collection of prescriptions

Dr Stanford referred to the report and asked that it be made perfectly clear that Clive is the main surgery and is a dispensing surgery; Wem is the branch surgery and is not a dispensing surgery.

Mr Vivian observed that many patients would be dependent on the bus service and requested that the ongoing provision of the service should be checked.

ACTION: Ms Gittins to check with the Local Authority regarding ongoing provision of the bus service.

Ms Bishop to compose a letter to patients which provides answers to the patient concerns and issues received in the Comment Box and also send a copy to the Local Authority, Overview & Scrutiny Committee, Healthwatch, and any other group who may be approached by patients regarding the closure.

Mrs Wilde confirmed that there had been 2 requests for the closure of small branches and consideration will be given to this as part of the wider Estates work.

The Committee agreed to support the proposal to close the Branch Surgery in Roden Grove, Wem.

PCCC-2019-12.095 – Primary Care Practitioners Report
The purpose of Mrs Wilde's report was to provide the Committee with a short update towards delivering the Governing Body's priority to use innovation and work in collaboration with NHS England as the commissioner of community pharmacy, dentistry and opticians to ensure improved patient access to all areas of primary care. This will in turn contribute towards reducing the pressure on the wider health economy.

It is a priority of Governing Body to expand the CCG's work into the other Primary Care contractors. Areas prioritised for further discussion are diabetes, frailty, ophthalmology and minor ailments. It was agreed by Governing Body that a further meeting should take place early in the New Year to explore those areas and help contractors understand the CCG's current position in those areas and then feed into how the services move forward.

Mrs Wilde invited questions.

Mr Timmis referred to smoking cessation and Local Authority cuts to those services and queried how pharmacists might be involved. Mrs Wilde replied that this forms part of the offer from NHS England to Community Pharmacy although the numbers who have taken this up are not yet known.

ACTION: Mrs Wilde to raise take-up of NHSE's offer to Community Pharmacy at the next Governing Body meeting.

PCCC-2019-12.096 – Primary Care Strategy Delivery and Progress Report

The purpose of Mr Morgan's report was to provide Primary Care Commissioning Committee with an update as to progress with delivery of the Shropshire and Telford & Wrekin STP Primary Care Strategy. The report provided an update on each of the 10 programmes within the Strategy.

None of the programmes were Rag Rated 'Red' and there is confidence that progress is being made in all areas. The level of progress varies from programme to programme as, in some areas, the CCG is waiting for national guidance or national programmes to be put in place. Overall, reasonable progress is being made.

Mrs Porter queried workforce, which was Rag Rated 'Green'. Mr Morgan provided the meeting with the Q2 workforce data which showed a very modest increase from Q1. The overall trajectory over the last 5 years for GPs indicates that there are more GPs but the Full Time Equivalent is static, i.e. there are more GPs but more of them are working part time.

Mr Vivian requested reassurance around delivery of the IT requirements. Mr Ellis advised that the 'Green' Rag Rating is around plans already in place, e.g. E-Consult which is being rolled out and the number of Practices using it is increasing weekly. However, some aspects of the roll out are beyond the control of the CCG, e.g. Office 365 and HSCN. These are being identified as risks/issues but the overall progress is being Rag Rated as 'Green'

Mrs Wilde advised that in relation to workforce/staffing, the CCG has a project in place around workload and workflow which should be taken alongside the workforce discussions to support General Practice improved access.

Mr Evans requested information regarding vacancy levels. Mr Morgan advised that Practices are not required to report vacancies although they are required to update their workforce numbers on the National Workforce Reporting system. A module exists for reporting of vacancies although it is not compulsory. Practices are asked regularly to advise the CCG of vacancies, particularly GP vacancies. The team will continue to request the information from Practices.

Mr Morris questioned the accuracy of certain figures within the report relating to workforce.

ACTION: Mr Morgan to check the figures within his report and respond directly to Mr Morris.

Dr Shepherd referred to possible support for recruitment and advertising which Practices find very difficult and very expensive. She suggested that a co-ordinated method of advertising vacancies might be introduced to improve the process. Mr Morgan confirmed that this was being followed up.

ACTION: Mr Morgan's report to the February PCCC to include examples of actions taken by

Practices regarding workforce and the service provided by GP Practices in light of ongoing changes taking place in the health economy.

The Committee accepted the report as assurance around delivery of the Primary Care Strategy.

PCCC-2019-12.097 – Medicines Management Strategy Progress Delivery Report

The purpose of the report was to provide an update on the progress of delivery against the Medicines Management Strategy in Primary Care in Shropshire, and provide an update on delivery against the strategic direction of the Medicines Management team and its operational plans and priorities for 2019/20.

Mrs Walker reviewed her report and invited questions.

Mr Vivian referred to Page 11 of the report and the paragraph relating to Medicines Safety and Reducing Hospital Admissions Related to Medicines (HARMs), and asked if there was an interface between the HARMs work and the Care Closer to Home demonstrator site. Mrs Walker replied that the Medicines Management team engages with the Care Closer to Home Working Group - particularly around care - but there is much work to be done around obtaining more prominent exposure for medicines HARM and safety.

Committee discussed the spend on dressings and Mr Morris advised that his Practice had addressed this issue by giving District Nurses a 7 day prescription to obtain dressings. Within 3 months, spend was within target.

Mr Morris also commented on the numerous difficulties being experienced in relation to out of stock drugs, and problems being encountered with switching patients to another drug. Mrs Walker confirmed that this is a problem nationally. Shortages particularly include HRT and contraception.

Mrs Wilde wished Committee to note that the Medicines Management team are now working across all Directorates and becoming much more widely involved in pathway work and outcomes as well as improving the overall quality of prescribing.

The Committee accepted the contents of the report as assurance towards delivery of the Medicines Strategy.

PCCC-2019-12.098 – Primary Care Finance Report

The Finance report provided an update to Primary Care Commissioning Committee regarding the financial position of the Delegated Co-Commissioning Primary Care services to Month 7 - October 2019.

- At Month 7 spend to date for 19/20 is reported as £299k under budget.
- The forecast underspend position for the Co-Commissioning budget is £704k, hence significantly reducing the in-year burden on the wider CCG position.

Mrs Skidmore was pleased to report a level of underspend against budget, which was initially over-committed and the CCG increased the initial delegated allocation from CCG baseline resources. It is anticipated that by the end of the financial year, this will represent an under-spend against plan of circa. £700k. Some elements of the under-spend are recurring and will be taken forward into the next financial year. However, Committee was asked to note that a number of items contributing to the in-year underspend are non-recurrent in nature and therefore will not be available to offset the cost pressure in future years.

ACTION: Mrs Skidmore to report to the February Committee details of the 2020/21 budget and the impact on the Long Term Plan.

Mr Timmis expressed his concern relating to the Clive Branch closure and a comment within the report that "this would leave money to be invested in the Estates strategy". Committee had stated on numerous occasions that the CCG is making developments for which it cannot afford the revenue cost. He asked Committee to note that the CCG is facing massive financial difficulties and cannot continue to refer to making Primary Care developments in Estates when no funding is available to pay for them.

Mr Timmis also commented that the manner in which the information in the report is supplied is very technical and suggested that it should be simplified for the benefit of those who are not from a financial/accounting background.

ACTION: Mrs Skidmore to review compilation of the Finance Report to simplify how the information is provided.

PCCC-2019-12.099 – Primary Care Quality and Improvement Indicators / Performance Report

Mr Allan's report included information relating to the Quality Outcomes Framework, an update on CQC activity since the October Committee, a Safeguarding update and any significant events that require reporting.

Mr Allan advised Committee that he would like to have a better understanding of the narrative behind some of the data on the Quality Assurance Framework and wished to bring an updated document to the next meeting.

ACTION: Mr Allan to investigate Rag Ratings and information supporting the data and bring an updated document to the next Committee.

Mr Allan's report was taken as read and questions were invited.

Mr Timmis referred to a recent Quality Committee meeting where the findings of the recent National Patient Survey on cancer were discussed. One of the findings from the survey was that 66% of patients felt that they had received the assistance they required. Although this figure is the national average, Mr Timmis was concerned that one third of patients did not feel they had received the support they needed from their General Practice. In light of this, he queried what action the CCG could realistically take to meet patient need.

Mr Allan suggested that the results of the Cancer Survey should come to a future Primary Care Commissioning Committee.

ACTION: Mr Allan to include the cancer survey data in a future report

Dr Stanford requested that the format of the report should be corrected in future papers to ensure information can be read with headings on appropriate pages.

PCCC-2019-12.100 – Primary Care IT Governance

Mrs Spencer, IT Delivery & Service Manager, reviewed her report, the purpose of which was to outline the governance process for the digital programme. The process will ensure alignment with the digital CCG and STP strategy, and will also review progress of projects and review mitigations and decisions.

A proposed governance structure was outlined within the report which would ensure a defined way in which decisions are made within the CCG. This structure also provides clear alignment with the STP and the Digital Enabling Programme.

It is proposed to establish a Digital Oversight Group, the first meeting of which will take place on Monday 9 December 2019. This initial meeting will review the Action Plan and ensure that the IT

Managers of both CCGs receive the necessary support to assist in delivery of the programme.

The Committee agreed the governance process for the Digital Programme.

PCCC-2019-12.101 – Primary Care Risk Register

The Committee reviewed the Primary Care Risk Register which had been updated by Mr Ellis.

The Register had been updated with Risk No. 10/19 relating to delivery of extended access following the withdrawal of weekend/Bank Holiday provision by Shropdoc/Shropcom.

Risk No. 9/19 relating to the closure of Whitehall Medical Practice remains on the Register as several hundred patients have yet to transfer to an alternative Practice. It is anticipated that this risk will be removed by the time of the February Committee. The risk relating to acceptance of new patients by neighbouring Practices has not materialised, mainly because of the support provided by the CCG. However, the CCG will continue to monitor this

The Committee agreed the updates to the Risk Register as outlined above.

PCCC-2019-12.102 – Any Other Business

Cycle of Business

It had been agreed by the Committee several months previously that the Cycle of Business would not be circulated as part of the Committee papers. Mrs Wilde requested confirmation from the Committee that they were still in agreement with this course of action.

The Committee confirmed that they were still in agreement with the above decision.

Updates from NHS England

Dr Stanford expressed his disappointment at the absence of updates from NHS England. None had been received for several months. He understood that attendance in person was not always possible, but expressed the view that a written update would be helpful in view of current events within the NHS at both national and regional level.

Mrs Wilde will circulate to Committee members the latest communication received from NHS England advising that the offer from NHS England to support delegated commissioning is being considerably reduced. As a result, Mrs Woods will not be attending the Committee going forward. Mrs Wilde has asked Mrs Woods to attend the February Committee to provide assurance as to how the gap will be filled.

ACTION: Mrs Wilde to circulate the latest communication received from NHS England relating to delegated commissioning.

Mrs Skidmore advised of a resource issue within Finance as NHS England were previously providing the transactional finance figures to support the report produced by Mr Eades. This work will now be picked up by the Shropshire Finance team.

PCCC-2019-12.103 – Date of Next Meeting

Mrs Wilde confirmed that the next meeting would take place on Wednesday 5 February 2020.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.042
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	27 November 2019
Chair:	Meredith Vivian, Lay Member - Patient and Public Involvement

Key issues or points to note:

- Dr Edwin Borman, Director of Clinical Effectiveness, and Mr Pete Jeffries, Associate Director of Quality, Governance & Risk, attended the meeting to provide an update from SaTH and to provide assurance that improvements were being made within the organisation. Specifically, the Committee was interested in cultural changes, evidence of taking a holistic view of patient safety, and information regarding improvements not yet achieved. Dr Borman and Mr Jeffries to return to the May Quality Committee to provide evidence that SaTH is a safer place for patients tomorrow and what will be done to make it safer still.

- Workforce deficits remain a high risk area throughout SaTH and ED in particular.

- There is a backlog on Autism Spectrum Disorder (ASD) assessments being undertaken by Midlands Partnership Foundation Trust (MPFT). The Committee supported the proposal to escalate the issue to the Clinical Quality Review Meeting (CQRM) as a matter of priority.

- Shropshire CCG and Shrewsbury and Telford Hospitals (SaTH) were over trajectory for Clostridium Difficile infection at the end of Quarter 2.

- A serious incident was reported by Shrewsbury and Telford Hospitals as a result of an endoscope washer-disinfector machine being left in service for five days after the receipt of positive quarterly tests for mycobacteria in rinse water. A full investigation was undertaken and assurance has been gained that no patient harm occurred.

Actions required by Governing Body Members:

- To note for information.

Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE
HELD IN MEETING ROOM B, WILLIAM FARR HOUSE
AT 2.00PM ON WEDNESDAY 27 NOVEMBER 2019

Present

Mr Meredith Vivian	Lay Member – Patient & Public Involvement (Chair)
Mr Keith Timmis	Lay Member for Audit & Governance
Mrs Sarah Porter	Lay Member for Transformation
Mrs Christine Morris	Chief Nurse
Dr Julie Davies	Director of Performance & Delivery
Dr Alan Leaman	Secondary Care Consultant
Dr Ella Baines	GP Safeguarding Lead
Dr Finola Lynch	GP Member
Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Mr Joe Allan	Interim Head of Quality, Shropshire CCG
Mrs Chris Billingham	Personal Assistant; Minute Taker

QC-2019-11.137 (Agenda Item 1) - Apologies
Mr Vivian welcomed members to the meeting.

Apologies were received from Dr Jessica Sokolov and Mrs Gail Fortes-Mayer.

QC-2019-11.138 (Agenda Item 2) - Members' Declaration of Interests
There were no declarations of interest.

QC-2019-11.139 (Agenda Item 3) – SaTH Update
Mrs Barbara Beal was unable to attend but will be invited to update the January 2020 Committee.

QC-2019-11.140 (Agenda Item 3) – Update of Governance of Serious and Untoward Incidents at SaTH
Dr Edwin Borman, Director of Clinical Effectiveness, and Mr Pete Jeffries, Associate Director of Quality, Governance & Risk, attended the meeting to provide an update from SaTH and to provide assurance that improvements were being made within the organisation. Specifically, the Committee was interested in cultural changes, evidence of taking a holistic view of patient safety, and information regarding improvements not yet achieved.

Mr Jeffries circulated handouts to the Committee.

Dr Borman referred to the reduction in the number of Serious Incidents which was a result of the categories of incidents changing. SaTH's approach to defining a Serious Incident has been revised. If any doubt exists regarding an incident it will be declared as a Serious incident If, on investigation, evidence is found to suggest otherwise, the incident will be downgraded. The level of governance has also been increased.

Mr Vivian asked how it would be known whether the organisational changes being made at SaTH were changing the culture. Dr Borman replied that the action plans for each incident incorporates the various changes to be made, and also the extent to which root causes of concern raised by the CQC are being addressed. There is still much work to be done in terms of changing the culture.

Dr Davies referred to concerns that existed around monitoring of compliance and the consequence for non-compliance.

Dr Borman replied that this would be monitored via the NHS Improvement "Just Culture" algorithm.

Dr Leaman referred to the Committee's request for graphs to illustrate historical SI's and Never Events, and queried why a different presentation had been prepared.

Mr Allan requested that SI RCA Action Plans should be triangulated with Investigation Reports as the findings of the report are not always identified on the Action Plan and therefore actioned.

The Committee discussed areas of least progress so far, and Mr Jeffries made reference to page 11 of the handout – Integration of Human Factors and Ergonomics. Funding has been secured from NHS Improvement and there is a plan to introduce human factors and ergonomics expertise to focus on several key safety risk areas. This will also help to upskill a core set of staff with skills relating to human factors and ergonomics and enable SaTH to apply those principles into investigations initially, and also incorporate them into a more proactive review of safety.

Dr Leaman commented that the Committee were not expecting a presentation such as the one brought to the meeting. Mr Vivian agreed, stating that the Committee had been expecting a review of what had been happening at SaTH over the last six months, and an update on the situation regarding patient safety.

Dr Leaman believed that the data presented in the handouts was extremely important and Committee members should have been given more time to absorb the information. He referred to the graphs relating to SI's which included Diagnostic Related incidents, Pressure Area incidents and Maternity incidents and asked whether there were any groups of SI's for which there were no graphs. Mr Jeffries confirmed that there would be groups for which there were no SI's. Dr Leaman believed that it would have been beneficial to see the graphs for the other categories of SI's in order to identify any groups of SI's for which there are no signs of improvement.

Pressure Area incidents had fallen significantly and Dr Leaman queried how this had been achieved. He also questioned how much that was impacting on overall SI figures and queried whether the dramatic fall in this category was responsible for the overall improvement in the number of SI's reported. He also referred to Never Events which seemed to be increasing and asked in which area of the hospitals these events were occurring.

Dr Borman replied that there had been a preponderance of events in ENT and Head and Neck. Other Never Events had occurred in Orthopaedics and Ophthalmology. He apologised to the Committee for the misunderstanding around the content of the presentation.

ACTION: Mr Allan to speak to CSU to request them to reprofile the graphical information contained within Mr Jeffries' handout.

The standard of Incident reports was discussed, and in particular mis-diagnosis and failure to act on test results.

Dr Borman replied that this is a huge cause of concern, and mis-diagnosis has meant that SaTH have missed opportunities to treat. Both paper and electronic systems are in operation, and the definitive version of patient records is paper notes. SaTH are aware that this must be resolved and there is an IT plan in place.

