NHS
Shropshire
Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277595
E-mail: SHRCCG.shropshireccg@nhs.net

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 15 January 2020
Chair	Dr Julian Povey	Time	1.00pm
Minute Taker	Mrs Sandra Stackhouse	Venue / Location	Lakeside Suite, Albrighton Hall Hotel, Ellesmere Road, Albrighton, Shrewsbury, SY4 3AG

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-2020-01.001	**Apologies** - Dr Colin Stanford	**Julian Povey**	***1.00***	*verbal*
GB-2020-01.002	**Members' Declaration of Interests**	**Julian Povey**	***1.00***	*verbal*
GB-2020-01.003	**Introductory Comments from the Chair**	**Julian Povey**	***1.05***	*verbal*
GB-2020-01.004	**Minutes of Previous Meeting** Meeting held on 13 November 2019	**Julian Povey**	***1.10***	*enclosure*
GB-2020-01.005	**Matters Arising**	**Julian Povey**	***1.15***	*enclosure*
GB-2020-01.006	**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 13 January** 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-2020-01.007	**Clinical and Financial Reports** Finance, Contracting Report incl. Quality, Innovation, Productivity & Prevention (QIPP) schemes	**Claire Skidmore**	***1.25***	*enclosure*
GB-2020-01.008	**Corporate Performance Reports** Governing Body Board Assurance Framework (GBAF)	**Sam Tilley**	***1.50***	*enclosure*

GB-2020-01.009	Performance and Quality Report	**Chris Morris/ Julie Davies**	***1.55***	*enclosure*
GB-2020-01.010	CCG Strategic Priorities	**David Evans**	***2.10***	*enclosure*
	Governance & Engagement			
GB-2020-01.011	Single Strategic Commissioner for Shropshire and Telford and Wrekin Update Report	**David Evans**	***2.20***	*enclosure*
GB-2020-01.012	Emergency Preparedness, Resilience & Response Annual Assessment	**Sam Tilley**	***2.35***	*enclosure*
BREAK			***2.45***	
GB-2020-01.013	SaTH Mortality	**Edwin Borman, SaTH**	***3.00***	*presentation*
GB-2020-01.014	Audit Committee – 30 October (summary)	**Keith Timmis**	***3.25***	*enclosure*
GB-2020-01.015	Healthwatch Report	**Lynn Cawley**	***3.35***	*enclosure*
	For Information Only/Exception Reporting		***3.40***	
GB-2020-01.016	Clinical Commissioning Committee – 16 October	**Sarah Porter**		*enclosure*
GB-2020-01.017	Finance & Performance Committee – 30 October	**Kevin Morris**		*enclosure*
GB-2020-01.018	Primary Care Commissioning Committee – 2 October	**Colin Stanford**		*enclosure*
GB-2020-01.019	Quality Committee – 30 October	**Meredith Vivian**		*enclosure*
GB-2020-01.020	System A&E Delivery Board – 22 October	**David Stout**		*enclosure*
GB-2020-01.021	North Locality Board – 26 September	**Mike Matthee**		*enclosure*
GB-2020-01.022	Shrewsbury & Atcham Locality Board – 19 September	**Deborah Shepherd**		*enclosure*
GB-2020-01.023	South Locality Board – 4 September	**Matthew Bird**		*enclosure*
GB-2020-01.024	**Any Other Business**	**Julian Povey**	***3.45***	*verbal*
	Date of Next Meeting • Wednesday 11 March 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 MONTGOMERY SUITE, LION QUAYS HOTEL RESORT, WESTON RHYN, OSWESTRY, SY11 3EN

AT 1.00 PM ON WEDNESDAY 13 NOVEMBER 2019

Present

Dr Julian Povey	CCG Chair
Mr David Evans	Accountable Officer
Dr Finola Lynch	Deputy Clinical Chair
Mrs Claire Skidmore	Chief Finance Officer
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 & Delivery
Mrs Christine Morris	Chief Nurse for Shropshire and Telford & Wrekin CCGs
Mrs Nicky Wilde	Director of Primary Care
Mrs Sam Tilley	Director of Corporate Affairs
Mr Keith Timmis	Lay Member – Governance and Audit (Vice Chair)
Mrs Sarah Porter	Lay Member - Transformation
Dr Colin Stanford	Lay Member

In Attendance

Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire – Observer
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-2019-011.132 - Apologies

2.1 Apologies were noted from:

• Mr David Stout	Interim Transformation Director
• Dr Jessica Sokolov	Medical Director
• Mrs Gail Fortes-Mayer	Director of Contracting and Planning
• Mr Vivian Meredith	Lay Member – Patient and Public Involvement
• Ms Rachel Robinson	Director of Public Health, Shropshire Council

Minute No. GB-2019-11.133 - 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:

- Dr Matthee declared that Market Drayton Medical Practice was a Member of the North Shropshire Primary Care Network (PCN).
- Dr Bird declared that Albrighton Medical Practice was a Member of the South East PCN.
- Dr Pepper declared that Belvidere Medical Practice was a Member of the Shrewsbury PCN.
- Dr George declared that Market Drayton Medical Practice was a Member of the North Shropshire PCN.

- Mr Evans declared that he was also the Accountable Officer for Telford and Wrekin CCG.
- Dr Povey declared that his practice was a Member of the Shrewsbury PCN.
- Dr Lynch declared that she was a Member of the South West Shropshire PCN.
- Mr Morris declared that Cambrian Medical Practice was a Member of the North Shropshire PCN.

3.2 There were no other additional conflicts of interest noted.

Minute No. GB-2019-11.134 - Introductory Comments from the Chair

4.1 Dr Povey reminded attendees that during the period in the run-up to the General Election on 12 December the CCG would be continuing business as usual but would be following the purdah restrictions by not promoting initiatives that could be seen as having an influence to promote one political party.

4.2 Attendees 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 wifi 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-2019-11.135 – Minutes of the Previous Meeting – 11 September 2019

5.1 The minutes of the previous meeting held on 11 September 2019 were presented and approved as a true and an accurate record of the meeting following one amendment:

For clarity, Mrs Skidmore advised that on Page 4, paragraph 8.19, line 3, to delete the remainder of the sentence after: 'Mrs Skidmore confirmed that …' and substitute: 'whilst £12.5m was the CCG's control total, the CCG's agreed plan for the year was £22.9m deficit.'

RESOLVE: MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the minutes of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 11 September 2019.

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

Minute No. GB-2019-11.136 – 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 this issue was marked as on-going with the West Midlands Ambulance Service. Dr Davies confirmed that Mrs Fortes-Mayer had held discussions with Stafford and Surrounds, and Herefordshire and Worcestershire CCGs to draw up a number of conclusions about what rural parts of the region wanted in terms of performance delivery targets and how to develop community alternatives with the support of the ambulance service. Mrs Fortes-Mayer was writing to the Regional Commissioner regarding the outcome and setting out the position for local rural systems and would bring an update to a future meeting as that progressed.

ACTION: Mrs Fortes-Mayer to give a progress update on conversations with other regional commissioners regarding the WMAS contract at the next Governing Body meeting.

b) GB-2019-09.115 – Quality Exception and Performance Report
Dr Davies reported that she had prepared an email containing information on the children's cancer performance and had experienced difficulty in sending to the Governing Body but would re-send the email. It was understood that this was based on very low numbers and as a result of one patient that had distorted the data, which the Planned Care Working Group had reviewed.

The CCG was working with Shrewsbury and Telford Hospital NHS Trust (SaTH) to improve communications between SaTH and the Referral Assessment Service (RAS) in terms of increased waiting times, which would be regularly communicated via the Primary Care Newsletter.

Mrs Morris reported that the focus on Urology rates had been quite high within the quality area. The Urology Navigator was now attending weekly meetings with SaTH to try and improve the process for patients to be seen more quickly and to ensure that they were receiving the correct

information. SaTH's Operational Manager had also negotiated additional consultant clinics to improve the speed of the Urology MDTs and the CCG was particularly seeing a slow improvement in performance in that area, which it was continuing to monitor and would be shown in the Performance Report.

ACTION: Dr Davies to resend the email she had prepared containing information on children's cancer performance to Governing Body Members.

c) **GB-2019-09.116 - Learning Disabilities Mortality Review (LeDeR) Annual Report** – An updated report had been circulated with the papers, which addressed the queries from the last meeting regarding the numbers of deaths of Shropshire patients with Learning Disabilities (LDs) and the numbers of patients with LDs prevalence.

Minute No. GB-2019-11.137 – Public Questions

7.1 Dr Povey advised that the written questions received 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-2019-11.138 – Finance, Contracting Report including Quality, Innovation, Productivity & Prevention (QIPP) schemes

8.1 Mrs Skidmore presented the mid-year report, which outlined the CCG's financial position at 30 September 2019 (Month 6), the key points of which to note were as follows:

The CCG continued to overspend against its plan each month and at Month 6 the CCG was showing a year to date overspend of £9.2m against the submitted plan. The forecast risk adjusted financial position was now a variance from plan of £22.1m, a total risk adjusted deficit in year of £45m. The CCG had seen a deterioration of £1m in its forecast outturn since the position reported at Month 5, which was unfortunate because some of the actions that it had started to put in place, that would help to improve its position, had started to come to fruition but there had been some adverse movements in other areas.

8.2 Of most note for Governing body Members at this stage was the shift in forecast in the prescribing budget, which the CCG was not alone in experiencing. This was a national issue that CCGs were encountering, which was driven by the Category M prescribing drugs. The CCG was reliant on forecasts on the EPACT system to produce its own modelling, which was a national system that records the CCGs' drugs spend, and unfortunately, due to the nature of that reporting system, it was always a couple of months behind so often there was a delay in something happening and the CCG was not aware of it through the reporting system. For Shropshire CCG, that had resulted in a £900K net deterioration in prescribing forecast and so there was an overall £1m deterioration, which was something that was beyond the CCG's control. NHSE/I was aware of this issue on a national level and it would be closely monitored.

8.3 Mrs Skidmore drew the Governing Body's attention to the CCG's QIPP Plan. There was a very marginal movement in the CCG's forecast between Month 5 and Month 6 and the report stated that the CCG was still forecasting an outturn of £16.67m (84% delivery). The CCG continued to review its projects in that it was still undertaking a significant risk assessment against some of those areas that both the QIPP Programme Board and the Finance and Performance Committee were closely monitoring. In particular, where the movement was driven by slippage in schemes, the CCG was focussing its energies on trying to slow down or stop that slippage. Mrs Skidmore reiterated what she had said before in that the CCG could not commission itself out of some of these issues. It was about the reliance on other partners in the system to try and embed the schemes to ensure they were delivering as expected.

8.4 Mr Timmis noted that one of the concerns that had been expressed on a number of occasions at the Finance and Performance Committee was about the pace in which the CCG was delivering some of the schemes and the slowness of some of the transformational schemes, which was of particular concern because it was not just about getting money out, which the CCG needed to do but some of the schemes would improve services for patients so that they live better and healthier lives. Mr Timmis, therefore, asked what was being done across the whole of the system to make sure the CCG a) was better at doing this quickly and b) was better at being more accurate in terms of confirming

when these schemes would deliver because it was of concern that yet again there were schemes that were set to deliver at a certain point in the year.

8.5 Mrs Skidmore explained that the CCG was more and more using the governance structures that had been set up for the STP to help the CCG with that particular issue. David Stout, Transformation Director, chaired the System Operational Sustainability (SOS) Group, which was not there to replicate the programmes of work that were happening already but there were operational people in attendance at that meeting working together to try and unblock some of the issues particularly around some of the schemes.

8.6 The SOS was also considering some proposals particularly around the SaTH and RJAH contracts where some overheating had been seen in some areas. So there were operational people from those trusts in the room to try and look at how the CCG might bring some of the overspend back.

8.7 To address the point about pace, which was crucial, at present the SOS Group met fortnightly with an intervening reporting cycle because the system partners had recognised that there should be no delays. There was a need to push forward on making those changes and even if some of those schemes did not show improvements in this financial year, the benefits would be seen moving into next year.

8.8 Dr Leaman asked about the WMAS contract overspend and asked if there was any incentive at all for the ambulance service not to convey patients to the hospital.

8.9 Mrs Skidmore confirmed that WMAS was paid by conveyance and was also paid for 'see and treat' and 'hear and treat' cases.

8.10 Dr Davies explained that there were more issues around WMAS' relative performance and the drivers for that. Work was being undertaken with the ambulance service looking at what the alternatives were so that it made sense for them to contact and to make use of those alternatives. At present, they operated to how they were held to account, which was their response times, but sometimes it was quicker for them to convey a patient than it was to access an alternative and that was where work was being conducted to align those incentives across the system.

8.11 Dr Bird added that certainly anecdotally ambulance crews did try not to convey as they would often contact the surgery to ask the GP to review a patient. Dr Davies confirmed that for a time the 'see and treat' cases were increasing, which also supported that position.

8.12 Mr Evans explained that the CCG had seen a significant increase in ambulance conveyances this year, which was associated with increased demand of services in general. It was disappointing that ambulance conveyances to RSH from the county as a whole had been the highest in the West Midlands over the last 18 months. It was not entirely clear why that was the case. The conveyances to PRH were not far behind in that RSH was running at approximately 20% and at PRH it was running at approximately 15%. There was one other system that was seeing an increase of similar proportions which was in the south of the West Midlands but other systems had seen much lower proportions. The CCG did not understand the increase and were working with WMAS as a system to try and understand it.

8.13 Dr Shepherd sought further clarification on the changes in the CCG's prescribing costs and asked if that was something that would influence and impact on prescribers.

8.14 Mrs Skidmore confirmed that there was a national pricing structure for the drugs and part of the process every year was that there was a levying up of drugs prices and payments to community pharmacies. Some years CCGs had gained and in other years they had not. It was unfortunate that this year it had been a shift that had pushed more resource to community pharmacies.

8.15 Dr Povey suggested that if he worked for NHSE/I he would consider that the CCG's £45m deficit was not good and sought clarification that the CCG was still reporting to its plan of £22m and not to its control total.

8.16 Mrs Skidmore confirmed that the CCG was still reporting to its plan. As part of the reporting regime for both Trusts and CCGs, which had been harmonised this year because there used to be separate regimes, the CCG was unable to officially change its forecast position without it going through a lengthy process. The Governing Body absolutely recognised that the CCG had done everything that it could to control any movement away from plan and that it was very clear about the actions taken and how far that might bring the CCG back to balance.

8.17 That position also needed to be endorsed and signed off by the regional regulator, NHSE/I and that as a process that could only happen at a quarter-end. The CCG, therefore, had an opportunity to review its position for Q2 at Month 6 and through the conversations that had taken place both at the Finance and Performance Committee and in the Governing Body's development session, the CCG had not felt confident to agree a number at that point in the year that it believed would not move again by the end of the year. The biggest reason for that was that at the same time SaTH was also going through the same process and the same considerations. SaTH had drawn up a conclusion that it had not got to a place where it was confident in fixing its number yet either, so it would be imprudent of the CCG as a commissioner to try and fix a number when its core provider had not done that for themselves. The conversations that the CCG had then had with NHSE/I had supported that action and the CCG was now looking to, through conversations with NHSE/I, make that application ready for its Q3 position. The CCG was in the process of drawing up the timelines with NHSE/I now to make sure that it gave itself plenty of time to for due consideration to that position before it put that case forward.

8.18 Dr Povey noted that last year, Dr Simon Freeman as the Accountable Officer, and himself were regularly invited, at least once a month, to meet with the regional team to be challenged about what work the CCG was undertaking around its finances and around the system performance. It appeared that these meetings had ceased and NHSE/I were addressing them in the system meetings, which Mrs Skidmore was attending with other system Chief Finance Officers (CFOs). Dr Povey asked Mrs Skidmore what the feedback to the system was.

8.19 Mrs Skidmore reported that the good thing from the CCG's position as a commissioner, was that NHSE/I were recognising that the financial pressures were not something that the CCG was going to resolve itself in isolation. The line of questioning from the Regional Finance Director was the same in terms of did the CCG understand what was driving its position; was it clear it was doing all that it could to try and halt any increase in numbers or pull back any areas of overspend; and obviously then asking what was the CCG's recovery plan and timeline for things coming back. It was now set in a context that it was not just the CCG's problem to solve, it was that the CCG had got to have its providers with it and this was proving more helpful.

8.20 Dr Povey referred to the discussion at the last meeting when the Governing Body asked what it could do more of to help address the financial position. A development session had been where the Governing Body looked at the financial challenges and what actions could be taken. That piece of work had now been completed which looked at the next steps and what more should the Governing Body be doing as there was an expectation to bring the CCG's financial spend down in line with its medium term plans and to get back towards a balance position. Dr Povey asked what else could Mrs Skidmore see as the CCG's next steps.

8.21 Mrs Skidmore confirmed that it would be helpful at least for the Governing Body to receive, comment and have input into the recovery action plans that were being put in place. There was the Project Management Office (PMO) structure and clear governance around how the CCG manages projects and how it monitors their impact and effectiveness. The CCG was just going through a process of refreshing those at present not least because it needed to input a next phase of information into the next system plan. Through the CCG's usual governance process this would happen anyway but it was expected that over the next few months, and through the CCG's Finance and Performance Committee, the next phases of those action plans would be brought to the Governing Body. Support for and endorsement of those items that the executive team have put in the plan would be really helpful.

RESOLVE: The Governing Body NOTED:

- ***The financial position at Month 6***
- ***The financial challenge for 2019/20 and the urgency required around developing mitigations to the risk of overspend***

ACTIONS: The Governing Body was asked to support and endorse the recovery action plans that were being put in place.

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2019-11.139 – Governing Body Assurance Framework (GBAF)

9.1 Mrs Tilley reported that there were no particular points on the current version of the GBAF that she specifically needed to bring to the attention of the Governing Body. Since the last meeting, the GBAF had been reviewed by the Executive Directors and the Audit Committee in October 2019 and the actions that had been identified in the Governing Body's July meeting had been completed, which were:

- Updates to the first two new risks on the GBAF to include the indication arrows in the assessment of risk column.
- To amend the first risk regarding Finance to state the CCG fails to deliver 'its plan' and not its 'control total'.

9.2 The Governing Body was asked to review the latest version of the GBAF and the detail of the risks set out in the document. The actions taken to mitigate the risks as set out in the GBAF were noted.

RESOLVE: The Governing Body:

NOTED the actions taken to mitigate the risks outlined on the GBAF; and
REVIEWED and CONSIDERED the detail of the GBAF risks highlighted as it conducts its business throughout the Governing Body meeting.

Minute No. GB-2019-11.140 – Performance and Quality Report
Julie presented and Chris was there for support

10.1 Dr Davies presented the Performance and Quality Report, which contained updates on the integrated quality and performance reporting for the CCG against all the key performance & quality indicators for Month 5 and 6 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 RTT
2wk wait (Breast)
2wk wait from GP referral
A&E 4hr target
Ambulance handovers >30mins and >1hr
RTT

10.2 The 62day Referral To Treatment (RTT), 2 week Breast symptoms and overall 2 week wait performance targets for the CCG were not achieved. The improvement plans continued to be closely monitored and there had been significant improvements in both 2 week performance standards. This had shown the expected improvement in August and was expected to continue to improve in September and October. The overall trajectory for the recovery of 85% 62day RTT target had been resubmitted to NHSE/I based on the ongoing impact of Urology and SaTH had committed to get to 83% by the end of March 2019.

10.3 Further improvement was dependent on the wider joint working with the University Hospital of North Midlands (UHNM) and their purchase of a second surgical robot. Bi-weekly calls remained in place with NHSE to also monitor delivery against these plans and provide support as required. The CCG's overall cancer performance was also affected by out of county providers and this was continually being progressed through the corresponding lead commissioners via the CCG's contract team with support as required from NHSE/I.

10.4 The increased IAPT access target run rate of 22% in place for 2019/20 was not fully achieved in August mainly due to staff being on annual leave. This was expected to recover and to be achieved for the full year.

10.5 A&E performance, having shown signs of sustained improvement in July and August, had dropped back to 65.9% in September. Demand for Shropshire remained above plan year to date and ambulance conveyances were increasing locally at a faster rate than elsewhere in the region. A chief executive meeting was scheduled for 18 November within WMAS to agree what system action could be taken to reduce this. Workforce levels had showed some slow signs of improvement. It was hoped that it would be agreed what system action could be taken to achieve some dedicated operational support from WMAS to look at how this could be reduced locally.

10.6 It had been reported that there was a 12 hour trolley breach in September and a harm pro-forma had been received. Assurance had been gained that although the patient experience was poor, the patient affected had not suffered any harm. There had also been a number of 12 hour trolley waits in October and over the past 48 hours due to pressure in SaTH there had been further 12 hour trolley breaches.

10.7 Both > 1hr and >30mins ambulance handover delays had increased in September as a result of an increase in the number of ambulances conveyed. Engagement from WMAS to improve this had been included on the agenda for the Chief Executive meeting in November. There had been difficulties experienced for WMAS to drive the improvement plan which had been raised with NHSE/I.

10.8 The CCG had continued to fail the Referral To Treatment (RTT) target year to date as a result of emergency pressures and the ongoing escalation into both sites' Day Surgery Units. The recovery of this target was being reviewed as SaTH looked to secure additional Vanguard capacity to protect elective capacity during the winter. A revised recovery trajectory had slipped and was being brought back to the Planned Care Working Group in November.

10.9 As at the end of August, the CCG had no over 52 week waiters and the look forward was also positive. This continued to be monitored weekly by the CCG for its patients across all providers, in county and out of county, to continue to minimize any >52 week breaches.

10.10 Workforce remained the key quality concern at SaTH, along with the heavy dependency on agency staff. Recent nursing recruitment drives in India had been successful. The CCG had an extraordinary meeting with SaTH in October to pick up the actions taken to improve the workforce position across the Trust. The CQC were expected to revisit the Trust that week.

10.11 The CCG was seeing signs of improvement in Looked After Children Services and Health Passports were now being offered although the uptake remained low.

10.12 Dr Lynch noted that the Quality Report did not include community quality issues and it was known that there were a number of care and quality issues that had been picked up with Shropshire Community Health Trust (SCHT) and Dr Lynch was unsure of the outcome of that.

10.13 Mrs Morris explained that last month the Strategic Commissioning Board meeting with SCHT took place where previous notes were fully discussed. There had been a very constructive conversation around points of concern that the CCG had identified. SCHT had committed to take forward some positive steps and greater transparency with the workforce, which as a region had been difficult. SCHT had committed to work with the CCG on community equipment and on all the issues that the CCG had identified, they had agreed to progress through joint working. It had felt that the meeting had concluded with a real commitment to work together which was positive.

10.14 Mr Timmis viewed the 62 day cancer wait was a real concern. It was probably out of date but some graphs had been viewed that had shown that SaTH's 62 day wait was amongst the worst in the country. Mr Timmis asked if that was still the up-to-date position.

10.15 Dr Davies reported that the 2 week problem had impacted upon the 62 day cancer performance. It was understood that the 62 day relative performance had improved but there was still work to do. SaTH's commitment to get back to 83% by March was as quick as it could be achieved in the constraints of the service. The most problematic area was Urology. Work was being undertaken on the network redesign which would give some sustainability. It was not thought that SaTH was continuing to be an outlier. It was thought that it was a temporary issue as a result of the 2 week problem and the capacity shortages were being addressed.

10.16 Mr Timmis raised a second question about the issues with the Midlands Partnership Foundation Trust (MPFT) and the unexpected deaths in the community, which had been discussed at the last Quality Committee meeting. Mr Timmis asked if this issue had been linked to the triage issues that the Care Quality Commission (CQC) had highlighted

10.17 Mrs Morris confirmed that the CCG had not received that as a feed coming through but MPFT had been asked to do some more work on those unexpected deaths but those were patients that were in the community; they were on MPFT's caseload and in most cases were taking their own lives. Discussions had been held with Public Health colleagues as well to join up on lessons learnt and to look at whether there was a trend that needed to be worked on collectively. The CCG had also agreed to do some work with Stafford and Surrounds CCG which was experiencing the same issue in their area. MPFT had been asked to benchmark this nationally to see if that was something that was happening across the country that the CCG needed to be fully cognisant of and to look to see if there was anything the CCG could put in place to try and mitigate that.

10.18 Dr Povey referred to SaTH's A&E performance and suggested that it was doing fairly poorly compared to other areas. In the past the Governing Body had received regular updates on what actions were being taken. Recently attention had tended to focus more on the future, ie Future Fit and the UTCs, etc and it was felt that there was insufficient time spent discussing A&E performance. Dr Povey asked what was actually being done at present to improve SaTH's A&E performance because it did appear to be constantly rated in the bottom poor performers.

10.19 Dr Davies updated the Governing Body on the priority areas outlined in the report. The main area that SaTH was working on was workforce and it was known there was a lot of work being carried out on this.

10.20 The other main area was on systems and processes. The CCG had seen that SaTH were implementing the same day emergency care and optimising the short stay to try and maximise the flow out of the Emergency Department (ED) and minimise the pressures there. There had been another piece of work that members were briefed on in the regional escalation meeting the previous week that Edwin Borman was undertaking around how to get more ownership of the specialties of their patients in ED and to encourage them to take those patients directly in order to take the pressure off the ED.

10.21 The CCGs were looking at the cause of the demand as the increase in ambulance conveyances needed to be understood. The CCG was hopeful that now WMAS had taken over the function of the NHS 111 service for the area, having better clinical assessment of that demand should see a reduction in conveyancing, which should reduce the pressure. In Shropshire, the CCG was also eager to try and get the admission avoidance scheme up and running in the Shrewsbury area for this winter. The CCG had hoped to launch that service in November but had been unable to owing to the local provider being unable to source the workforce to support that. Conversations were being held with the local authority and local provider colleagues, who have been asked for support plans by 12:00 noon on Friday. The provider who can support the quickest would be given the contract because the CCG needed alternatives to manage its patients in the community so they do not require being admitted to hospital.

10.22 Mr Evans added that the beds at Bridgnorth Community Hospital were being used for Stroke rehabilitation to free up capacity in the acute trust and also beds were being utilised at Bishop's Castle for orthopaedic rehabilitation to free up acute beds. The general feedback from escalation meetings was that NHSE/I believed the CCG was doing the right things but unfortunately it was the demand that was the real problem at the present time.

10.23 Dr Povey raised that in the past the Governing Body had had the time to discuss mortality rates and wondered whether that would be an interesting piece of work around some of the quality issues that had been seen at SaTH over the last year/two years.

10.24 Mrs Morris agreed that she would be happy to bring a paper to the Governing Body's next meeting. This was certainly something that was reviewed at the Clinical Quality Review meeting and information was provided on that through Edwin Borman. The Trust was not an outlier as reported against the four indicators but SaTH had found an anomaly related to stroke which it believed was a coding issue but more information was awaited on that.

RESOLVE: The Governing Body NOTED the contents of the report and the CCG actions contained within to recover performance and quality in those areas which were currently below target.

ACTION: Mrs Morris to invite Dr Edwin Borman, Director of Clinical Effectiveness, SaTH to present a report on SaTH's mortality rates at the next meeting.

GOVERNANCE & ENGAGEMENT

Minute No. GB-2019-11.141 – Single Strategic Commissioner for Shropshire and Telford and Wrekin – Update Report

11.1 Mr Evans referred to the report presented, the purpose of which was to provide an update on the application process for creating a single strategic commissioner across Shropshire, Telford and Wrekin. It was also proposed to make some immediate changes to the CCG's committee structure to help align decision-making during the transition period to becoming a single strategic commissioner.

11.2 Mr Evans said that he was mindful that the last Governing Body meeting had taken place before the 11 October panel meeting with NHSE/I on the CCG's application to create a new single strategic commissioner. The CCG had not been successful at that panel meeting in going forward to create a single strategic commissioner from April 2020. However, after having received the letter from NHSE/I they had recognized a number of strengths in the application and they felt that it was just a timing issue in terms of the CCG being fairly late in joining the process and therefore had not had sufficient time to submit a strong enough application.

11.3 The CCG was clearly strong in some of the areas and there was some further work to do in others. NHSE/I had also indicated that they felt that the CCG could submit an application before the next

deadline of September 2020. Discussions were being held with NHSE/I and there was a meeting scheduled for the following week to discuss a timeline on that. Internally it was felt that April 2020 was probably realistic in terms of submitting a further application. The advantage of this would be that the CCG would know earlier in the next financial year whether it would be successful or whether there was more work to do and to submit another application in September.

11.4 On behalf of the Governing Body, Mr Evans extended a special thank you to the team who had been working hard on the application because they had put in a huge amount of effort and work to get the CCG to where it was. Work was continuing to bring the two CCGs at an operational level together. Work would be proceeding with the management of change for executives and staff over the coming months. The executive management of change process would commence in the next two weeks and following the appointment of the executive team the management of change process would be continued for the remainder of the staff.

11.5 Reference was made to the paper presented, which included proposals around governance and how the CCGs could start to align the governance processes for the next year/18 months. The intention was not to go through the paper in detail but it did set out the context with a framework of how this could be done. Some of the committees were easier to bring together than others, for example, the Audit Committee. The Remuneration Committee was already operating as a Committees in Common. The two CCGs did have different structures around their committees for Performance, Finance and Quality and the CCGs were working through processes on how to implement joint working for those committees.

11.6 Agreement had been reached that at a point in time, which was to be determined, the business day for the two CCGs would move to a Wednesday. It would also enable joint committees to work in a different way because all the clinical board members and lay members would be working on the same day which would be advantageous.

11.7 Mr Timmis was supportive of the proposals outlined in the documents. The one area that Mr Timmis raised a query on was the Locality Committees because as there was a move to Primary Care Networks Mr Timmis asked if this would change the focus the CCG would need to have in the future and would the Locality Committees still stand.

11.8 Mr Evans' response was that the CCG would need to consider this question going forward. In both CCGs at the present time, the PCNs were in a very early developmental phase. As part of the operational function, as the CCG moved forward from next April, it would want to consider how it engaged with the membership across the county. Mr Evans did not envisage changing the locality structure at this stage but it was thought that the PCNs could be a different conduit in the future to continue with the member engagement.

11.9 Dr Povey referred to the CCG moving towards creating a new strategic commissioner where there would be placed based commissioning. It was considered that this would increase the move towards PCNs away from the localities. However, the CCGs were still membership organizations and there needed to be a way that CCG Members could feed in to the Governing Body in the way the system worked. Alignment of the CCGs constitutions needed to be considered. Shropshire CCG's constitution was different in that in its governance structure the localities were shown as subcommittees of the Governing Body whereas Telford and Wrekin CCG's governance structure showed its single Practice Forum was placed above the Governing Body. Dr Povey considered that that was where the CCG could see the localities.

11.10 Dr Matthee considered there was still a place for a forum as the PCNs did not match localities and so therefore there was an overlap. There were parts where the locality committees were undertaking more of the provider parts but it was a work in progress. At present, it was considered the locality committees were required because the PCNs were in no position to undertake the administrative, financial or legal work required but it was thought this would change as the structure developed.

11.11 Dr Povey's view was that one of the disappointing things about NHSE/I not allowing the CCG to create a new single strategic commissioning organization from 1 April 2020 was that essentially the CCG would be required to undertake all the work it was going to do for that but as two separate CCGs so actually it made it a lot harder, and more complicated to do. The new CCG needed to be based on consideration of whether there was a need for a new locality structure, which it was thought there probably was, but that would be for the membership of the new CCG to decide. It was disappointing NHSE/I had turned down the CCG's application, however, it was thought the system was not quite ready to take on a strategic commissioning role to work alongside an ICS and also the CCG needed to do further work on its place based commissioning plan.

11.12 Dr Matthee reported that the Locality Chairs had already commenced creating "cross-party lines". Dr Lewis had attended a Cancer Alliance meeting in Telford and Dr Shepherd and Dr Matthee had also been attending the forums to gain a better understanding. Dr Shepherd, Dr Bird and Dr Matthee certainly would be very keen to pursue joint working and with the Telford forum also moving forward. Dr Matthee agreed that if the CCGs were one organization it would be far simpler and considered the CCGs should pursue those plans.

RESOLVE: The Governing Body:

- ***NOTED the outcome of the NHSE/I application panel progress and actions taken to date on creating a single strategic commissioner for Shropshire and Telford and Wrekin;***
- ***NOTED the risks outlined;***
- ***CONSIDERED and APPROVED the proposed changes to the CCG's committee structure in principle as outlined in the report; and***
- ***NOTED that further amendments required to the CCG's Constitution and terms of reference to facilitate the proposal would be presented at the next Governing Body meeting in January 2020 for approval.***

ACTION: An item to be included on the next agenda for Governing Body approval of the amendments to the CCG's Constitution and Terms of Reference.

Minute No. GB-2019-11.142 – Shropshire CCG Strategic Priorities Update

12.1 Mr Evans updated the Governing Body on progress in relation to the strategic priorities for Shropshire CCG during 2019/20.

12.2 In June 2019, Shropshire CCG's Governing Body had attended a development meeting, which had focused on agreeing a set of strategic priorities for delivery during 2019/20. The following shortlist of priority areas had been agreed:

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

It was highlighted that there were workforce challenges particularly in primary care, planned care and cancer.

12.3 The shortlist had been formally agreed by the Governing Body at its confidential meeting in August 2019 and that regular updates would be brought back to each Governing body meeting to demonstrate progress in delivery. The report presented was the first of those updates, which included a high level performance indicator, and the creation of more detailed performance indicators would form part of the work to create a single strategic commissioning organisation.

12.4 Dr Shepherd noted that there had been a lot of discussion about working as a system and sought assurance that system-wide priorities were being aligned.

12.5 Mr Evans explained that some of the key areas already had mechanisms in place where the system worked together, for example, on urgent and emergency care there was an A&E Delivery Group and an A&E Delivery Board. There was also the Planned Care Working group and the Cancer Alliance, which comprised providers and commissioners. This was the start of the system aligning work and the priorities feeding into those areas.

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.

Minute No. GB-2019-11.143 – Winter Planning

13.1 Dr Davies presented the Powerpoint slides on Shropshire, Telford and Wrekin Winter Planning on behalf of Mrs Claire Old, Director for Urgent Care, which covered:

- Progress so far
- Winter Plan 2019/20 – demand and capacity modelling
- Challenges

- Next Steps

The purpose of the report was to present the system Winter Plan for this year for approval.

13.2 The development of the system Winter Plan for 2019/20 had been overseen by the A&E Delivery Group and the attached plan had been submitted to A&E Delivery Board in October where it had been recommended for approval by system partner Governing Bodies.

13.3 The plan had taken into account lessons learned from winter last year and included detailed acute demand and capacity modelling which remained an iterative process to ensure that demand forecasts for the remainder of the winter were accurate. It also included the wider system actions being taken to provide system resilience this winter including the flu campaign and communication plan.

13.4 In addition to this, Dr Davies reported that the CCG had been advised by NHSE/I of some additional monies that may not normally be available to the CCG and the system had acted very quickly within 48 hours in relation to this. Feedback received that morning had requested the CCG to submit some more suggestions and again this would be turned around that afternoon. There was a word of caution on that, however, as it was pointed out that money was not always the answer to solve the winter pressures; it was the access to workforce, which was limited. Governing Body Members were assured that the CCG was doing all that it could to either accelerate the schemes or requests for additional capacity and would be submitted to the regulators.

13.5 Dr Pepper queried the impact of The Trust using the day surgery beds. Dr Davies explained that this was included in the Performance Report. The use of the day surgery beds absolutely impacted on the Referral to Treatment (RTT) target. The CCG was very clear that it always left sufficient capacity for clinical urgent and cancer treatment, which was never affected but SaTH was down to 85% at the present. moment. It was understood that SaTH was not on its own and was in a reasonable comparative position with regard to RTT across neighbouring trusts.

13.6 Mr Timmis noted the comment about the challenge of engagement with WMAS and highlighted that this had been mentioned on a number of occasions in different reports. It was suggested that this had been sent to NHSE/I and Mr Timmis asked if a response had yet been received.

13.7 Dr Davies explained that it had been suggested, through the A&E Delivery Board, to hold a summit to work through the issues. David Evans, Accountable Officer, had written to the Chief Executive of WMAS inviting a representative to attend but there had been no response received to date. Mr Evans would be raising this with NHSE/I and at the Chief Executive meeting on 18 November, when NHSE/I would also be present.

13.8 Dr James referred to the pressures caused by Ward 35 not being open and asked what was the CCG's level of confidence of it opening in the New Year.

13.9 Mr Evans confirmed that SaTH had received the capital allocation from NHSE/I and the building work was proceeding. Progress was discussed fortnightly at each A&E Delivery Group meeting and it had been consistently reported that the ward would be open in January. Dr Davies further reported that confirmation had been received that the additional therapy staff were in place to commence in January.

13.10 Dr Leaman said that he was particularly interested in the ease by which SaTH could discharge patients into the community. He had been impressed by the service provided by the prestige nursing service, SaTH to Home, which allowed SaTH to discharge suitable patients at very short notice and to receive care from the prestige nursing service. Dr Leaman suggested that if there was any unallocated monies, could the service make more use of that. Dr Davies confirmed that this had been an option open to SaTH in terms of the bid they put forward.