Mr Vivian asked Dr Borman and Mr Jeffries to return to the May Quality Committee to provide answers to the following questions:-

- Will SaTH be a safer place for patients tomorrow?
- How will you know?
- What will make it safer still?

ACTION: Dr Borman and Mr Jeffries to update the May 2020 Quality Committee with answers to the three questions posed by Mr Vivian.

QC-2019-11.141 (Agenda Item 5) – Minutes / Action of Previous Meeting Held on 30 October 2019 and Action Log

The minutes of the previous meeting held on 30 October 2019 were reviewed and approved provided the following amendments are made:-

Page 3 – QC-2019-10.130 - National Cancer Patient Experience Results
The above survey found that 33% of cancer patients did not feel that they received the support they needed from their General Practice. This information should be reported to Primary Care Commissioning Committee.

Page 5 – Looked After Children
The last sentence of this item should read:-
"The Internal Audit report gave significant assurance on our arrangements for Looked After Children".

The Action Tracker was reviewed and updated as appropriate.

QC-2019-11.142 (Agenda Item 6) – Provider Exception Report (including SOAG)
Mr Allan's paper was taken as read and the Chair invited questions.

Shrewsbury and Telford Hospitals NHS Trust (SaTH)
Dr Davies referred to the section of the report relating to staffing in SaTH and queried how concerned the CCG ought to be.

Mr Allan advised that a lengthy discussion took place at CQRM with one of SaTH's Deputy Directors of Workforce. SaTH have been asked to provide further details by Consultant level as the information contained within the report was not detailed enough. A request was also made that information be supplied as to how SaTH will be preparing for winter.

Mr Timmis referred to Paragraph 6 of the report which mentioned the Ockenden report and queried whether agreement had been reached regarding a statement for the public section of the Governing Body. Mr Allan advised the Committee that the interim report had been 'leaked' to media outlets. The review has the potential to reduce public confidence in the Maternity service and impact on staff morale. The impact of the Ockenden review will be managed at CQRM.

SaTH were understood to be carrying out preparatory work for their Governing Body meeting on 28 November 2019 and expect to be challenged in the public arena. They are agreeing a position statement which will be shared with the CCG and a message will be issued to all staff regarding sharing of information with members of the public in order to ensure consistency.

Mr Timmis referred to the LMS Programme Board which had expressed concerns for some considerable time that an appropriate response had not been received from SaTH. The Programme Board did not feel that sufficient progress is being made on the recommendations from the Better Births report at the pace required by NHSE.

ACTION: Mrs Morris to submit a paper to the January Committee regarding the current maternity position at SaTH.

The Committee discussed Paragraph 7 of the report relating to cancer treatment, the reasons for delays in treatment, and the potential psychological harm to patients. A thematic review has been requested and the Cancer Lead Nurse will be updating the December CQRM. Mr Allan hoped to be in a position to update the January Quality Committee.

Primary Care
Mr Timmis queried Paragraph 23 of the report relating to a significant event within a Practice. He was particularly interested to establish whether this was linked to Severnside Practice or closure of the Whitehall Practice, as a commitment had been made that the closure of Whitehall has not caused any problems.

ACTION: Mr Allan to obtain the details of the significant event which occurred within a Practice.

MPFT
Dr Davies referred to the paragraphs within the report relating to MPFT and the backlog on Autism Spectrum Disorder (ASD) and advised the Committee that the Trust had still not supplied the CCG with a trajectory. She would have expected faster progress to be made, and requested that the Committee support a proposal that Mrs Morris should raise this subject at CQRM on Friday 29 November 2019. The Committee agreed with this proposal.

ACTION: Mrs Morris to raise the subject of the MPFT trajectory at CQRM.

Care Homes
Dr Lynch referred to Paragraphs 32, 33 and 34 of the report relating to the Frailty Collaborative.
She felt that it may be beneficial to change the wording slightly as the Frailty Collaborative has no governance and is not responsible for any outcomes relating to the ED Working Group or the CCG. She felt slightly uncomfortable at the reference made within the report that the programme will support the winter pressures.

ACTION: Dr Lynch to review and update the wording of Paragraphs 32, 33 and 34 within Mr Allan's report which relate to the Frailty Collaborative, and return to Mr Allan.

QC-2019-11.143 (Agenda Item 7) – Combined Quarterly Safeguarding Report
Mr Coan's report was taken as read.

The Committee discussed the proposed introduction of Liberty Protection Safeguards and Mr Coan advised the Committee that there had been considerable delay nationally. Delays included code regulations and impact assessment forms. Mr Cooper and Mrs Morris have agreed to send a letter to all Providers to assess the impact of this and ask relevant questions in order to assist the CCG to create their own impact assessment when the LPS is introduced in October 2020.

The Committee also discussed the CCG's responsibility to Looked After Children, which is to consider the initial health assessments and the review health assessments, and how they match up with national statistics. The intention is that the CCG will work with the Local Authority to ensure that the health needs of these children are met.

Mr Vivian asked whether the CCG was comfortable with the current arrangements and, if not, what improvements could be made. Mrs Morris replied that the CCG's Auditors had recently reviewed the process, which had resulted in significant assurance. In addition, the Safeguarding Boards perform their own audits, which is also a source of assurance. Mrs Morris believed that the CCG is meeting its statutory requirements to this group of children.

ACTION: Mrs Morris to send the Auditors' Safeguarding report to Mrs Billingham for circulation to the Committee.

Mr Timmis referred to the Child Sexual Exploitation inquiry and asked if the Committee was absolutely satisfied that this was only taking place in Telford.

Mr Coan replied that the Providers work across both Telford and Shropshire and the whole independent review of Telford will affect Shropshire as they are served by the same Providers. It has been agreed that the information and actions will be shared and monitored. In addition, Telford CCG had agreed to provide support for victims and witnesses of such exploitation who come forward.

QC-2019-11.144 (Agenda Item 8) – Infection Prevention & Control Report – Q2

Key issues and points to note within Mrs Kidson's report were:-

- Shropshire CCG and Shrewsbury and Telford Hospitals (SaTH) were over trajectory for Clostridium Difficile infection at the end of Quarter 2.
- A serious incident was reported by Shrewsbury and Telford Hospitals as a result of an endoscope washer-disinfector machine being left in service for five days after the receipt of positive quarterly tests for mycobacteria in rinse water. A full investigation was undertaken and assurance has been gained that no patient harm occurred.
- The CCG's IPC Lead accompanied the IPC Advisor from NHS England and NHS Improvement – Midlands and East Region, on a return visit to Shrewsbury and Telford Hospital in October. The visit demonstrated a continued focus and energy on IPC, which was identified both during the meetings and the clinical visits to the six clinical areas across the two sites. A sustainability review visit will be undertaken in April 2020.

Clostridium Difficile presents challenges across the entire health economy. Direct comparisons to the previous year are not possible because of changes in the reporting algorithm.

The next visit from NHS England and NHS Improvement is scheduled for 21 April 2020.

Mr Timmis referred to Paragraph 36 of Mrs Kidson's report regarding the Serious Incident involving the endoscope washer-disinfector machine which should have been taken out of service. Mrs Kidson advised that as a result of this incident, processes have been reviewed and a whole system change implemented.

QC-2019-11.145 (Agenda Item 9) – Patient Safety & Experience Report – Q2

Mrs Blay drew the attention of the Committee to the PPQ report submitted to Telford & Wrekin CCG, which was appended to her paper for information. Feedback received from PPQ indicates that they do not wish to see the Quality Committee report going forward, but would like the two CCGs to work more collaboratively.

Mrs Blay believed that Shropshire CCG needed to include more learning outcomes from their complaints. In contrast, the PPQ report very clearly shows when learning outcomes have been identified.

Going forward, Mrs Blay will provide more detailed comparative graphs in her report as requested by Dr Leaman at a previous Committee.

Mr Vivian referred to the Care Co-Ordination Centre and asked what changes were being made. Mrs Blay responded that a number of concerns had been raised by the CCC regarding different approaches being adopted across RSH and PRH for admission of TNO patients. Although they are one Trust, different processes exist across the two sites.

ACTION: Dr Davies to discuss CCC with Emma Pyrah and link into the learning outcomes from A&E Delivery Group.

Mrs Blay to include a Patient Experience Account in her update when she next attends Quality Committee with her Q3 report

QC-2019-11.146 (Agenda Item 10) – Healthwatch

Ms Cawley provided a verbal update, advising that although Healthwatch runs a health complaints advocacy service, there is no such service for those involved in Serious Incidents. She wished to understand how the Serious Incident process compares to the health complaints process and had met with Mr Borman, Director of Clinical Effectiveness at SaTH regarding the process. Ms Cawley has offered to be involved in creating a framework of information for families involved in the SI process based on the Healthwatch perspective.

ACTION: Ms Cawley to copy Mr Vivian into any correspondence regarding her work with SaTH on Serious Incidents.

Other key points of Ms Cawley's update were:-

- Healthwatch are about to produce a draft report on End of Life Care. She hopes to circulate a draft to services such as Shropcom in order to receive their response.
- At the request of Public Health, engagement has also been carried out around farmers' mental health.
- The current Hot Topic is "Access to Primary Care" and the actions taken by patients if they cannot get an appointment with a GP.
- In December, Ms Cawley is meeting with Kate Manning from Transforming Midwifery Care to discuss the consultation document.

ACTION: Ms Cawley to include Dr Lynch in her circulation of the draft End of Life Care report.

QC-2019-11.147 (Agenda Item 11) – Points to Escalate to CCG Board

- Ockenden report / Maternity Services
- Workforce and winter safety at ED

QC-2019-11.148 (Agenda Item 12) – Any Other Busines

There was no other business.

QC-2019-11.149 (Agenda Item 13) – Date and Time of Next Meeting

The next meeting will take place on Wednesday 29 January 2020 commencing at 2.00 p.m. in Meeting Room B, William Farr House.

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

System A&E Delivery Board

Notes & Actions

Meeting Title	A&E Delivery Board	Date	26 November 2019
Chair	Dave Evans	Time	14:30 – 16:30
Venue / Location	Seminar Room 1 SECC		

Attendee's

Present:	Dial in attendees:
Dave Evans (Chair) Claire Old Julie Davies Steve Gregory Sara Biffen Paula Clark Pam Schreier Lynn Cawley Lucy Roberts Sarah Dillion Kim Nurse Andy Begley Neil Nisbet Jess Sokolov Mark Tunstall Nicky Jacques Jayne Knott (note taker)	Sue Pearce

1.Apologies: Cathy Riley: David Stout: Jan Ditheridge: Clive Jones, Nigel Lee.

2.	**Minutes/Actions from previous meeting 22/10/19** Minutes of the previous meeting were approved as an accurate record. **Actions:** **Action 3.** • Conversations still on-going between Julie Davies/Edwin Borman re: pathways, to include PE pathway, chest pain pathway and respiratory pathway - to update next group meeting 3 December. • Streaming at PRH – Presentation at last group meeting which was circulated to Nigel Lee for the Trust. • No update yet from Dave and Clive Jones re: Community offer – Dave to pick up. • Dave Evans and Claire Old still to discuss setting up a workshop with other partners and GP's around primary care. **Action 5. Emergency Care dashboard –** Need to finalise winter schemes then update at next group meeting, then next board. **Action 7. Ambulance Demand –** Last week's meeting Anthony Marsh cancelled. Half day summit not arranged yet. Kim Nurse to speak to AM later today. Concerns around the rate of conveyances. **Action 8. Powys LA bed issues –** Call taken place with LA and PTHB, and agreed a number of points through winter . Claire Old has had follow up meeting. Need to follow-up progress

	against the schemes through the SAED group. Look at different contractual arrangements between Powys and SaTH? No winter plan for this winter. Should issues be escalated to the Welsh Assembly Government. Dave Evans to discuss with NHSEI. **Action 10. SaTH2Home –** Closed but monitor through SAED Group.
3.	**UEC Dashboard –** The Board discussed the numbers from the dashboard. There was a discussion around AMA being moved and whether things could be done differently with AMA/SDEC. Need GP support. Need senior challenge at the front door at peak times It was asked if this could be a Community Nurse from Shropcom as it was last year. Stocktake to review community staffing capacity. Identify by next week the capacity and demand to see whether or not we need additionality and at what grade and how it can be provided and to be mindful of financially implications. Lucy Roberts to help support, with Steve Gregory, Jess Sokolov. Dave Evans asked if improvements had been made with Criteria led discharge and pre-mid-day discharges? Someone employed for 2 days a week – rolling out on one of the wards at RSH next week then at PRH. Pre midday discharges are still at 17%
4.	**Future Fit – update –** Draft strategic outline case has gone to NHSI. Feedback received last week, essentially no issues. Challenge will be the possibility of a phased solution, and need to be in a position to describe what the phased solution will be. Architects are working up a number of possible options around phasing and scheduled to come back with ideas next week. Test to see if there are other ways this phasing could happen? Ambition is not to deliver a phased solution, but to use what comes out of that to underpin and support the case for the preferred option. Letter of support received from two CCG's with a number of caveats. Claire Old asked how often should this Board be updated. It was discussed and suggested that the shape of services discussed through STP/ SLG before the OBC goes in, then update at this Board. **Powys bed update-** • Sue Pearce from Powys joined the meeting via telephone- Dave Evans asked for an update on Powys bed issues – • There were a number of schemes planned by the LA to enhance capacity but they were not due to show benefits until the summer of 2020. • Winter schemes had been shared by Claire Old after the meeting, but the capacity that they would deliver against a background of up to 20 long stay MFFD patients on the list currently in SaTH was still unclear. Dave Evans asked Sue to seek clarity urgently and report back to the next A&E Delivery Group. • Sue also discussed that community beds were also unable to be used due to the number of MFFD patients unable to be moved into alternate pathways.
5.	**Winter letter –** Claire Old discussed the letter with the Board and went through the 6 main things that the National team have asked for: 1. General/Acute hospital beds - Still a challenge – overall position is 126 beds in January mitigated by ward 35. Concerns around staffing additional beds with agency. Solution - need better internal efficiency and managing demand either pre-or at the front door. 2. Work with LA/care packages – This work is being done, although Powys info needed.

	3. GP, out of hours services – done 4. Mental Health services – ED audit done, response good. Some issues with CAMHS especially with Powys. Results from the recent audit not available to answer this question, but should be available in the next two weeks. 5. Community health services –Could WMAS help with Twilight hours, data needed to look at reasons for twilight conveyances. 6. Flu vaccines – on trajectory, latest data (patients) from primary care. Region require a written response on pension schemes agreed (SaTH) no guarantee of more shifts. Winter visit on 13 December will be the assurance against these items as the Escalation meeting is not going ahead as planned on 5 December. Developing a delivery agreement – is this the winter plan? Mark Tunstall will enquire. (Mark has now confirmed this is a system delivery agreement (Winter Plan).
6.	**Escalation meeting prep** – Not needed as meeting 5 Dec cancelled **Site visit Prep –** Claire Old will address the 6 items already discussed and will write to Jeff Worrall through SAED Group. Julie Davies commented that there had been an ask to include RJAH in the surge plan. Claire mentioned that NHSEI had previously decided that RJAH did not need to be part of the winter escalation outside the Sheldon Ward beds. Dave Evans to write to Mark Brandreth, Claire Old to draft this.
7.	**TOR – SAED Board –** Reviewing TOR for SAED Board and group. Urgent Care working group suspended for now as no place within the governance structure and the business of this could be done through the SAED group without losing the keys pieces of work. Jess Sokolov suggested there was a need for clarity between the Board and the group. Look at TOR for both and widen the remit as it was thought that having both Board and group focusing on A&E Delivery wasn't particularly helpful when trying to look at the whole system. There was a suggestion that SAED Board joined with STP Board, Dave Evans happy to discuss option with SLG/ICS shadow Board. Revised TOR for Board and Group to the next Board meeting for sign off.
8.	**Any other business –** Lucy Roberts told the Board that ECIST were going through a restructure/reconfiguration which will change the operating role from the new year, which will have effect how much resource/input will be coming into to the system particularly into the Acute. More information will be available soon. There will be a stocktake of the focus work that has been done with the Acute over the past 14 months, this will be completed by next Tuesday 3 Dec. There will then be a meeting with Region etc to discuss future support within NHSEI. Lucy said that there will still be some support but not at the level it has been. Lucy will update next Board. Lynn Cawley from Healthwatch commented about winter messaging saying they hadn't seen anything. Pam Schreier said she would circulate any local messages.

Summary of Actions

Agenda Item	Action required	Owner	By when
3.	**Winter Plan-** • Conversations still on-going between Julie Davies/Edwin Borman re: pathways, to include PE pathway, chest pain pathway and respiratory pathway - to update next group meeting 3 December. • Streaming at PRH – Presentation at last group meeting which was circulated to Nigel Lee for the Trust. • No update yet from Dave and Clive Jones re: Community offer – Dave to pick up with Clive • Dave Evans and Claire Old still to discuss setting up a workshop with other partners and GP's around primary care	Julie Davies Dave Evans/Claire Old Clive Jones	28.1.20
5.	**Emergency Care Dashboard**: Need to finalise winter schemes then update at next group meeting, then next board.	Charles Millar	28.1.20
7.	**Ambulance demand** Half day summit to be set up.. No response from WMAS so Dave Evans to chase. **Update -** • *Last week's meeting Anthony Marsh cancelled. Half day summit not arranged yet. Kim Nurse to speak to AM later today. Concerns around the rate of conveyances*.	Dave Evans	28.1.20
8.	**Powys LA bed issues** Call taken place between Julie Davies/Nigel Lee/ LA and PTHB, and agreed a number of points through winter . Claire Old has had follow up meeting. Need to follow-up progress against the schemes through the SAED group. Look at different contractual arrangements between Powys and SaTH? No winter plan for this winter. Should issues be escalated to the Welsh Assembly Government. Dave Evans to discuss with NHSEI.	Dave Evans	28.1.20
6.	**Site visit Prep –** Claire Old will address the 6 items already discussed and will write to Jeff Worrall through SAED Group. Julie Davies commented that there had been an ask to include RJAH in the surge plan. Claire mentioned that NHSEI had said there was no need for this. Dave Evans to write to Mark Brandreth, Claire Old to draft this.	Dave Evans/Claire Old	28.1.20
7.	**TOR –T**OR for Board and group to be revised ready for next Board to sign off	Claire Old	28.1.20

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.044
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	North Locality Board Meeting
Date of Meeting:	28 November 2019
Chair:	Dr Katy Lewis

Key issues or points to note:

- Update on Single Strategic Commissioning Organisation and CCG finances
- VBC Policy to be discussed at CCC in December
- Concerns raised about ambulance delays and paramedics asking GPs for advice when they should be using *5
- Update on new Community Respiratory Pathways and nurse-led service
- SOOS – presentation about waiting times, KPIs, backlog reduction, pathways and criteria
- Integrated Urgent Care/111 – presentation about 111 and CAS (Clinical Advice Service)

Actions required by Governing Body Members:

- No actions required

Minutes of the

North Locality Board Meeting

Thursday 28 November 2019

The Venue at Park Hall, Oswestry

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr Adam Booth	Baschurch – Prescott Surgery	*Apologies*
Nicolas Storey	Baschurch – Prescott Surgery	Attended
Dr Tim Lyttle	Churchmere Medical Group	Attended
Jenny Davies	Churchmere Medical Group	Attended
Dr Angela Ayers	Clive Medical Practice	*Apologies*
Zoe Bishop	Clive Medical Practice	*Apologies*
Dr James Mehta	Hodnet Medical Centre	Attended
Christine Charlesworth	Hodnet Medical Centre	Attended
Dr Jonathan Davis	Knockin Medical Centre	Attended
Mary Herbert	Knockin Medical Centre	Attended
Dr Mike Matthee	Market Drayton – Drayton Medical Practice	Attended
Michele Matthee	Market Drayton – Drayton Medical Practice	Attended
Dr Santiago Eslava	Oswestry - Cambrian Medical Centre	Attended
Kevin Morris	Oswestry - Cambrian Medical Centre	Attended
Dr Stefan Lachowicz	Oswestry – The Caxton Surgery	*Apologies*
James Bradbury	Oswestry – The Caxton Surgery	Attended
Dr Yvonne Vibhishanan	Oswestry - Plas Ffynnon Medical Centre	Attended
Sarah Williams	Oswestry - Plas Ffynnon Medical Centre	*Apologies*
Dr Alistair C W Clark	Shawbury Medical Practice	*Apologies*
Joanne Clark	Shawbury Medical Practice	Attended
Dr Catherine Rogers	Wem & Prees Medical Practice	Attended
Caroline Morris	Wem & Prees Medical Practice	Attended
Dr Katy Lewis (Chair)	Westbury Medical Centre	Attended
Helen Bowkett	Westbury Medical Centre	*Apologies*
Dr Andrew Rogers	Whitchurch – Dodington Surgery	Attended
Elaine Ashley	Whitchurch – Dodington Surgery	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	Attended
David Evans	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Janet Gittins	CCG North Locality Manager	Attended
Heather Clark (Minutes)	CCG Personal Assistant	Attended
Amanda Laing	CCG North Locality Pharmacist	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Dr Julie Davies	CCG Director of Performance and Delivery	Attended
Bethan Emberton	CCG Commissioning and Redesign Lead Planned Care	Attended
Sarah Pezzaioli	SCHT Respiratory Team Leader	Attended
Cathryn Brownfield	SCHT Respiratory Specialist Nurse	Attended
Nina White	RJAH SOOS Service Manager	Attended
Dr Pir Shah	Sandwell & West Birmingham CCG - Clinical Lead – West Midlands Integrated Urgent and Emergency Care Transformation Directorate	Attended

Minute No NLB-2019-11.090 [Item 1] - Welcome & Apologies

1.1 Dr Katy Lewis welcomed those present for attending; apologies were recorded as above.

Minute No NLB-2019-11.091 [Item 2] - Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

Minute No NLB-2019-11.092 [Item 3] - Minutes of Meeting held on 26 September 2019

3.1 The minutes of the meeting held on 26 September 2019 were approved as an accurate record of the meeting and were signed by the Chair.

Minute No NLB-2019-11.093 [Item 4] - Matters Arising from Previous Meeting

4.1 Minute No NLB-2018-10.092 - Heart Failure and AF – Dr Lewis advised that Dr Deborah Shepherd was working on a cardiology pathway and these areas would be included in this; once completed Dr Lewis would bring it back to the meeting.

4.2 Minute No NLB-2019-09.081 – Public Health (Flu Vaccines) – Members advised that Public Health had written out to parents of all 2 and 3 years old about flu vaccines before practices had received any supplies, they asked for this issue to be raised with Rachel Robinson.

ACTION: Dr Lewis/Janet Gittins to raise flu vaccine scheme issue with Rachel Robinson.

4.3 Minute No NLB-2019-09.084 – Respiratory CLEAR – Dr Lewis reminded Members that Dr Sokolov would like access to practice data in order to complete the ongoing respiratory work, and to contact her if they were interested in the CLEAR programme.

4.4 Minute No NLB-2019-09.085 – Radiology – Janet Gittins advised that the contract team had requested a list of the services provided by RJAH (The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust) and were still waiting for a response, this had been a couple of weeks ago. Dr Davies advised that under their contract they had 10 working days to respond to requests such as this, and Janet Gittins confirmed that the list would be circulated once received. Dr Davies advised that the CCG were about to go through contract negotiations for the next year and if there were things that Members would specifically find helpful or wasn't already included in the service to let her know. Members stated that they would need to see the list of current services first to see what was available so they could then suggest things they would like to be included.

ACTION: Janet Gittins to circulate list of radiology services once received from RJAH.

Members to let Julie Davies know if they have any ideas of additional services that would be helpful to them – so CCG can bring to contract negotiations for next year.

4.5 Minute No NLB-2019-09.086 – IAPT/MH Services – The list of Trailblazer schools had not yet been received, Dr Davies advised she would chase this with Cathy Davies.

ACTION: Dr Davies to chase Cathy Davis for list of Trailblazer schools.

Minute No NLB-2019-11.094 [Item 5] – CCG Chair Update

5.1 Dr Povey advised that the application to form a Single Strategic Commissioning Organisation from April 2020 was turned down by NHS England. Feedback from NHS England was that there needed to be a financial plan for the system that balances and that the system was not yet ready for a strategic commissioner, the operational plan also needed further work. The CCGs were planning to submit another application in April 2020 in order to form the single organisation from April 2021. In the meantime the CCGs would continue to form a single management structure; the management of change process for this was now underway with the Executive Team at both CCGs.

5.2 NHS England also gave some feedback about what the CCGs should work on prior to April 2021 to bring the two CCGs closer together. Telford and Wrekin CCG had now agreed to change their clinical day to Wednesday to align with Shropshire CCG, which would help the CCGs move towards having Joint Committees or Committees in Common. Dr Povey explained the difference between these by saying that Committees in Common were when two committees meet at the same time but make two separate decisions, and Joint Committees are when individuals meet as one group to make one decision – legally this can only happen around commissioning decisions. There would also be a

proposal to streamline the CCG Boards which would be brought to the Membership for comments, and the constitutions would also be looked at in order to align them; this will happen over the next 6-9 months.

5.3 Dr Povey explained that by 2023/24 without any work there would be a system deficit of £150m, there was a financial plan that would bring the deficit to £100m, and further plans to bring the system deficit to £55m. Currently Shropshire CCG were £40-50m in deficit. Discussion took place about providers and the cost of having so many Boards to pay for. Dr Povey stated that all providers in the system would need to work together more closely and efficiently in the future working towards the ICP (Integrated Care Provider) model, and many CCGs were moving away from PBR (Payment By Results) and using block contracts more.

Minute No NLB-2019-11.095 [Item 6] – Locality Chair Update

6.1 Dr Lewis advised that the Value Based Commissioning Policy would hopefully be discussed at the Clinical Commissioning Committee in December.

6.2 West Midlands Ambulance Service took over the 111 contract from 5 November 2019. Members noted that discharge summaries were now easier to read and were all sent from the same place, they were also very detailed which was another positive. Dr Davies advised that there had been a significant improvement in calls being answered within 60 seconds. Ambulance dispositions were still higher than expected and dispositions to emergency departments were on par with the national average. Links were being made with other areas such as Herefordshire, Staffordshire and South Warwick to try and negotiate commissioning intentions with other rural parts of the region.

6.3 Members raised concerns with delays when making a 999 call from their practices; the delays were because the ambulance service deemed there to be a medical professional on site. Members gave examples of this happening in their practices and were reminded to raise these concerns on Datix. Some Members were also still receiving calls from paramedics asking to speak to the duty doctor to ask whether a patient should be taken to hospital. Members agreed that this was not a decision for them to make and the Ambulance Service should have clinical supervision provided by their service for this.

ACTION: CCG to raise concerns with Ambulance Service re GPs being asked by paramedics whether patients should be taken to hospital.

6.4 Dr Lewis advised that there had been a significant increase in Dermatology referrals. Dr Lewis and Dr Deborah Shepherd would be working on this by reviewing a number of randomly selected patients to look at why they were referred and whether they were appropriately referred. Dr Lewis would bring feedback to this meeting following this.

ACTION: Dr Lewis to bring feedback to the meeting following review of dermatology referrals.

6.5 There would be a pilot starting soon for non-medical referrers to request x-rays in primary care from SaTH (Shrewsbury and Telford Hospital NHS Trust). If the pilot works well it was hoped that this could then be started at RJAH.

6.6 Dr Lyttle asked about the integrated care record for care closer to home. Kevin Morris advised that this would be an IT system which would allow someone to view the whole of a patients care record and opens in a new window from EMIS. He had seen an example of the system and thought it would work quite well depending on how many people sign up to it.

Minute No NLB-2019-11.096 [Item 7] – Community Respiratory Pathways

7.1 Sarah Pezzaioli and Cathryn Brownfield attended the meeting to talk about the community respiratory pathways. There was a new COPD (Chronic Obstructive Pulmonary Disease) Nurse-Led Service with five nurses (4.2 WTE) offering clinics and domiciliary care. There will be weekly clinics in each locality for COPD patients with oxygen assessments every other week. It was explained that there was a total of five nurses, and Shropshire had been spilt into localities with a nurse each. The team will provide patient discharge support, education, medication optimisation and exacerbation management, with an overall aim to help patients self-manage their conditions better. It was hoped that this would improve quality of life and reduce burden on the Health Service. Patients referred to the service would need to have a diagnosis of COPD as the service was not currently commissioned for any other respiratory conditions.

7.2 Dr Matthee asked a question about medication optimisation. Sarah Pezzaioli advised that in the future the team were hoping to have a Respiratory Consultant available for MDT (multi-disciplinary team) meetings to manage complex patients, but there were no prescribers in the team at the moment which would need to be addressed. At the moment the nurses would be asking GPs to make any medication changes, but hoped to manage this in the future.

7.3 Discussion took place about acute management of patients. It was advised that the team were not commissioned for acute same day referrals but could accept urgent referrals and these patients would be seen within 48 hours. Concerns were raised about being asked to prescribe medication from someone other than a consultant and Members had experienced problems in the past because of this. Dr Povey advised that services across the country were now changing and patients were being treated and managed by multi-disciplinary teams with highly skilled members. Dr Vibhishanan stated that she had some patients with the team already and thought the service they provided had been very good. Dr Povey added that practices would need to build relationships and trust with the team.

7.4 Dr Matthee asked about technology as this had been neglected in the past e.g. patients having own SATS machines linked to the service or they could email in to raise concerns. Sarah explained that in her experience this had created increased work and anxiety for patients, but could be looked at further in the future.

7.5 Dr Matthee asked about oxygen as Members had discussed in the past the issue of the respiratory service being disjointed. This was explained by Dr Lewis who stated that if a patient was an inpatient and needed oxygen in order to go home the consultants in the hospital could prescribe oxygen, but if they were seen in the clinic and needed oxygen they have to be referred to the community service. Sarah was not aware of this but acknowledged that the service was disjointed, and noted that the team would need to be made aware of any oxygen requests. Dr Povey advised that part of the CLEAR would involve modelling what the respiratory service should look like.

7.6 The team were currently working on reviewing all patients on oxygen, following funding to deliver the QIPP target. Data was now available about this and the team would be meeting with the commissioners about this. It had highlighted the fact that the oxygen service is a huge part of the service itself and the current capacity was not enough to address the issues. Sarah explained the referral criteria for the oxygen service and confirmed that it was not an emergency oxygen service.

7.7 There was a pilot currently running for COPD self-management workshops with group sessions with up to 8 patients with COPD who are ambiguous about making changes. These would be delivered in a motivational interviewing manner and the whole team had now been trained on this. Patients will attend two workshops, with the first being 3 hours long looking at goal setting. There would then be phone calls every week for four weeks and then a second workshop. The pilot was currently located in Shrewsbury but may be rolled out to other areas if it works well.

7.8 It was confirmed that the Pulmonary Rehab Service had capacity issues and the waiting lists were getting higher. Programmes could only be put on in the locality hubs where there was sufficient demand and due to this it could take up to six months. The team asked Members to carry on referring and they would confirm waiting list times when referrals are received.

7.9 Sarah advised that she was negotiating a business case for an in-reach position within the team to help to facilitate early discharge from the hospital with a follow up within 48 hours of discharge. The team were also integrating with the IAPT team well and they join workshops to offer CBT (Cognitive Behavioural Therapy) to patients with higher levels of anxiety and depression.

7.10 Dr Eslava asked about palliative care and whether the team would be attending meetings in practices. Sarah asked Members to invite the team to meetings and they would try to attend them. Discussion also took place about quality and capacity and the need for the CCG to discuss allocation of funding with the Community Trust.

ACTION: Sarah Pezzaioli to circulate list of respiratory team nurses and areas covered.

Minute No NLB-2019-11.097 [Item 8] – Medicines Management Update

8.1 Amanda Laing and Clare Michell-Harding from the Medicines Management Team attended the meeting and gave a presentation to Members which contained the following topics:

- Commissioning – information re pain audit / stoma work and need to think about service for after end of March
- Care Home work - Think Food training in care homes and hospitals, Infant Milks audit
- Patient safety – PINCER (all in North signed up), Eclipse Live – all but 3 signed up, extra training would be available when basics done
- Miscellaneous information – Sativex advice change from NICE – CCG policy still not changed but will be reviewed, Semaglutide – one device provides enough for a month

8.2 Members discussed problems they were having with ScriptSwitch such as too many warnings appearing and having to change medication and then change it back again. Amanda asked Members to report any issues to her in the future so she could address them.

8.3 Dr Matthee asked about HRT (Hormone Replacement Therapy) and contraceptive medication as many seemed to not be available anymore. Amanda advised that there had been an issue nationally, and NHS England had sent out information about this.

8.4 Dr Matthee asked about the wound dressing PLT (Protected Learning Time) and that there were going to be guidelines and formularies sent out to practices but he hadn't seen them. Clare Michell-Harding advised that work was ongoing with SCHT (Shropshire Community Health NHS Trust) and issues had been raised at contract meetings. There was a direct ordering system for community nurses which started in Telford and had been rolled out across Shropshire, but there had been issues with out of date formularies which needed to be reviewed urgently. The new clinical guidelines and pathways were presented recently at the newly established Wound Care Group, a few comments and changes were needed but these would be published soon.

8.5 The team will be completing an audit starting with the Community Teams and Advanced Wound Healing team in Telford, and will be using the data to find keys areas to focus education and to create a rolling training programme.

Minute No NLB-2019-11.098 [Item 9] – SOOS – MSK Update

9.1 Nina White from SOOS (Shropshire Orthopaedic Outreach Service) attended the meeting and gave a presentation to Members which contained the following topics:

- SOOS waiting time standards
- Average waiting times
- Number of attendees
- KPI recovery / backlog reduction
- RJAH physio waiting times
- Referral criteria, process and pathway

ACTION: Heather Clark to circulate SOOS presentation to Members.

9.2 Nina confirmed that referrals submitted through the e-referral system (ERS) were immediately available to SOOS to triage. Dr Julie Davies advised that the CCG were aware of some delays that patients were experiencing with referrals and advised that the CCG would be looking into this by tracking some patients as it was not clear where the issues were. Dr Davies asked that Members send her any specific examples of this happening so that these patients could be included in the review – these should be sent to Janet Gittins in the first instance to collate responses from practices.

ACTION: Members to email any specific examples of SOOS referral delays to Janet Gittins.