13.11 Dr Davies explained that the service needed to be integrated into the full daily hub process because there had been examples when patients had been discharged on that service and the local authority had not been aware of patients who were being discharged in that 24 hour period. The CCG had asked for the service to be built into the daily hub process so that it was visible for all members of the system to see where the patients have been discharged to so that they can be managed appropriately.

13.12 Dr Davies confirmed that SaTH was now discharging a considerable number of patients that were not even on the medically fit for discharge list anymore. This indicated the extent of the system-wide working and discharge planning between the hospital and the local authorities had improved over the last 12 months.

13.13 Mr Evans added that one of the things this system was actually very good at and had received recognition for was the work that it had done both on delayed transfers of care and stranded and super-stranded patients. Whilst there was always work that could be done around the back door it was not the fundamental problem in terms of SaTH's A&E performance at present.

13.14 Mrs Morris considered that it was important to include the impact for Shropshire CCG and Telford and Wrekin CCG of the increase in the number of patients having fast track referrals for continuing healthcare, which would affect the CCG's budget. It was known that when SaTH was at maximum capacity, they would use the fast track process to discharge patients. It was important that this was factored into the plan because as the pressure is high in the Trust that area of spend would increase for the CCG.

13.15 Dr Povey referred to the paper and the section on what went well and what did not go well. It was noted that the service provided by the handover nurses had gone well but the role of the Hospital Ambulance Liaison Officer (HALO) had not been as successful. Dr Povey asked Dr Davies what was the difference in the roles.

13.14 Dr Davies explained that the handover nurses were there to specifically cohort the patients where they have been taken from an ambulance. They also facilitated the patients having an assessment for their clinical need as soon as possible to optimise the care for those patients. The role of the HALO, however, was to put in some challenge to the ambulance crews when conveying patients and whether they could have been dealt with in a different way or did not need to be admitted to hospital. The role had been intended to be a peer to peer challenge from the HALOs to the paramedics but it had been proven that the role was not adding value and had been a system decision that it was not value for money.

13.15 Dr Povey referred to the section on Winter Demand on page 7 of the report and asked what had been done to prepare the providers and system partners for the fact that the winter money did end at Easter.

13.16 Dr Davies reported that conducting a full review of demand and capacity had improved the position. There were also a few schemes in place and the latest scheme submitted to NHSE/I included the extension to the winter pressures monies to the end of April to cover the Easter period as well to try and alleviate the problem that had been seen last year. Fundamentally the winter pressure money was non-recurrent and finite and the CCG would have to try and manage that as best it could.

13.17 Dr Povey referred to the Long Term Plan and also that the letter from NHSE/I had highlighted the requirement to ensure that the two hour community response was in place and asked what the CCG's plans were to cover this.

13.18 Dr Davies explained that this was one of the key elements that had been included in the future model of SCCtH. Obviously the CCG's ability to cover this requirement was based on when the project was implemented but would not be delivered for this winter.

<u>RESOLVE</u>: THE GOVERNING BODY APPROVED the system Winter Plan 2019/20.

<u>Minute No. GB-2019-11.144 – Audit Committee – 30 October (summary)</u>

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

- The Audit Committee had approved minor updates to a series of policies.
- Internal Audit had given a very positive report that had informed the Committee that there were no outstanding IA recommendations. The Committee had received two reports of specific reviews, which gave Significant Assurance on Looked after Children and Full Assurance on Conflicts of Interest.
- Counter Fraud had reported the closure of an investigation they had passed to the national team. The Committee had also discussed the current position on the National Fraud Investigation data matching exercise.

14.2 Mr Timmis emphasised that it had been reassuring to receive so many positive messages, particularly that there were no outstanding IA recommendations. A thank you was extended to the excellent work of the CCG staff who had ensured the CCG had reviewed the action plans and ensured arrangements had been in place.

14.3 Mr Timmis expressed frustration that he had been hoping to attend with the answer about the mental health investment standard. The CCG had completed its work but because of delays nationally, he was unable to report formally the feedback from the external auditors but was not expecting to have anything of significance to report.

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

A. Process for the appointment of external auditors

15.1 Mrs Skidmore presented the report previously circulated, the purpose of which was to advise the Governing Body of the process for the appointment of external auditors and to seek approval of the Auditor Panel's Terms of Reference.

15.2 Mrs Skidmore explained that in recent times CCGs had been tasked with appointing their own external auditors. It had not always been the case but governance needed to be in place to ensure that an independent panel could make recommendations about the appointment of external auditors to the Governing Body for sign-off.

15.3 It was reported that there had previously been a process before Mrs Skidmore had commenced employment with the CCG where there had been a joint panel, which had gone through the procurement with Telford and Wrekin CCG. However, it had been necessary to prepare new Terms of Reference for the Panel, which had been supported by the Audit Committee for presentation to the Governing Body for agreement.

15.4 Key points to note were:

- The current contract with Grant Thornton expires on 31/03/20 and the CCG needed to ensure it had secured a contract for external audit services with effect from 01/04/20.
- The appointment of external auditors must be made through a local Auditor Panel, accountable to the Governing Body.

RESOLVE: THE GOVERNING BODY:

- ***NOTED the content of the report***
- ***APPROVED the adoption of the Auditor Panel Terms of Reference***
- ***APPROVED that the Auditor Panels of both CCGs meeting as Panels in Common to oversee the appointment process.***

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute Nos. GB-2019-11.145 to GB-2019-11.153

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

- Clinical Commissioning Committee – 17 July, 21 August & 18 September 2019
- Finance & Performance Committee – 25 September 2019
- Primary Care Commissioning Committee – 7 August 2019
- Quality Committee – 28 August & 25 September 2019
- System A&E Delivery Board – 28 August & 25 September 2019
- North Locality Board – 18 July 2019
- Shrewsbury & Atcham Locality Board – 18 July 2019
- South Locality Board – 11 July 2019.

16.2 Dr Matthee drew the Governing Body's attention to the summary for the North Locality Board's July meeting and that the Committee had been concerned that the respiratory service was ununified. Work was ongoing in looking at a strategy to try and streamline the services through SaTH and SCHT.

16.3 Dr Povey reported that there was a piece of work currently being carried out on respiratory services across the STP, which involved SCHT, SaTH and the CCGs, which was being led by Dr Sokolov. Dr Matthee explained that he had raised this because he agreed that this was a positive step in the move to integrate other services.

16.4 There were no further points raised in relation to the minutes.

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

Minute No. GB-2019-11.153 – Any Other Business

17.1 There were no further items raised.

DATE OF NEXT MEETING

The next scheduled meeting of the CCG Governing Body is:

- **CCG Governing Body Meeting (open to the public)**

  Wednesday 15 January 2020 – venue to be confirmed.

SIGNED …….. DATE ……

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 13 NOVEMBER 2019

Agenda Item	Action Required	By Whom	By When	Date Completed/ Comments
GB-2019-11.135 – 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	21.11.19
GB-2019-11.136 – Matters Arising [GB-2019-07.097 – Ambulance Demand Deep Dive – Progress Update]	Mrs Fortes-Mayer to give a progress update on conversations with other regional commissioners regarding the WMAS contract at the next Governing Body meeting. Dr Davies to resend the email she had prepared containing information on children's cancer performance to Governing Body Members.	Mrs Gail Fortes-Mayer Dr Julie Davies	Next meeting – 15.01.20 As soon as possible	Complete Complete
GB-2019-11.138 – Finance, Contracting Report including QIPP schemes	The Governing Body was asked to support and endorse the recovery plans that were being put in place.	ALL		
GB-2019-11.140 – Performance and Quality Report	Mrs Morris to invite Dr Edwin Borman, Director of Clinical Effectiveness, SaTH to present a report on SaTH's mortality rates at the next meeting.	Mrs Christine Morris	Next meeting – 15.01.20	Complete
GB-2019-11.141 – Single Strategic Commissioner for Shropshire and Telford and Wrekin – Update Report	Item to be included on the next agenda for Governing Body approval of the amendments to the CCG's Constitution and Terms of Reference.	Mrs Sandra Stackhouse	Complete – Item included on agenda for 15.01.20	21.11.19

NHS
Shropshire
Clinical Commissioning Group

Submitted Questions by Members of the Public
for the Governing Body meeting 13 November 2019

Name Date & Time	Submitted Questions	CCG Summary Response
George Rook Co-Chair of LEAP, the Lived Experience Advisory Panel, Dementia UK; and Co-Chair of the Shropshire and Telford Health Economy Steering Group	There are over 4,000 people living in Shropshire with dementia, and a further 2,500 people providing unpaid care for them. Currently there is no consistent model of support and care for these people across the county, and after diagnosis the only support commissioned from MPFT is crisis care through the home treatment teams to keep people out of Redwoods. The only two Dementia Companions work in Ludlow and Oswestry. People living with dementia do not have personalised care and living plans, and they do not have support to help them live well with this disease. Many will live for up to twenty years after diagnosis. Dementia is caused by disease in the brain. Those who live with the disease have a human right to support to enable them to live well, and a right under the Equality Act to equity of care and support with other diseases and protected characteristics. And yet, despite adopting a co-produced Dementia Plan four years ago, Shropshire CCG is failing to provide care and support for people living with dementia. 1 When will the CCG and future ICS/STP adopt a rights based approach to care and provide the care and support we need and are entitled to in order to live as well as we can with the disease that causes dementia? 2 What are the medium and long term plans for achieving consistent and appropriate care and support for people living with dementia in Shropshire?	1. The NHS does not provide services on a rights based approach it operates on a needs based approach. There is clearly significant dementia need as you rightly identify that needs meeting and that is the purpose of current papers and work plans going through the system and SCCG governance at present. 2. We have plans going through CCC working group currently that outline what has been achieved and what is still required against the original strategy. Investment is required and this is proposed within our overall MH short-medium term investment plans at an affordable level. This will be managed through the usual governance process of business cases and will need to be signed off as part of the overall CCG spending plans for the coming period. Dementia is also addressed through the STW long term plan which will be published later this year. ***Dr Julie Davies*** ***Director of Performance and Delivery***
Rachel Groom	I would please like to know when we can have a true, detailed update on BeeU and young persons mental health services in Shropshire run by MPFT. For	The CCG is engaged in regular discussions with the provider of BeeU Midlands Partnership NHS

Name Date & Time	Submitted Questions	CCG Summary Response
	months they have been building a sustainable business case, yet for 2 years no ASD assessments have been done and parents are still having appointments cancelled at hours notice. This is an ongoing issue that I have raised several times and still the service is inadequate, failing hundreds of families. Lives have been ruined due to lack of support, with my own child unable to live with me anymore. I believe MPFT are in breach of their contract and something urgently needs to be done. Please could I have a response to this that is not the normal corporate waffle, or blame shifting, just answers to when our children can start getting help and leading fulfilling lives.	Trust. This includes regular monthly contract and quality management discussions about how we are meeting the needs of Children and Young People with emotional and mental health needs, and children and young people with neurodevelopment issues. As part of these discussions both Shropshire and Telford and Wrekin CCGs have developed a waiting list initiative with MPFT and another provider Mental Health Wellbeing Service to offer those children and young people who have waited over 12months an ASD assessment, this work has commenced and families will be offered appointments to undergo the assessment process over the coming months. We have also been working as part of the wider health care and education system to achieve a multidisciplinary approach to neurological development support. The emphasis is on developing a panel of multidisciplinary expertise to advise and support schools to improve the coordination of support to children identified as possibly requiring neurodevelopmental assessment. ASD assessment is not always a straight forward process for CYP in the same way as it is for adults. In these cases closer working between health, LA and school will ensure that CYP are better supported earlier at school whilst also gathering further diagnostic information in line with NICE guidance as part of a comprehensive approach to assessment and diagnosis. CCGs working with partners as part of the Children and Young People Local Transformation Plan (CYPLTP) have successfully become part of the NHS National Mental Health in Schools Teams Trailblazer programme. By locating the new

Name Date & Time	Submitted Questions	CCG Summary Response
		mental health teams across key schools we are confident that relationships, competence and knowledge about early identification and prevention of mental health will significantly increase. Initial focus will be on building capacity in key schools. With the support of the Mental Health Support Teams (MHST) they will be much better equipped to offer a universal approach able to meet mild to moderate mental health needs. The impact of the new service will ensure that our BeeU specialist service continues to offer the more specialist support to those children with moderate to severe mental health needs. The majority of CYP experiencing mental health problems are seen well within national access times for intervention and any variations are scrutinised at the monthly contract meeting. It is acknowledged that a few CYP may have had their appointments cancelled and rearranged at short notice when a consultant may be off sick but the Trust try and minimise the impact of this. We are not aware of any appointments that have been cancelled for ASD. If you would like to share the details of any last minute cancellations (with the relevant permissions) we will of course look into them and get back to you directly. ***Dr Julie Davies*** ***Director of Performance and Delivery***
Gill George	**1. Smoking Cessation** The CCG wrote to GPs on 27th August 2019 with its new Commissioning Statement on smoking cessation. This instructs GPs that they should not routinely prescribe nicotine replacement therapy (NRT) products and should not routinely prescribe the prescription only medicines varenicline and bupropion. 1) How does this decision support the CCG's aspirations to improve population health and reduce demand for acute services? 2) What modelling has taken place on the impact of the withdrawal of these services on population health and on future health and social care costs (this in a county where COPD is a major cause of ill health and hospital admissions)?	The local authority commissioned smoking service ceased at the end of September 2019. All funding for this service including all prescribing costs was reimbursed by the local authority, therefore no cost to the CCG. Nicotine replacement therapy (NRT) is available to purchase from community pharmacy and supermarkets, at a similar cost to purchasing cigarettes and tobacco products. In line with the CCG's self-care policy, NRT products should

Name Date & Time	Submitted Questions	CCG Summary Response
	3) How is the decision in line with the NICE guideline 'Stop smoking interventions and services' (28 March 2018 ng92)? This comments that: *'**All the interventions are clinically effective, cost effective and cost saving** to both the NHS and local authorities. Most organisations will not need to change current practice, and **support to stop smoking services should remain a priority**.'* 4) How is the decision consistent with the NHS Long Term Plan? 5) What public consultation took place before the CCG took this decision? Your reply need not include the information that the local authority has stopped its own smoking cessation services except those offered to pregnant women. I know this. The questions are around the CCG's policy decision.	therefore not be **routinely** prescribed and patients signposted to community pharmacy who are ideally positioned to provide advice on the full range of NRT products and provide support. Varenicline (Champix) and Buproprion (Zyban) are prescription only medicines and are not available for patients to purchase. Good medical practice dictates that these medicines are only prescribed following an assessment of the patient and with the provision of appropriate follow up and behavioural support. Clinical evidence demonstrates outcomes are significantly improved when pharmacological options are accompanied by a support programme. If a clinical decision is made to prescribe, behavioural support options should be explored. Both pharmacological treatments and support programmes increase the rate of success; however the best results are seen when both are offered together. With the withdrawal of the Local Authority funded Help2Quit programme, NHS stop smoking support is limited within Shropshire. The CCG has advised that GPs should not routinely prescribe the prescription only medicines (POM) varenicline or bupropion for smoking cessation. GPs should only consider prescribing POM medication for smoking cessation where they choose to provide this alongside appropriate support and follow up as detailed in https://cks.nice.org.uk/smoking-cessation#!scenarioRecommendation GP practices are continuing to work with patients to support them to stop smoking; including making individual decisions to prescribe POM where they feel it is clinically appropriate to do so. Prevention is a key priority within the LTP locally and we will continue to work with the local authority public health team to determine how best

Name Date & Time	Submitted Questions	CCG Summary Response
		to meet the needs of our population in the future. Shropshire CCG remains committed to supporting our population to stop smoking within available resources and will monitor the impacts of the loss of Local Authority commissioned stop smoking services in Shropshire on smoking rates. ***Mrs Nicky Wilde, Director of Primary Care***
Gill George	**2. OOH Service Review** The 28th August Quality Committee discussed the GP Out of Hours service and the (late) 6 month review of this: *'Mr Timmis advised that a six month review of the service was due to go to the Governing Body and was now late. He was aware of issues relating to both delivery of the contract and performance. There was a period where information relating to this contract was being with-held by the Community Trust. It is important that the CCG sees a full review of the service that is being provided. Dr Davies advised that the review has been completed and the CCG needs to review the contents of the review and its recommendations.'* 1) Has the CCG reviewed the contents of the review and its recommendations? **2)** Will the review and any subsequent actions by the CCG, ShropCom or Shropdoc now be made public? If not, why not?	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. ***Dr Julie Davies, Director of Performance and Delivery &*** ***Mrs Gail Fortes-Mayer, Director of Contracting and Planning***
Gill George	**3. Non-Elective Demand** The Performance and Quality report to the Governing Body notes that *'ambulance conveyances are increasing locally at a faster rate than elsewhere in the region'.* The last SaTH Board meeting discussed a 10th September Emergency Department Oversight report. The report noted that in the preceding 4 months, there had been a 17% increase in activity at RSH ED and a 20% increase at PRH ED. Previous CCG Governing Body meetings have indicated that the CCG is working hard to establish the reasons that lie behind the marked and apparently sustained increase in demand for non-elective care in Shropshire. 1) What conclusions have been reached? 2) If we assume multifactorial causation, then what strands are thought most likely to lie behind increasing demand locally?	The main increase is due to patients being conveyed to both RSH and PRH by ambulance. There is a meeting with the system Chief Execs and the CEO of WMAS on the 18th November where this will be discussed and a half day summit is proposed for the whole system to work with WMAS on how we better manage this demand. ***Dr Julie Davies, Director of Performance and Delivery***
Gill George	**4. Care Closer to Home** The **Financial Position Month 6, 2019/20** report to the Governing Body indicates that two strands of Care Closer to Home initiatives may fail to meet their target	

Name Date & Time	Submitted Questions	CCG Summary Response
	cost savings: Phase 1 Admissions Avoidance by 26% and Phase 2 Case Management Demonstrator Sites by 50% (Paragraph 46, Table 4, QIPP Risk). The minutes of the 17th July CCC, within the papers for this meeting, record: *'Ms Wicks advised that the eight demonstrator sites had gone live on 3 June but informed that within 3 days an escalation meeting had been held through the pilot escalation group due to concerns with regard to Shropcom's workforce and whether they were able to deliver the model. The concerns were around providing a dedicated person at a practice level to be the case manager and the use of Matrons.'* The July 2018 'Overview of Care Closer to Home' indicates that there is *'no additional money to pay for this way of working'.* Q&As from the March 2019 Care Closer to Home workshop note *'The Programme aims to maximise the valuable expertise and experience we already have but to co-ordinate it to reduce duplication and increase efficiency to create a better service for patients.'* The assumptions behind Care Closer to Home work have been that there is no requirement for additional funding and no requirement for additional staff. A quick scan of this month's Governing Body paperwork suggests that both assumptions may be over-optimistic. There is a clear clinical need to build out-of-hospital capacity and meet clinical needs close to (or at) home. This is the only possible way of breaking with an ever-increasing demand for hospital care. But: 1) How confident is the CCG that Care Closer to Home requires no additional financial or staffing resources? Where is your evidence? 2) If the CCG is not confident of this, then how much money – given an escalating financial crisis – is now allocated for investment in Care Closer to Home initiatives? Do you believe you able to invest enough to achieve population scale health improvements and substantially reduce non-elective demand? 3) Arising from both questions, please share your current modelling on the impact of Care Closer to Home on non-elective demand, and your related financial modelling. 4) The Board Assurance Framework notes *'Phase 3 models are signed off and impact assessments are underway, due to be completed by end October'*. When will the Phase 3 models be shared with the public?	We have funded proof of concepts to test the new ways of working as to invest to save projects. These are still in their very early stages but impact to date is being reviewed with colleagues from ShropComm at the end of November. Current modelling of the CCtH programme still assumes that investment will be required in out of hospital services in order to avoid non elective admissions. Proof of concept work as mentioned above is underway and the outputs of this will be used to inform more detailed modelling though for now, an estimated 80% reinvestment of savings into new models is assumed for planning purposes. We have been given some urgent and emergency care non recurrent money from NHSE/I to support our admission avoidance pilot in Shrewsbury and we are working with our local providers as to how best to spend that money this year to maximum effect. Phase 3 work has been progressing but has been slowed by the availability of clinicians to complete impact assessments on the draft models. We have our provider's commitment to get that completed before Christmas. We also had another engagement event planned which has been delayed by the upcoming election. Once this has been completed and the clinical feedback we should be able to share this work in the New Year. ***Dr Julie Davies, Director of Performance and Delivery***
Gill George	**5. Whitehall Medical Practice Closure** Informal reports suggest an increase in waiting times for GP appointments following the closure of Whitehall Medical Practice. This would not be surprising, as neighbouring practices warned before closure that they lacked the capacity to take a significant number of additional patients.	The number of complaints reported to the CCG regarding access to primary care services did not increase in either September or October when the majority of patients

Name Date & Time	Submitted Questions	CCG Summary Response
	Is the CCG collecting data on patient experience following the closure? If so, what do the data show, and what additional support is in place for patients (and practices) from the CCG? If not, should more robust monitoring be happening?	transferred and the CCG will continue to monitor this. The CCG has provided support to the practices that registered the majority of patients from Whitehall Medical Practice and will continue to do so. In all correspondence to patients regarding the closure of Whitehall Medical Practice, the CCG has included the PALS contact details, however as each practice operates slightly different models of access to appointments, any specific issues should initially be raised via the individual practices complaints policy. ***Mrs Nicky Wilde, Director of Primary Care***
Diane Peacock	**Part One: The commissioning role** *Commissioning is the process by which health and care services are planned, purchased and monitored.* […] *Commissioning comprises a range of activities, including: assessing needs; planning services; procuring services; monitoring quality. The process, which is repeated typically on an annual basis, is often shown as a cycle.* https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing Link to NHSE commissioning cycle: https://www.england.nhs.uk/participation/resources/commissioning-engagement-cycle/ Q1a. What mechanisms are in place to enable members of the public to scrutinise the latest local Joint Strategic Needs Assessment (JSNA) and local public health predictive analytics that inform the quantitative and qualitative evidence base for specific 'service specifications' in primary care and community healthcare services under the auspices of this CCG? Q2a. Can the CCG confirm whether or not the methodology for generating 'service specifications' now draws on year-on-year workforce trend data for whole time equivalents (wtes) GPs, registered nurses and other clinical staff working in primary and community care settings?	Q1a. The JSNA are all on the public council website once they are agreed and signed off through the Health & Well Being Board. A specific one for older people inked to the development of care closer to home work has been delayed due to current pre-election restrictions but is due for sign off and publication in the New Year. Q2a. Commissioners do not specify workforce requirements in service specifications – increasingly we are working toward outcomes based specifications and it is the providers who

Name Date & Time	Submitted Questions	CCG Summary Response
		model the workforce requirements. Obviously at an STP level the long term plan requirements are being fed through a dedicated STW workforce group to plan the workforce requirements necessary to meet both national and local ambitions and health needs.
	Q2b. If the answer to Q2a is that it is not a national requirement to reproduce trend data, can the CCG explain how patient wellbeing and safety be assured <u>without</u> year-on-year comparators for evaluating the capacity of key clinical roles *against* (estimated & revised) year-on-year population variables and local health profiles? Q3. Can the CCG confirm which specific ONS population data were used when determining service specifications in Shropshire for 2018-2019? Q4. Other than agency staffing, is the CCG outsourcing any nursing services to private companies?	Q2b There is no national requirement for commissioners to reproduce staffing trend data. It is up to the providers to determine the workforce they require to deliver safe and effective services aligned to the specification in the contract. As a CCG this is monitored by the delivery of key quality and safety indicators as included with the service specifications. This is done through our monthly contract review processes with all our main providers. Where issues are identified through this process then commissioners request a more detail report on actual staffing levels, vacancies and plans to recruit and retain key staff as required. Q3 The CCG uses ONS data as one data source to underpin the activity planning assumptions used on an annual basis within individual provider contracts. Specifications are for the life of the term of the contract - it's the activity that is reviewed in terms of projected growth in demand linked to demographics on an annual basis. The national ONS population projections as published on the ONS website are used every year. Q4. The CCG commissions individual patient care packages aligned to NHS CHC to independent sector providers as required to meet their personal needs. ***Dr Julie Davies, Director of Performance and Delivery***
Diane Peacock	**Part Two: The ageing population, A&E and Care Closer to Home.** **Context:** On the 29th November 2018 DP received a response from the CCG to a	

Name Date & Time	Submitted Questions	CCG Summary Response
	written public question on claims made in FF and the STP about primary, community, local authority and the voluntary services collectively stemming the flow of emergency admissions over the next four years. DP asked for unequivocal assurances that the additional demands on other services would be adequately funded. **Response:** ***The CCG has modelled the likely reductions in emergency admissions that would result from more holistic care in the community using international best practice and evidenced from international studies. An assumption has been made that 80% of the savings from emergency admissions will need to be invested in community services to enable this to happen. These figures form the basis of the PCBC and the CCGs Medium Term Financial Plan.*** Q1. A year later, what is the evidence base to suggest that any assumed mitigation for relieving pressures on the acute sector will follow from the Care Closer to Home initiative and thus lead to investment in partner services? Q2. What specific *assessments of needs* have been conducted by the CCG - as commissioners - to ensure there is the capacity in key clinical roles in primary care (GPs and practice nurses) and community health (registered nurses) to underpin Care Closer to Home in Shropshire? Q3. What forms of patient management and risk stratification tracking are in place to monitor and evaluate the impact of Phase One of Care Closer to Home on subsequent paramedic call-out rates, A&E presentations, Acute Medical Unit referrals or acute admissions/readmissions?	Q1. The initial pilots for Care Closer to Home are only just up and running and if proven effective will be used to construct business cases for that investment to support the required shift. Q2. The CCG has commissioned a full needs assessment from the public health function of the local authority. This is being used as the basis on which to plan the capacity required of community services to meet the needs of our population. This is being shared with providers and the workforce implications will be worked through by the STW workforce group mentioned above. Q3. The impact of the Phase one, the Frailty front door is being reviewed currently, the main impact is reduced length of stay in the acute setting. It also reduces the number of main bed based admissions and increases the short stay admissions, e.g. AMU and Acute Medical Assessment. ***Dr Julie Davies, Director of Performance and Delivery***

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.007
Shropshire CCG Governing Body meeting: 15.01.20

Title of the report:	Financial Position Month 8, 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.

Key issues or points to note at 30th November 2019 (Month 8):

At Month 8 the CCG is showing a year to date overspend of £13.9m against the submitted plan. The forecast risk adjusted financial position has remained static at a variance from plan of £22.1m, a total risk adjusted deficit in year of £44.9m.
The CCG has experienced adverse movements in the forecast position between month 7 and 8, particularly in the following areas:

- £0.8m deterioration in overall CHC position
- £0.5m deterioration in overall community position (due to hospice charges and overperformance in CHEC and Wye valley contracts)

Improvements in the forecast of around £1.3m as listed below have succeeded in offsetting the adverse movement.

- (£0.4m) improvement due to grip and control work- small benefits across all areas of expenditure as result of CFO meetings with directors
- (£0.4m) improvement in other acute forecasts and prior year.
- (£0.1m) due to review of MH budgets.
- (£0.5m) improvement in primary care position due to GP prescribing, FP10s and rates rebates.

Prescribing forecasts continue to be reported in line with recent EPACT forecasts and based on the latest information the Cat M impact looks to be in the region of £1m for the full year for Shropshire CCG.

The significant overspend on Individual Care costs also continues in Month 8 with further increases contributing to a net £0.8m deterioration in the risk adjusted forecast, mostly due to adult joint funding costs.

Benefits have been identified during Month 8 through the CCG's financial recovery actions which have been released to the bottom line. The CFO has met with every executive director to review budgets which has resulted in the release of a number of small benefits across all areas of expenditure from forecasts.

There have also been benefits realised in month due to improved forecasts in GP prescribing, FP10s and rates rebates.

Current forecasts against the overall QIPP plan would suggest an outturn of £16.3m (82% delivery) with

£0.7m of this flagged as 'at risk'. Though £0.25m has been included as a potential mitigation to this as further Individual Commissioning savings are being ratified.

Forecasts for MSK, Heart Failure and Community schemes have deteriorated since last month but have been offset with improvements in forecasts for Medicines Management and Individual Commissioning.

A financial recovery plan is in place and actions to address the overspend are anticipated to impact on the run rate from January onwards. However, the CCG believes that given the scale of the risks flagged at month 8 the planned deficit will be exceeded at year end. Current potential mitigations do not cover the level of unmitigated risk which is reported as £22.1m. We continue to pursue options for reducing costs both internally and with our system partners but at this stage of the year, the scale of the return to the financial plan figure is too great to be deemed achievable in year.

The CCG is working with NHSE/I locally and the National NHSE/I Intensive Support Team to finalise its financial recovery plan and intends to submit a revised forecast for quarter 3. This has been discussed with the governing body and arrangements have been made to ensure the appropriate governance is followed in the submission of our revised position.

The underlying position is presented with a working assumption that management actions designed to hit plan are likely to be non-recurrent in nature. As actions develop further this position will be reviewed.

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.

Actions required by Governing Body Members:

The Governing Body is asked to:

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

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* Un-mitigated risk signals that, if risks were to materialise, the CCG would not have sufficient financial cover to offset these.	Yes

	The fragility of the CCG's finances should not be underestimated. The current position contains insufficient flexibility (contingency) to cover any unexpected expenditure arising before the end of the financial year. Any further unexpected expenditure will adversely affect our financial position over and above what is currently reported.	

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
Appendix B	B1 Financial Summary Position B2 QIPP Detail B3 Allocations B4 Category Run Rate Analysis

NHS Shropshire CCG
Governing Body Meeting - 15th January 2020

Financial Position Month 8 - 2019/20

Financial Performance Dashboard

1. The CCG's overall performance at 2019/20 Month 8 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- £13.9m above planned deficit	R
Cash	1.25% monthly drawdown	G
Better Payment Practice (App B-7)	>=95%	G

Summary Financial Position

2. The CCG has a financial plan for 2019/20 that delivers a £22.9m deficit. This is with a view to returning to in-year financial balance over time. When risks and mitigations are applied to the CCG's current position against this plan, this results in an unmitigated risk of £22.1m suggesting that, if all risks and mitigations materialise as reported, the CCG would exit the year with an in-year deficit of £44.9m.

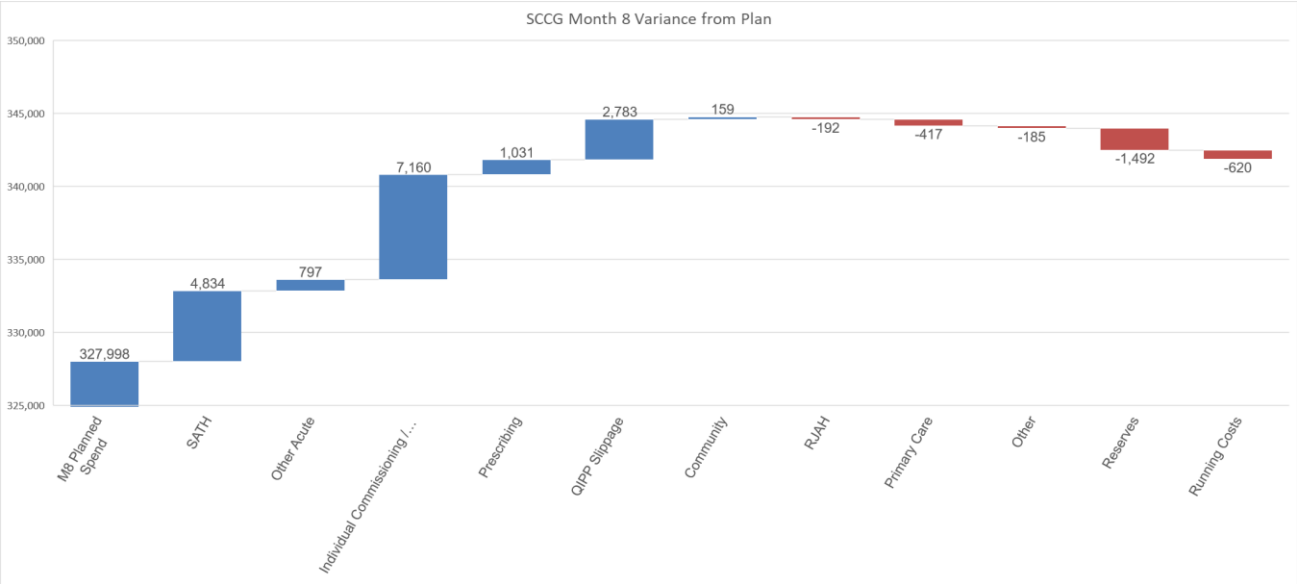
3. The table below outlines the financial position at Month 8 and further detail is provided at Appendix B-1.

Table 2: Summary Financial Position at Month 8

	2019/20 Budget	Forecast Outturn	Forecast Variance	Budget Year to Date	Actual Year to Date	Variance year to date	Net Risk	Risk Adjusted Forecast Variance
	£000	£000	£000	£000	£000	£000	£'000	£'000
Total Resource Limit	**472,892**	**472,892**	**0**	**312,761**	**312,761**	**0**		
Acute Services	232,467	246,804	14,337	156,023	164,315	8,292	1,245	15,582
Community Health Service	49,746	49,718	(28)	32,797	33,150	353		(28)
Individual Commissioning	35,432	42,876	7,444	23,621	28,356	4,734	30	7,474
Mental Health Services	42,769	45,579	2,810	28,528	30,603	2,075		2,810
Primary Care Services	63,386	64,580	1,194	41,996	42,500	505		1,194
Other	19,232	(5,616)	(24,848)	10,837	9,160	(1,677)	20,808	(4,040)
Running Costs	6,610	6,568	(42)	4,406	4,264	(142)		(42)
Co-Commissioning	46,104	45,237	(867)	29,791	29,509	(282)		(867)
Total Expenditure	**495,746**	**495,746**	**0**	**327,998**	**341,857**	**13,859**	**22,083**	**22,083**
Deficit/(Surplus)	**22,854**	**22,854**	**0**	**15,236**	**29,095**	**13,859**		**44,937**

Year to Date

Figure 1: Year to date variance from plan at Month 8



4. The bridge diagram above shows the difference between planned expenditure of £328m at Month 8 and reported actual expenditure of £341.9m.

5. When the resulting £29.1m deficit is compared to the planned deficit for month 8 (£15.2m) this shows a £13.9m YTD variance.

Contract Position Summary

6. Month 7 SUS data is now available and Month 8 contract positions have been calculated on this basis. Appendix A shows the detail around each of the contracts below.

SATH- Shrewsbury and Telford Hospital

7. The Month 8 position for SATH shows a year to date overspend of £5.3m (some of which is shown in QIPP slippage in the graph above) and a forecast outturn of £8.4m overspend.

8. The forecast has remained static overall since last month. Further detail of the continued overspend is provided in Appendix A.

9. Contract Performance Notices are currently open with SaTH for failure to achieve the constitutional targets relating to A&E and Cancer. These are discussed at both the contract review group and the planned care working group/emergency care working groups.

10. Discussions are currently underway between the CCG CFO and SATH's Director of Finance to finalise a year end agreement to bring stability to both individual

organisation and the system financial forecasts ahead of any formal amendments at Month 9.

RJAH- Robert Jones and Agnes Hunt

11. The RJAH contract is over performing by £610k year to date with a forecast outturn of £718k overspend. The CCG and the trust are working together to ensure that activity is managed back to plan. £170k of risk has been factored into the position until actions have been confirmed. This includes ongoing actions around patients being discharged as well as reducing the associated activity from long term patients.

12. Discussions are also underway between the CCG CFO and RJAH's Director of Finance to finalise a year end agreement.

WMAS- West Midlands Ambulance Contract

13. The Month 8 position at WMAS is a year to date overspend of £241k and a forecast overspend of £549k. Activity in October continues to be high at over 8% over performance for the second successive month. This has therefore brought the over performance YTD to just over 5.5%.

Betsi Cadwaladr University Health Board

14. During Month 8 the forecast expenditure against this contract has remained steady at an underspend of £320k due to significant underperformance in YTD activity against plan, particularly in the area of maternity services.

Out of Area Acute Contracts

Out of Area Acute Contracts continue to overheat at month 8. The main providers with over performance at Month 8 are University Hospital North Midlands (UHNM), The Wye Valley and Royal Wolverhampton Hospital overspends are largely due to emergency activity manifesting at greater than planned levels.

15. 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

16. Within community budgets over performance continues to be seen against the community ophthalmology contract with CHEC. The CCG is currently in discussion with the provider and has challenged the level of over performance due to data validation issues.

17. In month there has also been a significant increase in charges from the hospice in relation to fast track patients. These charges are currently being validated by the Individual Commissioning team. The Director of Nursing has agreed to fund any legitimate shortfall in costs this year but is currently negotiating a new contract with the hospice.

18. The Wye Valley community contract also continues to over perform. The main area of over performance relates to GP medical beds and this is currently being queried through the contracts team.

Individual Commissioning

19. Appendix A outlines the current position on Individual Commissioning (Continuing healthcare/complex care including mental health) which shows a YTD overall position of £6.7m overspend and a forecast outturn of £10.2m overspend. At Month 8 we continue to see high levels of expenditure particularly in Mental Health and the overall risk adjusted forecast has deteriorated by a net £800k since Month 7.

20. There has been a significant movement in month in relation to Adult Joint Funded Costs and a schedule of intended recharges received from the Local Authority. The Director of Nursing has met with the Local Authority to attempt to resolve disputes and the CCG's CFO has sent a letter to the LA to recommend quarterly reconciliation of costs to avoid unexpected charges late in the year.

21. The current position assumes that the over delivery of CHC QIPP year to date will continue and therefore the target of £2.8m will be exceeded by £250k. A further £250k of QIPP delivery has been highlighted as a potential mitigation to the financial position. £280k is built into the financial risk assessment to reflect an aged debt risk in relation to a CHC patient dispute with BCUHB.

Forecast Outturn

22. The forecast risk adjusted financial position has remained static since last month at a variance from plan of £22.1m, hence a total risk adjusted deficit in year of £44.9m.

23. 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 8 Risk Adjusted Position Movements

	£ m
Month 7 risk adjusted FOT variance to plan	**22.1**
Net deterioration in Individual Commissioning forecast	0.8
Deterioration in Community Forecast (hospice charges , CHEC overperformance , Wye Valley overperformance)	0.5
Improvement in forecasts across various expenditure lines due to grip and control work (CFO met with every director)	(0.4)
Improvement in other acute forecast including prior year review and restricted investments	(0.3)
Release of uncommitted MH expenditure	(0.1)
Improvement in primary care forecast (benefits from GP prescribing, FP10s and rates rebates)	(0.5)

Month 8 risk adjusted FOT variance to plan	22.1

24. The Individual Commissioning forecast deteriorated in month by £1.3m since last month. The main drivers of this include increased adult joint funded costs notified by the Local Authority; an increase in new patients and new retrospective claims. However, QIPP performance year to date is now showing signs of success and therefore the CHC QIPP has been increased by £0.25m this month. A further £0.25m has been included as potential mitigation for QIPP 'stretch'. Therefore, the overall net movement in the CHC risk adjusted position is a deterioration of £0.8m.

25. The community expenditure risk adjusted forecast has deteriorated in month by £0.5m. This is mainly due to £0.3m increased charges from Severn hospice in relation to fast track patients, £70k increased forecast overperformance on the Wye Valley Contract and £96k increase in the forecast on the CHEC contract. This month, the £175k hit from the Shropshire Community Trust QIPP has been included in the ledger position rather than as a risk, as no QIPP schemes have been identified for delivery with the trust.

26. During Month 8 the CCG's CFO has reviewed all budget lines and expenditure commitments with each director as part of a 'Grip and Control' exercise. This has led to a number of small benefits being released to the position across a number of budget lines and categories.

27. In other acute contracts there has been a £0.4m improvement in month. The main reason for this movement is that the UHNM contract has improved by £0.2m due to a review of prior year charges.

28. In Mental Health a review of all budgets and commitments has led to the release of £0.1m.

29. Current forecasts against the overall QIPP plan would suggest an outturn of £16.3m (82% delivery) with £0.7m of this flagged as 'at risk'. Though £0.25m has been included as a potential mitigation to this as further Individual Commissioning savings are being ratified. Forecasts for MSK, Heart Failure and Community schemes have deteriorated since last month but have been offset with improvements in forecasts for Medicines Management and Individual Commissioning.

30. In order to deliver a £22.9m deficit in year, there would need to be a £20.8m reduction in expenditure between now and the end of the year. The total value of this management action required is flagged as high risk and included in the financial risk assessment.

QIPP Summary

31. As at Month 8, a forecast position of £16.3m is reported against a plan of £19.8m. A further £0.7m has been identified as 'at risk of delivery' alongside £250k of mitigation, therefore if all risks and mitigations were to materialise, actual outturn delivery would be £15.8m. This is reported as the CCG's 'most likely' position. A detailed financial summary by scheme is included at Appendix B of this report.

32. In addition, the PMO team have constructed a ‘worst case’ scenario of £14.5m delivery. This is a PMO assessment for indicative purposes rather than a reported position from project leads and is based on an extension of assumed slippage in some of the high risk commissioning schemes. This assessment features within the £2.5m ‘worst case’ assessment for SATH’s position.

33. It is recognised that a number of schemes are not meeting anticipated QIPP targets and this has not been helped by an unprecedented demand in services over the past few months. There are a number of management actions that are underway to reduce expenditure and identify further QIPP to address the current gap. Alongside this, The PMO continue to review and assess all forecast positions and to pursue options to stretch delivery in year though recognising that there is little scope for savings to materialise in year so close to the end of the financial year.

34. During the month, Attain have continued to offer project support to existing schemes across Shropshire and Telford, and are helping to identify further programmes of work using benchmarking this has led to best practice evidence and experience from other health economies.

35. Whilst slippage is reported for some schemes in the QIPP programme, it should be noted that after review, schemes within Individual Commissioning and Medicines Management teams are now expected to exceed planned savings.

36. The System Operational Sustainability Group continue to meet on a bi-weekly basis with particular focus on developing system-wide propositions to support financial recovery.

37. Within the CCGs, the PMO team are continuing to capture and develop a pipeline of future years schemes ensuring that governance processes are followed. and detail is worked up that will support the contracting round for 2020/21.

QIPP Risk

38. 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 FOT risk applied at month 8 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	Risk Adjusted Postion £000's
£19,815	£16,258	£0,74	£0,25	£15,768

Scheme Name	Net Planned Savings £000's	Forecast Delivery(net) £000's	Confidence of Delivery £000's	Risk of Delivery £000's
COPD	£656	£285	£85	£200
HISU	£120	£120	£80	£40
CCtH – Admission Avoidance	£1,900	£500	£250	£250
CCtH – Demonstrator Sites	£1000	£706	£500	£250
Total Risk				**£740**

39. The PMO, in collaboration with executive leads and project managers, have identified the four schemes listed above as deemed to be carrying a risk that the figures reported in the overall position may not be achievable.

40. Individual Commissioning carries a mitigation of £250k which offsets some of this risk which is due to confidence in the potential to deliver further savings through the review programme and Out of Area Placements Scheme.

Risk and Mitigation

41. The Month 8 financial submission to NHS England highlights unmitigated risk of £22.1m. Detail of risks and mitigations is shown in the table below.

42. This shows the breakdown of risks and mitigations that takes the CCG from a planned deficit of £22.9m to a risk adjusted deficit of £44.9m. The bottom line, risk adjusted forecast, has not moved overall since last month.

Table 5: Key Risks and Mitigations

		Month 8
		£'000
RISK	**RISK DESCRIPTION**	
QIPP Risk	Latest risk assessment regarding QIPP delivery from scheme leads.	740
RJAH Risk	Risk that action plan won't deliver current forecast	170
CHC Betsi	CCG assessment of likely risk associated with Betsi Cadwaladr outstanding CHC case dispute	280
Acute Risk	Additional acute risk eg in relation to data submission errors	335
Other	Current management action to address gap	20,806
Total		**22,331**
MITIGATIONS		
Individual Commissioning QIPP	Additional stretch to existing QIPP	-250
Total		
Total Net risk		**22,081**

Underlying Financial Position

43. The underlying position at Month 8 is shown below. The table shows an underlying deficit of £48.4m. Actions to bring the YTD position back into line with the plan by year end have been assumed to be non recurrent in nature. As actions develop further this will be kept under review.

Table 6: Underlying Position at Month 8

	£'000	
Month 8 Forecast Position in ledger (in line with plan)	22,854	Deficit
Non Recurrent Items in Position:		
ACUTE non recurrent expenditure	943	
MENTAL HEALTH- non recurrent recharge agreement with Telford CCG	640	
COMMUNITY non recurrent expenditure- consultancy and 18/19 prior year hits	- 584	
PRIMARY CARE- non recurrent benefits- prescribing, rates rebates, release of uncommitted reserves inc incentive scheme	978	
CONTINUING HEALTHCARE- non recurrent expenditure- interims	- 41	
OTHER- non recurrent benefits- patient transport, 111 etc	521	
RUNNING COSTS- non recurrent expenditure- OD work etc	131	
Use of contingency recurrently need to reinstate next year	2,104	
Assumption that management action to meet plan is non recurrent	20,806	
Underlying Position at Month 8	**48,352**	Deficit

Run Rate

44. 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.

45. At Month 8 the CCG is showing a spend position that is £13.9m above the year to date plan. This is after taking account of the recovery plan benefits realised during Month 7 and Month 8 listed in the table below.

Table 7: Improvements in Month 7 and 8 Position

Action	£'000
Application of secured external funding	100
Finalisation of Betsi Cadwalladr Contract	300
Other Acute Improvement/Prior Year Review	600
Impact of Grip and Control	400
Primary Care improvements in forecast	500
	1,900

46. The current risk adjusted run rate of expenditure against plan has therefore reduced from an average of £2m a month to £1.7m a month due to the actions taken above.

47. If this rate of overspend continued to the end of the year on a straight line basis the CCG would be £20m away from the target. However, reserves/contingencies are phased into Month 12 to offset some of the cost pressure and there are a number of assumptions around QIPP delivery phasing which means that the straight line projection could be understating the true position.

Recovery Action and Oversight of the Reported Position

48. Financial recovery actions to address the overheating position are underway though some of these are not likely to impact on the run rate until JanuaryJanuary onwards. Where figures are available these have been included in the CCG 'best case' scenario. Other actions continue to be pursued but it is unlikely that benefits will be seen in year. Financial Recovery is discussed at the joint executive meeting on a weekly basis.

49. Despite best efforts, the CCG believes that given the scale of the risks flagged at month 8 the planned deficit will be exceeded at year end. Current potential mitigations do not cover the level of unmitigated risk which is reported as £22.1m. We continue to review and assess all forecast positions and to pursue options for reducing costs both internally and with our system partners but at this stage of the year, the scale of the return to the financial plan figure is too great to be deemed achievable in year.

50. The CCG continues to work with system partners to gain a better understanding of patterns of activity and the impact of the work we're doing to recover the financial position in order to support our application to revise the reported forecast outturn at Quarter 3 2019/20.

51. 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.

52. The CCG is not currently eligible for Commissioner Sustainability Funding (CSF) as it did not submit a financial plan that meets the NHS England required control total.

53. The CCG started the financial year with a cumulative deficit carried forward from 2018/19 of £76.6m, the submitted plan currently forecasts this to reach £99.5m by the end of 2019/20 but if the risk adjusted position materialises as anticipated, this will be significantly higher.

Potential Outturn Scenarios Against Submitted Financial Plan

54. During Month 8 the 'best case' and 'worst case' scenarios have been updated.

Table 8: Potential Scenarios

Month 7				Month 8				Reason for movement
	Best Case	Most Likely	Worst Case		Best Case	Most Likely	Worst Case	
	£'000	£'000	£'000		£'000	£'000	£'000	
	44,946	44,946	44,946		44,937	44,937	44,937	
RJAH risk doesn't materialise and recovery is delivered as modelled	- 500			RJAH risk doesn't materialise and recovery is delivered as modelled	-			RJAH movement back to plan now factored into financial position at a much lower level.
CHC deliver full QIPP target (i.e. risk doesn't materialise)	- 250			CHC deliver full QIPP target (i.e. risk doesn't materialise)	-			Reduced CHC QIPP risk now factored into position
Discretionary spend controls land running cost target and risk does not materialise	- 80			Discretionary spend controls land running cost target and risk does not materialise	-			Improvement on running costs through Grip and Control work now factored into position
ASD (Autism Spectrum Disorder) cost pressure/ bid for funding	- 56			ASD (Autism Spectrum Disorder) cost pressure/ bid for funding	- 56			Potential bid -still awaiting outcome
Hospice ast track proposal	- 33			Hospice fast track proposal	- 33			Severn hospice proposal- still being discussed
Elective activity reduced back to plan	- 400			Elective activity reduced back to plan	- 100			Based on revised assessment of latest figures being discussed at SOSG. RJAH impact already factored into position.
				Uncommitted primary care funding to be released into position	- 400			Potential release of Primary Care funding being discussed with NHSE/I.
SATH- further deterioration in forecast position			2,100	SATH- further deterioration in forecast position			2,500	Risk still in position. Early indications are that M7 data is high
WMAS- further deterioration in forecast position			100	WMAS- further deterioration in forecast position			100	WMAS potential further deterioration based on latest data
Out of Area- further deterioration in forecast position, full 100% of straight line forecast instead of current 75% assumption			400	Out of Area- further deterioration in forecast position, full 100% of straight line forecast instead of current 75% assumption			400	Reduced risk based on latest data from trusts
Individual Commissioning				Individual Commissioning			500	Potential deterioration in overall Individual Commissioning forecast given previous months trends
CCtH- despite project delivery, demonstrator sites do not deliver planned number of avoided admissions			370	CCtH- despite project delivery, demonstrator sites do not deliver planned number of avoided admissions			-	CCTH QIPP risk factored into SATH risk line.
	43,627	**44,946**	**47,916**		**44,348**	**44,937**	**48,437**	

55. The current assessment of the CCG's position suggests that the risk adjusted forecast is the most likely outturn scenario. Since month 8, the 'most likely' scenario remains static.

56. Unfortunately, the ‘best case scenario’ modelled has deteriorated by £0.7m. This is predominantly driven by crystallisation into the ‘most likely’ position of improvements in running costs and increased confidence in Individual Commissioning delivering their QIPP target. Also, figures for the anticipated impact of managing elective and outpatient activity back to plan have been revised downward based on further detailed discussions with SATH and RJAH.

57. The worst case scenario has remained relatively static and includes further risk around QIPP delivery for SATH, a potential deterioration in the WMAS forecast and potential deterioration in forecasts for other acute contracts.

Conclusion

58. As described above, the CCG is continuing to experience significant cost pressures at Month 8 but the overall risk adjusted forecast has remained static since Month 7 at a £22.1m deficit over plan. The CCG is working on its financial recovery plans and focus continues to be on delivering the financial recovery actions.

59. The CCG believes that given the scale of the risks flagged at month 8 the planned deficit will be exceeded at year end. Current potential mitigations do not cover the level of unmitigated risk which is reported as £22.1m. We continue to review and assess all forecast positions and to pursue options for reducing costs both internally and with our system partners but at this stage of the year, the scale of the return to financial plan figure is too great to be deemed achievable in-year.

60. The CCG is working with NHSE/I locally and the National NHSE/I Intensive Support Team to finalise its financial recovery plan and will be submitting a revised forecast for quarter 3. This has been discussed with the governing body and arrangements have been made to ensure the appropriate governance is followed in the submission of our revised position.

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	Net Risk £'000	Risk Adjusted Forecast Variance £'000
SaTH	149,892	158,318	8,426	99,681	105,011	5,329	575	9,001
RJAH	32,673	33,391	718	21,904	22,514	610	170	888
WMAS	14,616	15,165	549	9,609	9,850	241	0	549
NCAs & Other	35,286	39,930	4,644	24,829	26,940	2,110	500	5,144
Total Acute Services	**232,467**	**246,804**	**14,337**	**156,023**	**164,315**	**8,291**	**1,245**	**15,582**

KEY MESSAGES

At Month 8 the CCG is currently reporting an over performance of £8.3m YTD. This is primarily being driven by SaTH and Out of Area (OOA) providers.

The forecast for the year is £14.3m above plan or £15.6m when risk adjusted.

In month there have been two main movements to the forecast position. These are RJAH and other Acute contracts.

For RJAH the main movement is the reduced assumption around any benefit from the work to restrict activity to plan by year end.

The Other Acute Contracts section has deteriorated by £155k primarily due to further slippage with CC2H QIPP with this partially mitigated by one off prior year benefits.

The WMAS contract has not seen a change to it's FOT as activity was broadly in line with previous months, however seasonality may result in costs creeping up over the next several months .

The main risk to the position is that the QIPP that is expected to deliver in the second part of the year does not materialise.

The main QIPPs planned to deliver in Q3 and Q4 are Care Closer to Home as well as COPD at SaTH.

A-1a SaTH

NHS Shropshire Clinical Commissioning Group

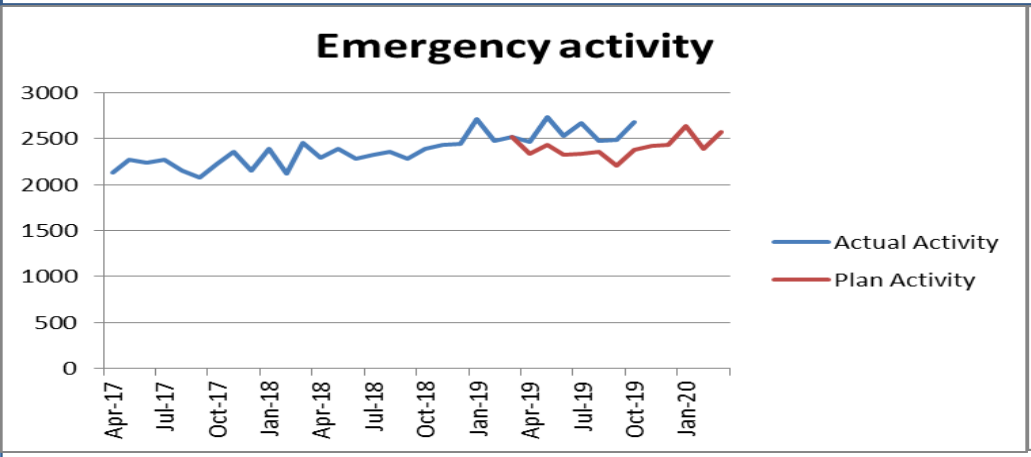
Shrewsbury and Telford Hospital Trust

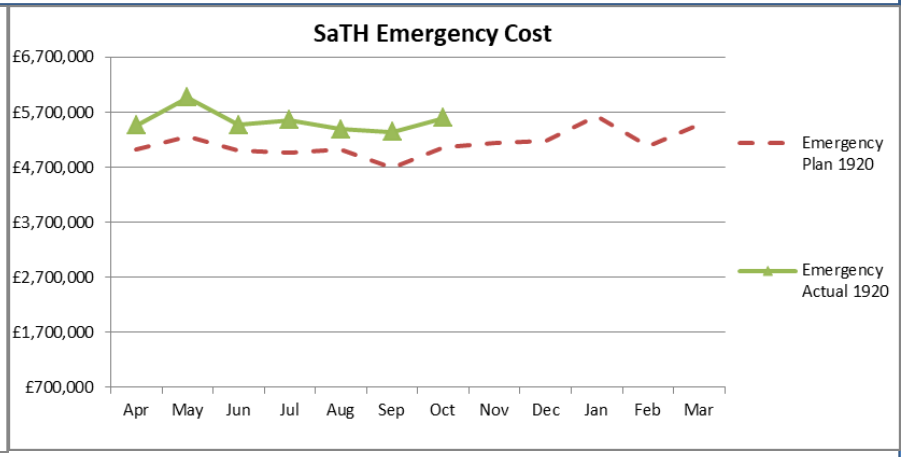
Shropshire CCG Position at Month 8 - Finance (Per Month 7 SATH Monitoring)

	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	Month 7 FOT Cost Variance £	In month movement £
Day Case	10,940,866	11,306,754	365,888	3.3%	16,284,975	16,828,781	543,806	3.3%	756,455	(212,649)
Elective	4,697,304	5,111,324	414,020	8.8%	6,847,723	7,443,574	595,851	8.7%	427,805	168,046
Emergency	40,209,838	44,506,534	4,296,696	10.7%	61,576,687	68,592,249	7,015,562	11.4%	6,876,392	139,169
Non Elective Other	4,144,324	3,972,388	(171,936)	(4.1%)	6,371,825	6,107,420	(264,405)	(4.1%)	(300,600)	36,196
CDU Adjustment		(345,400)	(345,400)	0.0%	0	(529,430)	(529,430)	0.0%	(546,896)	17,466
Critical Care	1,830,592	2,181,839	351,247	19.2%	2,745,861	3,272,692	526,831	19.2%	440,655	86,177
Outpatient Firsts	6,566,813	6,998,741	431,928	6.6%	9,731,420	10,371,732	640,312	6.6%	638,262	2,049
Outpatient Follow Ups	5,159,280	5,202,014	42,734	0.8%	7,631,711	7,694,945	63,234	0.8%	79,843	(16,609)
Outpatient Procedures	4,790,275	4,780,978	(9,297)	(0.2%)	7,114,656	7,100,919	(13,737)	(0.2%)	(25,379)	11,642
Accident and Emergency	6,953,506	7,568,895	615,389	8.9%	10,424,707	11,346,981	922,274	8.8%	961,545	(39,271)
Non PBR Variable	15,361,402	14,916,656	(444,746)	(2.9%)	22,813,286	22,109,773	(703,513)	(3.1%)	(764,510)	60,997
Non PBR Block	1,087,296	1,087,295	(1)	(0.0%)	1,630,944	1,631,000	56	0.0%	56	0
CQUIN	1,185,880	774,376	(411,504)	(34.7%)	1,778,820	1,392,359	(386,461)	(21.7%)	87,653	(474,114)
Blended Payment Rebate	0	(3,016,330)	(3,016,330)	0.0%	0	(4,639,051)	(4,639,051)	0.0%	(4,595,264)	(43,787)
MRET/Readmissions	(3,478,000)	0	3,478,000	(100.0%)	(5,217,000)	0	5,217,000	(100.0%)	5,217,000	0
Total	**99,449,376**	**105,046,061**	**5,596,685**	**5.6%**	**149,735,615**	**158,723,943**	**8,988,328**	**6.0%**	**9,253,017**	**(264,688)**
Prisoners	105,484	72,888	(32,596)		156,585	109,333	(47,252)		0	(47,252)
QIPP - COPD Admissions	0	0	0		0	(284,847)	(284,847)		(284,847)	0
QIPP - Heart Failure	0	0	0		0	(109,367)	(109,367)		(374,412)	265,045
QIPP - HISU	0	0	0		0	0	0		(50,959)	50,959
Agreed Principles	0	(33,706)	(33,706)		0	(50,558)	(50,558)		(50,112)	(446)
Penalties	0	(31,499)	(31,499)		0	(31,499)	(31,499)		(26,249)	(5,250)
Phasing Correction	125,662	0	(125,662)		0	0	0		0	0
FLS Rebasing	0	(43,096)	(43,096)		0	(39,261)	(39,261)		(39,261)	0
Total Over/(Under) performance	**99,680,522**	**105,010,648**	**5,330,127**	**5.3%**	**149,892,200**	**158,317,744**	**8,425,544**	**5.6%**	**8,427,177**	**(1,633)**

A-1a SaTH

NHS Shropshire Clinical Commissioning Group





SaTH Emergency Activity

Activity continues to be significantly over plan with activity being 10% over plan in October (excluding PRH CDU) bringing the over performance to 7.5% YTD. The main drivers are the same as previous months with these being listed below.

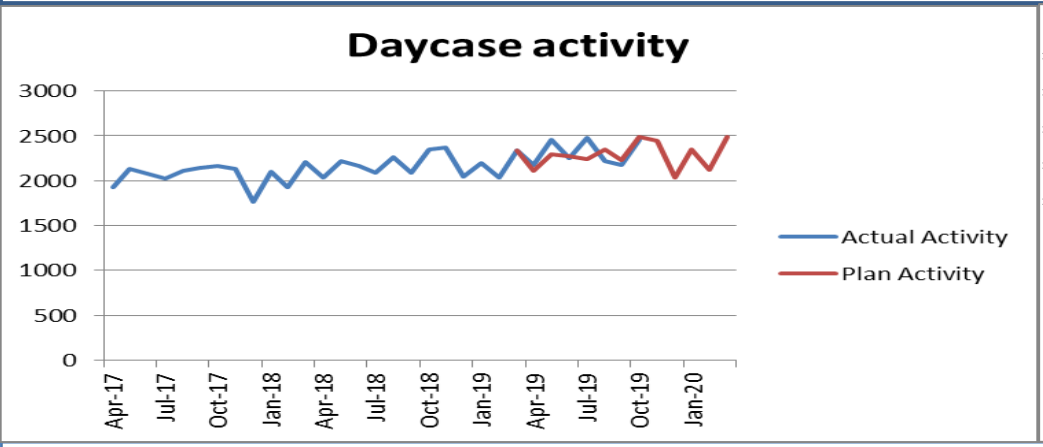
HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Cardiac Disorders	2,035	2,418	383	19%	3,101,061	3,791,285	690,224	22%
Nervous System Procedures and Disorders	1,058	1,170	112	11%	2,555,696	3,099,175	543,479	21%
Respiratory System Procedures and Disorders	2,055	2,345	290	14%	5,762,960	6,812,922	1,049,962	18%
Skin Disorders	362	471	109	30%	850,737	1,175,248	324,511	38%
Renal Procedures and Disorders	866	973	107	12%	2,836,219	3,114,700	278,481	10%

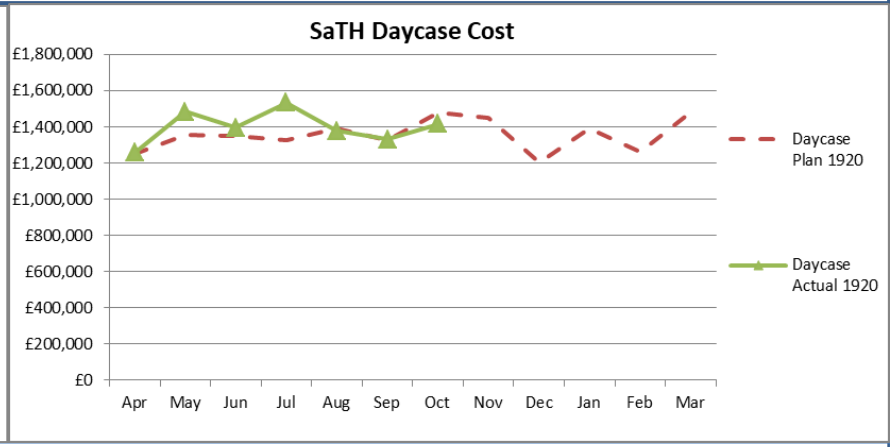
There are however several subchapters where activity is currently below plan

HRG Subchapter	Activity Plan	Activity Actual	Activity Variance	%age Activity Var	Price Plan	Price Actual	Price Variance	%age Price Var
Hepatobiliary and Pancreatic System Endoscopic Procedures	67	58	-9	-14%	358,177	285,356	-72,821	-20%
Orthopaedic Non-Trauma Procedures	97	83	-14	-15%	491,595	392,175	-99,420	-20%
Haematological Procedures and Disorders	237	234	-3	-1%	931,541	792,503	-139,038	-15%
Paediatric Respiratory Disorders	643	444	-199	-31%	536,994	341,941	-195,053	-36%

A-1a SaTH

NHS Shropshire Clinical Commissioning Group

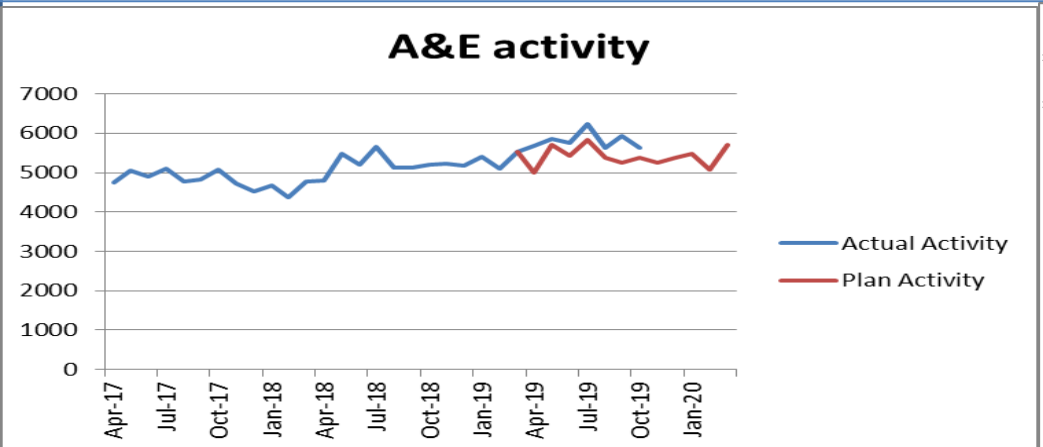


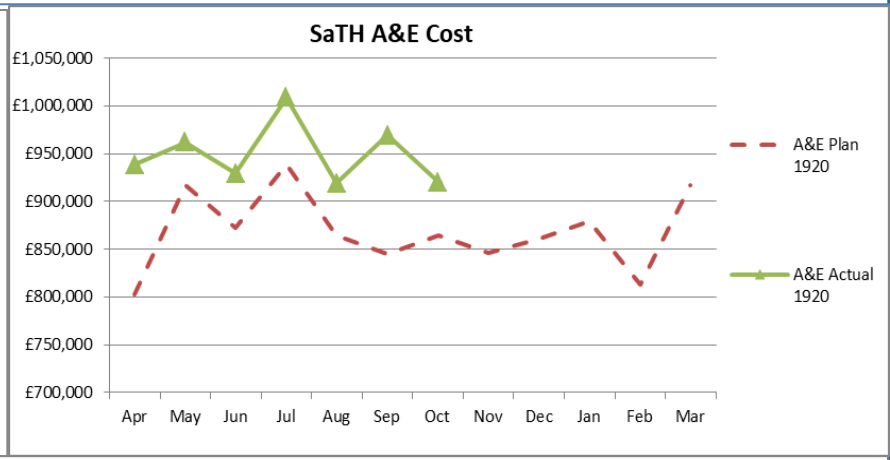


SaTH Daycase Activity

In October activity was 1% below plan and on plan in relation to finance resulting in the YTD position being 2% over for activity and 3% over for finance. The main specialities we have seen over performance are Gastroenterology and Gynaecology.

In relation to the HRG subchapters the main drivers of the over performance are *Eyes and Periorbita Procedures and Disorders*, *Digestive System Endoscopic Procedures* and *Assisted Reproduction Medicine*



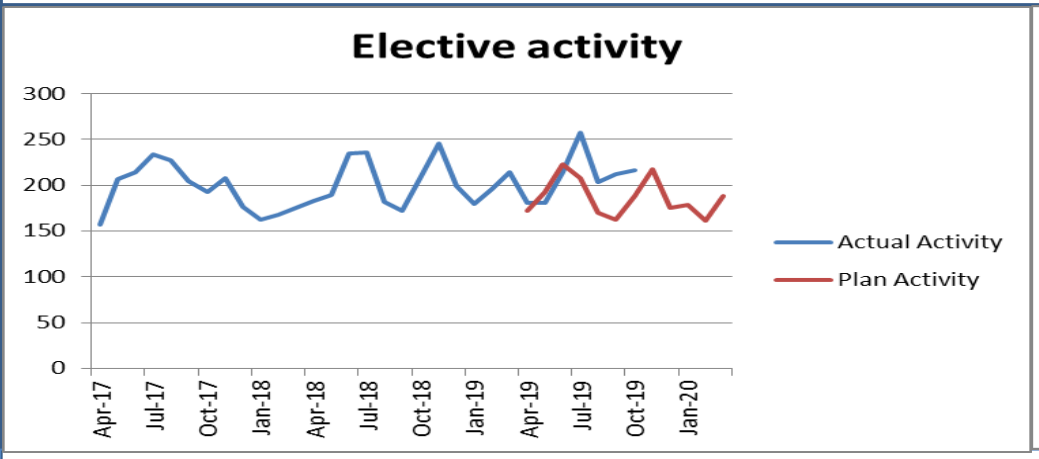


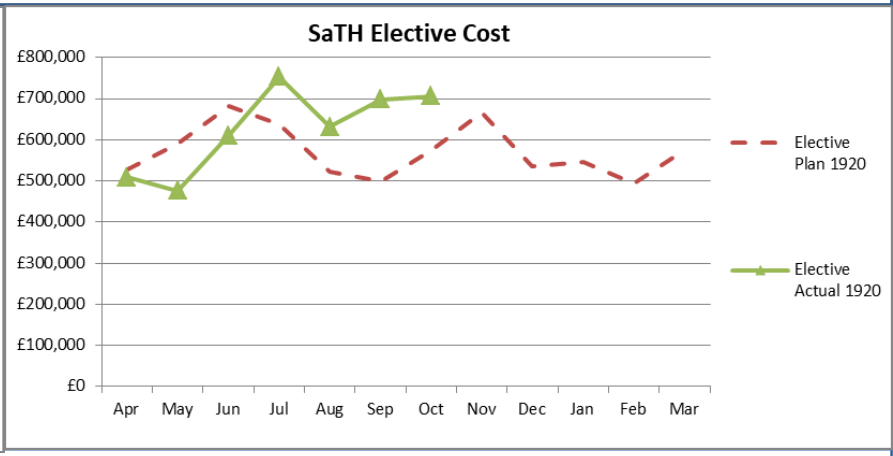
SaTH A&E Activity

In October we have seen over performance in relation to A&E of 5%, this has brought the YTD position to 7% above plan in relation to activity and 9% in relation to finance

A-1a SaTH

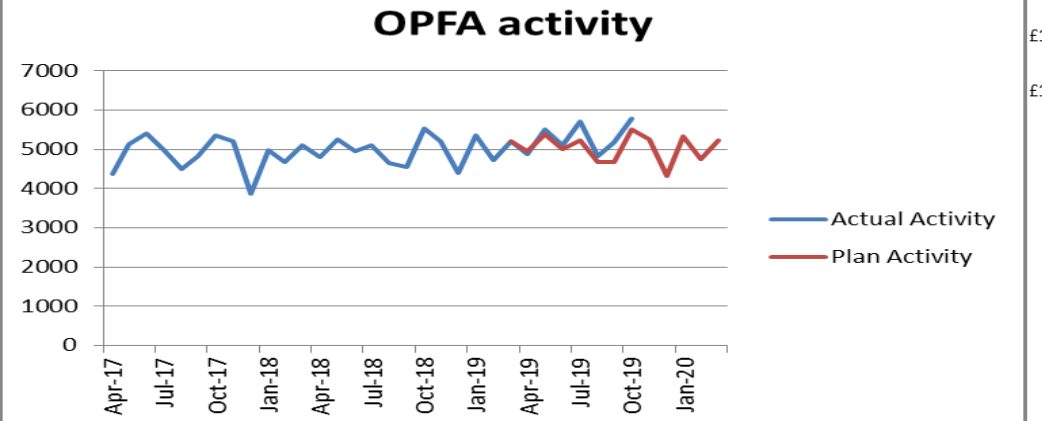
NHS Shropshire Clinical Commissioning Group

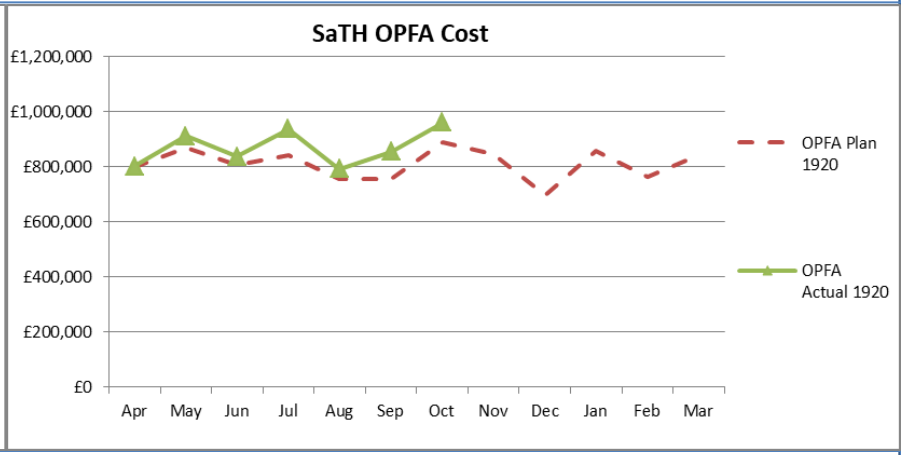




SaTH Elective Activity

In October activity was significantly above plan (16%) bringing the YTD to 11% and finance 6% 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 over performance of 5% in October in terms of activity and 8% in relation to finance bringing the YTD over performance to 4% for activity and 6% 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

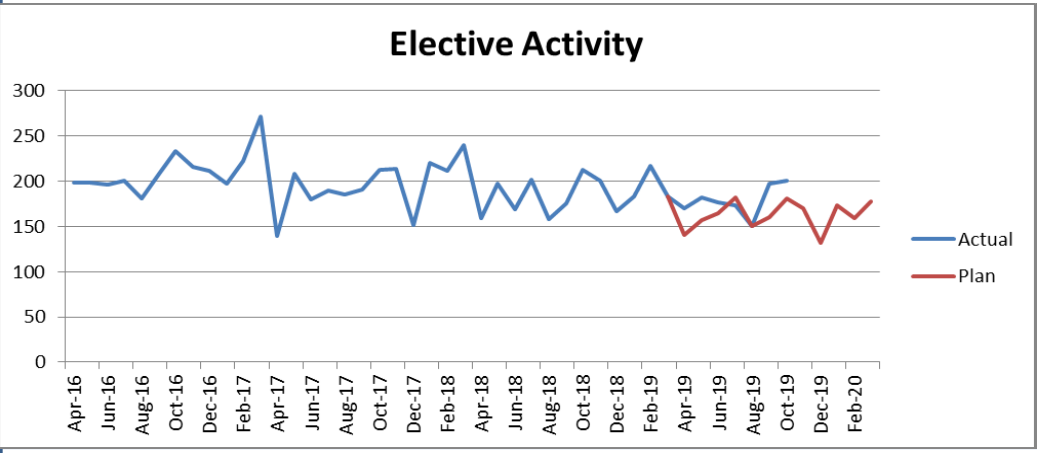
Shropshire CCG Position at Month 8 - Finance (Per Month 7 RJAH Monitoring)

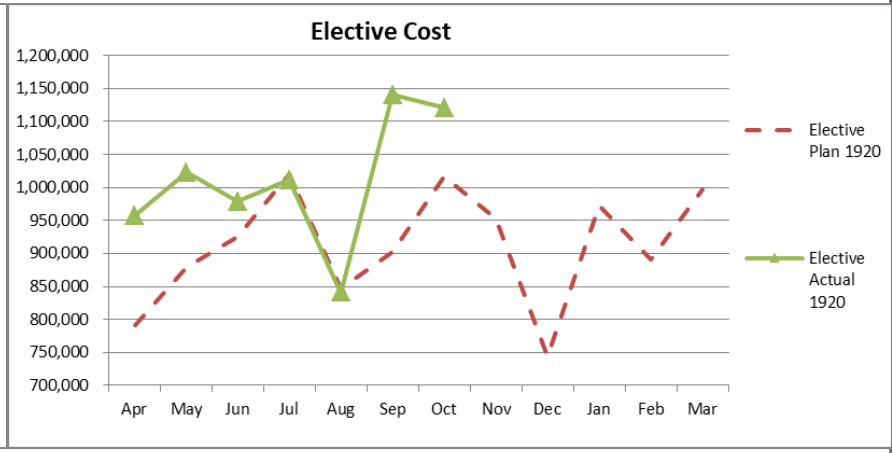
	Ytd Plan v Actual (£)				FOT 2019-20 Plan v Actual (£)			
POD	Ytd Cost Plan £	Ytd Cost Actual £	Ytd Cost Variance £	Cost Variance as % of Total Cost Variance	2019-20 Cost Plan £	2019-20 Cost FOT £	FOT Cost Variance £	FOT percentage Variance above Plan
Day Case	3,453,715	3,458,360	4,645	0.1%	5,149,986	5,156,912	6,926	0.1%
Elective	7,336,218	8,128,020	791,802	10.8%	10,939,355	12,120,045	1,180,691	10.8%
Non Elective Other	713,388	875,454	162,066	22.7%	1,063,764	1,305,428	241,664	22.7%
Regular Admissions	378,610	420,686	42,076	11.1%	564,562	627,303	62,741	11.1%
Outpatient Firsts	1,656,291	1,658,658	2,367	0.1%	2,469,768	2,473,298	3,530	0.1%
Outpatient Follow Ups	2,584,552	2,481,252	(103,300)	(4.0%)	3,853,938	3,699,903	(154,035)	(4.0%)
Outpatient Procedures	773,380	751,505	(21,875)	(2.8%)	1,153,220	1,120,601	(32,619)	(2.8%)
Non PBR Variable	2,828,055	3,113,007	284,952	10.1%	4,228,852	4,506,333	277,481	6.6%
Non PBR Block	1,927,527	1,827,862	(99,665)	(5.2%)	2,874,219	2,874,219	(0)	(0.0%)
CQUIN	251,939	256,795	4,856	1.9%	375,677	382,918	7,241	1.9%
Total	**21,903,674**	**22,971,599**	**1,067,924**	**4.9%**	**32,673,340**	**34,266,959**	**1,593,619**	**4.9%**
Riskshare	0	(432,000)	(432,000)		0	(648,000)	(648,000)	
Challenges	0	(17,620)	(17,620)		0	(17,620)	(17,620)	
Trust OP Recovery	0	0	0		0	0	0	
Commissioner Correction	0	0	0		0	0	0	
Theatre Recovery Plan	0	0	0		0	0	0	
Drug Legacy	0	(8,000)	(8,000)		0	(40,000)	(40,000)	
Non Elective Normalisation	0	0	0		0	0	0	
Q4 Adjustment	0	0	0		0	(170,000)	(170,000)	
Total position	**21,903,674**	**22,513,979**	**610,304**	**2.8%**	**32,673,340**	**33,391,339**	**717,999**	**2.2%**

A-1b RJAH

NHS Shropshire Clinical Commissioning Group

ELECTIVE POD





RJaH Elective Activity

In October we have seen continued over performance in relation to the Elective POD with October being £104k over plan. Year to date activity is 10% above plan and financially we are 11% over plan.