9.3 Nina explained that there were delays between admin processes following triage which were being addressed; the delays could be up to two weeks. The admin team had not had the capacity to deal with the volume of referrals which caused a backlog. Referrals also had to be dealt with chronologically due to RTT (Referral to Treatment) targets; but the backlog was a priority and a plan had now been put together and funded. Members advised that they had been told by RAS (Referral Assessment Service) that SOOS did not accept urgent referrals; Nina advised that this was incorrect.

9.4 Concerns were raised about the waiting time for physio with SCHT; patients can wait months to be seen. This then causes a further delay if patients need an onward referral to SOOS. Dr Matthee advised that the Community Trust had advised they had written to all patients that had been waiting for over 8 weeks. Dr Julie Davies reminded Members to report any issues such as this so that the CCG could address them. Kevin Morris added that he had been told by SCHT that the waiting list was at around 12-13 weeks.

9.5 A discussion took place about a message given to Members at a PLT session; they were told that all physio would be done by SOOS. Nina White explained that this was not correct and that there had been a misunderstanding about what was provided by SOOS and the Community Trust. Members advised that if patients were seen by the Community Trust, they were then being referred back to the GP to refer on to SOOS instead of referring directly; Nina confirmed this was not correct and they should be referring directly to SOOS. It was advised that discussions were ongoing about an integrated MSK service with one lead provider which would help to address the issues that had been raised.

ACTION: Nina White to send a link to the RJAH website where patient leaflets were available.

Minute No NLB-2019-11.099 [Item 10] – Integrated Urgent Care

10.1 Dr Pir Shah, Clinical Lead from the Integrated Urgent Care Team, attended the meeting to give an update about the service. He advised that the 111 service had been taken over by West Midlands Ambulance Service at the beginning of November. He also talked about the CAS (Clinical Advice Service) in which he had been a clinician for four years. He explained that 111 calls were answered by someone who isn't a clinician and they follow an algorithm called Pathways. One of the dispositions on the algorithm was for the call handler to talk to someone in CAS. CAS was made up of GPs, Nurse Practitioners, Dental Nurses, Mental Health Nurses and Pharmacists. About 50% of the calls that go through CAS were managed and completed by CAS rather than having a further appointment booked or ambulance called. Further discussions were ongoing to see what else could be included in the CAS.

10.2 A discussion took place about *5 which should be used if an ambulance is on site and the paramedics are not sure if a patient needs to be taken to hospital; they can ring *5 for a decision from a GP or Nurse Practitioner. This process started around March/April this year and 53% of these calls were not conveyed and were managed over the phone. Dr Shah also talked about *6 which could be used by nursing homes, there had not been many of these calls yet which may be due to the large turnover of care staff and new staff not being aware of the service.

10.3 Dr Shah talked about CPCS (Community Pharmacy Care Services); 70% of pharmacies have signed up to this. Patients could be referred by 111 to their pharmacy for minor illnesses and repeat prescriptions could be requested.

10.4 Members raised the issue about paramedics calling GPs for advice which was discussed earlier in the meeting. Dr Shah advised that this should not be happening and that Members could fill in a health professional feedback form if this happens as each form received has an end to end review to look at the issues. Members could also email Dr Shah directly to look into any issues; he would need the case number to look into the details and asked for any emails to be marked as urgent to bring them to his attention.

ACTION: Heather Clark to circulate Dr Shah's email address.

10.5 A discussion took place about 111 reports that were sent to practices. It was noted that if patients were advised to go to a pharmacist the practices do not receive reports about this but did receive dental health reports.

ACTION: Dr Shah to feed information back about practices not receiving reports if patients are sent to their pharmacy from 111 / and concerns about receiving calls from paramedics instead of them using *5.

Minute No NLB-2019-11.100 [Item 11] – Primary Care Update

11.1 The Primary Care update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No NLB-2019-11.101 [Item 12] – Commissioning Update

12.1 The Commissioning update paper was circulated to Members prior to the meeting. Concerns were raised about the crisis team; Dr Davies advised that this was one of the areas the CCG would be working on as part of the mental health transformation programme.

12.2 It was advised that there was a new ADHD (Attention Deficit Hyperactivity Disorder) and Autism pathway and all new referrals should now be sent from schools. An MDT panel would take place to identify the needs of the child and the support needed. Dr Davies advised that the two CCGs had agreed funding to clear the backlog; it was expected that the backlog would be cleared by the end of April but this was now likely to be June. This had been escalated with MPFT (Midlands Partnership NHS Foundation Trust) at their contract meetings. Members also raised concerns about the consultants who were retiring and how the service would be covered.

ACTION: Discussion on the new ADHD/Autism pathway to be on the agenda for the January locality meeting.

Minute No NLB-2019-11.102 [Item 13] – Any Other Business

13.1 A discussion took place about the increase in the transfer of work from the hospital to primary care. It was advised that this needed to be reported to the contracting team at the CCG but that Members should report anything like this to Janet Gittins in the first instance.

13.2 An issue was raised about consultants not referring on patients, and private consultants stating that they can't refer to other consultants. One Member reported that they received a rude letter from a consultant and they copied the patient in. Dr Davies asked members to report anything like this to her in the future.

ACTION: Bethan Emberton to look into the issue raised re consultant to consultant referrals.

13.3 Janet Gittins confirmed that she had sent out the contact details of the named Health Visitors and asked Members to let her know if they were not attending practice meetings or making any contact. Dr Matthee stated that there were vacancies in the school nurses team and he had not been receiving replies to emails.

13.4 Janet Gittins asked about the midwifery notifications as she had not received any emails from Members that month. Some Members reported not receiving any notifications.

Minute No NLB-2019-11.103 [Item 14] - Date of Next Meeting

14.1 The next meeting will take place on: **Thursday 23 January 2020** at **Drayton Medical Practice, Market Drayton** commencing at **2.30pm.**

A provider session will take place before the Locality Board from 1.30 – 2.30pm.

Future Meeting Dates

- Thursday 23 January 2020, Drayton Medical Practice, Market Drayton
- Thursday 27 February 2020, The Venue at Park Hall, Oswestry
- Thursday 26 March 2020, Drayton Medical Practice, Market Drayton

Signed: ……..... **Date:** ….....……

Dr Katy Lewis, Joint North Locality Chair

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.044b
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	North Locality Board Meeting
Date of Meeting:	23 January 2020
Chair:	Dr Michael Matthee

Key issues or points to note:

- Update on Single Strategic Commissioning Organisation, new Executive Team and plans for alignment of CCG constitutions and committees
- Low Risk Diabetic Foot Screening – discussions on how to cover this service if it was decommissioned
- PLT (Protected Learning Time) – discussions about format of these sessions and topics
- Concerns were raised about cataract referral difficulties
- Concerns were raised about physiotherapy waiting times
- It was noted that further topics were included on the agenda but speakers had cancelled at the last minute

Actions required by Governing Body Members:

- No actions required

Minutes of the

North Locality Board Meeting

Thursday 23 January 2020

Drayton Medical Practice

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr Adam Booth	Baschurch – Prescott Surgery	*Apologies*
Nicolas Storey	Baschurch – Prescott Surgery	Attended
Dr Tim Lyttle	Churchmere Medical Group	*Apologies*
Jenny Davies	Churchmere Medical Group	*Apologies*
Dr Anna Schur	Clive Medical Practice	Attended
Zoe Bishop	Clive Medical Practice	*Apologies*
Dr James Mehta	Hodnet Medical Centre	Attended
Christine Charlesworth	Hodnet Medical Centre	Attended
Dr Jonathan Davis	Knockin Medical Centre	Attended
Mary Herbert	Knockin Medical Centre	Attended
Dr Mike Matthee (Chair)	Market Drayton – Drayton Medical Practice	Attended
Michele Matthee	Market Drayton – Drayton Medical Practice	Attended
Dr Santiago Eslava	Oswestry - Cambrian Medical Centre	Attended
Kevin Morris	Oswestry - Cambrian Medical Centre	Attended
Dr Stefan Lachowicz	Oswestry – The Caxton Surgery	Attended
James Bradbury	Oswestry – The Caxton Surgery	Attended
Dr Yvonne Vibhishanan	Oswestry - Plas Ffynnon Medical Centre	Attended
Sarah Williams	Oswestry - Plas Ffynnon Medical Centre	Attended
Dr Alistair C W Clark	Shawbury Medical Practice	*Apologies*
Joanne Clark	Shawbury Medical Practice	Attended
Dr Catherine Rogers	Wem & Prees Medical Practice	Attended
Caroline Morris	Wem & Prees Medical Practice	*Apologies*
Dr Katy Lewis	Westbury Medical Centre	Attended
Helen Bowkett	Westbury Medical Centre	Attended
Dr Andrew Rogers	Whitchurch – Dodington Surgery	Attended
Elaine Ashley	Whitchurch – Dodington Surgery	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	Attended
David Evans	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Janet Gittins	CCG North Locality Manager	Attended
Heather Clark (Minutes)	CCG Personal Assistant	Attended
Amanda Laing	CCG North Locality Pharmacist	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Bethan Emberton	CCG Commissioning and Redesign Lead Planned Care	Attended

Minute No NLB-2020-01.001 [Item 1] - Welcome & Apologies

1.1 Dr Michael Matthee welcomed those present for attending; apologies were recorded as above.

Minute No NLB-2020-01.002 [Item 2] - Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

Minute No NLB-2020-01.003 [Item 3] - Minutes of Meeting held on 28 November 2019

3.1 The minutes of the meeting held on 28 November 2019 were approved as an accurate record of the meeting and were signed by the Chair.

Minute No NLB-2020-01.004 [Item 4] - Matters Arising from Previous Meeting

4.1 Minute No NLB-2019-11.093 – Public Health – Janet Gittins advised that she had not heard anything back from Rachel Robinson yet about the issue raised about the delay in practices receiving flu vaccines. Agreed that action could be closed.

4.2 Minute No NLB-2019-11.093 – Radiology – Janet confirmed that information about direct access had been circulated, there were no formal protocols. Practices had sent their views in about this and these had been sent to Dr Julie Davies who is working on new protocols and contracts for next year.

4.3 Minute No NLB-2019-11.095 – Calls from Paramedics – Members reported receiving less calls for advice from paramedics.

4.4 Minute No NLB-2019-11.095 – Dermatology Referrals – Dr Lewis advised that there had been an increase in dermatology procedures at the skin clinic for the whole CCG. Dr Lewis had completed an audit looking at 50 random patients with a procedure code sent to the CCG for payment. For 32 of these patients the procedure was for dermotoscopy. Dr Lewis didn't think that this should be charged as a procedure as it was more of an examination, and that most of these patients didn't require any other procedure.

4.5 Minute No NLB-2019-11.102 – Consultant Referrals – Bethan Emberton advised that she had sent some information to Janet Gittins about this query. The information found was not very clear was interpreted to say that private consultant referrals to NHS consultant referrals were allowed as long as the patient was not prioritised before others. Bethan stated that she had a meeting with the Nuffield the following week and would raise the issue there. Dr Povey thought that this issue may have occurred due to the hospital thinking they can only be paid for electronic referrals, but this only applies to GP referrals, consultant referrals can be accepted by the hospital.

Minute No NLB-2020-01.005 [Item 5] – CCG Chair Update

5.1 Dr Julian Povey advised that the CCG had been through the process of interviewing for the new joint Executive Team and the following roles had been appointed to:

Executive Director of Finance – Claire Skidmore
Executive Director of Transformation and Medical Director – Jessica Sokolov
Director of Performance – Julie Davies
Director of Planning – Sam Tilley
Director of Corporate Governance – Alison Smith

Chris Morris would be covering the Executive Director of Quality role, and Fran Beck would be covering the Director of Partnerships role until the end of March. These two posts would be advertised externally within a week or so. The main issue that had been raised by the other two localities was that there was no longer a Director of Primary Care in the new structure. Dr Povey explained that the trend nationally was for CCGs to have a Head of Primary Care or Assistant Director. The new directors were currently refining their roles with David Evans and once complete would be designing the structures of their directorates. Once structures were complete there would be a consultation period with staff through the formal management of change process. It was hoped that the full structure would be in place by April-June.

5.2 Dr Povey stated that when the Membership voted for the single strategic commissioning organisation last year, it was agreed that if the CCGs could not become one from April 2020, this would be from April 2021 with alignment of governance and meetings in the interim period. It had become apparent that this could not happen without aligning the constitutions. The constitutions were being worked on and would be brought to the Membership for approval once finalised. The CCGs would be aiming to have joint committees and committees in common and the suggestion for the Board would be to appoint joint lay members and secondary care doctor, and for each CCG to have 3 GPs on the Board. The CCG chair role was open to debate and the options could be that there was one chair for each CCG that alternated chairing the Board meeting or one chair for both CCGs. It was thought that there would be a period of consultation for this in February, with the hope that the new Board to be in place mid-June to early July.

5.3 Dr Povey talked further about the locality meetings and advised that there were no plans to change these as yet. Options for how the Locality Chairs would work in the new structure was still to be decided. One approach could be for the Locality Chairs to not attend the CCG Board but feed in to this through the other Board GPs. Another option could be that there would be one Chair from each locality that would sit on the CCG Board. The new Board positions would aim to split assurance from program redesign. Dr Vibhishanan stated that having the Locality Chairs attend the Board meetings meant that there was a greater knowledge of what was happening at the CCG to feedback to the localities. Dr Povey explained that if they were not to attend the Board there would need to be a relationship between the two for communication.

Minute No NLB-2020-01.006 [Item 6] – Locality Chair Update

6.1 Dr Matthee had no further information to discuss following the CCG Chair update.

Minute No NLB-2020-01.007 [Item 7] – Low Risk Diabetic Foot Screening

7.1 Bethan Emberton explained that a letter had been received from NHS England last April asking the CCGs to look at treatment targets, structured education and foot amputations rates in Shropshire, Telford and Wrekin. Major and minor amputations had increased in Telford, and minor amputations had increased in Shropshire. Recruitment of podiatrists in the area had also become difficult. In August 2019 Telford and Wrekin CCG decommissioned low risk diabetic foot screening from ShropCom (Shropshire Community NHS Trust) so that they could focus on the medium and high risk patients. The commissioner from Telford and Wrekin CCG had advised that there had been slow signs of improvement with patients being seen quicker and staying out of hospital. Shropshire CCG were also looking at the doing the same as Telford and Wrekin CCG and wanted to bring this proposal to the locality meetings to get Members views and ideas on how to do this. Diabetes UK had developed pathway criteria to identify medium and high risk patients and Telford were using this.

7.2 Dr Povey advised that NICE guidance recommended that low risk patients were seen once a year, medium risk patients were seen every six months and high risk patients seen 4-8 times a year. The suggested plan that was taken to the South Locality Board was that Shropshire CCG decommissioned the low risk foot screening and this was done by Primary Care instead. Nationally this had been done in Primary Care by GPs for many years but it has not been core activity in Shropshire.

7.3 Dr Lewis raised the issue of ShropCom being paid for this service and not achieving targets with no financial penalty, and the workload being moved elsewhere. Dr Rogers asked about funding for recruitment, and if ShropCom were not recruiting whether this money was available to use. It was queried whether ShropCom could use this money to employ HCAs (Health Care Assistants) to do this work rather than HCAs in Primary Care. The general feedback from Members was that Primary Care did not have the capacity to take on this work.

7.4 Dr Mehta asked how many WTE (Whole Time Equivalent) posts would be needed to cover the low risk foot screening and how many staff ShropCom were short of. Members also asked whether models had been looked at in other areas where GPs were paid for this work. There was a general agreement that the proposed 10 minutes for an appointment would also not be long enough, and training would be needed if it was expected to be done by Primary Care which would be an added cost.

ACTION: Bethan Emberton to find out how many WTE posts would be needed to cover low risk diabetic foot screening and how many posts ShropCom were short of. Also to investigate models in other areas where GPs were paid to do this work.

Minute No NLB-2020-01.008 [Item 8] – Medicines Management Update

8.1 Amanda Laing and Clare Michell-Harding from the Medicines Management Team attended the meeting and gave a presentation to Members which contained the following topics:

- Reminders for PDS searches and deadlines for submission
- Antibiotic training – train the trainer workshop on 7 February
- Diabetes training – injectable therapies 12 march
- Eclipse Live roll-out – all practices in the North Locality had signed up
- Further training for Eclipse was planned to be held in clusters in the near future

- Eclipse Live functions – vista module, diabetes module

8.2 Amanda gave a demonstration of the diabetes module in Eclipse and showed Members how to navigate the system and what information is provided. There were useful graphs for patients that track things such as weight, cholesterol, blood pressure and medication. There would also be an anti-coagulation module available on Eclipse in the near future.

Minute No NLB-2020-01.009 [Item 9] – Future Meeting Planning

9.1 A discussion took place about PLT (Protected Learning Time) sessions and the future of these. Dr Matthee and Dr Lewis advised that Telford and Wrekin CCG had six PLTs per year; they also have a quarterly GP Forum which was equivalent to the Shropshire locality meetings. Shropshire CCG currently had three PLT sessions per locality per year and cover for these were provided by Shropdoc, there were also six to eight locality meetings per locality every year.

9.2 Dr Lewis advised that the CCG plan for the PLT and locality meetings was not yet known but that there had been a suggestion to have two PLT sessions for partners to attend and it would be up to the practices to arrange their own cover rather than employing Shropdoc; these sessions would be central. This was suggested for the PLTs at the beginning of the year as Shropdoc had advised that they were not available for cover until later in the year.