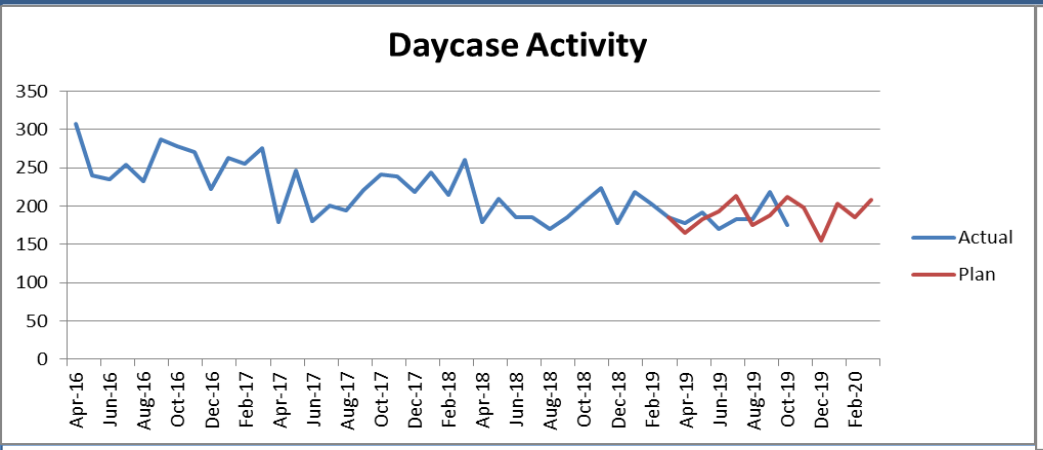
The main drivers of the over performance are Orthopaedic Non- Trauma Procedures however there is also significant over performance in relation to Spinal Procedures. As you can see below, the main driver of the over performance here relates to procedures relating to hips.

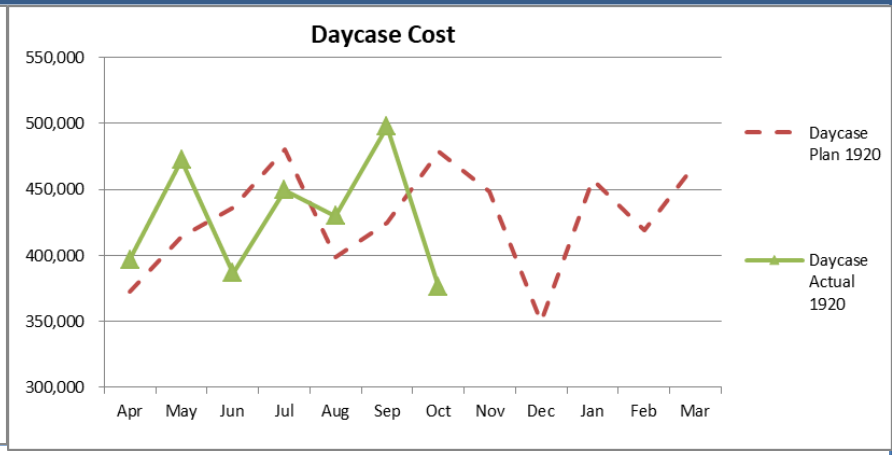
Orthopaedic Non-Trauma Procedures split

Body Part	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance	Variance Last Month
Elbow	12.0	18.0	6.0	56,085	63,580	7,495	12,541
Foot	58.6	76.0	17.4	258,195	324,375	66,180	64,818
Hand	18.9	26.0	7.1	55,855	87,856	32,001	30,406
Hip	273.7	363.0	89.3	1,847,606	2,435,597	587,991	489,574
Knee	360.4	353.0	(7.4)	2,306,287	2,255,631	(50,656)	(46,592)
Shoulder	46.2	42.0	(4.2)	235,503	225,154	(10,349)	3,732
Other	54.7	59.0	4.3	553,306	572,692	19,386	(397)
Grand Total	**824.4**	**937.0**	**112.6**	**5,312,838**	**5,964,885**	**652,047**	**554,082**

A-1b RJAH

NHS Shropshire Clinical Commissioning Group





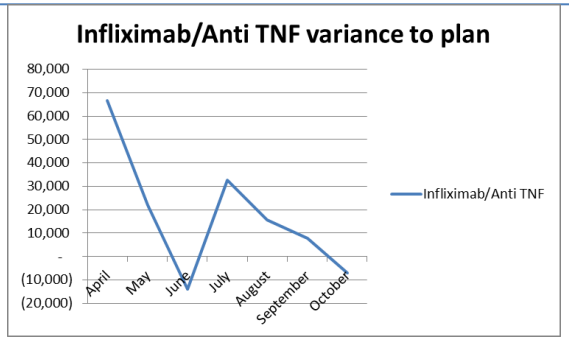
RJaH Daycase Activity

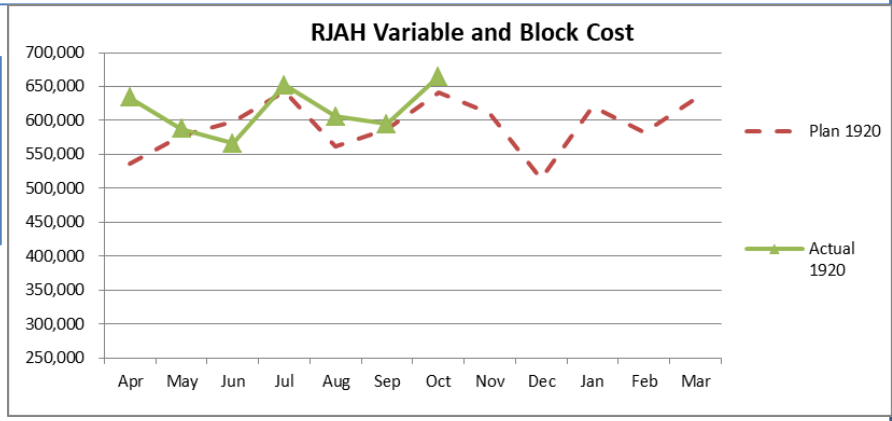
Within the Daycase POD we saw a significant underperformance of £102k within October which was 20% under plan with activity being 17% under plan. YTD activity is broadly on plan for both activity and finance with it being 2% under for activity and £4k over for finance.

The main drivers financially for this over performance are spinal procedures with it being almost 50% over plan (£18k) with Multiple Trauma and Gait Analysis being under plan by £18k combined YTD.

RJaH Others

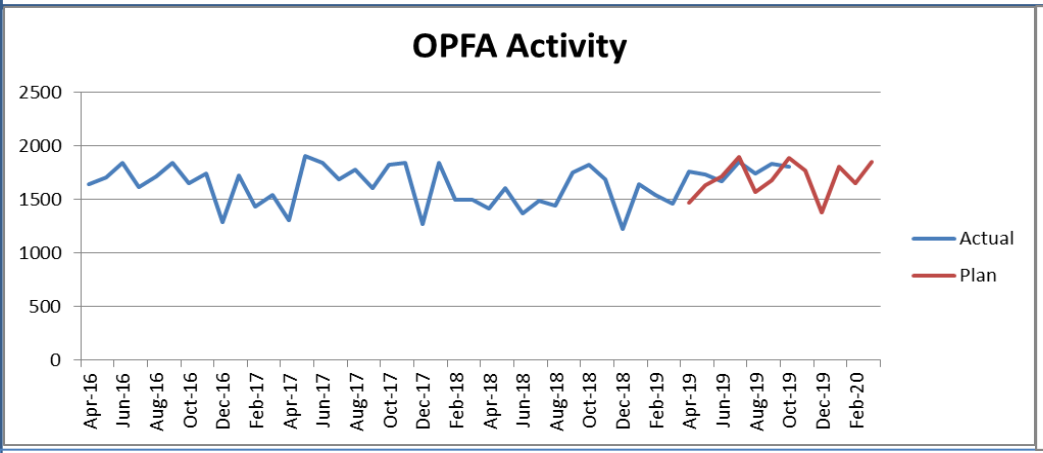
Within the 'other's the main over performance relates to the Inflixamab/Anti TNF drugs. Part of this we believe is a non recurrent hit due to less patients being given the drug in Q4 of 18/19 and receiving in the early part of Q1 19/20, the second is the increase in the number of patients on these drugs.

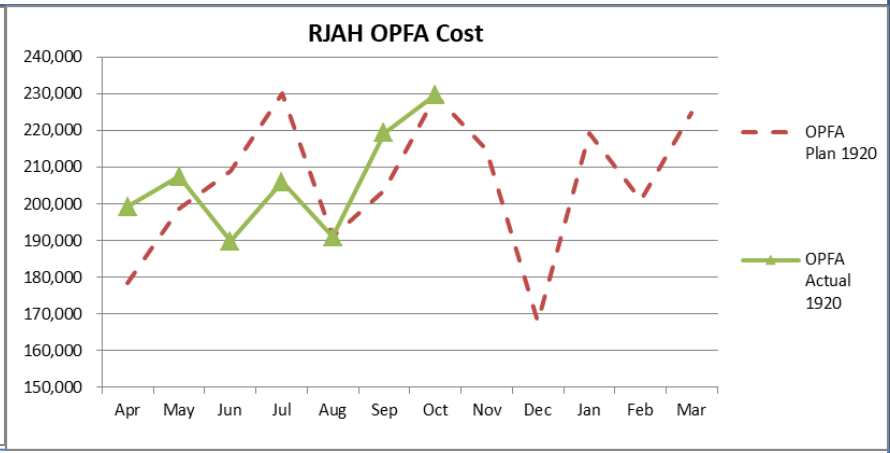




A-1b RJAH

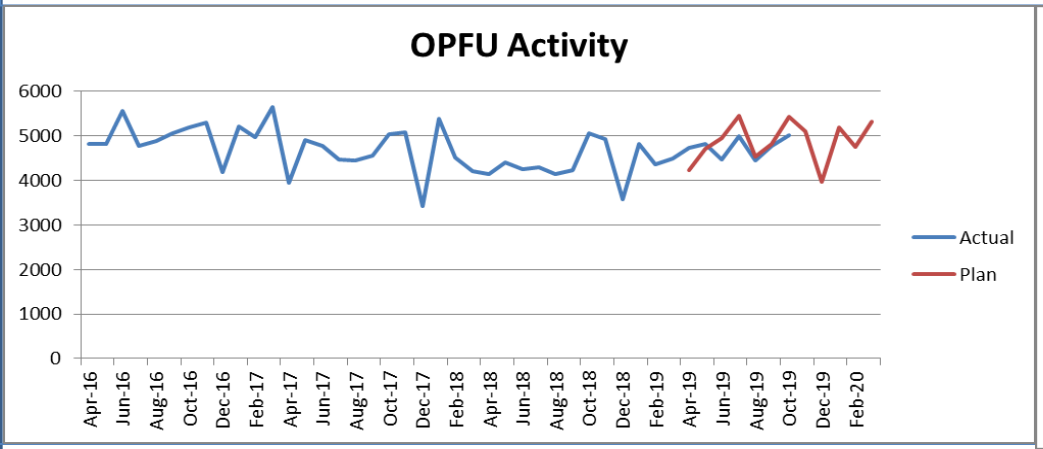
NHS Shropshire Clinical Commissioning Group

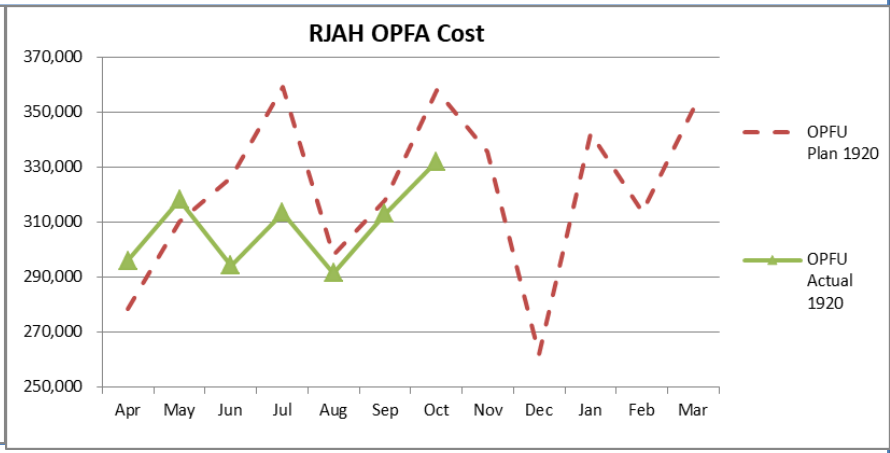




RJaH OPFA Activity

Within the Outpatient First Attendances we are 4% over in terms of activity but only £2k over in terms of finance. The main activity drivers are First Attendances in T&O and Occupational therapy attendances as well as DEXA scans.



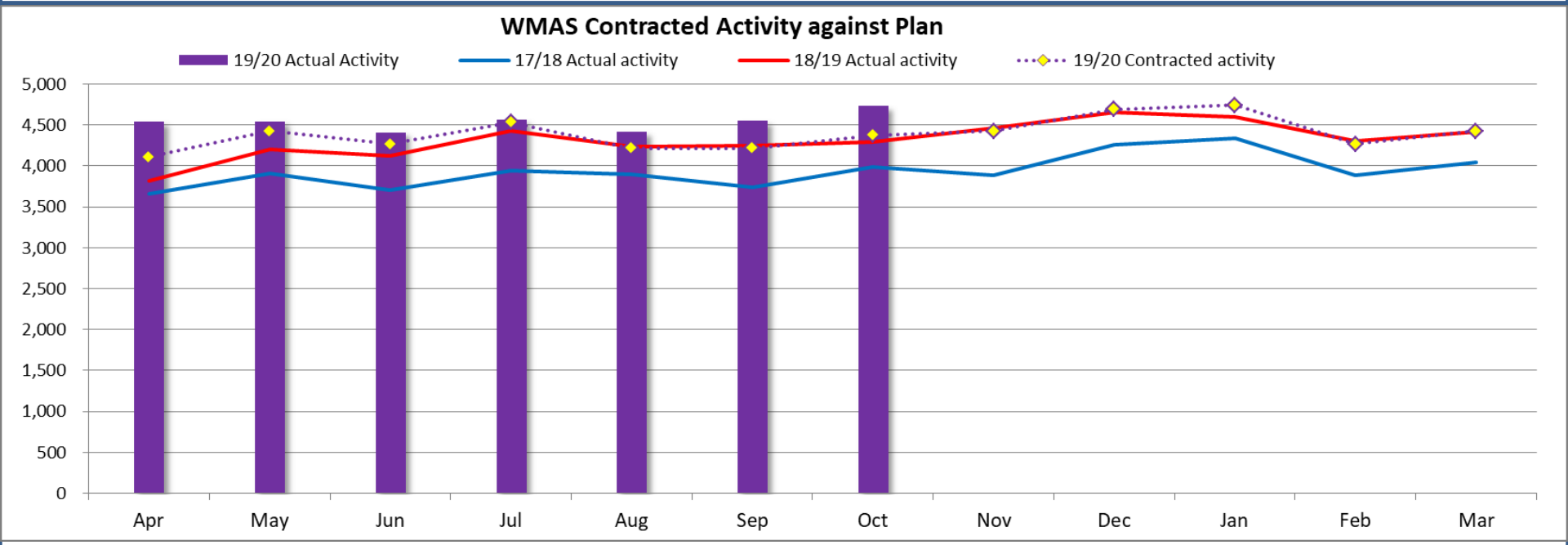


RJaH OPFU Activity

Within the Outpatient Follow Ups we are currently under performing by just under 3% for activity and £90k 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 8 Shropshire

M8		M12	
9,350,339	M8 Plan	14,227,706	M12 Plan
453,077	OP M7 + M8 Exp	805,032	FOT OP
32,163	HandChanges	106,908	HandChanges
13,774	Non Comp	24,403	Non Comp
9,849,353	**M8 Position**	**15,164,049**	**M12 Position**
1,021	Prior Year	1,021	Prior Year
9,850,373	**M8 Position Final**	**15,165,069**	**M12 Position Final**
		14,615,717	Annual Plan
		549,352	**Variance**
		-	**FOT Movement**

Activity in October continues to be high at over 8% over performance for the second successive month. This has therefore brought the over performance YTD to just over 5.5%.

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	27,368	31,394	4,026	9,136	11,163	2,027
Acute NCA's	3,734	4,602	868	1,215	1,445	229
Acute Special Placements	22	22	0	7	4	(3)
Winter Resilience	2,030	2,030	0	678	677	(1)
Future Fit	230	230	0	77	65	(12)
STP	175	190	15	58	58	(0)
Acute services - Other	357	362	5	119	118	(2)
High Cost Drugs	533	533	0	178	178	0
Acute Services Team	586	539	(47)	195	164	(31)
NCA & Others	**35,035**	**39,902**	**4,867**	**11,663**	**13,871**	**2,208**

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

<u>The main drivers in this area are as follows ;</u>

University Hospitals of North Midlands Trust - Forecasting an overspend against contract of £1,052k based on over-performing emergency activity £450k as well as a small number of high cost critical care patients (£208k in excess of plan).

Royal Wolverhampton Trust - Forecasting an overspend against contract of £550k, split between an over-performance in emergency activity £216k and daycase/elective activity £264k.

Wye Valley Trust – Forecasting an overspend against contract of £256k due to over-performance primarily within emergency activity £213k and accident and emergency attendances £75k.

Dudley Group Foundation Trust – Forecasting an overspend against contract of £230k due to emergency activity over-performance and high cost critical care provision in year.

Slippage in the Care Closer to Home (CC2H) QIPP (£2.9m) and VBC/MSK expected savings which should be appearing in the expenditure of the Trusts. (£250k and £231k respectively)

The finance team's 'Balance Sheet review' referred to last month has now been completed with a further improvement to the CCG's financial position of £206k. This confirms the reported prior year non recurrent benefit to be £508k, primarily driven by the finalised 18-19 UHNM position.

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	Net Risk £'000	Risk Adjusted Forecast Variance £'000
Community	49,746	49,718	(28)	32,797	33,150	353		(28)
Mental Health	42,769	45,579	2,810	28,528	30,603	2,075		2,810
Individual Commissioning	35,432	42,876	7,444	23,621	28,356	4,734	30	7,474
Primary Care	63,386	64,580	1,194	41,996	42,500	505		1,194
Total Non Acute Services	**191,333**	**202,753**	**11,420**	**126,941**	**134,609**	**7,668**	**30**	**11,450**

Key Messages

- Non Acute Services position at Month 8 shows a £7,668k YTD overspend and £11,420 forecast overspend, with a risk adjusted forecast of £11,450k. 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 (£2.7m of the £2.8m 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 £160k overspent year to date and £213k forecast overspend, due to non-achievement of QIPP and over performance in MIU activity. The MPFT position is a year to date overspend of £301k and forecast overspend of £452k mainly due to Psychiatric Intensive Care Unit (PICU) over performance.
- Additional costs in Mental Health are shown for the emerging cost pressure in ADHD. This represents £122k of the forecast overspend. This is offset this month by slippage on investment (£111k) and an underspend against Mental Capacity Act assessments (£18k).
- The community section is forecast to underspend by £28k with an adverse movement in the ledger position since last month due to recognising £175k (50%) of the SCHT QIPP slippage, £340k additional costs relating to Hospice at Home and a deterioration in the reported over-performance for Wye Valley Trust of £70k. The underlying forecast position also includes overspends in ophthalmology (£220k), Pain management (£82k) and Dermatology (£126k), less slippage on investment for Care Closer to Home/Other of £1.0m. Actions have been taken to address overspends for the ophthalmology, dermatology and pain management contracts including formal challenges to the providers for activity queries and re-negotiation of local prices.
- 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 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		40,766	213		27,035	27,195	160
Out of Hours	3,150		3,150	0		2,100	2,100	0
Total SCHT	**43,703**		**43,916**	**213**		**29,135**	**29,295**	**160**

The YTD position for the Main Contract is £160k overspent. This relates to contract over-performance and £117k YTD non-achievement of QIPP (50% of target to reflect the Risk share built into contract). The forecast is £213k overspent. Trends in activity will be monitored over the coming months through the Contract Review Meetings (CRMs). APCS Dermatology services have ceased, effective from September .

A summary of the activity performance to October is shown in the table opposite. The year to date and forecast overspend are based on current over-performance for MIU, (estimated £112k above plan at Month 8) – although Outpatient activity is underperforming to partly offset (£71k). Community Equipment and Continence lines are under-performing against both in year plan as well as compared to last year however these are part of the block contract.

QIPP expected under delivery has necessitated a proposal to enact the 50:50 risk share agreement across service lines previously discussed – this has been sent to the provider for consideration and agreement. In the meantime, monthly meetings continue to progress QIPP opportunities for schemes. These include MIU working patterns, Community Equipment and Continence.

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

Summary	M7 Activity Plan	M7 Activity Actual	M7 Variance
Hospital			
Imaging	4,504	4,766	262
Inpatients	1,030	919	(111)
MIU	16,443	17,748	1,305
Outpatients	7,811	6,940	(871)
Community			
Community	212,535	219,513	6,978
Equipment	116,962	88,609	(28,353)

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	30,730	291	20,293	20,487	194
0-25 Emotional Health & Wellbeing	2,874	3,035	161	1,916	2,023	107
Total MPFT	**33,313**	**33,765**	**452**	**22,209**	**22,510**	**301**

The MPFT (Main Contract) forecast overspend of £291k has deteriorated from £250k the previous month and relates to Psychiatric Intensive Care Unit (PICU) over performance. This is offset by an underspend against the Non Contracted Activity budget line of £272k, which includes out of area PICU – however, on the whole, mental health acute costs are on an upward trend and this is being monitored.

The latest monitoring (month 7) for the MPFT Main Contract shows an over performance of £170k, which is £194k extrapolated to month 8. 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 £161k relates to an inflationary dispute (£77k); and a cost pressure of £84k relating to Autism Spectrum Disorder (ASD) waiting times. The recurrent budget proposal for a new ASD model will be fed into next year's budget setting process.

The CCG has sent MPFT a final offer to resolve the inflationary dispute; and is awaiting a response.

Summary	M7 Activity Plan	M7 Activity Actual	M7 Variance
MH PbR Admitted Care	12,752	12,065	(687)
MH PbR Non Admitted Care	758,355	993,274	234,919
MH Non PbR	20,287	17,507	(2,780)
Specialist and Family Care	1,874	1,074	(800)
LD Services	4,502	4,802	300

The activity under the main contract is above plan as at month 7 (October). The over performance against PbR Non Admitted Care is mainly due to dementia activity which is being addressed through the Dementia Tariff Subgroup. A new approach has been agreed with the trust whereby stable care home patients will be offered needs led reviews rather than routine 6 monthly; which means the trust has commenced 'discharging' patients and they will have fast track access if required. This approach fits in the new pathway and makes sense for cost effective working; and will be fed into the next year's activity planning.

A-2c Individual Commissioning

NHS Shropshire Clinical Commissioning Group

At Month 8 the position across both core IC and Mental Health shows a YTD overspend of £6.74m and a forecast overspend of £10.18m. The forecast includes an assumption to over deliver against the QIPP target by £250K and a further potential mitigation to stretch it by another £250k.

Cost centre	Cost Centre Description	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Forecast Outturn	Forecast Variance
368522	Learning Difficulties S117	£506,924	£337,949	£665,729	£327,780	£862,475	£355,551
368541	Mental Health Collaborative Commissioning	£825,350	£550,234	£338,032	£(212,201)	£458,041	£(367,310)
368557	Mental Health S117	£5,092,738	£3,395,159	£4,961,417	£1,566,259	£7,267,177	£2,174,439
368561	Mental Health Specialist Services	£170,323	£113,548	£450,187	£336,639	£757,768	£587,445
	Mental Health	**£6,595,335**	**£4,396,890**	**£6,415,366**	**£2,018,476**	**£9,345,460**	**£2,750,125**
368682	IC Adult Fully Funded	£17,531,784	£11,687,856	£15,146,788	£3,458,932	£22,423,362	£4,891,578
368683	IC Adult Fully Funded PHB	£1,437,207	£958,138	£1,208,250	£250,112	£1,844,599	£407,392
368684	Adult Joint Funded	£5,116,873	£3,411,249	£4,122,312	£711,063	£6,850,869	£1,733,996
368685	Adult Joint Funded PHB	£0	£0	£46,885	£46,885	£70,200	£70,200
368687	Children's Joint Funded	£2,072,441	£1,381,628	£1,741,991	£360,364	£2,780,562	£708,121
368688	Children's Joint Funded PHB	£201,402	£134,268	£288,403	£154,136	£470,252	£268,851
368691	FNC	£7,939,684	£5,293,122	£4,952,297	£(340,825)	£7,262,271	£(677,413)
368796	Reablement	£556,951	£371,300	£456,907	£85,607	£584,191	£27,240
	Other CHC	**£34,856,341**	**£23,237,561**	**£27,963,833**	**£4,726,272**	**£42,286,307**	**£7,429,965**
	Grand Total	**£41,451,676**	**£27,634,451**	**£34,379,200**	**£6,744,749**	**£51,631,767**	**£10,180,090**

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 £0.8M since last month. The forecast overspend has deteriorated by £1.3m but this is offset by over achievement in QIPP of £250k in the forecast and a further potential QIPP mitigation of £250k. The main drivers of the increase in reported over spend include:

1. The IC Team are experiencing serious capacity issues in terms of Clinical Staff in post. This has led to a deterioration in the number of clinical reviews that are able to be performed which has in turn led to a backlog of costs included in Broadcare within the month of November. In addition, there is now a list of outstanding ratifications that are not currently included within Broadcare again due to capacity issues within the team. Issues here have resulted in an increase in forecast of £401K.
2. We have received a new schedule of intended recharges from Shropshire Council relating to Adult Joint Funded patients. We are showing an increased forecast within Broadcare of £354K for the year and having reconciled the intended recharges on the schedule to the associated values held within Broadcare, it can be seen that the overall difference is circa £20K for the year. This means that whilst the costs included on the Council schedule have increased, these increases have been accounted for within Broadcare. Whilst in total we are very close, it should however be pointed out that the detail has not been formally discussed or agreed and the very act of having these discussions may change the total recharges upwards or downwards.
3. The IC team have worked through a schedule of prior year Adult Joint Funded patients and concluded that certain requests included on this schedule are indeed payable. As a result, we have had to increase the forecast in month 8 by £244K to accommodate these costs .
4. There have been £58K of new retrospective payments included on the risk report in month 8 which have increased the forecast by this amount.

It is important to also note that:

a) The over spend above assumes that the IC team will over perform against their budgeted QIPP target of £2.78M for the year by £250K. In agreement with the Director of Nursing the QIPP risk has been removed this month and instead a further £250k potential mitigation/stretch to the target has been included in the risk adjusted position.

b) Urgent action is underway to review all cases and address problems that have emerged with backlog. However without the provision of further clinical staffing support, this task remains a major problem which could escalate further if activity increases over the winter period. 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.

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 £0.6m higher than allocation due to the underspend projected of £867k. At Month 8, the YTD underspend was made up of an overspend on Dispensing of £167k,and an increase in GMS costs linked to list size recalculation as at Sep19,which were offset by underspends in Premises £275k (£209K Rates rebate) Enhanced services £148k linked to Minor Surgery / Learning Dis Health Checks, Other GP services of £109k linked to P/Y Locum savings, plus APMS savings re Practice closure.
The forecast position reflects YTD savings, plus a £405k underspend on the GMS line relating to the release of currently uncommitted funds, an additional £152k Rates rebate due before the end of 19/20 and also cost/savings relating to the closure of the Whitehall practice in Sept19.

Prescribing

The latest data available relates to M6 and reflects the current National Prescribing system forecast. The position has improved by £129k 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.
There has also been a benefit in month due to FP10 realignment of costs between CCGs to reflect validated data.

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	M8 YTD Budget	M8 YTD Actual	M8 YTD Variance	Forecast Outturn	Forecast Variance	Net Risk	Risk Adjusted Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
General Practice - GMS	29,237	28,692	19,128	19,262	134	29,041	(196)		(196)
General Practice - PMS	375	375	250	250	0	375	0		0
General Practice - APMS	1,216	1,216	811	754	(57)	1,060	(156)		(156)
Enhanced Services	1,782	2,368	1,434	1,286	(148)	1,633	(149)		(149)
QOF	4,439	4,439	2,071	2,087	16	4,440	1		1
Premises cost reimbursements	5,420	5,420	3,789	3,514	(275)	4,911	(509)		(509)
Dispensing	2,508	2,508	1,574	1,741	167	2,762	254		254
Other - GP Services	1,071	1,071	724	615	(109)	959	(112)		(112)
Net Reserves	56	15	10	0	(10)	56	0		0
Co Commissioning Total	**46,104**	**46,104**	**29,791**	**29,509**	**(282)**	**45,237**	**(867)**		**(867)**
Other Primary Care Commissioning									
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Prescribing	49,603	48,824	32,609	33,249	640	50,108	1,284		1,284
Out Of Hours	3,150	3,150	2,100	2,101	0	3,150	0		0
Enhanced Services	2,696	5,620	3,477	3,477	0	5,570	(50)		(50)
									0
Primary Care Other									
- Central Drugs	1,257	1,257	838	899	61	1,349	92		92
- Oxygen	605	605	403	407	4	574	(31)		(31)
- Primary Care Comm Schemes	1,414	54	36	36	0	54	0		0
- Hospice Drugs	75	75	50	58	8	85	10		10
- Prescribing Incentives	315	315	210	167	(43)	272	(43)		(43)
- Care Home Advanced Scheme	230	230	153	135	(18)	200	(30)		(30)
- Primary Care Team	1,935	2,021	1,344	1,196	(148)	1,846	(175)		(175)
- Primary Care IT	978	1,235	775	775	0	1,372	137		137
- Primary Care Reserves	242	0	0	0	0	0	0		0
Primary Care Other Total	**7,051**	**5,792**	**3,809**	**3,673**	**(136)**	**5,752**	**(40)**		**(40)**
Total Other Primary Care Commiss	**62,500**	**63,386**	**41,995**	**42,500**	**504**	**64,580**	**1,194**	**0**	**1,194**
GRAND TOTAL	**108,604**	**109,490**	**71,786**	**72,009**	**222**	**109,817**	**327**	**0**	**327**

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	Net Risk £'000	Risk Adjusted Forecast Variance £'000
Patient Transport	3,301	3,184	(117)	2,201	2,008	(193)		(117)
NHS 111	1,173	1,241	68	768	771	3		68
Referral Assessment Service Team	423	386	(37)	282	254	(28)		(37)
Community & Care Co-ordinators	370	370	0	246	246	0		0
NHS Property Services	225	225	0	150	150	0		0
Better Care Fund	7,779	7,779	0	5,186	5,186	0		0
Reablement	557	584	27	371	457	86		27
Other	211	158	(53)	140	87	(53)		(53)
Commissioning Reserve	3,089	(19,543)	(22,632)	1,492	0	(1,492)	20,808	(1,824)
0.5% Contingency	2,104	0	(2,104)	0	0	0		(2,104)
Other Total	**19,232**	**(5,616)**	**(24,848)**	**10,837**	**9,160**	**(1,677)**	**20,808**	**(4,040)**

Key Messages

- The overall position on 'other' is a £1.7m underspend year to date and a forecast underspend of £24.8m. This underspend position is due to the release of the £2.1m contingency reserve in Month 12 and **around £20.8m further management action** that would be required to bring the position back to plan, (reflected in the commissioning reserve line). This is currently flagged in its entirety as at high risk and included in the financial risk assessment.
- 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.
- Reablement is forecast to overspend due to two patients with complex care packages which were not known at the time of setting the budget. One is a new patient and the other is an existing patient whose care package has become more complex.

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 8 running costs are underspent Year to Date by £142k due to non recurrent Pay and Non-pay savings.
- The forecast position is underspent by £42k which is less than the Year to Date underspend due to 'Single Organisation' costs factored into later months. This position includes savings due to the freezing of some vacancies and a reduction in non-discretionary spend as a result of the implementation of the recent 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 £'000	Risk Adjusted Forecast Variance £'000
Corporate Costs	3,692	3,717	25	2,461	2,357	(104)		25
Service Planning	767	832	65	511	562	51		65
Commissioning & Contracting	777	610	(167)	518	419	(99)		(167)
Strategy & Service Redesign	395	372	(23)	264	248	(15)		(23)
Finance	762	682	(80)	508	440	(68)		(80)
Governance	200	193	(7)	134	130	(4)		(7)
Nursing & Quality	149	162	13	99	109	9		13
Corporate Reserves	93	225	132	(32)	0	32		132
Running Costs QIPP	(225)	(225)	0	(56)	0	56		0
Running Cost Total	**6,610**	**6,568**	**(42)**	**4,406**	**4,264**	**(142)**	**0**	**(42)**

Cost of Agency/Interim Staff	Forecast Outturn £'000	%	Actual Year to Date £'000	%
Programme Costs	610	67%	478	70%
Running Costs	295	33%	210	31%
Total	905		687	

There are 9 interim staff in post as at month 8, a reduction of 2 compared to month 7. The forecast outturn assumes this will reduce to 5 from 01.01.20: 2 re STP, 2 re Commissioning and 1 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	790,552	790,552	-	1,185,828	-
Total Prevention Programme	**1,185,828**	**790,552**	**790,552**	**-**	**1,185,828**	-
Admissions Avoidance						
Assistive Technologies	1,613,090	1,075,393	1,075,393	-	1,613,090	-
Care Navigation / Co Ordination	649,175	432,783	432,783	-	649,175	-
Enablers for Intergration	3,666,234	2,444,156	2,444,156	-	3,666,234	-
Healthcare services to Care Homess	230,000	153,333.33	153,333	-	230,000	-
Intermediate Care Services	3,171,187	2,114,124.67	2,100,481	- 13,644	3,171,187	-
Personailised Healthcare at Home	331,501	221,001	221,001	-	331,501	-
Total Admissions Avoidance	**9,661,187**	**6,440,791**	**6,427,148**	**- 13,644**	**9,661,187**	-
Early Supportive Discharge						
Integrated Care Plannning	2,992,005	1,994,670	1,994,670	-	2,992,005	-
Total Early Supportive Discharge	**2,992,005**	**1,994,670**	**1,994,670**	**-**	**2,992,005**	-
Other						
SCCG funded LA expenditure	7,779,300	5,186,200	5,186,200	-	7,779,300	-
LA Funding expenditure	9,235,247	6,156,831	6,156,831	-	9,235,247	-
i BCF	10,120,779	6,747,186	6,747,186	-	10,120,779	-
Total Early Supportive Discharge	**27,135,326**	**18,090,217**	**18,090,217**	**-**	**27,135,326**	**-**
Grand Total:	**40,974,346**	**27,316,231**	**27,302,587**	**(13,644)**	**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

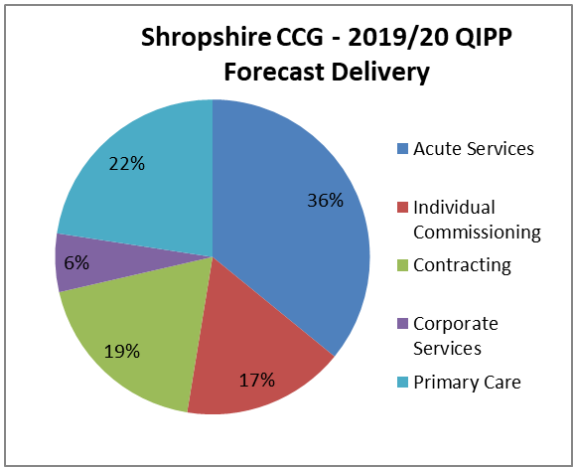
	2019/20 Plan			Month 8 YTD				Forecast					
QIPP Position M8	**Gross**	**Investment**	**Net**	**Plan**	**Actual**	**Variance**		**Forecast**	**Variance from Plan**	**%Variance from Plan**	**Risk**	**Mitigation**	**Adjusted Net Risk**
Category of Spend	£000's	£000's	£000's	£000's	£000's	£000's	% Achieved	£000's	£000's	%			
Acute Services	10,959	1,773	9,186	5,584	2,316	-3,268	41%	4,814	-4,372	52%	740		4,074
Individual Commissioning	2,871	87	2,784	1,734	2,085	351	120%	3,034	250	109%	0	250	3,284
Contracting	3,138	0	3,138	2,092	2,092	0	100%	3,138	0	100%	0		3,138
Corporate Services	1,000	0	1,000	665	187	-478	28%	1,042	42	104%	0		1,042
Primary Care	4,397	691	3,706	2,413	3,025	612	125%	4,229	523	114%	0		4,229
Total	**22,365**	**2,550**	**19,815**	**12,488**	**9,704**	**-2,783**	**78%**	**16,258**	**-3,557**	**82%**	**740**	**250**	**15,768**

The information above details the 2019/20 QIPP Plan and position as at Month 8. The CCG is forecasting to deliver £16.3m of QIPP against a target of £19.8m

Key messages

- QIPP is forecast to deliver **£16.3m** by the end of the year which is -**£3.5m** below plan
- This carries a further **£0.7m** of risk with **£0.25k** mitigation bringing a total net risk position of **£15.8m**
- The reduction in forecast from last month is mainly due to MSK, Heart Failure and SCHT. There has been an increase in forecast for Meds Management and CHC.
- It is essential that the CCG continue to generate and develop additional cost savings
- 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

It is essential that the CCG continues to generate and develop additional cost saving initiatives across the organisation as well as focusing on joint opportunities with Telford CCG and those opportunities at a system wide level.



A- 7 Allocations

NHS Shropshire Clinical Commissioning Group

The CCG allocations at Month 8 are shown below:

	Recurrent £000	Non Recurrent £000	Total £000
Cummulative Allocations up to Month 7	466,656	5,390	472,046
Month 8 allocation adjustments:			
Transfer of TCP funds to Telford CCG		(1,080)	(1,080)
Transfer of Early Discharge funds to Telford CCG		(32)	(32)
Cancer Alliance Q3		120	120
Charge Exempt Overseas Visitor (CEOV) Adjustments		871	871
UEC FUNDING		194	194
Winter Funding		773	773
Total In-Year Resources 2019/20	466,656	6,236	472,892
Return of Cumulative Deficit		(76,726)	(76,726)
Total Cumulative Resources 2019/20	466,656	(70,490)	396,166

Appendix B 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 8.

	OCT-19	NOV-19	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	82,208	16,733	(65,475)
Accounts Receivable	1,940,917	2,425,583	484,666
Inventory	0	0	0
Investments	0	0	0
Other Current Assets	2,023,126	2,442,316	419,190
Current Assets	2,023,126	2,442,316	419,190
TOTAL ASSETS	2,023,126	2,442,316	419,190
Accounts Payable	41,468,016	43,959,475	2,491,459
Accrued Liabilities	200,000	228,473	28,473
Short Term Borrowing	0	0	0
Current Liabilities	41,668,016	44,187,948	2,519,932
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	(39,644,890)	(41,745,632)	(2,100,742)
Total Taxpayers Equity	(39,644,890)	(41,745,632)	(2,100,742)
TOTAL EQUITY + LIABILITIES	2,023,126	2,442,316	419,190

Appendix B-1
Shropshire CCG
2019/20 Financial Summary Position as at Month 8

	2019/20			2019/20			2019/20	
	Recurrent Budget	Non Recurrent Budget	Annual Budget	Budget Year to Date - month 8	Actual Year to Date - month 8	Variance Year to Date - month 8	Forecast Outturn	Outturn Variance
	£000	£000	£000	£000	£000	£000	£000	£000
RESOURCES								
Programme Allocation	415,476	6,236	421,712	279,740	279,740	0	421,712	0
Deficit Brought Forward		(76,726)	(76,726)	(51,151)	(51,151)	0	(76,726)	0
Co-Commissioning Allocation	44,570		44,570	28,615	28,615	0	44,570	0
Running Costs Allocation	6,610		6,610	4,407	4,407	0	6,610	0
Total resource limit	**466,656**	**(70,490)**	**396,166**	**261,611**	**261,611**	**0**	**396,166**	**0**
EXPENDITURE								
Acute Services								
Shrewsbury and Telford Hospitals NHS Trust	149,892		149,892	99,681	105,011	5,330	158,318	8,426
Robert Jones and Agnes Hunt FT	32,673		32,673	21,904	22,514	610	33,391	718
West Midlands Ambulance Service Contract	14,616		14,616	9,609	9,850	241	15,165	549
Other Acute Contracts	27,368	433	27,801	19,726	21,755	2,028	31,779	3,978
Acute NCA's	3,741		3,741	2,578	2,800	222	4,502	761
Acute Special Placements	22		22	15	11	(3)	22	0
Winter Resilience	2,030		2,030	1,368	1,368	0	1,897	(133)
Future Fit	230		230	153	129	(24)	187	(43)
STP	175		175	117	117	(0)	398	223
Acute services - Other	168		168	127	127	0	168	0
High Cost Drugs	533		533	355	311	(44)	473	(60)
Acute Services Team	586		586	391	323	(68)	504	(82)
Acute Reserves	0		0	0	0	0	0	0
Acute Services Total	**232,034**	**433**	**232,467**	**156,023**	**164,315**	**8,292**	**246,804**	**14,337**
Community Health Services								
Shropshire Community Trust	40,553		40,553	27,035	27,195	160	40,766	213
Other Community Services	6,687	194	6,881	4,220	4,441	221	6,680	(201)
Palliative Care	2,312		2,312	1,541	1,514	(27)	2,272	(40)
Care closer to home reserve	0		0	0	0	0	0	0
Community Health Services Total	**49,552**	**194**	**49,746**	**32,797**	**33,150**	**353**	**49,718**	**(28)**
Individual Commissioning								
Complex Care	26,360	0	26,360	17,573	22,555	4,982	34,440	8,080
Funded Nursing Care	7,939	0	7,939	5,293	4,952	(341)	7,262	(677)
Complex Care Team	1,133	0	1,133	755	849	93	1,174	41
Continuing Care Reserves	0	0	0	0	0	0	0	0
Individual Commissioning Total	**35,432**	**0**	**35,432**	**23,621**	**28,356**	**4,734**	**42,876**	**7,444**
Mental Health Services								
Midland Partnership FT	33,314	0	33,314	22,209	22,511	302	33,766	452
Other NHS Mental Health Contracts	(392)	0	(392)	(261)	(455)	(194)	(503)	(111)
Mental Health NCA's	1,253	0	1,253	835	654	(181)	981	(272)
Mental Health - Other	1,727	218	1,945	1,312	1,478	166	1,934	(11)
Mental Health - TCP	54	0	54	36	0	(36)	55	1
S117 Placements	6,595	0	6,595	4,397	6,415	2,018	9,346	2,751
Mental Health Reserves	0	0	0	0	0	0	0	0
Mental Health Services Total	**42,551**	**218**	**42,769**	**28,528**	**30,603**	**2,075**	**45,579**	**2,810**
Primary Care Services								
Prescribing	48,824	0	48,824	32,609	33,250	640	50,108	1,284
Central Drugs	1,257	0	1,257	838	899	61	1,349	92
Oxygen	605	0	605	403	407	4	574	(31)
Enhanced Services	2,728	2,892	5,620	3,477	3,477	0	5,570	(50)
Out Of Hours	3,150	0	3,150	2,100	2,100	0	3,150	0
Primary Care Commissioning Schemes (Dermatology)	54	0	54	36	36	0	54	0
Hospice Drugs	75	0	75	50	58	8	85	10
Prescribing Incentives	315	0	315	210	167	(43)	272	(43)
Care Home Advanced Scheme	230	0	230	153	135	(18)	200	(30)
Primary Care Team	2,021	0	2,021	1,344	1,196	(148)	1,846	(175)
Primary Care IT	1,157	78	1,235	775	775	0	1,372	137
Primary Care Reserves	0	0	0	0	0	0	0	0
Primary Care Services Total	**60,416**	**2,970**	**63,386**	**41,996**	**42,500**	**505**	**64,580**	**1,194**
Other								
Patient Transport	3,301	0	3,301	2,201	2,008	(193)	3,184	(117)
NHS 111	1,173	0	1,173	768	771	3	1,241	68
Referral Assessment Service Team	423	0	423	282	254	(28)	386	(37)
Community & Care Co-ordinators	370	0	370	246	246	0	370	0
NHS Property Services	225	0	225	150	150	0	225	0
Better Care Fund	7,779	0	7,779	5,186	5,186	0	7,779	0
Reablement	557	0	557	371	457	86	584	27
Other	211	0	211	140	87	(53)	158	(53)
Other Total	**14,039**	**0**	**14,039**	**9,345**	**9,160**	**(185)**	**13,927**	**(112)**
Reserves								
Commissioning Reserve	668	2,421	3,089	1,492	0	(1,492)	(19,543)	(22,632)
0.5% Contingency	2,104	0	2,104	0	0	0	0	(2,104)
Reserves Total	**2,772**	**2,421**	**5,193**	**1,492**	**0**	**(1,492)**	**(19,543)**	**(24,736)**
Running Costs								
Corporate Costs	3,692	0	3,692	2,461	2,357	(104)	3,717	25
Service Planning	767	0	767	511	562	51	832	65
Commissioning & Contracting	777	0	777	518	419	(99)	610	(167)
Strategy & Service Redesign	395	0	395	264	248	(15)	372	(23)
Finance	762	0	762	508	440	(68)	682	(80)
Governance	200	0	200	134	130	(4)	193	(7)
Nursing & Quality	149	0	149	99	109	9	162	13
Corporate Reserves	(132)	0	(132)	(88)	0	88	0	132
Running Cost Total	**6,610**	**0**	**6,610**	**4,406**	**4,264**	**(142)**	**6,568**	**(42)**
#REF!	45,873	0	45,873	29,637	29,509	(128)	45,222	(651)
#REF!	231	0	231	154	0	(154)	15	(216)
Co Commissioning Total	**46,104**	**0**	**46,104**	**29,791**	**29,509**	**(282)**	**45,237**	**(867)**
Total Expenditure	**489,510**	**6,236**	**495,746**	**327,998**	**341,857**	**13,859**	**495,746**	**0**
Budget (Surplus)/Deficit	**22,854**	**76,726**	**99,580**	**66,387**	**80,246**	**13,859**	**99,580**	**0**

Total Resource Limit	**466,656**	**(70,490)**	**396,166**	**261,611**	**261,611**	**0**	**396,166**	**0**
Total Expenditure	**489,510**	**6,236**	**495,746**	**327,998**	**341,857**	**13,859**	**495,746**	**0**
Budget (Surplus)/Deficit	**22,854**	**76,726**	**99,580**	**66,387**	**80,246**	**13,859**	**99,580**	**0**
Deficit Brought Forward			(76,726)	(51,151)	(51,151)		(76,726)	0
In Year (Surplus)/Deficit			**22,854**	**15,236**	**29,095**	**13,859**	**22,854**	**0**

Appendix B-2
Shropshire CCG
2019/20 QIPP Month 8

QIPP Month 8 Position

		Plan			Month 8 YTD			Forecast M8		Risk			M7 Forecast	
Budget Area	QIPP Scheme	Gross Savings	Investment	Net Savings	M8 YTD Plan	M8 YTD Actual	M8 Variance	Forecast Delivery M8	Variance from Plan M8	Risk	Mitigation	Risk Adjusted Position	Forecast Delivery M7	Risk
Acute Services	Additional VBC	250	0	250	167	415	248	415	165			415	415	
	Autism and Aspergers Provision	20	0	20	0	0	0	20	0			20	20	
	Category 1 PLCV Activity	35	0	35	23	33	9	41	6			41	39	
	COPD Admissions	656	0	656	364	0	-364	285	-371	200		85	285	
	Dermatology Commissioning Options	42	0	42	28	28	0	42	0			42	42	
	Ex-Tel (Investment)		133	-133	-74	0	74	0	133			0	0	
	Ex-Tel (SaTH)	764	0	764	424	0	-424	0	-764			0	0	
	Fracture Liasion Service	115	220	-105	-70	-25	45	-58	47			-58	-58	
	Frailty front door	420	420	0	0	0	0	0	0			0	0	
	Heart Failure	374	0	374	208	0	-208	128	-247			128	374	200
	HISU	120	0	120	67	40	-27	120	0	40		80	120	40
	Home Oxygen Assessment and Review Service	51	0	51	29	13	-16	40	-11			40	52	
	MSK Service Redesign EL other	232	0	232	155	77	-77	155	-77			155	155	
	MSK Service Redesign DC Other	44	0	44	29	15	-15	29	-15			29	29	
	MSK Service Redesign DC RJAH	305	0	305	203	25	-178	25	-279			25	25	
	MSK Service Redesign DC SaTH	94	0	94	62	47	-16	47	-47			47	47	
	MSK Service Redesign EL RJAH	2,043	0	2,043	1,362	809	-553	1,148	-894			1,148	1,679	
	MSK Service Redesign EL SaTH	255	0	255	170	110	-60	70	-185			70	70	
	MSK Service Redesign OPFA RJAH	98	0	98	65	0	-65	0	-98			0	0	
	MSK Service Redesign OPFU RJAH	22	0	22	15	57	42	70	48			70	70	
	RTT Relaxed Target	770	0	770	512	513	1	770	0			770	770	
	SCHT (Contract 1) inc APCS	350	0	350	233	35	-198	175	-175			175	350	175
	Shropshire Care Closer to Home (Admissions Avoidance)	2,900	0	2,900	1,611	0	-1,611	500	-2,400	250		250	667	500
	Shropshire Care Closer to Home (Demonstrator Sites)	1,000	0	1,000	556	124	-432	706	-294	250		456	706	500
	Shropshire Care Closer to Home (Investment)	0	1,000	-1,000	-556	-20	536	-27	973			-27	-27	
	Commissioning Stretch	0	0	0	0	0	0	0	0			0	0	
	Home Oxygen Service (National)	0	0	0			0	47	47			47	47	
	Big 6 Paediatrics	0	0	0	0	0	0	6	6			6	6	
	Dermatolgoy APCS	0	0	0		20	20	61	61			61	61	
	Total	10,959	1,773	9,186	5,584	2,316	-3,268	4,814	-4,372	740	0	4,074	5,943	1,415
Individual Commissioning	CHC AQP	329	0	329	197	0	-197	0	-329			0	0	
	CHC Stretch Target	1,000		1,000	600	0	-600	23	-977			23	23	
	Childrens Placements	500	0	500	300	205	-95	500	0			500	500	250
	Collaborative Commissioning	300	0	300	200	0	-200	0	-300		250	0	0	
	Review Programme	452	0	452	301	1,356	1,055	1,645	1,193			1,895	1,395	
	Mental Health Out of Area (Commissioning / Cygnet)	290	87	203	135	524	388	866	663			866	866	
		2,871	87	2,784	1,734	2,085	351	3,034	250	0	250	3,284	2,784	250
Contracting Services	Mental Health Rebasing of the Contract	600	0	600	400	400	0	600	0			600	600	
	DOH Service	757	0	757	505	505	0	757	0			757	757	
	RJAH Contract	852	0	852	568	568	0	852	0			852	852	
	SaTH Contract	623	0	623	415	415	0	623	0			623	623	
	SCHT (Contract 2)	306	0	306	204	204	0	306	0			306	306	
		3,138	0	3,138	2,092	2,092	0	3,138	0	0	0	3,138	3,138	
Corporate	Running Costs Review in year	225	0	225	149	187	38	267	42			267	225	80
	Running Costs Review towards 20%	775	0	775	516	0	-516	775	0			775	775	
		1,000	0	1,000	665	187	-478	1,042	42	0	0	1,042	1,000	80
Primary Care Services	Appliances (Stoma)	40	22	18	12	31	19	36	18			36	36	
	Appliances (Wound)	180	0	180	120	0	-120	40	-140			40	40	
	Biosimilars (RJAH)	431	0	431	288	239	-49	350	-81			350	264	
	Biosimilars (SaTH)	386	0	386	258	483	225	720	334			720	579	
	Biosimilars (Other)					21	21	31	31			31	28	
	Biosimilars (Credits)					23	23	35	35			35	22	
	Care Home Prescribing	440	24	416	277	360	83	416	0			416	416	
	Co-Commissioning Efficiences	216	0	216	144	144	0	216	0			216	216	
	Diabetes	150	47	103	69	66	-2	103	0			103	103	
	DOLVs	100		100	67	89	22	120	20			120	120	
	Drug Switches	300		300	200	272	72	300	0			300	303	
	Prescribing Stretch Target	133	0	133	89	0	-89	0	-133			0	0	
	Prescription Ordering Direct (POD)	1,030	578	452	301	697	396	982	530			982	852	
	Respiratory	220	20	200	133	129	-4	200	0			200	220	
	Scriptswitch	500	0	500	333	455	121	600	100			600	600	
	Self-Care (OTC)	100		100	64	14	-50	80	-20			80	80	
	Self-Care (OTC) NHSE Stretch	170	0	170	58	0	-58	0	-170			0	0	
	Total	4,397	691	3,706	2,413	3,025	612	4,229	523			4,229	3,879	
Grand Total		22,365	2,550	19,815	12,488	9,704	-2,783	16,258	-3,557	740	250	15,768	16,744	1,745

Appendix B-3
Shropshire CCG
Allocations 2019/20

Full list of current allocations and adjustments at Month 8

	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 secondarty 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**

Appendix B-4

Category Run Rate Analysis

	M8 YTD Variance from plan	FOT variance from plan on straight line basis	Current FOT variance at Month 8	Difference in FOT	Main reasons for difference
	£'000	£'000	£'000	£'000	
Acute	8,292	12,438	15,582	3,144	Main drivers are SaTH £431k, Other Acute Contracts £936k. For SaTH the main drivers are CQUIN non achievement in Q1 and 2 for £431k, QIPP forecast to deliver in Q3 and 4 of £-395k as well as the contract as a whole being slightly phased into the back end of the year. For Other Acute Contracts there is a prior year benefit of £508k, as well as further slippage in CC2H QIPP forecast. Risk adjustments in the forecast also include QIPP risk and risk recently flagged by SATH around activity submisisons.
Community	353	530	(28)	(558)	Planned spend on CCTH projects is less than anticipated, IPMS and CHEC prior year costs totalling reduce run rate by £230k; Hospice costs up to December only thereby reducing run rate by £116k, APCS Derm from SCHT contract ceased service so run rate reduces by £30k
Individual Commissioning	4,734	7,101	7,474	373	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	2,075	3,113	2,810	(303)	£278k relates to Individual Commissioning, the explanation for which reflects the same as above
Primary Care	505	758	1,194	437	YTD position includes prior year Prescribing benefit, and also Primary Care Team savings reduce towards the final months of this year.
Other	(1,677)	(2,516)	(4,040)	(1,525)	£2m contingency phased into M12, offset by £1.2m expenditure against reserves assumed in mth12. £1.5m reserves utilised in YTD position, (straight line utilisation would be £2.1m).
Running Costs	(142)	(213)	(42)	171	One organisation' costs built into latter part of year
Co Commissioning	(282)	(423)	(867)	(444)	Release of uncommitted reserves, and also Rate rebate receipts still to come,included in forecast but not YTD position.
TOTAL	**13,858**	**20,787**	**22,083**	**1,296**	

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.008
Shropshire CCG Governing Body: 15.01.20

Title of the report:	**Governing Body Board Assurance Framework (GBAF)**
Responsible Director:	**Sam Tilley - Director of Corporate Affairs**
Author of the report:	**Sam Tilley - Director of Corporate Affairs**
Presenter:	**Sam Tilley - Director of Corporate Affairs**

Purpose of the report:
To update Governing Body on the latest iteration of the GBAF and ask that the Governing Body reviews the detail of the risks set out in the document.

Key issues or points to note:

The GBAF was previously presented at the Governing Body meeting in November 2019. The GBAF has since been reviewed and updated by Executive Directors.

The Governing Body is asked to note the actions taken to mitigate risks as set out in the actions column of the Framework and to give consideration to the risks outlined on the GBAF as it considers its business throughout the Governing Body meeting.

In light of the work being undertaken to bring together Telford and Wrekin CCG and Shropshire CCG into one strategic commissioning organisation work has commenced to align the organisations Assurance Frameworks and further detail on this will be presented to the Governing Body in due course. However, in light of this work the finance risk has been updated to reflect a more common position across the two CCGs. The Governing Body is asked to support this interim amendment

Actions required by Governing Body Members:

GBAF - the Governing Body is asked to:

- Review the detail of the GBAF risks and highlight any updates required
- Consider the risks highlighted in the GBAF as it conducts its business
- Support the interim amendment to the Finance risk (Risk No. 1)

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 *This report sets out the range of corporate risk faced by the CCG and their mitigation actions*	Yes

Governing Body Assurance Framework Version 17.9
updates for the Governing Body January 2020 shown in red

Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk /Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
	Key Principle 1 - Deliver a continually improving Healthcare and Patient Experience **Key Principle 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation)** **Key Principle 3 - Achieve Financial sustainability for future investment** **Key Principle 4 - Visible leadership of the local health economy through behaviour and action** **Key Principle 5 - Grow the leaders for tomorrow (Business Continuity)**										
/1/18	CS	Key Principle 3	**1. Finance** There is a risk that the CCG fails to deliver its plan for 2019/20 and that the underlying position going forward will deteriorate rather than improve:	Robust financial model with sufficient detail to model growth, inflation and QIPP sensitivities Comprehensive QIPP Programme in place; overseen by Finance and Performance Committee QIPP Programme Board (meets monthly): QIPP PMO. Buisness case challenge/due diligence on schemes Constitution, Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation Suite of financial policies and procedures (supported by AGC 27.6.18) Robust contract challenge mechanisms with major providers. Signed Contracts for 19/20 Finance and contract reports to Finance and Performance Committee and Governing Body, highlighting risks and mitigating actions Regular GB consideration of the finance position and oversight of management actions Disinvestment Process	Lead Committee - Finance and Performance Committee Regular reporting of Finance, QIPP, Contracting and Performance position to Finance and Performance Committee and Governing Body Completion of internal audit recommendations; outstanding audit actions reviewed at Audit Committee. Assurance gained through seeing improving internal audit ratings for finance and QIPP Action Trackers for Contract Management Meetings with Providers and escalation where required through exec level Strategic Commissioning meetings NHSE escalation meetings in place Budget Manager handbook and training programme in place	**Gaps in controls (GC):** **GC**1: Budget manager training and refresh of support materials and policies now complete. GC2: gaps in contract management process identified. GC3: CHC process issues remain GC4: Development of robust Financial Recovery Plan **Gaps in Assurances (GA):**	Extreme Likelihood 5 x Impact 5 = 25	GC2: Action plan in place; owned and regularly reviewed by CFO and DoC. Actions to be delivered through Q2 and 3 19/20. Update on progress given to August Audit Committee. GC3: Joint working across CHC and finance teams with a focus on sharing good practice and harmonising procedures. Financial forecasting methodology bedded in; finance focus is on robust information to support forecasting and QIPP delivery. Weekly CHC team meetings (with finance in attendance) held which incorporate review of QIPP activites. Impact will be tested through monthly review of the finance position. GC4: Financial Recovery plan developed and will be submitted to NHSE/I as part of the application to amend the forecast at Q3. This includes enhanced governance and increased grip and control but further plans to curb expenditure are currently only holding the position rather than improving it due to the deteriorating position in both emergency and individual commissioning expenditure. Executive team to continue to develop actions to reduce expenditure for remainder of the year and accelerate delivery of 20/21 QIPP.	Likelihood 4 x impact 4 = 16	Claire Skidmore	6.1.20

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72/16	AS 20/09/16 NEW	Key Principle 1	**2. Quality and Safety** There is a risk that the CCG fails to commission safe, quality services for its population	CQRM meetings with providers Quality and Safety visits Triangulation of information and exception and escalation reporting to Quality Committee National and local reporting Healthwatch CQC QSG NHSE Joint Commissioning Serious Incident Panel Quality Strategy and Delivery Plan including achievable milestones included. SaTH: • The CQC has taken urgent enforcement action where deemed necessary and this remains subject to legal process. • Weekly Regulation 31 audit submissions to CQC received by CCG • 'Safe today' calls continue with Trust Executive Clinicians • Daily and monthly quality indicators and outcomes work continues- Trusts IMT remains a barrier • Unannounced site visits undertaken Quality controls other providers: Restructure of quality team priorities to ensure alignment of new leads against other competing priorities QIPP Quality impact assessments, procurement and contracting requirements etc. Workforce lead in place Delivery Plan will be monitored bi-monthly at Quality Committee New SI policy and process to be shared with Quality Committee	**Lead Committee - Quality Committee** CQRM meetings with providers which feed into the Quality Committee. Minutes of QC meeting and Chairs report presented monthly to QC, Public Governing body Executive team meetings, reports, escalation Clinical Commissioning Meeting WMQRS Formative Review of Quality, Patient Safety and Experience Function, Structure, systems & process and assurance report received June 2019. WMQRS review of Quality, Patient Safety and Experience Structure, systems & process and assurance February 2019. Quality strategy and operational delivery plan signed off at September's Quality Commitee WMQR Review of Critically Ill and Injured Children at SaTH with action plan in place NHSE&I chaired Safety Oversight and Assurance membership to monitor the SATH quality improvment plan delivery. Senior CCG lead for strategic system working group now in place along with Chief Nurse on LWAB .	**Gaps in Controls (GC):** GC1: Workforce issues in health and social care economy increasing and increased quality risks in system mean that capacity in team to effectively monitor and manage the escalating risks is compromised. This is compounded by need to ensure the increased number of QIPPs, reprocurement and contracting requirements are met. Existing system wide workforce groups not impacting as quickly as the service provision requires it to manage risk **Gaps in Assurance (GA):** GA1: Sufficient business intelligence support to provide up to date quality data and benchmarking information from which to highlight and focus on concerns. GA2:Reporting to the Quality Committee requires a review on level of detail provided to provide correct level of assurance to the governing body, refer to WMQR of SCCG Quality comittee as aprt of wider review GA3: Limited assurance on management of SI process as detailed by internal Audit report. Revised policy and process in place and signed off at September Quality Committee and Audit Committee	Likely x Major = 16	GC1: Workforce oversight of providers via CQRMs, STP Stratgeic Workforce Group and LWAB continues Sytemwide People Plan in development to align with NHSE People Plan. GA3: Procurement for serious incidents and mortality review complete. Review to be timetabled to comence and be completed by late 2020 GA3: Action plan to address the limited assurance in place. New SI policy and process to be shared with Quality Committee in September 2019. Revised Quality Strategy produced awating sign off from NHEI	Possible x Moderate = High 12	Chris Morris	6.1.20
73/16	AS 20/09/16 NEW	Key Principle 1	**3. NHS Constitution** There is a risk that the CCG fails to meet its NHS Constitution targets either fully or sustainably	Planned Care Working Groups for Cancer and Referal to Treatment Times (RTT) in place	**Lead Comittee: Finance and Performance Committee** Provider Remedial Actions report via the Monthly Contract meetings . Updates from A&E Delivery Group & Board included in the monthly performance reports to Finance & Performance Committee and bi-monthly to Governing Body. Monthly contractual performance data	Gaps in Assurance (GA): GA1: Lack of SaTH medical /surgical representation at the PCWG	Likely x Major = Extreme 16	GC1: A&E Delivery Group now includes clinical input (both SaTH and CCG) and focuses on actions to improve ED systems and processes, Same Day Emergency Care (SDEC), Frailty, Ambulance Demand and for the back door Home First. - Pathway Zero and Integrated discharge teams. The two latter schemes are to ensure the system remains one of the best in the region for DTOC which remains <2%. MFFD is varying from 50-75 due to the rate at which patients are made ready during the week. Now A&E Delivery Group focusing on demand managment with emphasis on avoiding admissions (Shrewsbury pilot and working with WMAS on providing alternative clincial advice for Care Homes) GC2: SaTH have committed to a significant investment in both nursing and medical staffing for ED to improve performance and improvements are being seen in middle grades and nursing but will not have a significant impact this winter. System wide demand and capacity planning remains a key enabler. The in-hospital element has been refreshed to include the short stay capacity requirements but this now needs refining to take into account the impact of adopting the Same Day Emergency Care principles as part of the NHS long term plan. Further work on the system wide demand and capacity has been delayed due to no system owner being identified despite escalation to the A&E Delivery Board. For RTT this is impacted by SATH being permanently escalated into both DSUs. The system is working to better manage demand to achieve this + SATH have invested in additional Vanguard capacity to maintain a level of clinically urgent elective activity throughout the winter. GC4: Cancer performance has improved in Q3 and breast symptoms and 2wk are now achieving. 62 day cannot be delivered until wider capacity issues resolved for Urology. Progess has been made in this area with SaTH agreeing a formal parnership arrangement with UHNM which will see increased access to robotic surgery from February 2020. GC3: The gaps in controls and assurance have been escalated with SATH via the System Urgent Care Director. GA1 - clinical representation for planned care now through the Elective Transformation Board	Possible x Moderate = High 9	Julie Davies	6.1.20

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74/16	AS 20/09/16 NEW	Key principle 1, 3 and 4	**4. Transformation** There is a risk that the CCG fails to effectively lead transformation of local health services across acute, community and primary care to ensure sustainability for the future.	Sustainability & Transformation Plan (STP) Board and workstreams developed across acute (Future Fit) and 2 neighbourhood working areas SRO leads and support staff in place Future Fit Implementation Oversight Group - includes all providers Transformation Dashboard Clinical Commisioning Committee Clinical Commissioniong Committee Working Group Independent STP chair Alliance Agreement in place with Shropshire Council and ShropComm to drive the changes in the Care Closer to Home programme.	**Lead Committee - Clinical Commissioning Committee** Standing reporting item on Governing body agenda on development of STP Plans. STP standard item on CCC agenda Regular updates to CCG Board and standard update report produced CCG represented in the governance structure of the STP Senior Leaders Group (SLG) NHSE Assurance Meetings	**Gaps in Controls (GC):** GC1: The CCG recovery plan remains to be fully developed although strong progress is being made with NHS England GC2: Shropshire Care Closer to Home programme still under development GC3: Further work required to strenghten STP governance arrangements **Gaps in Assurances GA):**	Almost certain x Major - Extreme 20	GC1: NHSE continues to regularly meet with the CCG to oversee its recovery plans and implementation process. In May 2019 both SCCG and T&W CCG approved plans to become a single strategic commissioner. Plans to achieve this by 1 April 2020 are underway. This will support the recovery programme by reducing costs, duplication and inefficiencies and will create a more robust commissioning voice that is aligned to the STP footprint. Although the creation of the single strategic commissioner has been delayed by 12 months to April 2021 as a result of NHSE/I declining the CCCs application work still continues to bring the CCGs closer together in the intervening period GC2: Case Management pilot is live in 8 GP practives and will run for 9 months. Additional resources have been requested from Providers to deliver the increased activity to community teams. An investment business case is being developed in Janaury 2020. Phase 3 models are signed off and impact assessments are underway, due to be compelted by end October. GC3: The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020	Possible x Major = High 12	David Stout	1.10.19
75/16	AS 20/09/16 NEW	Key Principle 1 and 2	**5. Communication and Engagement** There is a risk that the CCG will fail to effectively engage and communicate with its CCG members, the public, partners and stakeholders and the CCG staff.	Communications and Engagement Plan and Strategy Dedicated comms team to support Future Fit and STP Individual Communication and Engagement plans for significant pieces of work Staff newsletter GP newsletter Patient Advisory Group (PAG) Governing Body Press briefing sessions Strong relationship with Shropshire Healthwatch and other patient groups Communication and Engagement arrangements for all QIPP schemes	**Lead Committee - Clinical Commissioning Committee** 360 Stakeholder survey feedback Equality Delivery System2 reporting Feedback from Shropshire Healthwatch via formal reporting and feedback into Governing body Monitoring of complaints, PALS and MP letters with regular reporitng to Quality Committee	**Gaps in controls (GC):** GC1: Improve communications to staff and member practices GC2: Capacity of CCG Communications and Engagement Team GC3: Lack of dedicated engagement expertise within Communications and Engagement Team **Gaps in Assurances (GA)**:	Likely x Major = Extreme 16	GC1: There is a rolling programme of communicatioin and engagement with both staff and member practices in light of the Governing Body's approval to move to a single strategic commissionin organisation with T&WCCG. A programm of communication and enaggement is currently under development. This wlll go beyond staff and member practives and will include wider stakeholder and the public. A stakeholder event in planned for the end of January 2020 supported by a survey GC2: The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Current demands are enhanced due to supporting major programmes of transformation and redesign and forthcoming consultations in relation to MLU and Care Closer to Home, as well as an increased level of public and press interest regarding the CQC interventions regarding maternity and A&E services at SaTH. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagment capacity and expertise in the Future Fit/ STP team GC3: Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagment capacity and expertise in the Future Fit/ STP team	Possible x Major = High 9	Sam Tilley	6.1.20

Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk /Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
76/16	AS 20/09/16 NEW	Key Principle 5	**6. CCG Workforce Resilience and trust** There is a risk that the current financial situation impacts negatively on existing CCG staff resilience and retention levels and prevents successful recruitment in the future.	Clear staffing structure which meets the needs of the organisation Executive team prioritising key workstreams. Sickness absence data Statutory and Mandatory Training Staff newsletter Staff survey Staff appraisals and one to ones Staff Hero Awards Procurement of dedicated Organisational Development and Human Resource to support transition to a single strategic commissioning organisation Utilisation of ESR system to manage mandatory training	**Lead Committee - All** Line management 1:1 with staff Training reports reviewed by Directors Staff Survey results Staff briefings CCG workforce data reviewed by Governing Body and Executive Team regularly Joint Executive Team meetings Weekly Single Strategic Commissioning Organisation update Reports	**Gaps in controls (GC):** GC1: Clear and structured OD plan for the organisation GC2: Maintenance of Statutory and Mandatory Training targets **Gaps in assurances (GA):**	Likely x Major = Extreme 16	GC1: Further to the approval by the Governing Bodies for the creation of a single Strategic Commisioning organisation, SCCG and T&WCCG have procured an OD partner and dedicated HR input to support this work. An Organisational Development Plan has been developed and an implementation plan is being finalised. Workstream meetings have begun to meet more formally to manage the specific task realting to the transition workstream. OD work with staff has commenced GC2: The CCG's statutory and mandatory training compliance is being moritored and reminders have been given to staff in this regard	Possible x Major = High 9	Sam Tilley	6.1.20
77/16	AS 20/09/16 NEW	Key principle 1,2,3 and 5	**7. Sustainability of Provider Workforce** There is a risk that providers ability to deliver services and remain financially viable is not sustainable.	Primary Care Workforce Strategy Primary Care Workforce Group (PCWG) led by NHSE with remit to look at sustainable Primary Care Workforce for the future. Secondary care: Contract monitoring via CQRM, A&E Delivery Board, QSG, and external reviews - CQC WMQRS LHE Clinical Sustainability Group Provider has key processes for managing staff shortages to minimise risk STP Workforce Group and Local Workforce Action Board (SLWAB) in place with remit to support the implementation of robust workforce strategies and sustainable workforce and education plans	**Lead Committees - Quality Committee, Primary Care Committee** <u>Primary Care</u>: Individual GP practice visits Reporting to PCC and Governing Body. PCWG reporting into PCC GPFV workforce section assured by NHSE Primary Care workforce survey Staffordshire/ Shropshire Primary Care Programme Management Office for GP Forward View oversees delivery of the GPFV plan which includes Primary Care Workforce <u>Secondary Care</u>: Reporting from CQRM to QC and then onto Governing body Regular updates shared by commissioners at North Midlands Quality Surveillance Group (QSG) chaired by NHS England. SWLAB reporting into QC NHSI supporting acute trust with recruiting from overseas. Modernisation of services includes review of traditional stffing arrangements to encourage grester felxibility and wider skill mix.	**Gaps in controls (GC):** GC1: Workforce issues in health and social care economy increasing and increased quality risks in system mean that capacity in team to effectively monitor and manage the escalating risks is compromised. This is compounded by need to ensure the increased number of QIPPs, procuremnet and contracting requirements are met High agency use still reported by providers. GC2: Gaps in terms of mechanisms for effectively working together across the system to address this issue . GC3: Need more effective local system wide (health, social care and private industry) approach to recruitment and retention to bridge gap and support long term planning. Providers often appointing from same pool of candidates GC4: Full analysis of Acute Trusts position and options for business continuity GC5: long term workforce planning via Future Fit and STP workforce workstream **Gaps in assurances (GA):**	Like x catastrophic = Extreme 20	**GC1:** Workforce oversight of providers via CQRMs, STP Stratgeic Workforce Group and LWAB continues Sytemwide People PLan in development to align with NHSE People Plan. **GC2 & GC3**:STP workforce group and LWAB in place which coordinates apprenticeship schemes/staffing passport and back office functions to maximise staff flow and competencies. STP workstream to realign as part of system savings plan. STP workforce proceses in place. **GC4**: Oversight of SATH Trust workforce improvement plan monthly via the NHSEI Safety Oversight Assurance Group. Workforcce deep dive planned for 22/10/19 **GC5:**Full Business Case for Future Fit will be prepaered in November 2019 for future acute trust workforce plan to be reviewed. Awaiting sight of this formally.	Possible x Major = High 16	Chris Morris	6.1.20

Risk ID	Opened by/ when	Map to key Principle	Summary title of risk and fuller description of risk	Key Controls Summary of existing controls / systems in place to manage the risk	Source of Assurance Summary of existing assurances that provide confidence that the existing controls relied upon are operating effectively and that action plans to address weaknesses are implemented.	Gaps in Controls/Assurances Summary of gaps in existing controls or assurances at the time the risk is identified or subsequently updated.	Assessment of risk level - Low / Medium / High / Extreme Risk /Movement of risk rating	Action / Lead Name / Timescale Identify what actions can be taken to fill gaps in controls and assurances and to also assist in achieving the residual target risk rating by the end of the financial year	post mitigation Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Owner	Amend/ Review: name and date
61/15	Accountable Officer / Chair	Key principle 1, 2,3 and 4	**8. Stakeholder and Patient support and trust** Failure to maintain stakeholder (including membership) and Patient/Public trust and support leading to negative organisational reputation because of the following reasons-: - Financial performance challenges - Leadership challenges - Organisational culture challenges - NHSE CCG Assurance - 'needs improvement'	Annual Stakeholder 360 degree survey Patient engagement programmes associated with key workstreams Quality Impact Assessments Equality Impact Assessments Patient Insight service Patient Experience service Patricipation in STP workstreams Better Care Fund Communications and Engagement Plan in relation to transition to a Single Strategic Commissioning Organisation Programme of Line Manager Training in place	**Lead Committee - Governing Body** Results of 360 degree stateholder survey Patient Insight reporting Patient Experience reporting Commuications and Engagement Plan Communications and engagement planning for each work programme Joint Executive Team	**Gaps in controls (GC):** GC1: capacity within the organisation and the Communications and Engagement team to meet the communications and engagement requirements GC2: Gaps in staff training opportunities **Gaps in assurances (GA):**	Like x catastrophic = Extreme 20	GC1: The volume of transformation work being undertaken by the CCG is significant and capacity remains an issue. Current demands are enhanced due to supporting major programmes of transformation and redesign and forthcoming consultations in relation to MLU and Care Closer to Home, as well as an increased level of public and press interest regarding the CQC interventions regarding maternity and A&E services at SaTH. Work plans and priorities are kept under continuous review and adjustments made where necessary to maximise capacity and responsiveness. Working arrangements with T&WCCG have been reviewed and a joint interim structure is now in place to ensure capacity is maximised and duplication reduced, along with work to maximise communication and engagment capacity and expertise in the Future Fit/ STP team GC2: Staff training opportunities being continuosly monitored. Mental Health Awareness training planned for staff	Possible x Major = High 9	Sam Tilley	6.1.20
71/16	GB 8.2.17	Key Principles 1, 3	**9. Impact of Social Care Funding Challenges** Risk of individuals escalating into acute hospital care or not being able to be discharged from acute hospital care thus impacting adversely on the capacity and capability of health services	BCF plan and development of associated Partnership Agreement Joint Commissioning Board ToR Sustainability and Transformation Plan approved by NHS England Performance data DTOC performance reported monthly BCF Partnership Agreement and Joint Commissioning Board ToR to be completed	**Lead Committee - Clinical Commissioning Committee** Clinical Commissioning Committee Health and Wellbeing Board Regular reporting regarding hospital and community service performance DTOC data	**Gaps in controls (GC):** GC1: Full implementaiton of Care Closer to Home Programme GC2: Lack of impact assessments in relation to cessation of services by Local Authority **Gaps in Assurances (GA)** : GA1: Fully formed STP governance structure	Almost certain x Major - Extreme 20	GC1: Delivering care Closer to Home to reduce demand failure in the acute setting. Demonstrator site procurement for admission avoidance in Shrewsbury area in progress. GC2: On going dialogue with Shropshire Council regarding service cessation impacts GA1: The STP governance structure has been agreed and a Shadow ICS Board is being put in place from February 2020	Possible x Major = High 9	David Stout	6.1.20
78/16	GB 10.10.18	Key Principle 1	**10. Management of 0-25 Health & Wellbeing Service.** Risk of lack of assurance of quality and safety of current service, in particlular for a number of legacy patients	Additional capacity in SCCG through MH Programe Director System Action Plan System Communication plan Contractual levers where required NHSE oversight	Lead Committee CQRM T & F Group H&W Board overview NHSE executive assurance process	**Gaps in controls (GC):** GC1: Workforce plan in delivery; poor data sources remain a concern; **Gaps in Assurances (GA):** GA1: Lack of pace in improvements has been resolved with the delivery of the recovery action plan more effective than the previous RAP	Major x Possible = High 12	GC/GA1:Concerns raised by visit of the Intensive Support Team , a comprehensive action, communication and governance plan was developed by the contract lead provider and has now been delivered.The CYP LTP group continues to meet quarterly. The original workforce development plan has been delivered and the remaining issue related to skilled capacity for ASD diagnostic assessments is being resolved by commissioning additional capacity. The providers are on trajectory to reduce these long waiters and continues to be managed through the MPFT Strategic Commissioning Board. A new model of acre has been agreed and now implemented to deliver this service in the future within appropriate waiting times.	Possible x Major = High 9	Julie Davies	6.1.20

Governing Body Issues Log July 2019						
Issue ID	Date	Description	RAG	Management Response	RAG status after action	Owner
7.19	6.1.0	Financial Position At month 6 the CCG's expenditure run rate exceeds plan and recovery of the forecast position is unlikely		The GB, executive team and budget managers are briefed on this position and the consequences of spend continuing to accrue at current levels. Escalation meetings are taking place regularly with NHSE/I colleagues. The Governing Body and Finance Committee have discussed submitting a formal amendment to the CCG forecast financial position at Month 9/Q3. The Governing Body and Executive Committee have been involved in the development of a financial recovery plan including enhanced governance and grip and control.		CS
2.18	01-Apr-18	**Quality & Safety** Triangulation of intelligence from a range of sources has highlighted a range of Quality issues for ongoing management		Working with providers to ensure patient safety. Ongoing monitoring arragenments in place. Quality Strategy and delivery plan developed to focus action where needed. Utilising NHS quality escalation framework in addition to our own reporting mechansms to identify and manage concerns SaTH actions and monitoring • The CQC has taken urgent enforcement action where deemed necessary and this remains subject to legal process. • Weekly Regulation 31 audit submissions to CQC received by CCG • 'Safe today' calls continue with Trust Executive Clinicians • Daily and monthly quality indicators and outcomes work continues- Trusts IMT remains a barrier • CCG seeking to commission a review mortality data and learning from deaths • Unannounced site visits undertaken • WMQ Review of Critically Ill and Injured Children at SaTH with action plan in place - daily oversight of service provision in EDs via safe today process. • NHSE&I Chaired SATH Safety and Oversight Assurance meeting and Maternity Oversight meeting in place attended by Chief Nurse and Medical Director. Review of Maternity Care underway as commissioned the Secretary of State for Health is in progress. Media coverage is on national platforms which impacts on staff within SATH and confidence in maternity services for the population		CM
4.18	6.1.20	**Constitutional Targets** Failure to meet targets on A&E 4 hour wait and Cancer 62 day RTT		Cancer 62 day RTT- SaTH have detailed remedial action plans by tumour site including findings of the recent NHSI deep dive. These are monitored via the monthyl contract meetings and assurance calls with NHSE/I. Also work is ongoing with the Cancer alliance to target 4 tumor sites where regionally there are challenges upper and lower GI, Lung and Urology. Additional funding for project management capacity has been provided by the Alliance to support this work. A&E - The national ECIST continue to make an impact in supporting SaTH to improve systems and processes incldugn the implementation of Same Day Emergency Care. Workforce issues remain the largest single issue, but plans for increasing the nursing and middle grade workforce are in place and been executed which is having a positive impact but not in time for this winter. Consultant staffing is now an issue again with fewer WTE this winter than in 2018. The CCG is supporting the Trust by ensuring delayed transfers of care are kept to a minimum (<2%), patients who are medically fit for discharge are discharged within 48-72hrs. The CCG is also working with WMAS and community provider to try to better manage demand and reduce conveyance to hospital and subsequent admissions.		JD
1.2	6.1.20	**System Management** Financial risks of pressure to manage the whole LHE system rather than just the finances of the CCG impcts on the CCG. Significant deficits now seen in neighbouring Trusts and CCGs. Development of financial modelling associated with Future Fit is led by partner organisations. This work needs to be refreshed		CFO to ensure alignement of assumptions through system financial plan, including Future Fit		CS

Risk Matrix

Risk Matrix		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

		Low risk
		Moderate risk
		High risk
	15 - 25	Extreme risk

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.009
Shropshire CCG Governing Body meeting: 15.01.20

Title of the report:	Governing Body SCCG Performance & Quality Report 2019/20
Responsible Director:	Julie Davies, Director of Performance & Delivery 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 & Delivery

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 7 and 8 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

Both the 2wk Breast Symptoms and 2wk from GP referral were both achieved in October for the first time this year and is a direct result of the successful delivery of the improvement plans. The achievement however will be short lived as although the radiology capacity has been addressed, SaTH now have some long term sickness issues with surgeons. 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. The Trust has committed to get to 83% by the end of March 2019.

Further improvement is dependent on the wider joint working with UHNM and the region. The second robot will go live in February and will provide additional capacity for Shropshire patients. 31 day subsequent treatment surgery is now recovering as a direct result of the improvement in the 2wk performance. This will continue and although the 2wk performance is at risk it is not expected to be sufficient to stop this target being achieved for the year end. 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 recovered as predicted since the dip in August and has achieved for the past two months.

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. Following the recent Winter Assurance meeting with NHSE/I, support and engagement from WMAS has improved with named resource for the local system to work with. This resource will allow the dedicated ambulance working group to focus specifically on reducing conveyances and ambulance handover delays. Workforce levels and now sustained increases in demand are the main issues although workforce is showing some signs of improvement but slowly and not in time to have a material impact during winter. There was a significant increase in 12hr trolley waits in October and November, and the level has increased further during December and January to date. These are being reported up through NHSE/I and the harm pro-formas are being received and assurance gained to date that although the patient experience was poor the patients affected did not suffer any harm. This is under constant review by the Quality team who are also making 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.

Both > 1hr and >30mins ambulance handover delays have gone back up in October and November as a result of the increase in the number of ambulances conveyed and the high levels of escalation. 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. The recovery of this target is being reviewed as the Trust have secured additional Vanguard capacity to protect clinically urgent elective capacity during the winter and a revised recovery trajectory has slipped but will be brought back to the Planned Care Working Group in February when the system has a better view of the overall impact of the ongoing winter pressures.
The CCG had 0 over 52 wk waiters at the end of October and the look forward is also positive. This continues to be monitored weekly by the CCG for its patients across all providers to continue to minimize any >52 wk breaches.

Workforce remains a significant risk for SaTH and recruitment of middle grade medical staff continues to make progress although there is still a reliance on agency staff. Nursing staff recruitment is progressing and following successful recruitment in India the Trust is taking the recruitment initiative to Ireland.

SaTH presented a thematic review of 104+ day cancer breaches harm reviews at

December 2019 CQRM. There was an increase in patients requiring urology cancer services due to workforce issues and complex pathways although a number of measures have been put in place to support this pathway. No patients experienced harm as a result of the delay. CQRM will continue to receive information relating to harm reviews following extended waits associated with cancer pathways.

61 patients waiting in excess of 12 hours in A&E and all patients reviewed through a harm-proforma came to no harm as a result of the delay. The CCG quality team continues to work with SaTH to prevent avoidable harm associated with delays within A&E and this is discussed at CQRM.

Following concerns raised by the CCG regarding unexpected community deaths reported as serious incidents MPFT presented a themed review at the December CQRM and as a result will undertake further work that will be discussed at CQRM in January 2020.

Actions required by Governing Body Members:

The Governing Body is asked to NOTE the contents of the report and seek assurance from the CCG actions contained within to recover performance & quality in those areas which are currently below target.

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

January 2019

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 October 2019 and November 2019 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	5	4	3	4
Elective Access					
Urgent & Emergency Care	12	2	1	10	11
Mental Health	5	4	5	1	0
Learning Disability	4	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	3	0	2	3	1

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%						71.8%
	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%						90.2%
	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%						85.7%
	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%						85.3%
	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%						41.1%
	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%						97.0%
	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%						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%
	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%						98.0%
	One-year survival for all cancer				2016 72.2% National 72.8%												
	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 symptomatic rates and overall 2 week wait standard has improved so that the standards have been met for these indicators for the first time for a considerable number of months. This is at risk from November due to long term sickness amongst some of the surgeons. 62 day wait performance also improved during the month to 75.2% 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 improved for surgery to now be just short of the standard. This target is expected to be achieved for the full year. 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 72.4% 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).	Daily and weekly assurance and escalation meetings are continuing to manage patient treatment lists as effectively as possible. The trust is actively seeking locums to provide the required surgical capacity to mitigate the impact of the long term sickness. Additional clinics have been introduced in Gynaecology. Improvement plans are in place for all tumour sites. These include closer monitoring of PTL list, additional MDT processes and process and pathway improvements. Recruitment initiatives are being progressed but there are some time gaps before new appointments will be in place. A second robot has been confirmed at UHNM to come on line in February and a SaTH surgeon has been trained to use it which will be of benefit to Shropshire patients. Additional clinics are scheduled where possible and booking office staff liaises with patients to encourage uptake of earliest appointments. SaTH continues to work with the Cancer Alliance to implement improvements to meet the faster diagnosis standards and to implement improvements in line with national recommendations

	in the Lung, Upper GI and Endoscopy pathways.
Key Quality Risks and Issues	
Cancer Breaches – in October 2019 (latest available validated quality figures) 12 patients waited more than 104 days for their cancer treatment: 1 colorectal, 7 urology, 1 upper GI, 1 breast, 1 upper GI and 1 haematology. Causes of the delay in the main include patient choice, workforce and delayed diagnostics.	Harm pro-formas are awaited from the clinician / operational team responsible for each individual patient. Urology workforce issues and unable to recruit to locum posts. Cancer Lead Nurse presented a harm pro-forma themed review at December 2019 CQRM which provided assurance that those patients who waited >104 days had not come to harm.

3.2 The performance at SaTH by tumour site for October 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.

Oct-19	2 week performance			62 day performance		
Tumour Site	**SaTH**	**National**	**Comparison**	**SaTH**	**National**	**Comparison**
Breast	98.8%	93.1%	Better	76.3%	77.1%	Worse
Childrens cancer	100.0%	95.0%	Better			
Gynaecological	93.2%	92.9%	Better			
Haematological	75.0%	95.9%	Worse			
Head & Neck	95.1%	94.8%	Better			
LGI	95.7%	86.4%	Better	56.6%	63.7%	Worse
Lung	29.3%	96.2%	Worse	58.8%	66.5%	Worse
Skin	91.4%	89.3%	Better	100%	92.8%	Better
Testicular	100%	96.8%	Better			
UGI	86.0%	91.5%	Worse			
Urological	96.6%	95.3%	Better	58.1%	71.1%	Worse

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
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%					
	IAPT Recovery Rate (CCG/MPFT)	2018/19	53.8%	50%	57.9%	55.9%	50.6%	52.4%	52.3%	51.6%	51.1%					
	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% 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%					
	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%					
	Out of Area placements for acute mental health inpatient care - transformation				166	176	191	90								
	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%								

Mental Health:	
Key Performance Headlines Risks and Issues	**Actions to Address**
IAPT performance was reported at 1.9% in October. Although the monthly performance was below target, the CCG is ahead of plan at the end of Q2 and the provider remains confident of achieving the year end objective of 22%. The recovery rate target of 50% has been achieved consistently through the year. As at Q2, 2019/20, 95.3% patients on CPA were followed up within 7days against the 95% standard. As at the end of October the CCG is achieving 100% 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.	The CCG has already invested additional funds into the service in the current year.
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.	KPIs for the service are starting to show some level of improvement and additional staff training is being progressed The main risk is perceived to be problems in additional recruitment which is likely to remain a challenge for the Trust for the foreseeable future
Key Quality Risks and Issues	
MPFT reported 7 serious incidents (SI) in November 2019 with the main theme being unexpected deaths within the community.	MPFT presented a themed review in December 2019 at CQRM and further work is planned for January 2020 to include an annual SI report and mortality report. CCG is working closely with Staffordshire CCG to gain assurance around the learning and how this is being used to inform future patient pathways.

The MPFT CQC report was published on 5th July 2019. The overall rating of the Trust remains ‘Good’. The ‘Effective’ domain has been identified as requiring improvement. A number of requirement notices have been issues by CQC.	The Trust are working on the required service improvement plans, which are being reviewed by CQRM, with added assurance being sought through attendance of site visits.

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)		64% (2017/18: CCG)												
	Completeness of the GP learning disability register	2017/18	0.49% (England)		0.52% (2017/18: CCG)												
Maternity	Maternal smoking at delivery	Q2 2019/20	10.4% (England)		11.0%			10.1%									
	Neonatal mortality and still births per 1,000 population	2015	4.64		6.12 (2016: 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%**					70.5%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2017/18	77.5% (England)		80% (2017/18: 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	The CCG is comfortably within the top quartile nationally on this measure.
Maternity Maternal smoking at time of delivery is reported on a quarterly basis. Q2 2019/20(10.1%) showed a reduction against Q1performance (11.0%).	The level is slightly better than the average rate for England as a whole.
Dementia Dementia diagnosis continues to perform above the national standard, November 2019 achievement was 70.5% 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 80% for Shropshire CCG, with the England average being 77.5% (2017/18).	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	
MPFT Learning Disability (LD) and Autism Spectrum Disorder (ASD).	ASD waiting lists for assessment is being managed through the development of a six month plan commenced in October 2019 and all families have received letters outlining which providers will undertake the assessment. Multi-agency workshops, led by the CCG, to develop an all age LD and ASD strategy have taken place with families / carers and service users with further events planned for January 2020.
CQC inspected maternity services during the visits in April 2019 and November 2019 and the final report is with SaTH for final accuracy checking before	CQC acknowledged the delay in publishing findings from visit undertaken in April 2019 and recognised that

publication.	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.

6 URGENT AND EMERGENCY CARE -

6.1 A&E Performance and Ambulance Handover Delays

Urgent and Emergency 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
	Achievement of milestones in the delivery of an integrated urgent care service				6	6	6	6	6	6	6	6					
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 2018/19	2074 (England)		Q1 2019/20 774.36			Q2 2019/20 895.62									
	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%					69.4%
	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					123
	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					5942
	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					1522

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 64.4% in October and 65.6% in November. 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
Workforce limitations continue to be the key problem for SaTH. There is concern about the level of consultant cover post January when consultant capacity will be reduced following a resignation.	Recruitment of middle grade medical staff continues to make progress although there is still a reliance on agency staff. Recruitment initiatives are being progressed and extended cover arrangements have been agreed with BMI. Nursing recruitment is progressing with interviews scheduled from the last round of advertising and a further recruitment initiative to Ireland
Numbers of Super Stranded patients (>21days LOS) remains problematic at SaTH though some recent improvements have been achieved at PRH	Delayed Transfers of Care remain very low in the local heath economy and processes continue to work well with local authorities to facilitate discharges as quickly as possible. Wider criteria have been adopted for the discharge of patients to SCHT for rehabilitation and additional discharge routes through 'Home First' and 'Pathway 0' have been put into operation with some promising early results.

Reported Ambulance handover delays (over 60mins) have deteriorated recently as the effects of winter begin to be felt.	Ambulance handover improvement plans are in place between SaTH and WMAS and additional administrative support has been funded to ensure any handover delays are recorded as accurately as possible. The A&E Delivery Board has agreed an increased focus on work to avoid conveyances to ED. This includes accelerating admission avoidance schemes through the Care Closer to Home Project and the introduction of a professional help line for paramedic staff to provide advice designed to avoid unnecessary conveyances to ED. The recent transfer of the NHS111 service to WMAS is also anticipated to provide potential for reducing conveyances as a result of this and the 999 service being delivered by a single provider. Following the recent Winter Assurance meeting with NHSE/I, support and engagement from WMAS has improved with named resource provided for the local system to work with. This resource will allow the dedicated ambulance working group to focus specifically on reducing conveyances and ambulance handover delays.
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.	SaTH has been in special measures for 13 months 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 a Risk Summit was held on 13 December 2019. The Risk Summit was an opportunity for all partners and stakeholders to determine how the Trust can be further supported. The Risk Summit 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 identified the following issues of concern: • Managing the deteriorating patient and sepsis • Triage of children with ED • Children leaving ED before being seen • Restraint of patients not in line with guidance • Lack of mental health risk assessments A number of other concerns were identified across the organisation relating to documentation, incomplete risk assessments and governance.	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 will continue from January 2020.
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. Medical staff recruitment and retention remains a significant risk to the Trust. Vacancies advertised are receiving little or no interest and one ED consultant has recently resigned. Agency usage remains a significant number of the consultant workforce, in particular, within ED. Workforce is discussed each month at CQRM.
There were 61 x 12 hour trolley waits reported in A&E at SaTH in November 2019. December 2019 has seen an increased number being reported due to demand and capacity issues.	The harm pro-forma completed indicated that the patients came to no harm as a result of the delay. CCG has not seen an increase of complaints / concerns raised by the patients or public. 12 hour trolley waits continue to be presented and discussed at CQRM each month.

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.

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						11:55
		SCCG	20:26		20:16	19:46	23:25	22:52	20:38	21:00	22:43						21:32
	Category 2 (mm:ss): 90th Percentile	WMAS	22:12	36mins	22:22	21:31	23:57	23:44	23:06	24:10	25:21						23:30
		SCCG	33:29		34:51	32:21	36:54	37:08	39:09	39:38	38:10						37:05
	Category 3 (mm:ss): 90th Percentile	WMAS	76:14	90mins	78:47	69:49	99:36	109:47	88:08	109:15	121:43						**97:09**
		SCCG	71:19		81:14	71:59	95:54	106:25	89:30	134:01	129:48						**100:05**
	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						145:51
		SCCG	101:36		122:44	111:52	163:58	144:28	90:49	165:10	175:21						138:29
	Crew Clear delays of > 30 minutes (RSH + PRH)	2018/19	709	Zero Tolerance	40	12	12	13	9	14	13						113
	Crew Clear delays of >1 hour (RSH + PRH)	2018/19	15	Zero Tolerance	3	0	0	0	0	1	2						6
	Delayed Transfers of care attributable to the NHS (LA)	2017/18	3381	Reduction 2016/17 Outturn	274	281	223	281	284	324	571						2238
	DTOC Rate (SaTH)			3.5%	1.3%	0.8%	1.5%	1.7%	1.1%	1.6%	1.7%						1.7%
	DTOC Rate (RJAH)			3.5%	6.4%	3.4%	4.4%	6.4%	4.0%	4.9%	5.9%						5.9%
	Population use of hospital beds following emergency admission	Q2 2018/19	500.5 (England)		Q1 2019/20 799.28			Q2 2019/20 814.44									

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 4 calls in October but, failed the standards for categories 1, 2 and 3 calls.	Performance issues are raised regularly with the Regional lead commissioner
DTOC (SaTH) – In October 2019, the number of delayed days was 1.7% of patients delayed. This is ahead of the 3.5% target at SaTH. The RJAH deteriorated to 5.9%, though this figure includes complex spinal patients. At SCHT, the October value deteriorated to 5.7%. 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.

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	2018	83.8% England	88.6%													
	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)	1.14 (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%						89.4%
	RTT - incompletes (SaTH)	2018/19	92.3%	92%	87.5%	87.8%	87.0%	86.0%	85.8%	86.1%	85.0%						86.5%
	RTT - incompletes (RJAH)	2018/19	89.8%	92%	87.5%	87.2%	86.6%	85.1%	83.6%	88.5%	88.0%						86.4%
	No. of 52 Week Waiters (CCG)	2018/19	56	0	0	0	0	0	0	0	0						0
	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%						1.6%
	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%						1.3%
	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%						1.5%
	Cancelled Operations - no. of patients re-admitted within 28 days (SaTH)	2018/19	5	Zero Tolerance	2			1									3
	Cancelled Operations - no. of patients re-admitted within 28 days (RJAH)	2018/19	1	Zero Tolerance	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 October (88.5%).	The performance is monitored at the Planned Care Working Groups for both SaTH and RJAH. Recovery for SaTH is directly impacted by the ongoing winter pressures and a long term recovery plan will be required in the new year. For RJAH, the issue of delivery is related to the decreasing overall waiting list and commissioners are working with the Trust to balance delivery of 18wks with financial pressures.
SaTH failed to achieve their overall RTT target in October at 85.0%. This is largely due to the overspill from emergency cases limiting elective capacity and capacity limitations in outpatients. RJAH reported 88% overall in October, failing to achieve the target	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. 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 October there were 0 x 52 week waiters reported for the CCG.	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 October to 21,500 against a target of 19,284. The rate of increase in these numbers has slowed considerably in the last couple of months. Performance against the 99% standard for waiting time for a Diagnostic Test was failed by the CCG in October with a level of 99.1%.	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. There is a risk that overspill from emergency capacity during the winter will have an impact on the RTT numbers over the coming months.
Cancelled Operations –SaTH failed the target in Q2, 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.
The national primary care commissioning team has announced that they expect all CCGs to have created a system for GP remuneration for either attending or providing reports for Child Protection conferences. They have also suggested that the scheme extends to adult safeguarding. This is due to difficulties noted at a national level regarding GP engagement and information sharing with child protection work.	Both CCGs have been discussing how to further scope the likely impact. A comprehensive paper written by the lead for Children's Safeguarding will be submitted at Board level for decision making
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 December 2019 with no home have been identified further escalation. CCG continue to undertake quality assurance visits to care homes and triangulate findings with CQC and Health Watch

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%												

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	1						1
	Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)	2017/18	46	43	3	5	8	5	2	6	4						33

9 Recommendation

The Governing Body is asked to NOTE the contents of the report and the CCG actions contained within to recover performance in those areas which are currently below target.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.010
Shropshire CCG Governing Body: 15.01.20

Title of the report:	Shropshire CCG Strategic Priorities Update
Responsible Director:	David Evans – Accountable Officer
Author of the report:	Sam Tilley – Director of Corporate Affairs
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 January 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 Stout 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, the admission avoidance service procured by the CCG is now live, and will be closely monitored to understand impact and enable learning. Information relating to the impact of the case management pilot continues to be collated for formal analysis, but early indications suggest this is having a beneficial effect on patient experience and on NEL activity in pilot areas. The CCG continues to play an active role in the system support to the front door, including working with ShropDoc to trial a professional line for paramedic use to help direct patients to the most appropriate setting for their need. Again, this will be closely monitored for impact and information gathered during this trial will be used to inform future plans.
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	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	Lead: Nicky Wilde Discussions have taken place with NHS England as 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

but to the full range of Primary Care Providers.	turn will reduce the pressure on the wider health	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. 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- verbal update can be given to January's governing body and formal paper to the March meeting. KPI: To be confirmed following the March Governing Body Meeting

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 transformation Board. Commissioners now awaiting formal correspondence from Providers re an alliance arrangement Commissioners have worked up the service specification for the new model of care, potential contractual arrangements and the financial envelope for the new service were considered and agreed by Clinical Commissioning Committee in November. KPI: to be agreed following MSK Transformation Board when method of implementing the new model has been agreed.
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 Work is underway on a number of fronts to ensure there are sustainable cancer services for STW. There is a dedicated cancer workforce group at an STP and wide (Staffordshire) level. The Cancer Strategy Board are 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 & NHS Improvement have been sponsoring the development of a strategic commissioning intention to respond to the publication of the specialised kidney, bladder and prostate cancer service specification published earlier this year. The specification would appear to require significant reconfiguration of urological cancer services, potentially from seven centres to four in the West Midlands. An 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 Next Steps: A Urology Partnership Board responsible for 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. 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: The first meeting of the RDC Steering Group has taken place with discussion on the pathway and focus on the steps involved in the route to diagnosis, the inclusion and exclusion criteria for the service, the referral form and the primary care filter function tests. It was agreed that these processes will be consistent across the region and to support the evaluation. It is anticipated 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 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. 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: To agree the urology network partner

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.011
Shropshire CCG Governing Body meeting: 15.01.20

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 an alternative approach to change the CCG's Constitution, to help align decision making with Telford and Wrekin CCG's Constitution during the transition period to becoming a single strategic commissioner.

Key issues or points to note:

In adopting a shared Constitution whilst retaining two CCGs until April 2021, a number of key pieces of work will need to be completed; drafting of a new shared Constitution and consultation and approval by the respective CCG memberships, a management of change process for existing governing body members and recruitment/election processes to appoint shared governing body members with Telford and Wrekin CCG.

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;

- Note and provide feedback on the new advice from NHS England 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;

- Note 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 CCG for approval; and

- Approve 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.

Monitoring form
Agenda Item: GB-2020-01.011

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

NHS Shropshire CCG Governing Body Meeting 15th January 2020

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 Shropshire CCG.

1.5 The report presents an alternative approach to that made in a report presented in November, to streamline existing governance structures of both CCGs in the next few months in preparation for creation of a single staff structure and to align as closely as possible decision making by both CCGs during this interim period.

1.6 The report also presents some changes to the current CCG's Constitution to reflect the recent establishment and appointment to a new Director structure.

2. Report on progress of the programme

2.1 The NHS England/NHS Improvement Panel provided some positive feedback on the application submission and some suggestions on how both CCGs could enhance the joint application. The Panel also made a firm offer to support 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:

- 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

The programme plan and timescales have been revised accordingly.

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.

2.3 Public engagement on the proposal to create one single CCG across Shropshire, Telford and Wrekin was due to start in December, but had to be postponed due to purdah as a result of the general election. This has now been scheduled in January and February 2020 with public engagement launch event taking place on 24th January in Shrewsbury. In addition we are also arranging 2 hour pop ups at Oswestry Library, Darwin Shopping Centre Shrewsbury, Ludlow Library, Park Lane Centre Telford, Telford Shopping Centre and Tesco Supermarket Wellington. The engagement feedback will be captured via an online and hard copy survey form.

2.4 As previously stated, the management of change process to create one single staffing structure for senior managers and staff has started and will continue regardless of the delay in a successful application. A management of change process for existing Directors started in November and concluded in December 2019 and the following appointments have been made:

Executive Director of Finance (CFO)	Mrs Claire Skidmore
Executive Director of Transformation	Dr Jessica Sokolov
Director of Corporate Affairs	Miss Alison Smith
Director of Performance	Dr Julie Davies
Director of Planning	Mrs Samantha Tilley

The following roles have not been appointed to and will go out to national advert for recruitment:

Executive Director of Quality
Director of Partnerships

2.5 Following the appointment of Executive Directors and Directors, staff structures will start to be developed in the New Year with a view to staff management of change beginning in February and completing in April/May 2020.

2.6 The highest risk to the programme currently is to maintain momentum now that we have a new re-application date of 30 April 2020. However, the CCGs now have additional time to refine the evidence base and to provide the detail that has been lacking in our commissioning strategy and operating model.

3. Alternative proposal to align existing governance structures of NHS Shropshire CCG and NHS Telford and Wrekin CCG

3.1 Both CCGs are now exploring the options to align their respective governance structures and processes to allow a single management and staff team to support, both CCGs efficiently and effectively in the interim period running up to the creation of a single strategic Commissioner in April 2021.

3.2 A paper presented at the Governing Body meeting in November, outlined in broad terms an option to adopt Committees in Common and Joint Committees to help align the governance structures of both CCGs. The Governing Body noted the report and gave its support in principle and asked for a more detailed report to be presented in January, that would outline in detail amended terms of reference, change of business day and schedule of committee meetings with a view to approval and implementation from March 2020 onwards.

3.2 However, shortly after this Governing Body meeting on 11th November 2019, the CCG Programme representatives met with NHS England/NHS Improvement colleagues to discuss and agree an amended timeline for re-application. In this meeting the alignment of governance structures was raised and a suggestion made for the CCGs to explore other options available to align decision making. Subsequently, the then Director for Corporate Affairs and Executive Lead for Governance and Engagement met with NHS England/NHS Improvement Governance Lead to discuss the options available, over and above that of Committees in Common and Joint Committees, already considered by both CCG Governing Bodies.

3.3 The outcome of this meeting was as follows:

- Technically speaking each CCG must retain a single Constitution. However, it would be for each CCG to determine how much content of their Constitutions are the same, but there is nothing to preclude the CCGs adopting, as two separate legal entities in this interim period, a (new model) Constitution that has almost exactly the same content, barring obvious differences like name, location, geography covered and membership.
- That the shared Constitutions of both CCGs could go as far as outlining the same Board composition for both CCGs with shared statutory Governing Body members; Clinical Chair, Accountable Officer, Chief Finance Officer, Lay Member Governance, Lay Member PPI, Secondary Care Doctor, Registered Nurse and shared non-statutory Governing Body Members; GP/Healthcare Professional members and Lay Member Primary Care. This has been implemented in other CCGs.
- A single shared Constitution could then facilitate, in a more comprehensive way, Governing Bodies meeting in common, committees in common, the same scheme of reservation and delegation and standing orders. This in turn would enable CCG processes and procedures to be more fully aligned over the period leading up to April 2021.