9.3 There was general agreement from Members that in-house PLTs were preferred as the events were more focused, and that they would like more PLTs. If there would be more PLTs they would prefer less locality meetings. Members suggested having 4-6 locality meetings a year depending on the number of PLTs. It was agreed to keep the locality meetings as they were for now until more is known about the future of the CCGs and PCNs (Primary Care Networks).

9.4 Dr Matthee asked for topic suggestions for the upcoming locality meetings and PLTs. A discussion took place about PCNs and whether there would be cross-over of work going forward. Kevin Morris advised that in 12 months' time PCNs would come under the ICP (Integrated Care Provider), and CCGs would become Strategic Commissioners whose members will still be the GP practices. Strategic Commissioners would specify outcomes and give money to the ICP to deliver these outcomes, how this would be delivered would be up to the ICP. What would need to be discussed at the locality meetings would have a different focus in the future as there would be no involvement in pathways as this would be discussed as providers.

ACTION: Members to send suggestions for PLT and Locality meeting topics to Janet Gittins, as well as any further ideas about number of meetings/PLTs and how to manage them.

Minute No NLB-2020-01.010 [Item 10] – Primary Care Update

10.1 The Primary Care update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No NLB-2020-01.011 [Item 11] – Commissioning Update

11.1 The Commissioning update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No NLB-2020-01.012 [Item 12] – Any Other Business

12.1 Eye Care Services - Dr Catherine Rogers advised that she was experiencing ongoing problems with referrals to ophthalmology for cataracts. A patient was referred back from the optician as they wanted the practice to refer on for cataract surgery. It was also not very clear on their letter what they had done or who the patient had seen. Dr Lewis added that she had received letters stating that a patient had been "referred to hospital for surgery" and so thought this had been done, but it was actually an action for the GP to do. There was also an issue with MECS (Minor Eye Conditions Service) as patients have had to ring around nine providers before they were accepted. There was also confusion around follow up appointments; Dr Lewis stated that one letter stated a patient needed a follow up in three months and this didn't happen; after checking she was told that the GP should refer the patient to hospital for this.

12.2 Bethan Emberton advised that she was aware of the issues and was working with CHEC (Community Health and Eye Care Ltd) to resolve these. RAS (Referral Assessment Service) had been informed that if they received any referral directly from an optician for cataract surgery this would now go

straight to secondary care instead of to CHEC. A solution was being worked on for the referrals that were being sent back to GPs. Bethan advised that there had been ongoing IT system issues for referrals from opticians to secondary care and it was hoped that there would be some news back from the CCG contracts team soon about how to resolve this issue.

12.3 A discussion took place about cataract refinement. It was found that previously when patients were referred straight to hospital for cataract surgery about 40% did not want to have the procedure. Cataract refinement is when a patient attends to see an Optometrist first who then provides them with information, the patient then has a period of time to consider if the procedure was right for them before seeing the Optometrist again. Members questioned whether this could be done in primary care for the same payment. Dr Povey suggested inviting Claire Roberts, the CCG Optometric Adviser, to attend a future meeting to discuss the issues further.

ACTION: Claire Roberts, CCG Optometric Adviser, to be invited to a future meeting.

12.4 Physiotherapy - Dr Matthee raised an issue about waits for physiotherapy which were especially long in Whitchurch and Market Drayton. In January there were 385 people on the waiting list with a 13 week wait, which was a big increase from the October figures of 289 on the waiting list and an 8 week wait. Dr Vibhishanan advised that she had referred a patient to physio who then sent the patient to see an OT (Occupational Therapist) who told the patient to go back to their GP to be referred to a hand surgeon. This should have been referred directly to SOOS (Shropshire Orthopaedic Outreach Service) and had been raised as an issue on Datix.

Minute No NLB-2020-01-013 [Item 13] - Date of Next Meeting

13.1 The next meeting will take place on: **Thursday 27 February 2020** at **The Venue at Park Hall, Oswestry** commencing at **2.30pm.**

A provider session will take place before the Locality Board from 1.30 – 2.30pm.

Future Meeting Dates

- Thursday 27 February 2020, The Venue at Park Hall, Oswestry
- Thursday 26 March 2020, Drayton Medical Practice, Market Drayton

Signed: ……..... **Date:** ….....…….

Dr Michael Matthee, Joint North Locality Chair

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.045
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Shrewsbury & Atcham Locality Board Meeting
Date of Meeting:	21 November 2019
Chair:	Dr Deborah Shepherd

Key issues or points to note:

- Locality Chair Update - Discussion took place about rising demand in the system, increases in referrals for gynaecology ultrasounds and dermatology, and future PLT sessions.
- CCG Chair Update - Update on progress towards a single strategic commissioning organisation.
- Introduction to new Director of Public Health and presentation on plans and priorities for public health in Shropshire.
- Medicines Management Update about antibiotic prescribing – decision made to have an anti-biotic/UTI workshop at a future meeting.
- Update from the BeeU Service in regards to recruitment and targets. They advised of a new ASD waiting list initiative and pre-referral panel, and Trailblazer scheme in schools.
- Discussion took place about the NHS Diabetes Prevention Programme and Members were encouraged to continue to refer into the programme.
- Initial discussions took place about plans to decommission low risk diabetic foot screening.

Actions required by Governing Body Members:

- No actions required

Minutes of the

Shrewsbury & Atcham Locality Board Meeting

Thursday 21 November 2019

Board Meeting Room, Severn Fields Health Village,
Sundorne Road, Shrewsbury, SY1 4RQ

Member Name	Practice	Attendance
Dr D Shepherd (Chair)	CCG Locality Chair & Locum GP	Attended
Dr J Pepper	Belvidere	Attended
Caroline Davis	Belvidere	Attended
Dr M Fallon	Claremont Bank	Attended
Jane Read	Claremont Bank	Attended
Dr E Baines	Marden	Attended
Zoe George	Marden	Attended
Dr Julia Visick	Marysville	Attended
Izzy Culliss	Marysville	Attended
Dr Sarah Watton	Mytton Oak	Attended
Adrian Kirsop	Mytton Oak	*Apologies*
Dr R Bland	Pontesbury	*Apologies*
Heather Brown	Pontesbury	Attended
Dr B Roberts	Radbrook Green	Attended
Angela Treherne	Radbrook Green	Attended
Dr P Rwezaura	Riverside	Attended
Tracy Willocks (Vice Chair)	Riverside	*Apologies*
Dr D Martin	Severn Fields	*Apologies*
Timothy Bellett	Severn Fields	Attended
Dr L Davis	South Hermitage	*Apologies*
Caroline Brown	South Hermitage	Attended
Dr E Jutsum	The Beeches	Attended
Helen Steel	The Beeches	Attended
Dr K McCormack	Worthen	Attended
Cheryl Brierley	Worthen	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	Attended
David Evans	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Jenny Stevenson	CCG Locality Manager	Attended
Heather Clark (Minutes)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	*Apologies*
Carrie Jenkins	CCG Shrewsbury & Atcham Locality Pharmacist	*Apologies*
Rachel Robinson	Director of Public Health	Attended
Claire Parrish	MPFT Service Manager BeeU	Attended
Clare Neill	MPFT Associate Director of Communications and Strategic Partnerships	Attended
Vicki Pike	CCG Senior Commissioning Manager (Secondary Care)	Attended

Minute No S&ALB-2019-11.099: Item 1 - Welcome & Apologies

1.1 Dr Deborah Shepherd, Locality Chair, welcomed and thanked Members for attending and introductions were made. Apologies were noted as above.

Minute No S&ALB-2019-11.100: Item 2 – Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

Minute No S&ALB-2019-11.101: Item 3 – Locality Chair Update

3.1 Dr Shepherd provided some highlights from the report she provided to Members:

Winter Planning – The A&E Delivery Group had approved winter monies funding and practices should have been contacted about bids for this. Commissioners would like to encourage innovation; new ideas would be supported. It would be important to gather data to look at the positive and negative impacts to learn lessons for the future.

3.2 Rising Demand in System – The rise in demand mainly in emergency and non-elective care was not completely understood and had been causing a knock-on effect for planned care. It had been noted that quite a few two week wait referrals were being received which were not meeting the referral criteria; there was a thought that these were being used to get urgent access because waits were so long for routine appointments. Some specialities were now looking at how to put on urgent clinics. There was also an issue with patients being referred on the two week wait pathway that don't know why they are being referred. Dr Shepherd reminded Members to please have this conversation with patients; there was a leaflet available that was very helpful. Dr McCormack suggested that GPs and Consultants need to be giving the same message to patients and explain to them that they were being referred for possible cancer and not suspected cancer. Dr Shepherd added that there were challenges in meeting targets for some specialities such as lung, breast, prostate and Upper/Lower GI but that most were near target. Dr Shepherd was involved in a piece of working looking specifically at the lung two week wait pathway. It was also mentioned that the problem with pension tax rules was also causing waiting list problems.

ACTION: CCG to raise issue re GPs/Consultants giving same message to patients about two week wait referrals.

3.3 Increase in Dermatology Referrals – There has been an increase in Dermatology two week wait and routine referrals by around 20% since spring. The CCG could not understand why this was and Dr Shepherd asked if Members had any ideas or suggestions. One suggestion was that the APCS Dermatology service, that was phased out from spring and finished in August, could have affected this. Another suggestion was that if patients were being seen by Health Harmonie to investigate a lesion and a second lesion was found patients were then sent back to their GP to re-refer for the second lesion separately; this may have caused the extra referrals to be recorded.

ACTION: Jenny Stevenson/Dr Deborah Shepherd to feedback to CCG suggested reason for increase in Dermatology referrals.

3.4 Gynaecology Ultrasound Referrals - The referrals for gynaecology ultrasound scans also dramatically increased in October across both CCGs and the reason for this was unknown. It was suggested that a recent relevant storyline in Coronation Street may have influenced this.

ACTION: Jenny Stevenson/Dr Deborah Shepherd to feedback to CCG suggested reason for increase in gynaecology ultrasound referrals.

3.5 Cardiology – An issue was raised about the wait for cardiology appointments, and even urgent referrals could take months. Dr Shepherd explained that previously the team only had rotas arranged six weeks in advance, now clinics could be booked six months in advance. The team were aware of the problem and there were a number of things being worked on to improve pathways. The team are fully staffed with Consultants but the demand for the service was increasing.

3.6 Non-medical Referrers – Dr Shepherd advised that the CCG was a step closer to having non-medical referrers be able to request chest x-rays in primary care; protocols had been approved by the CCG. There would be a pilot with three ACPs (Advanced Clinical Practitioners) from Severn Fields to test the processes with SaTH (The Shrewsbury and Telford Hospital NHS Trust), this was then hoped to be rolled out to a wider pilot in spring.

3.7 Asthma – Personalised asthma action plans for children had been worked up and hopefully would be approved by the Area Prescribing Committee the following month.

3.8 GP Consultant Exchange Scheme – Members should have received an email from Alison Jones about the exchange scheme; this was about pairing up with consultants to spend half a day in each other's workplaces. If anyone was interested they were to contact Alison Jones.

ACTION: Members to contact Alison Jones at SaTH if they are interested in the GP Consultant Exchange Scheme.

3.9 Next year's PLT sessions – A meeting took place to discuss the PLT (Protected Learning Time) sessions and it was proposed that these would continue next year in the same format with three meetings; two locality wide and one in-house. There would be a further meeting in the New Year to discuss topics and how to provide cover; representatives from the localities would be invited to this meeting. The meetings would be aligned to localities due to the logistics and cost of aligning to PCNs (Primary Care Networks). Concerns were raised by Members because of this and they felt that it was a huge shame to not have everyone together from the PCNs. Dr Shepherd advised that she would take this back for discussion with the CCG. The argument for the decision was that the networks do not align with the localities which becomes complicated for cover, the CCG does not fund any other provider education therefore the justification for the CCG funding is that it aligns and supports CCG commissioning priorities and not provider priorities. Discussions had taken place about supporting networks if they wanted to put on education events of their own and how these requests are reviewed and approved. Dr Povey added that there were big issues with covering PCN areas rather than localities as this would affect the geographical cover for ShropDoc; though it would be reasonable to take it back to have a wider discussion. Also as part of the wider discussion it needed to be decided whether the CCG continued to have localities or whether it should align with the PCNs. Dr Shepherd also advised that at the wider meeting in January the group would also be looking at cover and whether ShropDoc were the best for this or if there were any other options.

ACTION: CCG to take comments and suggestions back about PLTs / discuss at wider meeting in the January.

3.10 Feedback from PLT – Dr Baines advised that she had seen the feedback from the safeguarding session as she had just started as lead for safeguarding. There was some good feedback but also some quite negative points about the presentation rather than the content, the audio-visual was poor and the presentation was poor. This would be taken back and discussed with the safeguarding lead.

3.11 Future Locality Meeting Topics – It was suggested having a topic to cover safeguarding areas such as coding and note keeping. Dr Baines explained that she would be meeting with the named GP for safeguarding in Telford about this as they already had a programme up and running for various GP forums on different subjects and would look to do more face to face training which is more relevant.

Minute No S&ALB-2019-11.102: Item 4 – CCG Chair Update

4.1 Dr Povey advised that the application to create a Single Strategic Commissioning Organisation was turned down by the NHS England regional team. The main reasons for this were that the financial plan didn't bring the system back into financial balance, the strategy and operating model needed further development and the system wasn't ready for a strategic commissioner. Meetings had taken place with NHS England to discuss plans to resubmit the application and the next application was planned to be submitted in April 2020.

4.2 Work was still ongoing to create a single management team and structure for the two CCGs. The Executive Team would be going through the management of change process in December and once the available posts were recruited to the rest of the CCGs structures would be looked at.

4.3 NHS England had encouraged the two CCGs to bring both of their constitutions in line which the CCGs will be working on in the near future. There would also be a realignment of sub-committees of the Boards, some of which will meet as joint committees or committees in common. Dr Baines asked about the two constitutions and if they were drastically different. Dr Povey explained that Telford and Wrekin CCG had the new model of CCG constitution and Shropshire CCG had the older one. There was also a difference around the Boards and where the localities fit. The localities in Shropshire are sub-committees of the Board and in Telford their GP Forum sits above their Board. There were other small differences such as names and functions of committees. A proposal would be brought to Members as soon as possible.

Minute No S&ALB-2019-11.103: Item 5 – Open Discussion – "Hot Topics" from Practices

5.1 No further items were raised by Members as topics were covered in items 3 and 4.

Minute No S&ALB-2019-11.104: Item 6 – New Public Health Director

6.1 Rachel Robinson, Director of Public Health for Shropshire attended the meeting to introduce herself and to give an update on the delivery of Public Health outcomes across Shropshire. Ms Robinson gave a presentation to the group which covered the following areas:

- Context for delivery – background information, prevention, priority outcomes
- Public Health's key health and wellbeing priorities – Smoking in pregnancy, mental health, diabetes diagnosis, weight
- Vision for Public Health – importance of not working in isolation
- Key areas of work 2019/20

6.2 Rachel Robinson talked about the decommissioned Help 2 Slim and Help 2 Quit services and explained that even though this was not ideal the services were not getting the outcomes needed and this was an opportunity to do something differently. There was now a piece of work ongoing to understand where the need was, and to map current services. Discussions were also ongoing with the STP (Sustainability and Transformation Partnership) looking at better ways of working e.g. with leisure services for weight management. Rachel added that the smoking in pregnancy service had been kept by Public Health and there was now an options paper available for a new service as improvements were still needed; the service needed to be more embedded in the hospital. Other areas have models for smoking which work very well but services and need were already changing rapidly e.g. with online and workplace services.

Minute No S&ALB-2019-11.105: Item 7 – Medicines Management Update

7.1 Carrie Jenkins sent apologies for the meeting but provided some data about antibiotic prescribing as it was antibiotic awareness week. All but three practices in the locality were meeting the target for antibacterial prescribing, and all practices were doing well and were meeting targets for co-amoxiclav, cephalosporin and quinolone. It was stated that changes in quinolone prescribing guidance came out earlier this year and Members were all aware of this. It was confirmed that notifications now appear on ScriptSwitch and patient leaflets had been very useful.

7.2 There was local antibiotic guidance from December 2017 provided in the packs for Members, the CCG were working on a new version which should be out this year. The national guidance was discussed and Members felt this was better than the current local guidance. Flowcharts were also provided in the packs from Public Health England, along with a link to a website for resources.

7.3 Dr McCormack talked about uncomplicated UTIs and thought that Members were being overwhelmed by all the information provided, and it was a lot to have to think about when seeing a patient. Information needed to be more realistic and useable for a patient consultation. Dr Shepherd advised that there were practices that used EMIS templates that may be useful. Members felt that peer to peer work would be useful for this piece of work and it should be covered in a workshop type session at a future locality meeting where practices could bring examples of what they were currently doing.

ACTION: UTI Workshop to be arranged for a future locality meeting.

Minute No S&ALB-2019-11.106: Item 8 – BeeU Update

8.1 Claire Parrish and Clare Neill from MPFT (Midlands Partnership NHS Foundation Trust) and Vicki Pike from Telford and Wrekin CCG attended the meeting to give an update about the BeeU Service. The service had now recruited into all posts, with an extra two substantive consultants; one in Shropshire and one in Telford. Two doctors from the Pakistan Army were also in rotation with the service, and there were now three Occupational Therapists (OTs) offering sensory group work. There was a drive in the service to reduce medication and improve therapeutic interventions. As part of the OTs work to reduce Melatonin use, those who were currently prescribed would be attending sleep clinics. BeeU were working with Early Help and the 0-19 Service to put on groups in the community for those who don't meet the requirement for the secondary service but do need help with sleep.