3.4 There are some clear merits in moving to a shared Constitution now for the two CCGs, rather than adopting the changes proposed in the November paper to Committee terms of reference, which would only provide a part solution to managing and supporting two legal entities over a period of 15 months.

- Although we would retain two CCGs with their respective governing bodies, by appointing/electing to shared Board positions, this would allow both governing

bodies to meet in common at the same time on the same day, thus supporting more streamlined decision making on strategic issues.

- It would create a shared committees in common structure; streamlining assurance and supporting timely decision making by the Board.
- It would provide one clear shared governance structure for both CCG staff to work to, but also for strategic partners in the STP/ICS to help align their decision making with on key collaborative work.
- The work required for a shared Constitution to be implemented now would be done once, as this could then be adopted with minor amendments for the new single CCG in April 2021.
- Will make a significant contribution to 20% administration savings in 2020/21.

3.5 However, this would need to be enacted as soon as possible to limit the additional pressure on management and staff of servicing two different governance structures. In order to take this option forward:

I. a new Constitution that could be adopted by both CCGs would need to be developed, consulted upon and agreed by both CCG membership and ratified by NHS England;
II. a management of change process for existing Board members from both CCGs would need to be undertaken; and
III. recruitment and elections to shared roles on two Governing Bodies would need to be completed.

3.6 Currently detailed timelines have not been developed, but the working assumption at the moment is that this could be completed by May/June 2020, although this is ambitious and may have to change dependent on what parts of the process would need to be done consecutively.

3.7 The Governing Body are asked to note that by the CCGs pursuing this option rather than the one set out in the November paper, the CCG would be reverting back to its original plan of developing a new Constitution in January/February 2020 when we were originally working on the assumption that a single CCG would be created in April 2020.

4. Proposal to amend the CCG Constitution

As the management of change process to appoint to the new Executive Directors and Directors structure has been concluded, the CCG's current Constitution needs to be amended to reflect this.

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

- Page 10 Foreword – amend to new Accountable Officer
- Page 31 Composition of the Governing Body – amend current description of Director of Nursing, Quality and Patient Experience to Executive Director of Quality, add the Executive Director for Transformation as a voting member of the Governing Body and add after Chief Finance Officer in brackets (Executive Director for Finance)
- Page 55 section 2.2.8 and 2.2.9 amend role description of Director of Nursing, Quality and Patient Experience to Executive Director of Quality,

- Page 57 add Executive Director of Transformation as an additional section 2.2.11 describing appointment process, term of office, eligibility, reasons for removal and notice period.
- Page 60 section 3.7.2 add in Executive Director for Transformation as eligible to vote on the Governing body and change the descriptor of (c) to Executive Director of Quality.
- Page 66 Scheme of Reservation and Delegation – responsibility column change from Director for Contracting and Planning to Director for Performance for tendering and contracting procedures.
- Page 137 appendix H Primary Care Commissioning terms of Reference - voting members and attendees

It is recommended that the CCG Governing Body approve the proposed amendments to the current Constitution outlined above and in appendix 1 attached, to ensure that the Constitution remains accurate.

5. 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;

- Note and provide feedback on the new advice from NHS England 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;

- Note 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 for approval; and

- Approve 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 members of the Governing Body to reflect the newly created Executive structure.

Appendix 1 – Excerpts of the current CCG Constitution showing proposed changes

Page 10

FOREWORD

Shropshire Clinical Commissioning Group (CCG) was established as a statutory NHS Body on 1 April 2013.

A CCG is a membership organisation and the constituents, as defined by the Health and Social Care Act, are the primary care providers who hold a registered list of patients, i.e. GP practices ("practices"). The CCG is therefore the agent of the practices within a defined geographical area.

As a statutory body it is essential that a CCG has a Constitution and a Governance Structure.

This Constitution is based upon the Model Constitution produced nationally for CCGs and as such it is complex, detailed and written in legal language. Put simply however, it sets out the arrangements made by Shropshire CCG to meet its responsibilities for commissioning care for the people for whom it is responsible.

It describes the governing principles, rules and procedures that the Group will apply to ensure probity and accountability in the day to day running of the CCG; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the goals of the Group.

The Constitution originated from work undertaken over a period of months during which local stakeholder consultation was undertaken and has developed to reflect the evolution of the CCG as it strives to enhance the ways it meets the need of its population.

The Constitution applies to the following, all of whom are required to adhere to it as a condition of their appointment:

- the Group's member practices
- the Group's employees
- individuals working on behalf of the Group; and
- anyone who is a member of the Group's Governing Body (including the Governing Body's Audit and Remuneration Committees)
- anyone who is a member of any other committee(s) or sub-committees established by the Group or its Governing Body

Dr Julian Povey	Mr David Evans
Chair	Accountable Officer

Page 31 section 6.10.2

6.10.2. ***Composition of the Governing Body*** - the Governing Body shall not have fewer than six members and comprises:

a) Clinical Chair (drawn from the GP members)

b) Vice Chair (undertaken by the Lay Member for audit, remuneration and conflict of interest matters)

c) Five GPs (one of whom may perform a Deputy Clinical Chair role)

d) One Practice Representative

45 ~~See section 4.4 on Principles of Good Governance above~~

46 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

e) Four Lay Members:

i) one to lead on audit, remuneration and conflict of interest matters
Ii) one to lead on patient and public participation matters
Iii) one to lead on performance matters and primary care
iv) one to lead on transformation matters

f) One registered nurse (Executive Director of Quality ~~Nursing, Quality and Patient Experience~~)

g) One secondary care specialist doctor

h) The Accountable Officer

i) The Chief Finance Officer – CFO (Executive Director for Finance)

j) Three Locality Chairs (who are also locality member practice representatives)

h) The Executive Director for Transformation

For the purposes of this Constitution it should be noted that the CCG Chair is the Clinical Leader of the CCG

Page 58 sections 2.2.8. and 2.2.9

2.2.8. **The Registered Nurse**, as listed in paragraph 6.10.2 of the Group's Constitution – This role is fulfilled by **the Executive Director of Quality ~~Nursing, Quality and Patient Safety and Experience~~** as listed in paragraph 6.10.2 of the Group's Constitution, is subject to the following appointment process:

a) **Nominations** – N/A.

b) **Eligibility** – Fulfilling the various criteria outlined in the Job Description and Person Specification for the role.

c) **Appointment process** – The Executive Director of Quality ~~Nursing, Quality and Patient Experience~~ shall be appointed by the CCG in line with the process prescribed by NHS England.

d) **Term of office** – N/A.

e) **Eligibility for reappointment** – N/A.

f) **Grounds for removal from office:**

i) Breach of Employment Contract Terms (NHS or other);

ii) Consistent failure to perform the duties incumbent on the role for which

iii) they are employed – resulting in the implementation of the formal performance management process as outlined in the Group's HR Policies;

iv) Disqualification under regulations governing who can be a member of the

v) Governing Body of a Clinical Commissioning Group;

vi) Disqualification under professional regulations pertaining to their specific

role /professional body.

g) **Notice period** – The period of notice required will be as set out in the individual

Contract of Employment; or, in the case of disqualification (from either their professional body, or as set out in the regulations for eligibility to be a member of the Governing Body of a Clinical Commissioning Group) removal would be automatic and immediate.

2.2.9 **The Executive Director of Quality ~~Nursing, Quality and Patient Safety and Experience~~ (Registered Nurse)**, as listed in paragraph 6.10.2 of the Group's Constitution, is subject to the following appointment process:

a) **Nominations** – N/A.

b) **Eligibility** – Fulfilling the various criteria outlined in the Job Description and Person Specification for the role.

c) **Appointment process** – The Executive Director of Quality ~~Nursing, Quality and Patient Experience~~ shall be appointed by the CCG in line with the process prescribed by NHS England.

d) **Term of office** – N/A.

e) **Eligibility for reappointment** – N/A.

f) **Grounds for removal from office:**

i) Breach of Employment Contract Terms (NHS or other);

ii) Consistent failure to perform the duties incumbent on the role for which they are employed – resulting in the implementation of the formal performance management process as outlined in the Group's HR Policies;

iii) Disqualification under regulations governing who can be a member of the Governing Body of a Clinical Commissioning Group;

iv) Disqualification under professional regulations pertaining to their specific role/professional body.

g) **Notice period** – The period of notice required will be as set out in the individual

Contract of Employment; or, in the case of disqualification (from either their professional body, or as set out in the regulations for eligibility to be a member of the Governing Body of a Clinical Commissioning Group) removal would be automatic and immediate.

Page 57 new section 2.2.11

2.2.11 The **Executive Director for Transformation,** as listed in paragraph 6.10.2 of the Group's Constitution, is subject to the following appointment process:

a) **Nominations** – N/A.

b) **Eligibility** – Fulfilling the various criteria outlined in the Job Description and Person Specification for the role.

c) **Appointment process** – The Executive Director for Transformation shall be appointed by the CCG in line with the process prescribed by NHS England.

d) **Term of office** – N/A.

e) **Eligibility for appointment** – N/A.

f) **Grounds for removal from office:**

i) Breach of Employment Contract Terms (NHS or other);

ii) Consistent failure to perform the duties incumbent on the role for which they are employed – resulting in the implementation of the formal performance management process as outlined in the Group's HR Policies;

iii) Disqualification under regulations governing who can be a member of the Governing Body of a Clinical Commissioning Group;

iv) Disqualification under professional regulations pertaining to their specific role/ professional body.

g) **Notice period** – The period of notice required will be as set out in the individual

Contract of Employment; or, in the case of disqualification (from either their professional body, or as set out in the regulations for eligibility to be a member of the Governing Body of a Clinical Commissioning Group) removal would be automatic and immediate.

Page 60 section 3.7.2

3.7. Decision making

3.7.1 Chapter 6 of the Group's Constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the Group's statutory functions. Generally it is expected that at the Group's /Governing Body's meeting decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

3.7.2 Eligibility – the following people are eligible to vote:

a) Six GP/Primary Healthcare Professional members (which may include the Chair);

b) Four lay members (which may include the Chair and Vice Chair);

c) One registered nurse (Executive Director of Quality ~~Nursing, Quality and Patient Safety and Experience~~);

d) One secondary care specialist doctor;

e) The Accountable Officer;

f) The Chief Finance Officer;

g) Three Locality Chairs.

h) The Executive Director of Transformation

Page 67 Appendix C

Table showing who has responsibility for respective decisions

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 Performance~~Contracting & Planning~~	Other Committee
REGULATION AND CONTROL	Consideration and approval of applications to NHS England on any matter concerning changes to the Group's Constitution.			Y						

Page 137

Governing Body Primary Care Commissioning Committee

Terms of Reference

Introduction

1. In accordance with NHS England's statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 of the afore mentioned Act to Shropshire CCG. http://www.legislation.gov.uk/ukpga/2006/41/pdfs/ukpga_20060041_en.pdf

2. The CCG has established the Shropshire CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

3. It is a Committee comprising representatives of Shropshire CCG.

Statutory Framework

4. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 section 13Z of the afore mentioned Act.

5. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

    a) Management of conflicts of interest (section 14O & see): https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

    b) Commissioning decisions to be made in line with Shropshire CCG's Conflicts of Interest policy.

    c) Duty to promote the NHS Constitution (section 14P);

    d) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

    e) Duty as to improvement in quality of services (section 14R);

f) Duty in relation to quality of primary medical services (section 14S);

g) Duties as to reducing inequalities (section 14T);

h) Duty to promote the involvement of each patient (section 14U);

i) Duty as to patient choice (section 14V);

j) Duty as to promoting integration (section 14Z1);

k) Public involvement and consultation (section 14Z2).

7. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

a) Duty to have regard to impact on services in certain areas (section 13O);
b) Duty as respects variation in provision of health services (section 13P).

8. The Committee is established as a sub-committee of the Shropshire CCG Governing Body in accordance with Schedule 1A of the "NHS Act".

9. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

10. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the Shropshire CCG area under delegated authority from NHS England.

11. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Shropshire CCG, which will sit alongside the delegation and Terms of Reference.

12. The functions of the Committee are undertaken in the context of a desire to promote commissioning of primary care services to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

13. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

14. This includes the following:

a) GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
b) Directed Enhanced Services;
c) Design of local incentive schemes as alternatives to current schemes e.g. the Quality Outcomes Framework (QOF);

d) Design and approval of Local Improvement Schemes, if applicable
e) Decision making on whether to establish new GP practices in an area;
f) Approving practice mergers, closure of practices; and
g) Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

15. The Committee will also carry out the following activities:

a) Plan, including needs assessment, primary [medical] care services in the Shropshire CCG area;

b) Undertake reviews of primary [medical] care services in Shropshire CCG area;

c) Co-ordinate a common approach to the commissioning of primary care services generally;

d) Effective management and monitoring of the primary care budget for commissioning of primary [medical] care services in Shropshire CCG area. Ensuring the budget is balanced annually and evaluated for the best use of resources.

e) Review and receive feedback from the Primary Care Working Group.

f) Assurance of the delivery of the GP Forward View

Geographical Coverage

16. The Committee has responsibility for all patients registered with a GP practice (either permanently or temporary) and requiring access to primary care services. within the Shropshire CCG area only.

Membership

17. The Committee shall consist of:

Member	Rationale
• Lay Member for performance matters and primary care, Chair (v*)	External, strategic, impartial chairperson with expertise in the NHS
• Lay Member for transformation and Lay Member for patient and public participation matters, of which one to be Vice Chair (v*)	
• Accountable Officer or deputy i.e. Director of performance and service redesign (v*)	Ensure the CCG carries out its duties and responsibilities and improves health services for the local population
• CCG Chair (v*)	Ensure the CCG carries out its duties and responsibilities and improves health services for the local population and to provide clinical oversight
• Chief Finance Officer (Executive Director of Finance) or appropriate finance officer (v*)	To monitor financial balance and ensure value for money
• Secondary Care Specialist Doctor (v*)	Secondary care link to potential integration of services
• Director of Primary Care or deputy (v*)	Delivery of delegated commissioning of primary care ensuring sustainable and resilient primary care services
• Executive Director of Quality ~~Nursing and Quality~~ or deputy or quality representative as appropriate (v*)	Ensuring the committee is responsible for the commissioning of high quality health services Management of conflicts of interest and governance
• Executive Director of Transformation ~~Director of Corporate Affairs~~ or deputy (v*)	Non conflicted view of the achievement of good health outcomes
• External GP (v*)	

*V=voting rights

The following shall be in attendance:

- Lay Member with responsibility for Conflicts of Interest (as required)
- NHSE Primary Care lead or Primary Care Contracts Manager
- CCG Head of Primary Care
- Locality Chairs (South, Shrewsbury & Atcham, North)

- Practice Representative
- Director of Partnerships

18. The Chair of the Committee shall be the Lay Member for performance matters and primary care, as appointed by the Governing Body. If the Chair is absent from the meeting, the Vice Chair shall preside.

19. **Statutory Observers (for Part One of the Meetings)**

- Healthwatch Shropshire
- Health and Wellbeing Board representative
- NHS England
- Secondary care

20. **The Committee may also** extend invitations to other personnel with relevant skills, experience or expertise as necessary to enable to address matters before the Committee or as part of the Committee's cycle of business to support with the decision making process. These representatives will be noted in the minutes as 'in attendance'.

Meetings and Voting

21. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than seven days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

22. The Committee shall reach decisions by a simple majority of members present. However, the aim of the Committee will be to achieve consensus decision-making wherever possible. Where voting is necessary the Chair will determine if any parties will need to abstain due to a conflict of interest. Each Committee member shall have one vote. Where a vote is tied the Chair will have the casting vote.

23. Those staff deputising for Committee members unable to attend will be afforded the same voting rights as the Committee member themselves

Quorum

24. Quoracy will be a minimum of four members which must include :

- Lay Member
- Executive Lead (Accountable Officer or Director of Primary Care)
- Finance Representative
- Clinical Member

25. The Committee will remain quorate even if a clinical representative has to subsequently leave the meeting due to conflicts of interest.

Frequency of Meetings

26. The Primary Care Commissioning Committee will meet no fewer than four times per year.

27. Meetings of the Committee shall:

    a) be held in public at least once a quarter,

    b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Conduct of the Committee

28. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

29. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by Terms of Reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

30. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

31. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

32. The Committee will present its minutes to NHS England and the Governing Body of Shropshire CCG at their meetings held in public for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 29 above.

33. The CCG will also comply with any reporting requirements set out in its Constitution.

34. It is envisaged that these Terms of Reference will be reviewed annually, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model Terms of Reference from time to time.

Accountability of the Committee

35. In line with Prime Financial Documents and Scheme of Delegation of the CCG, the committee will:

    a) Review arrangements for the Commissioning of primary care in line with delegated authority from NHS England.

    b) Within existing governance arrangements recommend developments and resource to be directed to Primary Care Commissioning.

    c) Evidence compliance with matters arising in relation to potential conflicting interests in relation to the content of these Terms of Reference.

Decisions

36. The Committee will make decisions within the bounds of its remit.

37. The Committee may reserve the right to refer certain decisions to the CCG Governing Body, in particular in relation to financial matters, as determined by the Chair

38. The decisions of the Committee shall be binding on NHS England and Shropshire CCG.

39. The Committee will produce an executive summary report which will be presented to Midlands & East Region of NHS England and the Governing Body of Shropshire of the CCG each month for information.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.012
Shropshire CCG Governing Body Meeting: 15.01.20

Title of the report:	**Annual Emergency Planning Resilience and Response Assessment**
Responsible Director:	**Sam Tilley - Director of Corporate Affairs**
Author of the report:	**Sam Tilley - Director of Corporate Affairs**
Presenter:	**Sam Tilley - Director of Corporate Affairs**

Purpose of the report:
To update the Governing Body on the outcome of the annual Emergency Planning Resilience and Response assessment undertaken by NHS England.

Key issues or points to note:

CCG's are required to participate in an Emergency Planning Resilience and Response assessment each year which is undertaken by NHSE.
On the basis of this assessment NHSE allocate an assessment rating which may include actions for improvement. In 2018/19 Shropshire CCG received a rating of full compliance. This rating has been maintained into 2019/20.

NHSE have proposed both Shropshire CCG and Telford & Wrekin CCG increase the number of on call staff who are involved in emergency planning exercises to further support and enhance the emergency planning skills within the organisation. This will now be taken forwards as an action in conjunction with the usual annual cycle of EPRR activities.

A copy of the NHSE assessment outcome letter is attached

Actions required by Governing Body Members:

The Governing Body is asked to:

- Note the content of the report, in particular the continued rating of Full Compliance
- Support an on-going programme of EPRR work to ensure the Full Compliance rating can be maintained.

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, please provide details of the risks*	No

EPRR – Midlands
NHS England / Improvement
Anglesey House
Towers Business Park
Wheelhouse Road
Rugeley
Staffordshire
WS15 1UL

Mobile: 07710 152944
Email address: marcelcomer@nhs.net

Director of Corporate Affairs

Date: 24 October 2019

Dear Sam

Re: 2018 / 19 EPRR Assurance Process – Shropshire Clinical Commissioning Group

Subsequent to the submission of your Core Standards for EPRR 2019 / 20 (Self-Assessment) and Confirm & Challenge meeting undertaken on 7 October 2019, I can confirm that NHS England / Improvement (North Midlands) have evaluated Shropshire CCG Compliance Level to be ***fully compliant.***

Compliance level	Definition
Non compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

Whilst it was recognised that some good work has taken place since last year, there are improvements that will be required over the next 12 months in the following areas.

POST CONFIRM & CHALLENGE TABLE					
Ref	**Domain**	**Standard**	**Post Confirm & Challenge RAG**		
			Substantial	**Partial**	**Non**
Recommendations: Consider better attendance at exercises for all on call staff to enable staff to consolidate EPRR training during live events.					

Please can I take this opportunity to thank you for all your hard work over the last 12 months and your continuing support as part of the Core Standards Process.

Yours sincerely

Marcel Comer
Head of EPRR - Midlands (North and Central Midlands localities)
NHS England and NHS Improvement

Copy to:

Fran Steele, Director of Strategic Transformation / Locality Director, NHS England / Improvement

Oliver Newbould, Director of Intensive Support, NHS England / Improvement

Nick Hardwick, Director of Performance, NHS England / Improvement

Jeff Worrall, Director of Performance & Improvement, NHS England / Improvement

Jenny Dawson, Operations & Delivery Coordinator, NHS England / Improvement

The Shrewsbury and Telford Hospital NHS Trust

Mortality Update

Dr Edwin Borman

Director for Clinical Effectiveness

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CHKS Dashboard: October 2018 – September 2019

Description	Local Numerator	Local Denominator	Oct 18 - Sep 19	Oct 17 - Sep 18	Change	Peer Value	Performance
HSMR (Hospital Standardised Mortality Ratio)	1561	1750	89.22	91.05		90.10	
SHMI (Summary Hospital-Level Mortality Index) +	2312	2279	101.46	99.30		99.72	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018	1683	2849	59.07	61.72		65.40	
Mortality Rate	1683	171752	0.9799%	1.0930%		1.1438%	
RAMI (Risk adjusted mortality index) 2018	1683	1910	88.10	87.71		88.46	
Rate of Mortality in hospital within 30 days of elective surgery	2	3276	0.06105%	0.06355%		0.12798%	
Rate of Mortality in hospital within 30 days of Non elective surgery	86	7926	1.0850%	1.0945%		1.3485%	
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	7	236	2.9661%	3.793%		4.719%	
Rates of mortality in hospital within 30 days of emergency admission with a stroke	99	947	10.454%	11.255%		11.874%	
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	4	326	1.2270%	0.5935%		3.0920%	
Deaths in Low Mortality CCS Groups	16	12540	0.12759%	0.18983%		0.10759%	
Post operative pulmonary embolism or deep vein thrombosis	5	26186	0.019094%	0.03943%		0.03754%	
% Still Births	18	4202	0.4284%	0.4553%		0.3808%	
Mortality Rate - Admitted via A&E	1291	34207	3.774%	4.312%		3.416%	

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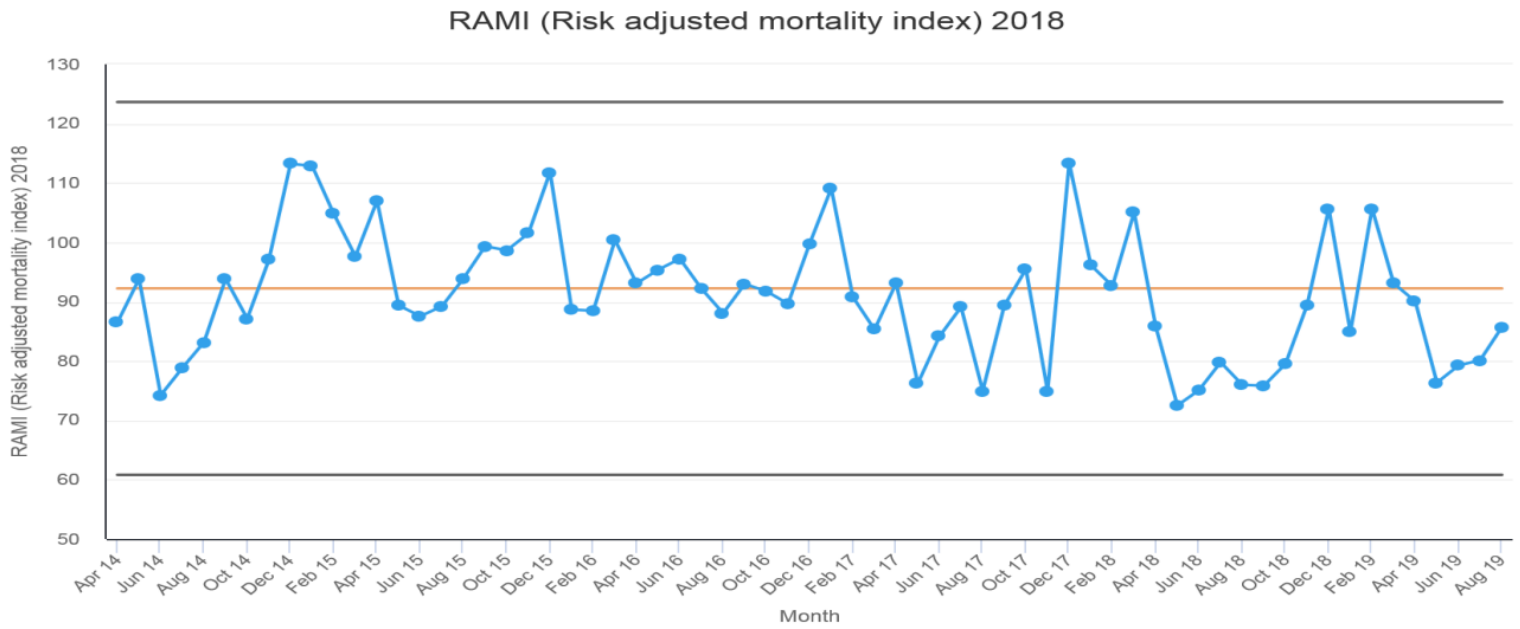
5 year Risk Adjusted Mortality Index SPC: currently 88.1



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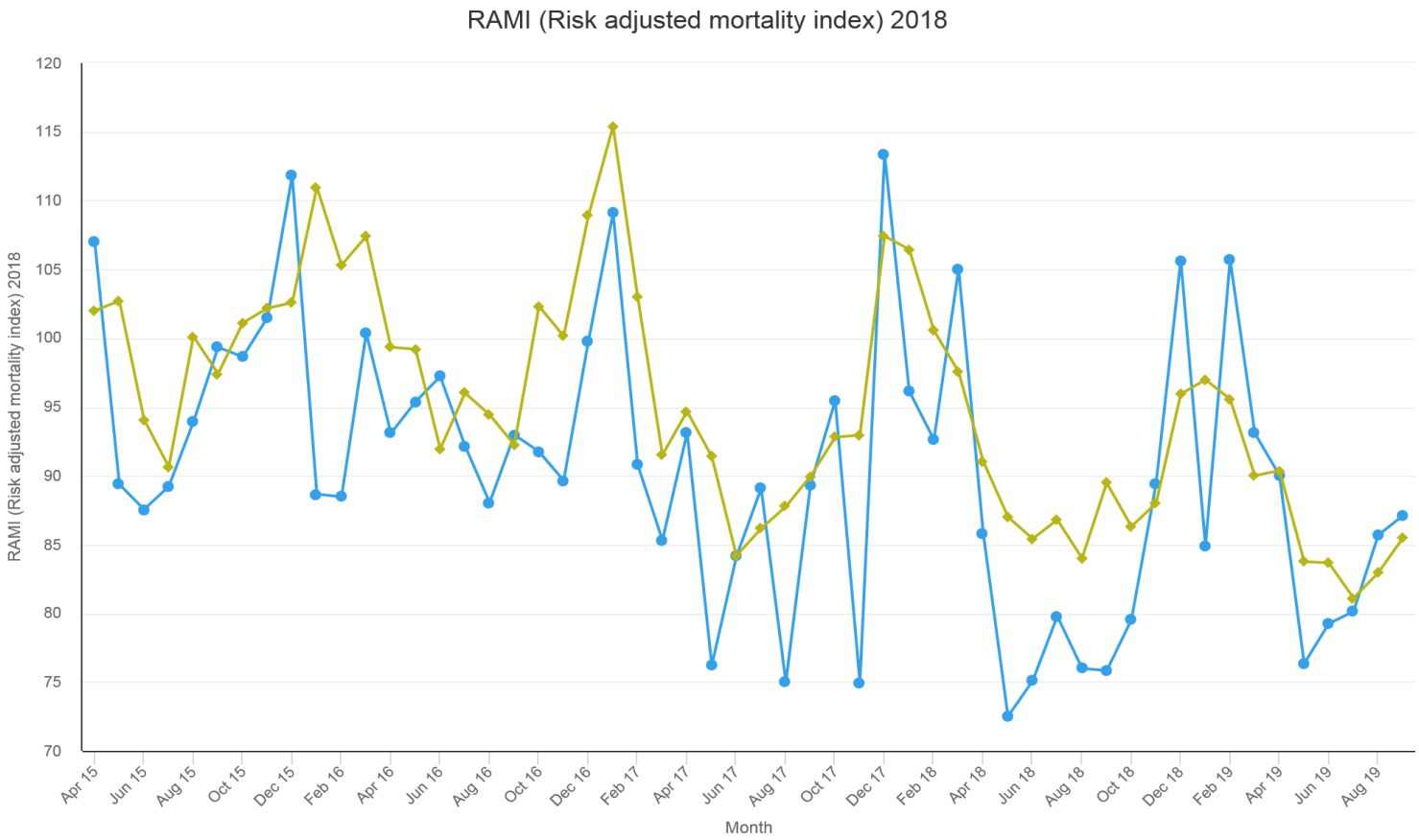
RAMI monthly Peer comparison - Trust blue, Peer yellow



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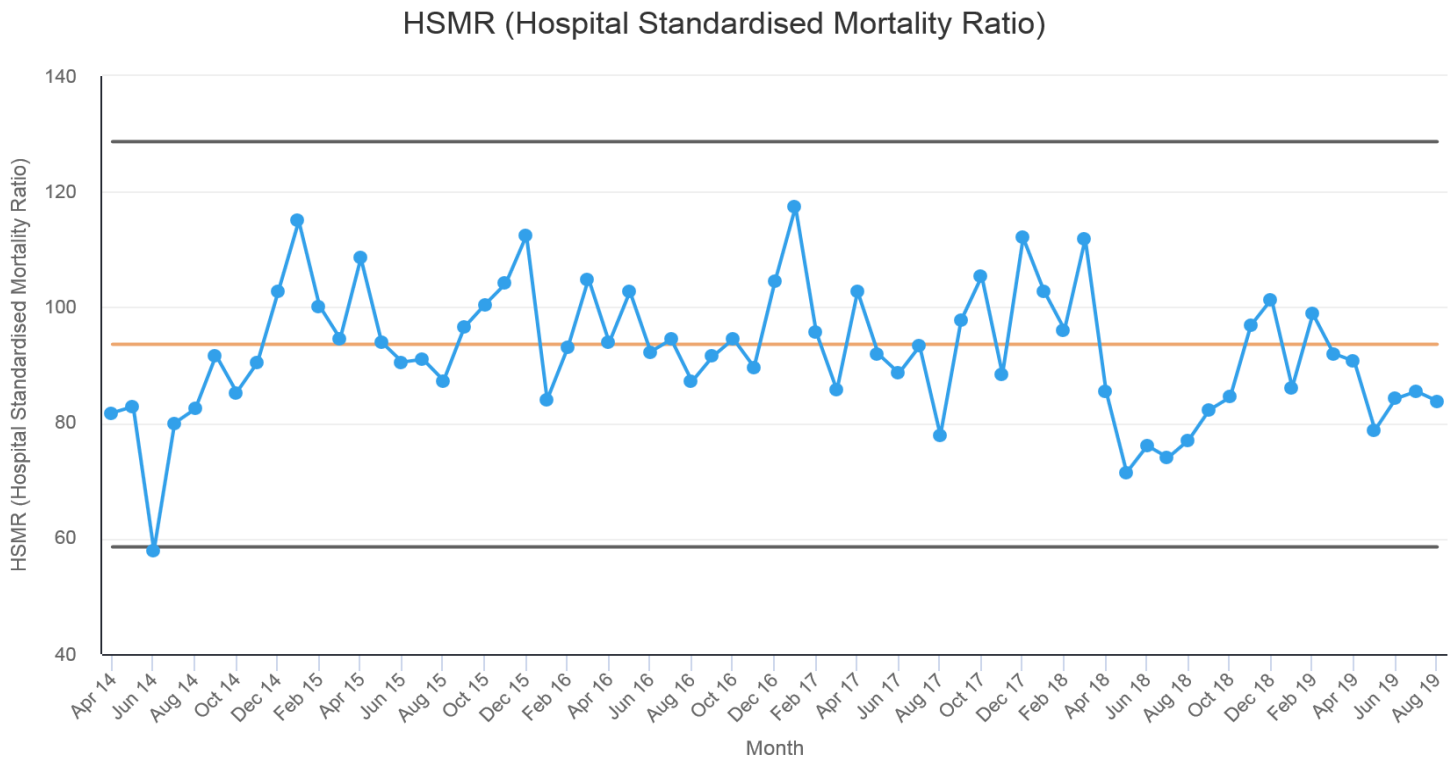
5 year Hospital Standardised Mortality Ratio SPC – currently 89.22



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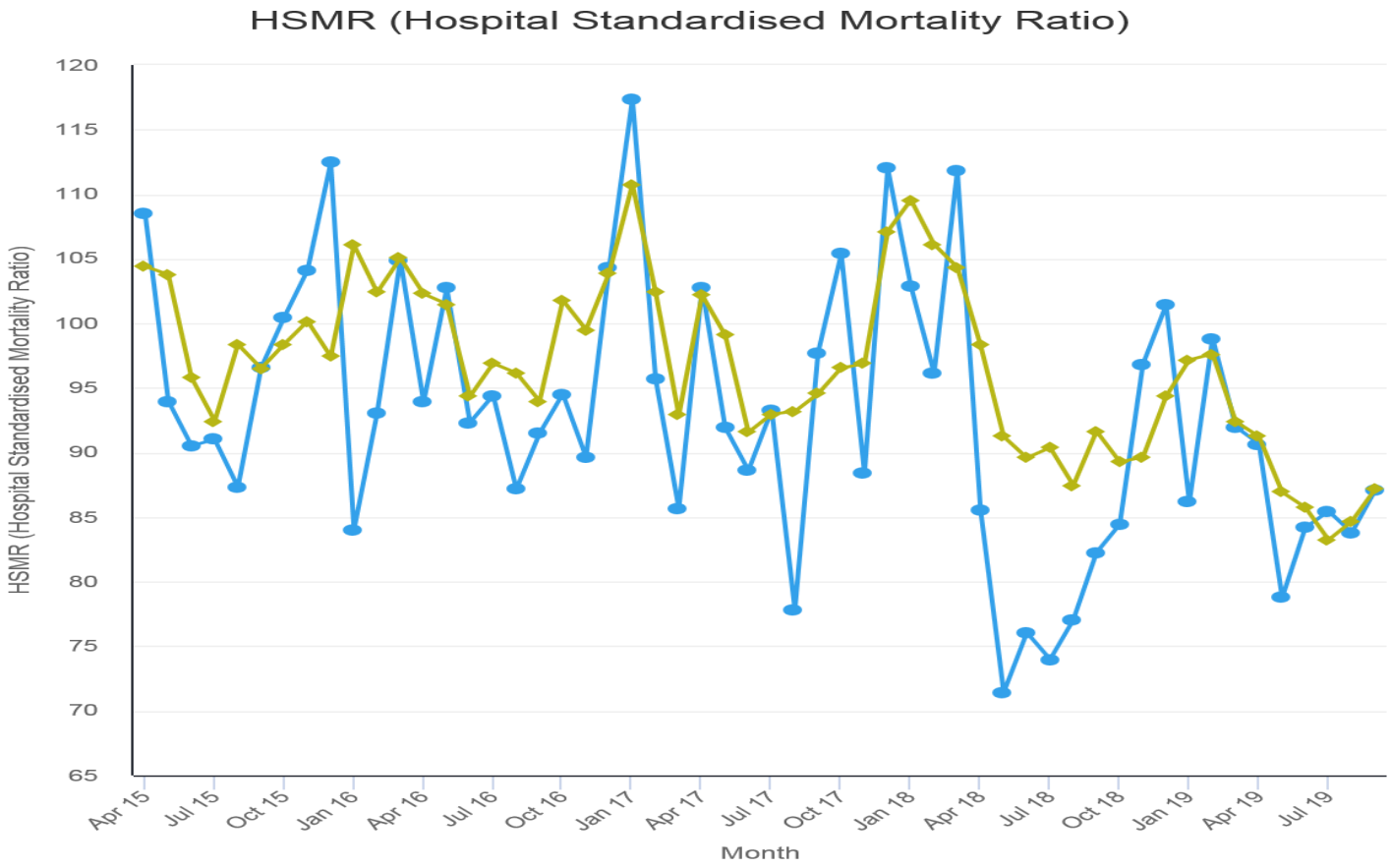
HSMR monthly Peer comparison - Trust blue, Peer yellow