8.2 The service was within the 18 week RTT (Referral to Treatment) target for consultant appointments apart from ASD (Autistic Spectrum Disorder) which was a national problem. BeeU were working on an ASD waiting list initiative for those who had been waiting over 12 months. BeeU would be seeing all children under the age of 11, and the Emotional Health and Wellbeing Service would be seeing children over the age of 11. Forms had been completed with parents to give consent to share information. BeeU were working on a sustainable model with commissioners to provide a service going forward; a business case had been prepared and the team were hoping to start recruitment early next year.

8.3 The Trailblazer scheme had been launched and BeeU were recruiting to this now. This initiative was funded by HEE (Health Education England) for supporting young people in schools. There would be two teams, one based in Telford and one in Shropshire and approximately 18 schools had been identified in each area that would be working with the Trailblazers. Schools will be working with Education, Health and Wellbeing Practitioners that have completed a nine month training course at university, there was also a band 5 Practitioner, band 6 and a Team Manager. Schools will be getting first-hand support with low level mental health which is hoped to reduce referrals into secondary mental health services and

primary care. The Trailblazers will be initially funded for 2 years by HEE (7 practitioners) and the CCG had committed to funding them after this.

8.4 BeeU were also working with Health and Local Authority commissioners to look at putting together a pre-referral panel. It had been found that there are a high number of referrals (approx. 50%) that don't meet the criteria (particularly ASD). The pre-referral panel was already up and running in Telford and was now being worked on for Shropshire, this would be for anyone with ASD or ADHD (Attention Deficit Hyperactivity Disorder). The panel would be led by education and there were a large number of organisations involved in the panels so that the school could then have a comprehensive plan at the end of it for each child. The panel started in Telford this month and is hoped to start in Shropshire in the New Year; further communication would be sent out about this. The aim would be that all referrals would come from schools as they have all the information needed. It was confirmed that GPs could still make referrals to BeeU but that the preference was for these to now come from schools. If GPs were approached by schools to make referrals they should ask the schools to do this; BeeU were continuing to work with schools in the area to ensure that this message was clear. One of the next steps would be for the Trailblazers to work with non-state schools. BeeU were also working with a company call Landau who could work with children who are not attending school and can help to re-engage the child with school and get back into education. Members were advised to refer to BeeU so they can refer on to Landau.

8.5 The BeeU access team had now integrated with the adult access service and now both had identical processes, SOPs (Standard Operating Procedures) and triage processes. The access team was now fully recruited to and it was hoped that the two separate phone numbers would become one phone number for both adults and young people in the near future; further communication would be sent out about this soon. It was confirmed that the adult service was commissioned to take new referrals from age 18. BeeU could continue to see patients after 18 but would transition them to the adult service when appropriate.

8.6 A discussion took place about the drop-in service at Palmers Coffee Shop. Members had received feedback that young people with anxiety or social phobias were not comfortable waiting in a non-confidential waiting area, and having open discussions in a room with their peers. Claire Parrish was aware of young people not staying at the service and also the service being too busy and having to turn people away, but had not received any other negative feedback at the contract meeting with the Children's Society. It was suggested that perhaps the Trailblazers would be more appropriate for children who are not comfortable with the drop-in service, or different venues could be looked at if the current ones were not appropriate. These suggestions would be discussed at future contract meetings.

ACTION: Claire Parrish to bring to future contract meeting concerns about venues and discuss whether alternative venue was needed for drop in service.

8.7 A query was raised about GPs being requested to prescribe Melatonin and whether there should be a shared care agreement for this. Dr Shepherd confirmed that she would clarify this with the Medicines Management team.

ACTION: Dr Shepherd to discuss query in regards to Melatonin prescribing requests with Medicines Management Team and whether there is a shared care agreement in place.

8.8 A question was asked about urgent referrals. Claire Parrish confirmed that all crisis referrals were triaged and received a phone call within 4 hours; most urgent referrals were called on the same day and routine referrals within 7 days. Integrating with the adult access team had helped to achieve this. It was confirmed that the band 6 Mental Health Professionals look at all the referrals and make calls to parents to determine the level of urgency for each referral. The BeeU service operates 9am-5pm; discussion took place about who to refer to outside of these hours. It was confirmed that young people over the age of 16 could be dealt with by the adult access team. Children under the age of 16 with evidence of same-day self-harm should be admitted to A&E, if no evidence of this they would have to wait until the following day to be seen.

8.9 A discussion took place about the impact of LAC (Looked After Children) on the tier 2 system. It was explained that this had a huge impact, and the service particularly received a large number of out of area referrals. There were also issues with CCG payments and referrals not being completed in the correct way (e.g. there should be either social worker or CAMHS to CAMHS referrals). It was acknowledged that these processes needed to be reviewed.

8.10 For information, it was advised that the BeeU website could be found at the following address: https://camhs.mpft.nhs.uk/beeu

Minute No S&ALB-2019-11.107: Item 9 – National Diabetes Prevention Programme

9.1 Jenny Stevenson explained that the CCG were getting a lot of pressure from NHS England to increase referrals into the programme and asked Members if they had any tips to share. To date Shropshire CCG had made 1079 referrals; there were 1500 across Shropshire Telford and Wrekin (about 32% of the target for the two year period) with 375 coming from the Shrewsbury and Atcham Locality. The locality was also the only one where all practices had now referred into the programme.

9.2 There was a new invitation letter available on EMIS. Previously all patients had to contact their practice who then made the referral, whereas the new invitation allows the patient to contact Ingeus directly. Venues for the programme had been an issue as the sessions fill up very quickly and there was now a waiting list. Ingeus were now planning to book sessions three months ahead to help reduce this. There were also very few sessions available in the wider county.

9.3 It was confirmed that the CCG would be asking for the NDPP searches to be run centrally again to look at numbers. One of the reasons for this was because it was thought that the numbers expected to be referred were too high. Mid-point outcome data was good but there hadn't been any provided since.

9.4 Patients would now be able to self-refer once they had received a letter from their GP, it was hoped that this would reduce the workload for practices. There was also discussion around the Social Prescribing overlap and how this may be a good option for patients who were not yet ready to attend the NDPP group sessions.

Minute No S&ALB-2019-11.108: Item 10 – Minutes of Meeting held on 19 September 2019

10.1 The minutes of the meeting held on 19 September 2019 were agreed as a true and accurate record of the meeting and were signed by the Chair.

Minute No S&ALB-2019-11.109: Item 11 – Matters Arising

11.1 Dr Shepherd provided an update on the following actions from the previous meeting:

Minute No S&ALB-2019-09.090 – Communications with SaTH – An update was provided about the GDPR (General Data Protection Regulation) issue and sharing of information to investigate SaTH contract breaches. All breaches should still be sent to the general reporting email address, but this was now monitored by the Quality Team (rather than contracting team as before) as they are allowed to see patient identifiable information. An information sheet would be circulated about this soon which contains a summary about all the things the hospital should be doing. The Quality Team had also acted on the issue around out of date GP information and would continue to monitor this with providers.

Minute No S&ALB-2019-09.093 – Health Visitors – Members reported improved contact with Health Visitors and were now aware of their contact details.

Minute No S&ALB-2019-11.110: Item 12 – Primary Care Update

12.1 The monthly Primary Care Update had been circulated to Members prior to the meeting and there were no further questions about this.

Minute No S&ALB-2019-11.111: Item 13 – Commissioning Update

13.1 The monthly Commissioning Update had been circulated to Members prior to the meeting and there were no further questions about this.

Minute No S&ALB-2019-11.112: Item 14 – Any Other Business

14.1 Structured Education for Newly Diagnosed Diabetes – Belvidere Medical Practice had received a letter from the Community Trust advising that all courses were now on hold for 2020 until funding had been arranged and anyone who wished to attend could still be referred but would be put on a waiting list.

ACTION: CCG to look into the reasons for the hold on diabetes structured education courses.

14.2 UTI Service - A question was asked about whether a UTI service was still commissioned from community pharmacies and if so whether a list of the current providers was available.

ACTION: CCG to look into and provide list of current providers of UTI service.

14.3 Neurology – A discussion took place about the current Neurology Service as patients still had to go to New Cross Hospital in Wolverhampton, and the service did not have enough capacity. It was confirmed that this was a CCG priority and work was ongoing to commission a formal service linked with New Cross Hospital. There was a national shortage of Neurologists and regionally a hub and spoke model was being looked at. Another issue was the specialist nurse support which was also supposed to be provided by New Cross locally in the interim arrangements, but was not currently working as it should. There were also issues raised about scans not being able to be transferred from Oswestry and Shrewsbury to Wolverhampton and patients have had to have scans completed again.

ACTION: CCG to feedback that scans are not transferring between Oswestry/Shrewsbury and Wolverhampton.

14.4 Diabetic Foot Screening – A concern was raised about the current service not having the capacity to see all patients and how this affected QOF (Quality and Outcomes Framework) performance. It was confirmed that this was a known problem to the CCG and was currently being reviewed. In Telford the low risk diabetic foot screening had been decommissioned from the Community Trust to enable them to focus on the moderate to high risk screening; General Practice were now covering the low risk screening in Telford. This was also the case in the majority of other areas of the country. A proposal to do the same in Shropshire was discussed at the South Locality Board meeting; following feedback from this meeting it was decided to create a Task and Finish Group to discuss a way forward. A question was asked about whether any money was left in the contract that could be used to train people in practices to deliver this service. Dr Shepherd advised that she would ask about this.

ACTION: CCG to ask about surplus money in Diabetic Foot Screening contract – if there is any and whether it could be used for practice training for low risk screening.

Minute No S&ALB-2019-11.113: Item 15 - Date and Time of Next Meeting

15.1 The next formal meeting will be held on **Thursday 16 January 2020** in **Severn Fields Health Village, Sundorne Road, Shrewsbury, SY1 4RQ** commencing at **2.00pm.**

15.2 Further meeting dates:

Thursday 19 December 2019 - CANCELLED
Thursday 16 January 2020
Thursday 20 February 2020
Thursday 19 March 2020

Signed: .....…….. **Date:** ……

Dr Deborah Shepherd, Locality Chair

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.045b
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	Shrewsbury & Atcham Locality Board Meeting
Date of Meeting:	16 January 2020
Chair:	Dr Deborah Shepherd

Key issues or points to note:

- Locality Chair Update – update on the CCG re-organisation and formation of a single management team, finance update and discussion about winter pressures.
- Discussion took place about future development of the CCG, PCNs, ICS and ICP – update on the process to become a single strategic commissioning organisation, role of localities and appointment of new directors.
- The locality Members agreed to defer election of a new Locality Chair until July due to changes ongoing with the CCGs.
- Medicines Management update on the paediatric asthma management plan, hydroxychloroquine guidance and general updates on performance and training available.
- Discussion took place about issues with the provision of low risk diabetic foot screening in Shropshire.
- The Community Respiratory team attended the meeting to talk through their new pathways and services available.

Actions required by Governing Body Members:

- No actions required

Minutes of the

Shrewsbury & Atcham Locality Board Meeting

Thursday 16 January 2020

Board Meeting Room, Severn Fields Health Village,
Sundorne Road, Shrewsbury, SY1 4RQ

Member Name	Practice	Attendance
Dr D Shepherd (Chair)	CCG Locality Chair & Locum GP	Attended
Dr J Pepper	Belvidere	*Apologies*
Caroline Davis	Belvidere	Attended
Dr M Fallon	Claremont Bank	Attended
Jane Read	Claremont Bank	Attended
Dr E Baines	Marden	Attended
Zoe George	Marden	Attended
Dr Julia Visick	Marysville	*Apologies*
Izzy Culliss	Marysville	*Apologies*
Dr Sarah Watton	Mytton Oak	Attended
Adrian Kirsop	Mytton Oak	*Apologies*
Dr R Bland	Pontesbury	Attended
Heather Brown	Pontesbury	*Apologies*
Dr H Bale	Radbrook Green	Attended
Angela Treherne	Radbrook Green	*Apologies*
Dr P Rwezaura	Riverside	Attended
Tracy Willocks (Vice Chair)	Riverside	Attended
Dr D Martin	Severn Fields	Attended
Timothy Bellett	Severn Fields	*Apologies*
Dr L Davis	South Hermitage	Attended
Caroline Brown	South Hermitage	Attended
Dr E Jutsum	The Beeches	Attended
Helen Steel	The Beeches	*Apologies*
Dr K McCormack	Worthen	Attended
Cheryl Brierley	Worthen	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	Attended
David Evans	CCG Accountable Officer	Attended
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Jenny Stevenson	CCG Locality Manager	Attended
Heather Clark (Minutes)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Carrie Jenkins	CCG Shrewsbury & Atcham Locality Pharmacist	Attended
Bethan Emberton	CCG Commissioning and Redesign Lead – Planned Care	Attended
Sarah Pezzaioli	ShropCom Respiratory Team Leader	Attended
Sharon Hamer	ShropCom Central Locality Respiratory Nurse	Attended

Minute No S&ALB-2020-01.001: Item 1 - Welcome & Apologies

1.1 Dr Deborah Shepherd, Locality Chair, welcomed and thanked Members for attending and introductions were made. Apologies were noted as above.

Minute No S&ALB-2020-01.002: Item 2 – Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

Minute No S&ALB-2020-01.003: Item 3 – Locality Chair Update

3.1 Dr Shepherd provided some highlights from the report she provided to Members:

CCG Re-organisation – The formation of a single management team had taken place and the new directors had been appointed; roles and responsibilities of the new posts were being clarified. As part of the process moving forward to form a single CCG it was agreed to look at forming joint committees or committees in common. To facilitate this both CCG constitutions would need to be aligned. This would be a complicated process and would need to involve a Membership vote on any proposals. It would also be important to start thinking about how Members would be represented going forward and to think about whether locality meetings would continue and in what format.

3.2 Finance Update – The CCG Governing Body met on 15 January 2020 and received an update on the CCG finances. The CCG were in deficit by just under £45m at month eight, and it was expected that this would be at £47m by year end. There was a lot of work ongoing to save money, but this was being offset by emergency demand and complex healthcare.

3.3 Other Updates - Breast two week wait targets had improved, though one of the breast surgeons was now off sick. There was good news for urology with a second robot for prostate surgery at Stoke, and one of the local surgeons in Shropshire was trained to use this.

3.4 Winter Pressures - There had been a difficult winter with a huge increase in 12 hour trolley waits, particularly in December and January. The demand had been similar to last year and there was a lot of ongoing work to reduce demand and increase flow through the hospital. This had caused a knock on effect in routine care with waits increasing. Dr Fallon advised that ShropDoc were running a two week pre-admission GP triage pilot, this was used if WMAS (West Midlands Ambulance Service) staff were not sure whether to transfer a patient to hospital. Dr Povey added that WMAS were now running 111, they also had a capacity cell to help redirect ambulances, and paramedics should be using *5 to speak to clinicians for advice.

Minute No S&ALB-2020-01.004: Item 4 – Future Development of the CCG, PCNs, ICS and ICP

4.1 Dr Julian Povey explained that following the application to become a Single Strategic Commissioning Organisation, NHS England felt that the two CCGs were not ready to do this from April 2020 but were encouraged to apply again to form a new organisation from April 2021. To do this the CCG constitutions and meetings would need to be aligned by having either committees in common or joint committees. There would also be a proposal for the CCG Boards to be streamlined by sharing the same lay members and secondary care doctor; this would be in line with what the CCG Membership voted for before the application. Any changes to the CCG constitutions would need to come to Members for a vote and approval.

4.2 Feedback received from Members had showed that localities did add a lot into the CCG structure and would need to remain in some form; this would need to be discussed and agreed in the near future. A key area that did need addressing was the role of the Locality Chairs and whether they would remain Governing Body Board Members as well. There would also be a piece of work to look at CCG GP Board Members, and the proposal that was voted on previously suggested having three GPs from each CCG on the Governing Body. There would also need to be a decision made about the CCG Chairs and whether this would become one position to cover both CCGs, or whether there would be two Chairs that alternated chairing the Board meetings.

4.3 The new joint executive team roles had been appointed to apart from two roles which would now go out to advert, these were Director of Partnerships and Executive Director of Quality. These roles were currently being covered by Fran Beck and Chris Morris until the end of March. The next step would be for the directors to look at the structures for their directorates and once these were decided the rest of the CCG staff would go through the management of change process.

4.4 Tracy Willocks asked about the new Executive structure and why there was no Director of Primary Care after Shropshire had spent time building up this directorate. Dr Povey advised that it was recognised that Primary Care was very important but that CCGs do not always need a Director of Primary Care, and the trend nationally was to have a Head of Primary Care. David Evans expanded on this by stating that Primary Care was incredibly important and there was a reason for the design of the structure. The NHS was in a very fluid environment at the moment with movement towards ICP (Integrated Care Providers), ICS (Integrated Care System) and PCNs (Primary Care Networks) – none of which have any statutory responsibility; this would remain with the CCGs and Trusts. The role of CCGs would be changing moving forwards towards becoming Strategic Commissioners and the structure was designed to enable the CCGs to move towards whatever the ICS/ICP becomes in the future. David explained that the two director posts of Transformation and Partnerships were much more focused on delivery and would

probably move into the ICPs at a time in the future when the ICP was mature enough. The other five roles of Planning, Finance, Quality, Performance and Corporate were the core basis of a strategic commissioner. There would still be a need to maintain a Primary Care Team and there would be a Head of Primary Care sitting at assistant director level to lead the team.

4.5 David Evans explained that the whole system was going through a process of significant change at the moment and was beginning to work better together. As the CCGs moved towards becoming more strategic they will move away from 'widget counting' and payment by results and move towards giving the system a set sum of money to deliver outcomes, and it would be up to the system how to deliver this. The CCGs would not get involved in how the money was spent or delivered apart from monitoring quality and outcomes. Outcomes would need to be decided with clinical input and debate. Dr Povey added that these changes were a while away yet, and would take about 18 months – 3 years.

Minute No S&ALB-2020-01.005: Item 5 – Chair / Vice Chair Elections

5.1 Dr Shepherd explained that Tracy Willocks had been the Vice-Chair for the locality for a long time and would like to stand down; she thanked Tracy for her commitment and valued support and discussions. The locality would now have to think about the role of the Vice-Chair and whether this continued; the North and South Locality don't have Vice-Chairs though there was provision for this in their terms of reference. As well as this, Dr Shepherd explained that her term as Chair was due to end in March. This should be a straight forward process but due to changes happening at the CCG the Chair role would likely become different going forward. Elections could still take place if the locality wanted, but another suggestion was to postpone any elections until July; by this time the position should be clearer. The terms of reference and constitution state that elections for Locality Chairs should take place every three years, but this could be extended if agreed by Members.

5.2 All Members agreed to defer the election of a new Chair for a maximum of four months to July, and also to think further about the Vice-Chair role at this time.

Minute No S&ALB-2020-01.006: Item 6 – Open Discussion – "Hot Topics" from Practices

6.1 Dr Fallon stated he had been receiving letters from the Gynaecology service asking for blood tests he had not heard of and asking if a patient would benefit from aspirin. He wanted to know if there was a formal response to deal with these types of requests. Dr Fallon advised that he was happy to continue prescribing if medication was started in secondary care but they should not be asking GPs to start prescribing.

ACTION: Dr Fallon to send details of prescribing and blood test requests from the Gynaecology Service to Jenny Stevenson/Dr Shepherd.

6.2 Dr Bale asked if other Members had experienced quality issues with Everlight Radiology Reporting Service. Dr Baines agreed that there had been a variety of quality in reports. Dr Shepherd advised that she believed this was a contracted out service as the Radiology Service did not have capacity. Dr Fallon also reported issues with getting reports back if urgent as sometimes the Radiology Service send a batch of reports over to Everlight and cannot get them back individually. Dr Shepherd reminded Members to report issues such as this through Datix.

ACTION: Jenny Stevenson/Dr Shepherd to discuss reported issues around Everlight Radiology Reporting Service with the Quality Team at the CCG.

Minute No S&ALB-2020-01.007: Item 7 – Medicines Management Update

7.1 Asthma Documents - Clare Michell-Harding explained that following the respiratory workshop in the locality meeting looking at paediatric asthma, a group was put together to work with clinicians in the hospital to put together a local health economy document for paediatric asthma management plan, and smart asthma management plan for children over twelve. The documents had now been approved and uploaded to EMIS; Carrie Jenkins would be visiting practices to go through this. There will also be an official launch across the CCG with a notice in the newsletter on GP Team Net. The documents had been completed jointly with school nurses and will be implemented as part of school care plans.

7.2 Hydroxychloroquine Guidance - There had been a huge problem nationally with the new guidance from the Royal College of Ophthalmology for Hydroxychloroquine that had been referred to the Regional Medicines Optimisation Committee. The guidance suggested that there was a gold standard assessment for patients, but the type of test the guidance suggested was not available. The new guidance was written following a study in America, it was confirmed that the level of evidence the guidance is written from is low and was not an essential test, just a gold standard test. The test suggested was an ocular CT scan with FAF element – the OCT scan could be provided by the community opticians if patients pay for

it, but not the FAF element. At the moment it was recommended that Members follow what was in the SPC and British Society of Rheumatology guidance.

7.3 Further discussion took place about the eye tests; Clare Michell-Harding explained that an audit had taken place with two students from Keele University, but the results had not yet been received. It was clear that practices were recommending that patients get eye tests but information was not always sent back or being recorded. Dr McCormack stated that there were no agreed read codes for these tests and therefore systems like Eclipse wouldn't pick these patients up. Clare confirmed that this affected approximately 640 patients in Shropshire and 400 in Telford. Members agreed for a statement to be sent out asking for a shared care protocol to be put in place by beginning of April or GPs would stop prescribing.

ACTION: Jenny Stevenson/Dr Shepherd to take back issues of read codes for annual/five year eye tests, and ask the Local Optical Committee to ensure that opticians notify GPs when tests are completed.

Clare Michell-Harding to send out statement asking for shared care protocol for Hydroxychloroquine to be put in place by beginning of April, and confirm in email to practices what has been sent out.

7.4 Carrie Jenkins presented some slides to the Members which included the following information:

Reminders:

- PDS – Any outstanding quarter 3 safety searches were due by 24th January.
- PDS – Salbutamol usage in 12 months (SABA – Short Acting Beta Agonist) search for completion and submission by end of March.
- Antibiotic training – TARGET Train the Trainer Workshop 7th February at William Farr House – this was open to GPs, Practice Nurses or Pharmacists.
- Diabetes training injectable therapies 12th March – closing date 21st February.

Eclipse Roll Out:

- North and Shrewsbury and Atcham – there were a small number of practices left to sign up.
- South – Last cohort of practices to commence roll out.
- The team will be organising a drop in training day at William Farr House – please email Carrie Jenkins if interested in attending.

ACTION: Members to email Carrie Jenkins if they were interested in attending the Eclipse drop in training day at William Farr House.

Respiratory Update, PDS respiratory element:

- Reduce ICS (Inhaled Corticosteroids) use where appropriate
- Increase use of LAMA/LABA (Long Acting Muscarinic Antagonist/Long Acting Beta Agonist) combination inhalers
- Review triple therapy – make best use of cost effective triple therapy where indicated (Trelegy/Trimbow)

Links to documents currently available:

- COPD Treatment Guidelines Nov 2019
- ICS Weaning Protocol

Respiratory Work in Progress:

- COPD management plan.
- COPD rescue pack guidance/pathway.
- Personalised asthma action plan to be available in EMIS shortly.

ACTION: Carrie Jenkins to find out if parts of the asthma action plan could auto-populate and if it will save into EMIS after it has been completed.

Antibiotic/UTI Peer Review – Next locality meeting 20th February

- Members to bring examples of in-house processes to facilitate shared learning.
- Microbiologist will be attending the workshop.

Insulin generic prescribing – Carrie advised that she was working with practices to get these switched onto branded insulin. Meetings had taken place with SaTH (The Shrewsbury and Telford Hospital NHS Trust) and ShropCom (Shropshire Community Health NHS Trust) about this. There were currently over 300 generic prescriptions in Shropshire.

Minute No S&ALB-2020-01.008: Item 8 – Diabetic Foot Screening - Discussion

8.1 Bethan Emberton explained that Telford was an outlier on major and minor foot amputations and Shropshire for minor. Diabetes was also an NHS England/Improvement priority for the next three years. ShropCom were struggling to recruit podiatrists so had started to pull away from some of the services they delivered for low risk patients so that they can focus on the medium and high risk patients. Telford CCG had made a decision not to commission low risk foot screening, and the same will be proposed for Shropshire CCG. It was decided to bring this to all localities for feedback and set up a task and finish group to find out views and thoughts about this. It had previously been proposed that the low risk foot screening could be done by a HCA (Health Care Assistant) in Primary Care.

8.2 Dr McCormack explained that the LMC (Local Medical Committee) were aware of this and felt that it had been dropped on Primary Care at a time when they already feel inundated. Dr Shepherd explained that the CCG were not saying Primary Care should do this, but there was a gap. The guidance stated that medium to high risk screening should be done by a specialist service; low risk could be done by a lower skilled person in a community setting. There had been a NICE endorsed study that showed that low risk patients didn't come to harm if they didn't have specialist foot screening. Dr Baines advised that when she worked in London it was normal for low risk screening to be done in Primary Care as part of a patient's annual review.

8.3 Dr Shepherd added that there was no extra funding for the low risk screening due to ShropCom having a block contract. They would be receiving the same amount of money for doing things differently and focusing on medium to high risk patients. The decision about low risk foot screening had not yet been decided as input was needed from Members and it would have to be agreed by the Clinical Commissioning Committee.

8.4 Dr Povey explained that the original proposal was presented to the South Locality and everyone had the same concerns about capacity in Primary Care to provide this service. There was recognition that nearly everywhere else in the country completed low risk screening in Primary Care, but also that it had not been done in Shropshire so would be a big change. Other options needed to be looked at as feedback from Members was that Primary Care did not have the capacity for this.

ACTION: Members to send any ideas for Low Risk Diabetic Foot Screening to Bethan Emberton.

8.5 Bethan also stated that there would be a small pot of money available in 2020/21 from NHS England to spend on four diabetes targets: MDT foot clinics in acute trusts, specialist diabetes nurses for inpatients and outpatients, structured education and primary care. This would be a small amount on non-recurrent funding of around £100k for the STP (Sustainability and Transformation Partnership), this money would not be received until next year but ideas were needed soon on the best way to spend the money. Suggestions from Members included a weight management and stop smoking service, monofilament equipment for foot pulses, employing a HCA for the end of next year to complete all the annual reviews and low risk foot screening, and purchasing a diet book for patients (Kent and Bromley CCG bought the Michael Moseley 800 calorie diet book for all diabetic patients).

ACTION: Bethan Emberton to send something out to practices to ask for suggestions on how to spend the diabetes funding.

Minute No S&ALB-2020-01.009: Item 9 – Community Respiratory Pathways

9.1 Sarah Pezzaioli and Sharon Hamer attended the meeting to talk about the community respiratory pathways. The Respiratory Service was now a nurse-led service with four elements: COPD (Chronic Obstructive Pulmonary Disease) service, oxygen assessment, pulmonary rehab and COPD self-management workshops. The team were not yet commissioned to look after any other respiratory conditions other than COPD. There were five nurses in the service (4.2 WTE) to cover five localities.

9.2 The COPD service will be offering clinics and domiciliary care. There will be weekly clinics in each locality for COPD patients with oxygen assessments every other week. The team will provide patient discharge support, education, medication optimisation and exacerbation management, with an overall aim to help patients self-manage their conditions better. Domiciliary care could be provided, for example, for End of Life patients who cannot leave the house or people who need oxygen assessments at home. Current waiting times for the COPD service were around two weeks, with oxygen assessments being 2-3 months; urgent referrals can be seen within 48 hours. The nurses in the team could not prescribe at the moment but were aiming to do this in the near future. The team would need to write to GPs to prescribe or make changes to medication at the moment. Dr Fallon asked about 'Fit to Fly' assessments, it was advised that these were not something that the team did.

9.3 For the home oxygen service patients would need to have a reason for chronic hypoxia; and if no known reasons this would need to be investigated first. The team will also visit patients who are discharged with oxygen to check they are using it correctly and will monitor them regularly. As anyone could prescribe oxygen, it was requested that Members let the team know about these patients so that they could monitor the patient and add them to their concordance list. The team were flexible on prescribing oxygen for people who smoke and they would need to assess each patient on an individual basis.

9.4 The pulmonary rehab service was a six week programme where patients are invited to attend a two hour session for education and exercise once a week, and a one hour session for exercise once a week. There was a long waiting list for this service at the moment with about a 4 month wait for an assessment.

9.5 The COPD workshop was a self-management programme to help behaviour change in patients and the whole team had been trained in motivational interviewing. There would be two workshops five weeks apart with weekly phone calls in-between. Early outcomes showed that almost all patients had achieved their goals so far. There had also been a lot of problems with anxiety and depression therefore the team would now be working closely with the IAPT (Improving Access to Psychological Therapies) team to offer help and direct access for patients. Tracy Willocks asked about smoking and weight loss and whether the team could help if this was one of the goals set. Sarah advised that if a patient set a goal to stop smoking or lose weight the team would help them using motivational interviewing. The workshop was a pilot and would end in April; Bethan Emberton advised that a case to continue the workshops after April would be taken to CCC (Clinical Commissioning Committee) and asked Members to refer into the workshops to improve this case.

Minute No S&ALB-2020-01.010: Item 10 – Minutes of Meeting held on 21 November 2019

10.1 The minutes of the meeting held on 21 November 2019 were agreed as a true and accurate record of the meeting and were signed by the Chair.

Minute No S&ALB-2020-01.011: Item 11 – Matters Arising

11.1 Jenny Stevenson provided an update on the following actions from the previous meeting:

Minute No S&ALB-2019-11.101 – GP Consultant Exchange Scheme – Some GPs had expressed an interest in the scheme but had not heard back from Alison Jones.

ACTION: Jenny Stevenson to chase Alison Jones for further information following interest expressed in GP Consultant Exchange Scheme.

PLT (Protected Learning Time) Sessions – A meeting still needed to be arranged to discuss the PLT sessions; these would also now have to align with Telford and Wrekin CCG. Jenny advised that she could not see a problem with holding the PLT sessions on a PCN footprint. The CCG were also keen for there to be practice input into the planning of the PLT sessions.

Minute No S&ALB-2019-11.105 – Medicines Management – The UTI Workshop would be held for an hour at the end of the February Locality Meeting. A discussion took place about the length and content of the workshop and it was advised that this would be looked at and further information sent out before the meeting.

Minute No S&ALB-2019-11.106 – Melatonin – Clare Michell-Harding advised that there was no additional monitoring and therefore no shared care document in place for Melatonin. There was an information document in Telford which outlined things such as doses, how it is being used on an unlicensed basis and requirements from specialists; it also advised that patients should be reviewed every six months. This document would be uploaded onto the CCG website soon. A sleep clinic had also been set up to address issues with Melatonin.

ACTION: CCG to investigate who runs the sleep clinic and ways to refer.

Minute No S&ALB-2020-01.012: Item 12 – Primary Care Update

12.1 The monthly Primary Care Update had been circulated to Members prior to the meeting and there were no further questions about this.

Minute No S&ALB-2020-01.013: Item 13 – Commissioning Update

13.1 The monthly Commissioning Update had been circulated to Members prior to the meeting and there were no further questions about this.

Minute No S&ALB-2020-01.014: Item 14 – Any Other Business

14.1 A question was asked about the antibiotic training on 7 February and whether there was a list of what the training covered. Carrie Jenkins advised that this was a train the trainer session to give more awareness of antibiotic prescribing.

ACTION: Carrie Jenkins to send around the agenda for the antibiotic training on 7 February with some more information.

Minute No S&ALB-2020-01.015: Item 15 - Date and Time of Next Meeting

15.1 The next formal meeting will be held on **Thursday 20 February 2020** in **Severn Fields Health Village, Sundorne Road, Shrewsbury, SY1 4RQ** commencing at **2.00pm.**

15.2 Further meeting dates:
Thursday 20 February 2020
Thursday 19 March 2020
Thursday 16 April 2020
Thursday 21 May 2020
Thursday 18 June 2020
Thursday 16 July 2020
Thursday 17 September 2020
Thursday 15 October 2020
Thursday 19 November 2020
Thursday 21 January 2021
Thursday 18 February 2021
Thursday 18 March 2021

Signed: .....…….. **Date:** ……
Dr Deborah Shepherd, Locality Chair

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-03.046
Shropshire CCG Governing Body meeting: 11.03.2020

Committee Meeting Summary Sheet	
Name of Committee:	South Locality Board Meeting
Date of Meeting:	6 November 2019
Chair:	Dr Matthew Bird

Key issues or points to note:

CCG Chair Update – The Chair and Accountable Officer attended the meeting to talk to Members about the next steps for creating a Single Strategic Commissioning Organisation. They explained that the application had been rejected by NHS England but the CCGs were planning to submit a further application the following year. The process to create a single Executive Team had started and the CCGs would continue to develop a single structure. An update was also given about CCG finances.

Diabetic Foot Screening – Members discussed a proposal for a new pathway for low risk patients. Concerns were raised about this being done in Primary Care as there was not the capacity for it.

Public Health – The new Director of Public Health attended the meeting and gave an update on the delivery of public health across Shropshire. Concerns were raised about the Help2Slim and Help2Quit services that had been decommissioned. It was confirmed that the smoking in pregnancy service remained and was being improved.

Social Prescribing – A presentation was given about the findings from the final evaluation. Members asked for further clarity on the 40% reduction in GP appointments for patients in the scheme and how this was calculated.

SOOS – A presentation was given which covered referral data, performance data and waiting time information. An issue was raised about availability of appointments for patients in the South Locality. Members were advised that SOOS were in the process of recruiting staff to specifically work in the South.

MECS/Ophthalmology – Concerns were raised about delays in appointments for urgent referrals, it was agreed that this would be discussed with the appropriate team at the CCG and confirmation circulated about referral criteria.

Actions required by Governing Body Members:

- No actions required

Minutes of the

South Locality Board Meeting

Wednesday 6 November 2019

Bridgnorth Medical Practice

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr Matthew Bird (Chair)	Albrighton	Attended
Val Eastup	Albrighton	*Apologies*
Dr Dale Abbotts	Alveley	*Apologies*
Lindsey Clark	Alveley	*Apologies*
Dr Adrian Penney	Bishop's Castle	*Apologies*
Sarah Bevan	Bishop's Castle	*Apologies*
Dr Gwen Potter	Bridgnorth	Attended
Sandra Sutton	Bridgnorth	Attended
Dr Mohammed Shah	Broseley	Attended
Nina Wakenell	Broseley	Attended
Dr Bill Bassett	Brown Clee	*Apologies*
Vicki Brassington	Brown Clee	*Apologies*
Dr Alex Chamberlain	Church Stretton	Attended
Emma Kay	Church Stretton	Attended
Dr Paul Thompson	Cleobury Mortimer	Attended
Mark Dodds	Cleobury Mortimer	Attended
Dr Juliet Bennett	Clun	Attended
Peter Allen	Clun	*Apologies*
Dr David Appleby	Craven Arms	Attended
Susan Mellor-Palmer	Craven Arms	Attended
Dr Shailendra Allen	Highley	Attended
Sudhanshu Consul	Highley	*Apologies*
Dr Catherine Beanland	Ludlow – Portcullis	*Apologies*
Rachel Shields	Ludlow – Portcullis	Attended
Dr Graham Cook	Ludlow - Station Drive	Attended
Jodie Billinge	Ludlow - Station Drive	*Apologies*
Dr Jennie Bailey	Much Wenlock & Cressage	*Apologies*
Sarah Hope	Much Wenlock & Cressage	*Apologies*
Dr Richard Shore	Shifnal & Priorslee	*Apologies*
Theresa Dolman	Shifnal & Priorslee	Attended
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Clinical Chair	Attended
David Evans	CCG Accountable Officer	Attended
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Tom Brettell	CCG South Locality Manager	Attended
Heather Clark (Minute Taker)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	*Apologies*
Shola Olowosale	CCG Locality Pharmacist	*Apologies*
Rachel Robinson	Director of Public Health	Attended
Penny Bason	STP Programme Manager	Attended
Nina White	RJAH - SOOS Service Manager	Attended
Bethan Emberton	CCG Commissioning and Redesign Lead – Planned Care	Attended

Minute No SLB-2019-11.090: Item 1 – Welcome & Apologies

1.1 Dr Matthew Bird, Locality Chair, welcomed and thanked Members for attending and introductions were made. Apologies received were recorded as above.

Minute No SLB-2019-11.091: Item 2 – Members' Declaration of Interests

2.1 Members were reminded of the requirement to complete a new Declaration of Interests form annually. No new declarations of interest were made.

ACTION: Heather Clark to send email reminders to Members with out of date declarations.

Minute No SLB-2019-11.092: Item 3 – Minutes of Formal Meeting held on 4 September 2019

3.1 The minutes of the meeting held on 4 September 2019 were agreed as a true and accurate record and were signed by the Chair.

Minute No SLB-2019-11.093: Item 4 – Matters Arising from Previous Meeting

4.1 Tom Brettell gave the following updates about the actions from the previous meeting:

Minute No SLB-2019-07.073 – Commissioning Intentions – No ideas had been received to date for commissioning intentions.

Minute No SLB-2019-09.083 – CHEC Referrals – Tom Brettell had raised the CHEC (Community Health and Eye Care Ltd) referral issue with the Quality Team at the CCG. Chris Morris, Chief Nurse and Julie Davies, Director of Performance and Delivery, would be taking the issue forward. Tom requested that members continue to send any examples to him of referrals that are sent back.

Minute No SLB-2019-09.085 – RightCare Data – The data was presented at the previous meeting but it was still unclear how the locality would move this forward. Practice level data had now been received and was ready to circulate. It was decided that this data would be sent out for practices to review and identify the areas where they are outliers; ideas for next steps should then be sent to Tom Brettell which may be used for a future agenda item.

ACTION: Heather Clark to circulate practice RightCare data, practices to review data and send ideas for next steps to Tom Brettell.

Minute No SLB-2019-11.094: Item 5 – Locality Chair's Update

5.1 Dr Bird welcomed David Evans the new Joint Accountable Officer for Shropshire CCG and Telford and Wrekin CCG.

5.2 Dr Bird apologised for what happened at the PLT (Protected Learning Time) afternoon and thanked Members for their feedback. Dr Bird added that he did attend the North Locality PLT session which was positive and from this he advised that the Big 6 documents were available on EMIS. He explained that if anybody wanted his notes from the session he could circulate these. The safeguarding session concerns that were raised were being taken forward by the Quality Team at the CCG.

ACTION: Matthew Bird to send out his notes from the North Locality PLT session to those that requested them.

5.3 The FIT (Fecal Immunochemical Test) would be available soon, hopefully December, and David Whiting at the CCG would be leading on this. There would be pathways and further information sent out about this.

5.4 Dr Bird advised that there was a GP Supervisor course on 14th January 2020 at Shrewsbury Town Football Club, run by Keele University; Dr Bird added that he went on the course last year and it was very good and was a free course.

5.5 Dr Bird encouraged practices to refer patients onto the Diabetes Prevention Programme as they were not receiving enough referrals. Rachel Shields advised that she had a protocol for this that launches all the alerts and documents needed and had increased referrals. The service also provided a clinic at the practice as a few patients were referred in one go. Bethan Emberton advised that a self-referral form would soon be available on EMIS to send out to patients.

ACTION: Rachel Shields to send EMIS protocol to Tom Brettell to circulate to practices.

Minute No SLB-2019-11.095: Item 6 – CCG Chair's Update

6.1 Dr Julian Povey thanked Members for their support for the application for the Single Strategic Commissioning Organisation. The application was rejected by NHS England and the main reasons for this were system issues such as not having a medium-term financial plan for the system, and not having a sufficiently developed operational model at place level. NHS England also thought that the rest of the system wasn't ready for a strategic commissioner yet. NHS England was keen for the CCGs to continue with the work and over the next few months the CCGs will be working to develop these plans and make a further application early next year. David Evans had been appointed as the Joint Accountable Officer across both CCGs and had started the process of change to create a single Executive Team; who will in turn create their own directorate structures. The CCGs were also working on developing a constitution for when the two CCGs do become one CCG in April 2021; this may involve work in aligning the two CCG constitutions so that they are the same by this time.

6.2 Shropshire CCG has an estimated year end deficit of £40-50m. Telford and Wrekin CCG has an estimated year end deficit of £10m, SaTH (Shrewsbury and Telford Hospital Trust) £17m deficit and RJAH (Robert Jones and Agnes Hunt Orthopaedic Hospital) are estimating to break-even. The system needs to work together to address this. There is a large spend in complex healthcare, orthopaedics and emergency care. The system finance needs to be addressed with a major redesign and in the future providers need to work much more closely together.

6.3 The IRP (Independent Review Panel) reviewed the FutureFit process and agreed with the plans. They made some recommendations which included having experts involved in the pathways of care and maximise ambulatory care that can be done in the Urgent Care Centre. Feedback following this had been that there should be an A&E Local in Telford though there is no definition of what an A&E Local is yet. The hospital now has to develop a strategic outline case by June 2020 and a full business case by March 2021.

Minute No SLB-2019-11.096: Item 7 – Diabetic Foot Screening Pathway Proposal

7.1 Bethan Emberton attended the meeting to talk about the proposal for a new diabetic foot screening pathway. She explained that this pathway had been looked at with the aim to focus specialist skills and improve overall outcomes. Bethan added that there was a workforce issue in the Community Trust as they were unable to recruit enough Podiatrists, and a number of complaints about the service had also been received from Primary Care. It was thought that moving the low risk foot screening into primary care would free up the Podiatrists to focus on the medium-high risk patients. The CCG were looking into decommissioning the service from the Community Trust and this was the first part of the consultation before a decision on this was made. Bethan Emberton explained that ideally a decision on this would be needed before the new contracts start on 1st April 2020.

7.2 Following a review of the RightCare data, it showed that Telford was an outlier for foot amputations. It was decided that Telford would take part in a pilot to move low risk foot screening back into Primary Care and this went live in August. Feedback was requested from Shropshire Members as to whether this was the best way to manage patients in Shropshire. Feedback received from the LMC (Local Medical Committee) showed they had concerns about capacity in Primary Care and they didn't see the foot screening as core GP work. Dr Bird explained that the proposal was that low risk foot screening was done in practices mainly by HCAs (Healthcare Assistants), there would be no extra payment for this as it was included in QOF (Quality and Outcomes Framework).

7.3 Dr Povey explained that his research into this showed that most other areas in the country covered low risk screening in Primary Care, though he could understand the LMC view. He clarified that QOF wasn't payment for doing the work it was payment for meeting a threshold target. Dr Povey suggested that the CCG would need to complete an impact assessment before anything was taken forward.

7.4 It was questioned how long screening would take by HCAs as the proposal document stated it would only take five minutes, and also whether HCAs would be the most appropriate people for this. Members also felt there was a potential to create more medium risk people if the HCAs were overly cautious. Members felt that an appointment would take about fifteen minutes, and not five minutes.

7.5 Dr Potter advised that this was tried in Bridgnorth previously and faced significant resistance from nurses and HCAs, as they felt they would need significant training. Members thought that more information was needed from other areas and how they work and whether their systems were good or bad, and feedback was needed from the Telford pilot.

Minute No SLB-2019-11.097: Item 8 – New Public Health Director

8.1 Rachel Robinson, Director of Public Health for Shropshire attended the meeting to introduce herself and to give an update on the delivery of Public Health outcomes across Shropshire. Ms Robinson gave a presentation to the group which covered the following areas:

- Context for delivery – background information, prevention, priority outcomes
- Public Health's key health and wellbeing priorities – Smoking in pregnancy, mental health, diabetes diagnosis, weight
- Vision for Public Health
- Key areas of work 2019/20

8.2 Rachel Robinson talked about the decommissioned help to slim and quit smoking services and explained that even though this was not ideal the services were not getting the outcomes needed and this was an opportunity to do something differently. Public Health had kept the smoking in pregnancy service and was currently looking at how to improve this service as Shropshire has high smoking in pregnancy rates. Obesity rates are also high in Shropshire.

8.3 A question was asked about NHS health checks and if there was any data about the benefits of these. Ms Robinson explained that there was local data available that she could provide, and there was an ongoing national review of the whole process looking at how to target patients and improve the scheme. Evidence shows that the health checks do work.

ACTION: Rachel Robinson to share Shropshire health checks data.

8.4 Rachel explained that healthy life expectancy definition was based on things such as long term conditions, disabilities and quality of life. It was confirmed that obesity rates were based on QOF and only goes by patients weighed in the past year, Members advised that practices could provide the weights of all patients if requested.

8.5 Dr Allen asked about social prescribing and whether Public Health was looking at this as there could be patient needs where there are no services available. It was confirmed that gaps in services were being looked at.

Minute No SLB-2019-11.098: Item 9 – Social Prescribing – Findings from the Final Evaluation

9.1 Penny Bason attended the meeting to give a presentation about the findings from the final evaluation of Shropshire Social Prescribing. The presentation covered the following areas:

- Focus of evaluation – aim, objectives and methods used
- Measures used
- Overarching findings
- Shropshire Model of Social Prescribing
- Results – reasons for referrals, health service use, changes in MYCaW (Measure Yourself Concerns and Wellbeing)
- Results – Patient Activation Measure, Loneliness, Physiological Data
- Conclusion
- Further information available

9.2 A question was asked about the 40% reduction in GP appointments for patients who took part in the scheme. Penny explained that this would probably be while patients were still in the program; information was not yet available about what happened to patients once they left the programme. Rachel Robinson advised that this was looked at in Warwickshire and it was found that even six months after initially being in the social prescribing service patients still had a reduction in GP appointments. Members requested clearer information about the 40% reduction in GP appointments and how this was calculated as the figures provided were not very clear.

ACTION: Penny Bason to provide clearer information about the 40% reduction in GP appointments and how this was calculated.

9.3 Advisors had reported that there were many patients with high emotional needs which could be quite difficult for the advisors. It would be important to think about how to support them and how to develop the programme in the future.

9.4 Members discussed help to quit smoking services and Penny Bason advised that patients could still be referred to social prescribing for this as some had already been motivated to quit. Dr Allen talked about

Pathfinder in Smethwick where there is group counselling available for smokers. Rachel Robinson agreed that different things work for different people and a range of different services were likely needed.

Minute No SLB-2019-11.099: Item 10 – Medicines Management Update – Eclipse Live

10.1 Clare Michell-Harding and Shola Olowosale gave their apologies and therefore there was no update from the Medicines Management Team.

Minute No SLB-2019-11.100: Item 11 – SOOS – MSK Update

11.1 Nina White from SOOS (Shropshire Orthopaedic Outreach Service) attended the meeting to give a presentation and update about the SOOS service, the presentation included the following points:

- Referrals into SOOS
- Number of attendances
- Average waiting time to first appointment for GP referrals
- SOOS KPI Recovery – backlog reduction
- Information on SOOS locations and number of sessions
- SOOS Performance - % of total referrals into secondary care YTD = 48.08% (target = 39%)
- Clinical safety issues
- Diagnostics data

11.2 Nina acknowledged that one of the key issues for access for the South Locality was that many of the sessions available were based in Oswestry which is far for patients to travel. Nina explained that there were less sessions in the South due to venue availability and staffing; she would now be advertising for staff to work specifically in the South as there were some current staff leaving the service (this would be around March 2020).

11.3 Another key issue was that at the start of the service it wasn't ready to take the number of referrals it was receiving but were now starting to use the capacity in the service. 30% of patients were now seen within 20 days. There were also administrative issues with processes between RAS (Referral Assessment Service) and SOOS which adds to patient waits. This was being addressed and improvements should be seen by February/March 2020.

11.4 An increase of emergency spinal patients being seen through SOOS was also causing problems and showed that there was a lack of clarity between urgent and emergency pathways. This has impacted on capacity in the team as they spend longer with these patients, and impacts the patients as they are referred onto the wrong pathway.

11.5 The standardised referral form was circulated to Members before the meeting and Nina explained that this was put into the service specification by the CCG in April 2019 and helps to capture all the information needed by SOOS for triage. It was questioned why MSK referrals couldn't go direct to SOOS instead of going through RAS but it was explained that this is how the CCG and NHS England had commissioned the service.

11.6 Nina Wakenell gave had an example of a referral that took nine months from referral for the patient to be seen; Nina White asked for the details to be shared with her so she could investigate this.

ACTION: Nina Wakenell to share example with Nina White of the referral that took nine months so she is able to investigate the reasons for this.

11.7 It was explained that currently RAS sort referrals from the E-Referrals System (ERS) into speciality and sub-speciality and put them onto the SOOS triage list, this takes around 2-5 days. Once the referrals are sent to SOOS they are triaged within 2 days, and marked either for secondary care or for SOOS. If the referral is marked for secondary care RAS will instigate the process they have for patient choice. If a referral is marked for SOOS the administrative team at RJAH then have to input the patient information onto the RJAH system before they can be booked an appointment.

11.8 Members asked about urgent referrals, Nina White explained that the service did take urgent referrals and they had to be seen within two weeks. These referrals could be marked as urgent on ERS, and these have to be triaged within 24 hours and SOOS try to see them within 10 working days; if they cannot be seen within 10 days they are referred to secondary care or taken to MDT and discussed with a consultant.

ACTION: Dr Bird to write to the CCG on behalf of the Locality re inequitable SOOS service in the South Locality and ask whether other CCG SOOS equivalents could be used instead.

Minute No SLB-2019-11.101: Item 12 – Commissioning Update

12.1 The Commissioning update paper was circulated to Members prior to the meeting; there were no further questions raised about this.

Minute No SLB-2019-11.102: Item 13 – Any Other Business

13.1 Ophthalmology - Dr Appleby raised concerns about MECS (Minor Eye Conditions Service) and the Ophthalmology Service. He received an optician's letter which stated that a patient should be seen within four weeks but the patient had an appointment booked in Cheltenham for February next year. This was an urgent referral but there were no appointments available sooner locally. Bethan Emberton advised that information may need to be shared again about which referrals should be referred to each service as some should be sent to RAS to be referred to the Community Ophthalmology Service (e.g. glaucoma).

Addition to minutes requested by Dr Appleby: The original appointment was booked for 10/02/2020; it was then brought forward by Cheltenham to 16/12/2019. The patient was originally seen by the optician on 21/10/2019 and referred by the practice on 24/10/2019.

ACTION: Dr Appleby to share information about urgent referral with Tom Brettell in order for him to discuss with the RAS team.

Bethan Emberton to share information with Tom Brettell to circulate re what referrals should be sent to RAS and what should be sent to MECS.

Minute No SLB-2019-09.103: Item 14 – Date of Next Meeting

14.1 The next formal meeting will take place on: **Thursday 9 January 2020** at the **Mayfair Centre, Church Stretton** at **3.30pm.**

14.2 Dates of future meetings:

Thursday 9 January 2020	Mayfair Centre, Church Stretton
Thursday 6 February 2020	Bridgnorth Medical Practice
Thursday 5 March 2020	Mayfair Centre, Church Stretton

Signed: …….. **Date:** ……

Dr Matthew Bird, Locality Chair