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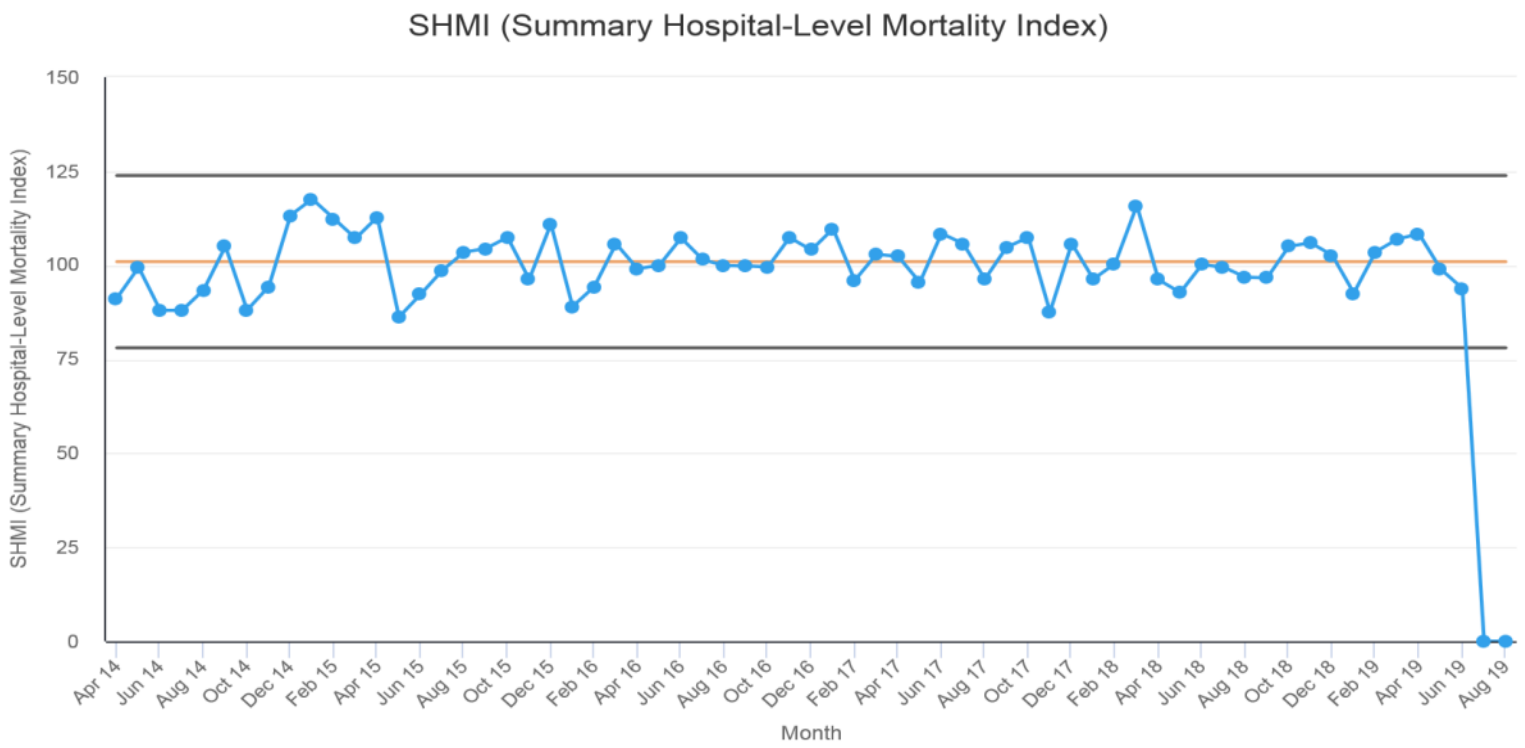
5 year SHMI SPC – currently 101.46



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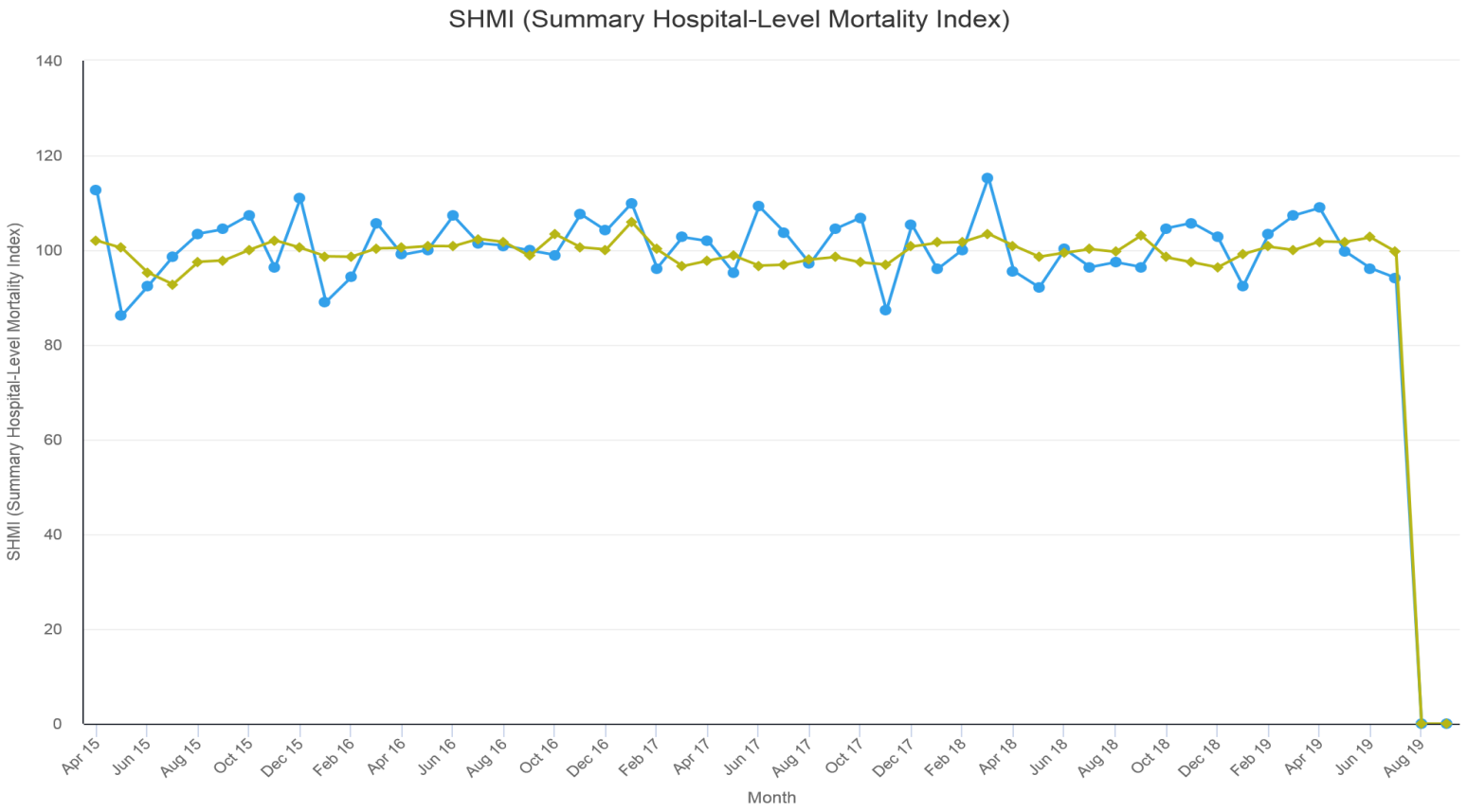
SHMI monthly Peer comparison – Trust blue, Peer yellow



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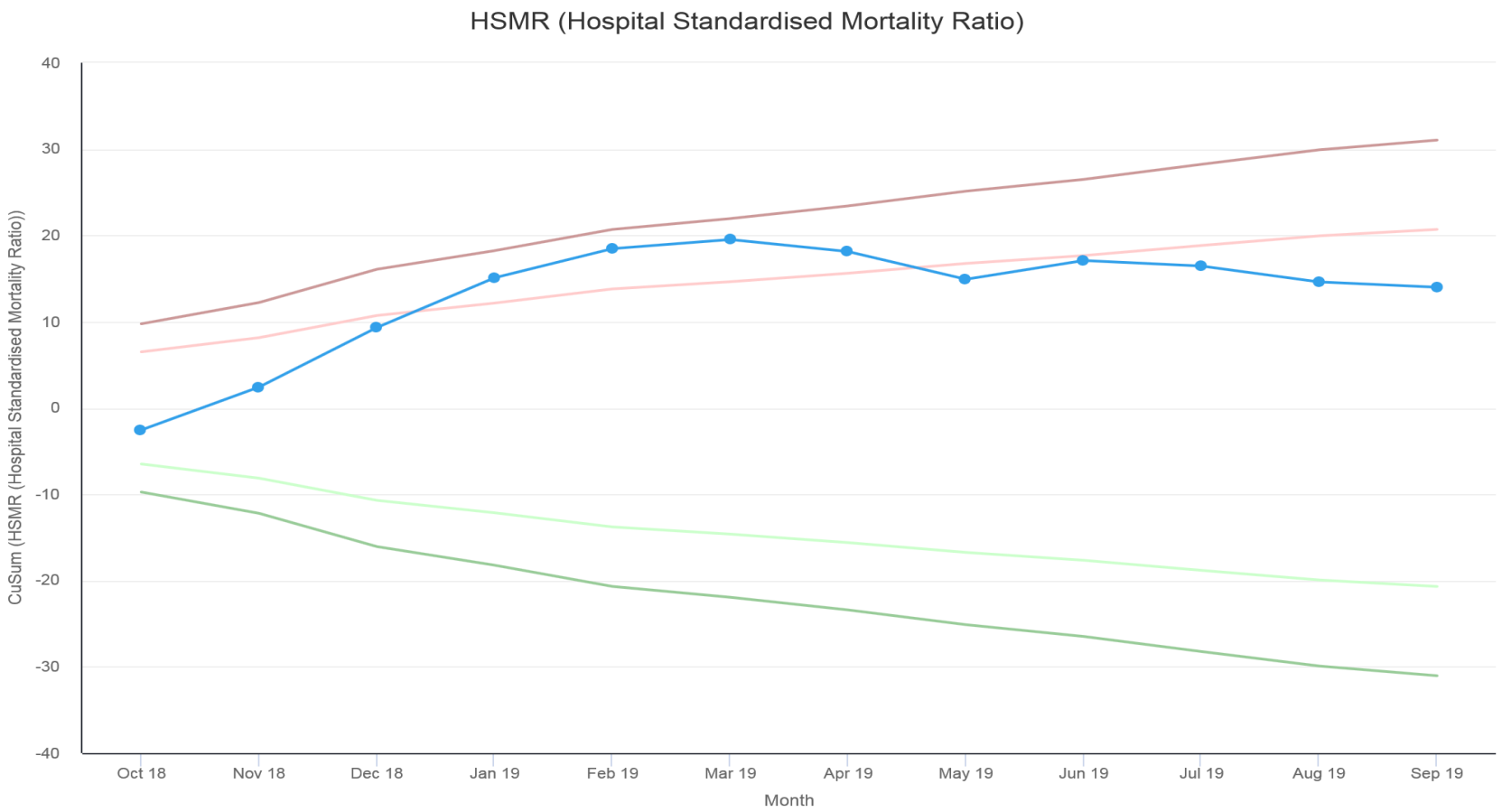
Acute cerebrovascular disease HSMR has improved



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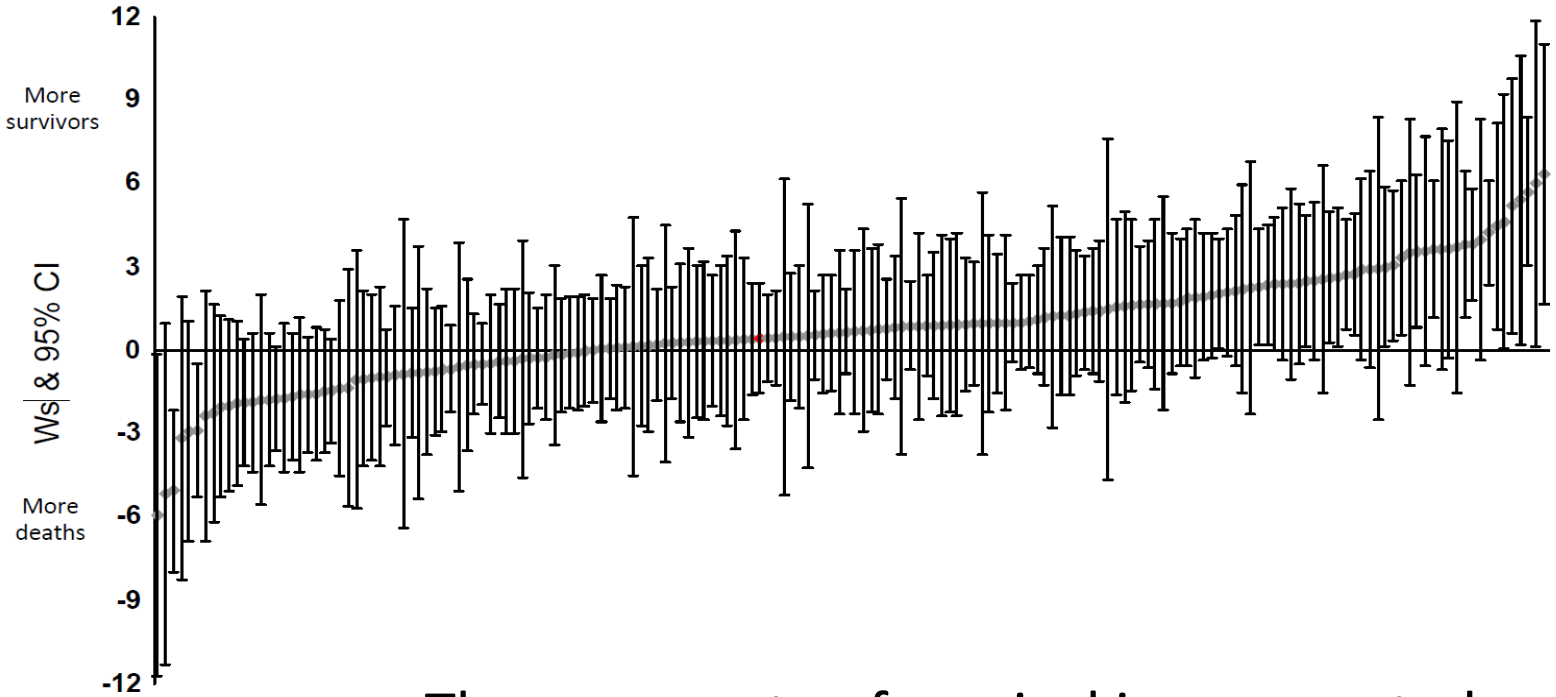
TARN Rate of survival: 01 April 2019 to 31 July 2019

Royal Shrewsbury Hospital



The excess rate of survival is as expected

The survivor /death ratio is 0.86

The data can be viewed with confidence

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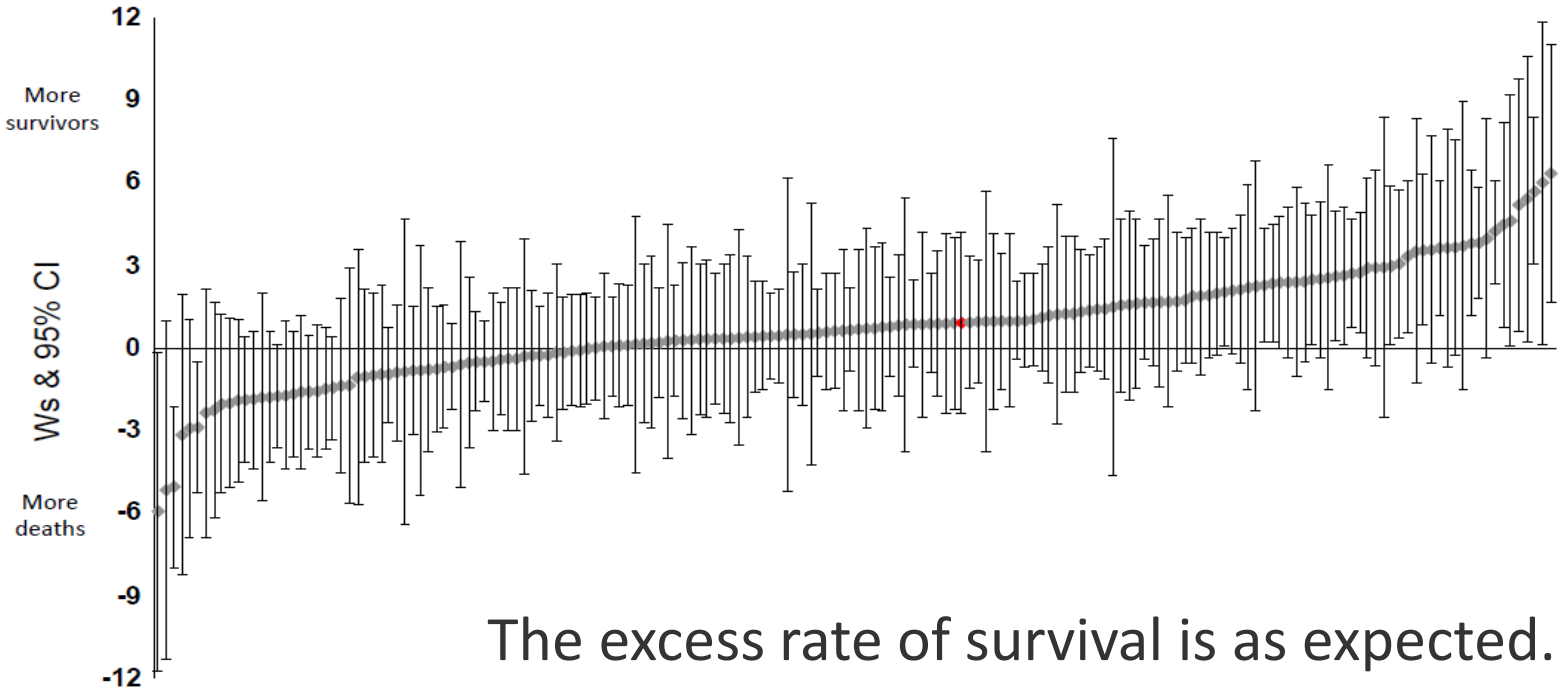
TARN Rate of survival: 01 April 2019 to 31 July 2019

Princess Royal Hospital



The excess rate of survival is as expected.

The survivor /death ratio is 1.18

The data can be viewed with confidence

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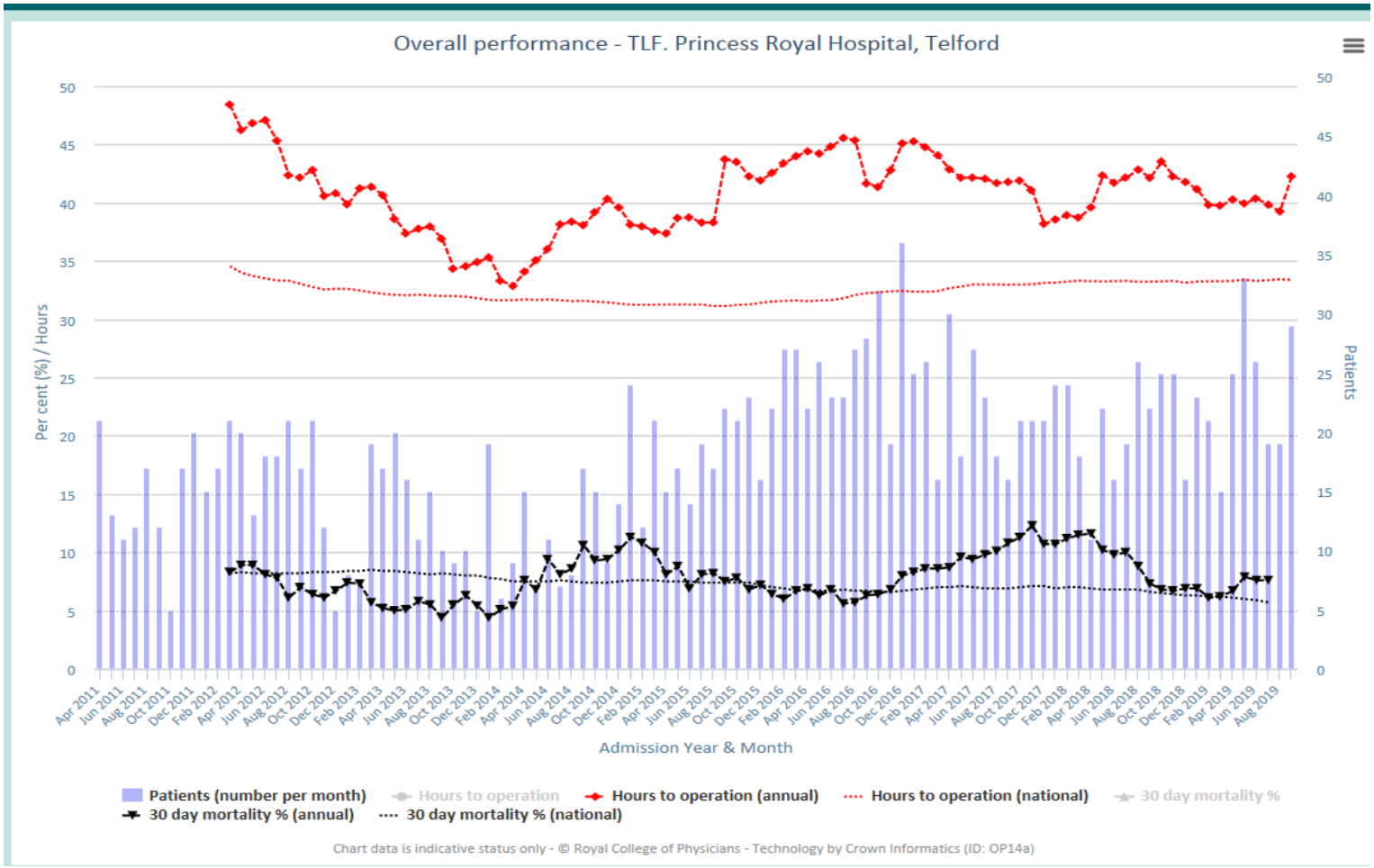
At PRH… NHFD 30 day Mortality has improved since 2018 but shows a slight increase above peer in Q2



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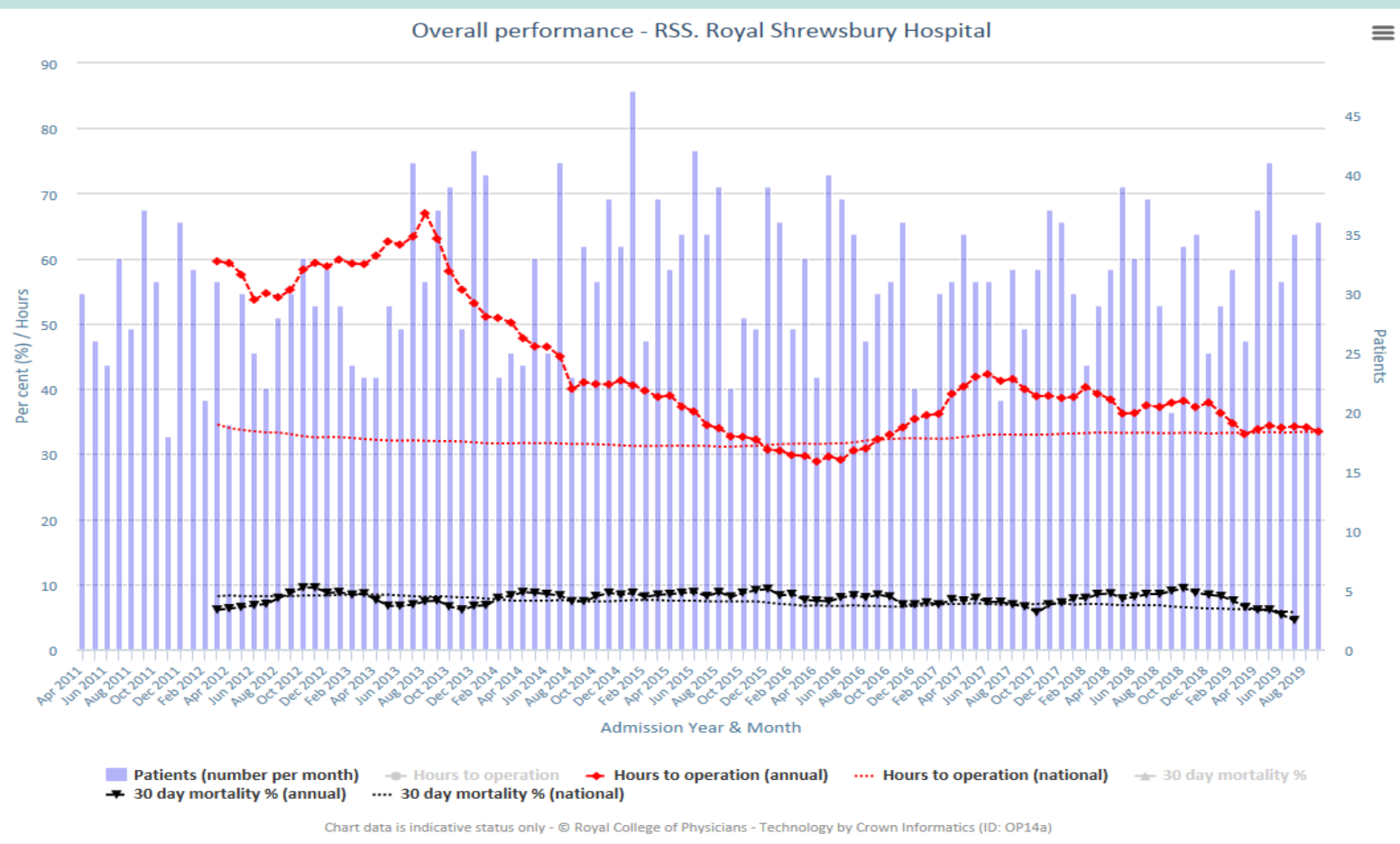
At RSH… NHFD 30 day Mortality has improved since 2018 and currently is below peer comparator



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Questions?

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NHS
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Clinical Commissioning Group

Agenda item: GB-2020-01.014
Shropshire CCG Governing Body meeting: 15.01.20

Title of the report:	Report from Audit Committee 16 December 2019
Responsible Director:	Sam Tilley, 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 16 December 2019 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 Financial Systems and Moderate Assurance on Financial Reporting and Delivery.
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 a series of self-review tools from our main providers. There is one outstanding for SaTH.

Actions required by Governing Body Members:

- Note the content of the report.
- Directors are asked to ensure committee papers are delivered on time. Committee chairs will consider whether to accept any late submission of papers.

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 16 December 2019
Keith Timmis: Lay Member –Governance & Audit

Matters arising

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

2 Concern was raised about the number of papers that have been issued late for a variety of CCG meetings. This fails to give attendees adequate time to read and consider the issues and recommendations. The Committee asked Mrs Tilley to raise this with the executive team.

Emergency Planning Resilience and Response

3 We discussed the annual assessment for our arrangements for Emergency Planning Resilience and Response. Our arrangements were again judged to be "fully compliant".

Internal audit

4 Internal audit reported there was good progress on outstanding internal audit recommendations.

5 The Internal Audit report on financial systems concluded there is Significant Assurance for our arrangements. They noted the progress that has been made over the last year. The Chief Finance Officer reported on the development of a formal reconciliation process with Shropshire Council that will speed up transactions where possible and identify disputed items.

6 The report on financial reporting and delivery concluded with Moderate Assurance for our arrangements. The processes for reporting were rated highly, with actions being highlighted for forecasting, particularly on QIPP.

External audit

7 As I reported to the Governing Body in my previous report, external audit have completed their work on the special review of mental health expenditure. We are not expecting to have any issues of significance to report to the Governing Body.

8 NHS E&I are still asking CCGs to delay publication of the results of this work. The release of the reports is not expected until later in January 2020. NHS England and NHS Improvement will publish consolidated results, key themes and proposed next steps.

9 Our contract for external audit ends at the close of this financial year. Both Shropshire and Telford & Wrekin CCG auditor panels have agreed a process to ensure we have an external auditor in place for 2020/21.

Counter Fraud

10 The Local Counter Fraud Specialist reported on the self-review tools completed by our local suppliers. There is one outstanding for SaTH. There were no significant issues from the tools to report to you.

11 The NHS Counter Fraud Authority is proposing to introduce a new system of "fraud champions". There are few details on this role, or how it links with existing structures. Future reports will provide details as they become available.

Other matters

12 The Committee provisionally agreed to delegate agreement of the draft accounts before submission to the CFO and Chair of the Audit Committee (as we did last year). The full Audit Committee will receive an update at its meeting later in April, with a full review of the accounts and the report from the external auditors in May.

Next meeting

13 The next Audit Committee is scheduled for 26 February 2020.

NHS
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Agenda item: GB-2020-01.015
Shropshire CCG Governing Body meeting: 15.01.2020

Title of the report:	Healthwatch Shropshire: Highlights September – December 2019
Responsible Director:	Lynn Cawley (Chief Officer)
Author of the report:	Lynn Cawley (Chief Officer)
Presenter:	Lynn Cawley (Chief Officer)

Purpose of the report:

The purpose of the report is to update the CCG Governing Body on the activities and impact of Healthwatch Shropshire.

Key issues or points to note:

The team continues to work to meet all our statutory functions and key priorities for 2019-20.

Since we last reported to the SCCG Governing Body we have:

- Completed our Hot Topic report on End of Life and Palliative Care
- Asked people to share their views with us on 'Access to Primary Care' and we are currently completing a number of Enter & View visits to GP practices to speak to patients
- Followed up our report on Maternity Mental Health by running a focus group in Oswestry at the request of the LMS to find out what a group of new mums know about the mental health support available, how they access peer support and how they prefer to access information
- Started a new piece of work for Healthy Lives to explore what Social Prescribing should look like for 16-25 year olds
- Been invited to attend STP Cluster Meetings to represent the patient voice
- Published an Enter & View report on 'Dementia Care in Shropshire Care Homes' summarizing our findings from visits to eight care homes across the county
- Published Enter & View reports for four wards at Royal Shrewsbury Hospital

Actions required by Governing Body Members:

The Governing Body is asked to note the contents of this 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*	Yes/No
2	Health inequalities *If yes, please provide details of the effect upon health inequalities*	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 *If yes how will this be mitigated*	Yes/ No

NHS Shropshire Clinical Commissioning Group

Shropshire CCG Governing Body meeting 15th January 2020

Healthwatch Shropshire: Activities September – December 2019
Lynn Cawley, Chief Officer, Healthwatch Shropshire

Introduction

Gathering and understanding people's experiences of using local services is fundamental to informing the activities of Healthwatch Shropshire (HWS).

As well as continuing to deliver on our statutory functions, our priorities for 2019-20 are:

1. Mental health and well-being, e.g. 0-25 services, quality of dementia care in care homes
2. Adult social care, e.g. partnership work around discharge and care at home
3. Primary Care, e.g. access, technology and shared care records, out-of-hours
4. Prevention and Social Prescribing, e.g. community resilience

Our Annual Report for 2018-19 was published in June:

http://healthwatchshropshire.co.uk/sites/default/files/hws_trustee_report_financial_statements_ye_310319_signed.pdf

Report

1. Intelligence

1.1 Hot Topic

- August – September: End of Life / Palliative Care

Background: HWS had already considered the value of this being the subject of a Hot Topic in order to find out more about people's experiences of end of life and palliative care services. When approached by the CCG to ask if we could help to gather feedback from people about their experience of palliative care following a change of out-of-hours provision it was agreed that a Hot Topic would be a softer approach to gathering this feedback than a targeted questionnaire.

SaTH did not agree to include our flyer in Swan (Bereavement) Packs until the end of September and the Community Engagement and Communications Officer attended a 'Living Well' session at Severn Hospice on Thursday 21st November which meant the drafting of the report was delayed. At the time of writing this report, we have received 33 experiences, which include comments on a range of services. We have shared the draft report with providers and the CCG for comment. The report with be published WB 13th January 2020.

- October – December: Access to Primary Care

During this time we focused our engagement on asking people to share their experiences with us on accessing GP appointments, including 'extended access' appointments and what they do when they can't get an appointment when they want/need it (e.g. going to a Pharmacy, UCC, A&E). We sent a questionnaire to all Practice Managers to find out how appointments are made available and how patients are informed about the 'extended access' offer. We decided to widen our reach by also conducting Enter & View visits to some practices to speak to patients. We are hoping these visits will be completed by the end of January 2020 so our findings can be included in the final report.

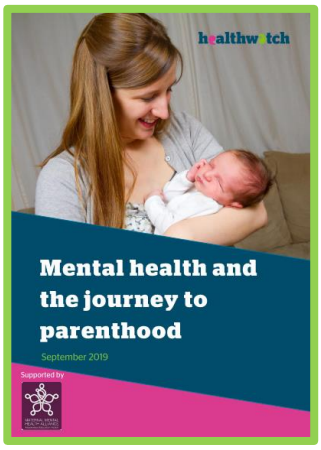
- December – January: Winter Messaging / Speak Up

Each year Healthwatch Shropshire uses our engagement channels to promote winter messaging to support the local health and social care system.

We are also supporting the Healthwatch England 'Speak Up' campaign to continue to encourage the public to share their views with us about all health and social care services.

1.1.1 Hot Topic Update:

- Maternity Mental Health (Peri-natal Mental Health)



Following our Hot Topic on Peri-natal Mental Health in September 2018, we were selected by Healthwatch England as one of five local Healthwatch to conduct wider engagement to inform their national report on Maternity Mental Health. This project was undertaken January – March 2019 and our 'Maternity and Mental Health Engagement Report' was published 24th June 2019. This report fed into the Healthwatch England report 'Mental health and the journey to parenthood' published September 2019.

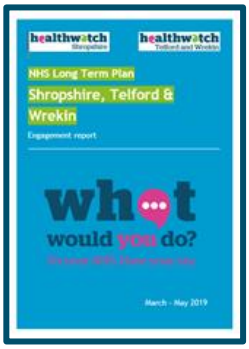
https://www.healthwatch.co.uk/mental-health-and-journey-parenthood (Healthwatch England webpage)

https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20190904%20Mental%20Health%20and%20Maternity%20Report%20%20FINAL%20%20-%20Compressed%20Webready_0.pdf (Healthwatch England Report)

Telford & Wrekin CCG decided that they would like a similar piece of work completed in their area and commissioned HWT&W to complete this using the model and resources developed by HWS. This report has now been published.

Since completing our reports, Healthwatch Shropshire and Healthwatch Telford & Wrekin have both supported the LMS by holding a follow-up focus group to speak to people to find out if they know what support is our there for maternity mental health, how they access peer support and how they would like to access information. The feedback from these focus groups have been shared with the LMS. It is expected that the LMS will work to hear from more people across the county by creating an on-line survey.

1.2 STP Long Term Plan



Following the publication of the NHS Long Term Plan in January 2019, NHS England asked all local Healthwatch to give people the opportunity to have their say on how the national plan should be delivered locally. HWS were the coordinating Healthwatch working with Healthwatch Telford and Wrekin across the Shropshire, Telford & Wrekin Sustainability and Transformation Partnership footprint to complete a range of public engagement activities between March and May 2019. In total, we heard 641 views (376 in Shropshire, 265 in Telford & Wrekin).

Our report was published 15th July 2019 and we are continuing to highlight our findings and recommendations at meetings across the STP regarding the local long-term plan.

http://healthwatchshropshire.co.uk/sites/default/files/uploads/HWS,HWT&W_What_would_you_do_report.pdf

1.2.1 STP Long Term Plan Update:

Lynn Cawley (Chief Officer) gave a presentation on our findings to the STP Communications and Engagement Workstream 3rd July 2019 and to the Health and Wellbeing Board (HWBB) 14th November 2019. The Chair and Vice Chair of the HWBB both commented on the quality and value of the report. Accountable Officers from Shropshire and Telford & Wrekin CCGs agreed with their comments and re-iterated that our findings have been considered when developing the local Long Term Plan. Lynn emphasised the need for on-going public engagement across the system so that the public feel fully informed and involved when the plan moves towards implementation. The Chair and Board members agreed.

2 Communications and engagement

2.1 Update on engagement activities

The Community Engagement and Communications Officer (CECO) is continuing to build links with:

- Working people, in particular the farming community (e.g. to ask their views on mental health support and the Suicide Prevention z-card produced by Public Health)
- Mental health services, including MPFT and Shropshire Council, to help us reach those people with experiences of using a range of mental health services.

Our Annual Event will take place on 4th March 2020 (at the request of VCS colleagues we have spoken to). The focus of the event will be prevention and community resilience.

2.2 Social prescribing report

Following the publication of our engagement report 'Social Prescribing: Exploring Barriers' in March 2019, Shropshire Council's Healthy Lives have shared the report and our findings at a regional and national level with the Social Prescribing National Network and NHS England to be added to their websites. The response to the report and our findings has resulted in Healthy Lives asking us to complete a second piece of work to understand what Social Prescribing should look like for 16-25 year olds, including their views on volunteering (their motivations for volunteering and what the barriers to engagement might be for this age group). We will be running focus groups and are in the process of putting a questionnaire on our website that we will be promoting.

2.3 Partnership working

We continue to attend meetings across health and social care and have now been invited to attend the Sustainability and Transformation Partnership Cluster meetings. It has been suggested that Healthwatch Shropshire and Healthwatch Telford & Wrekin should be invited to speak to the Senior Leadership Group to explain our role and discuss how we can work with the STP going forward.

For example, one of the functions of Healthwatch Shropshire is to provide the public with advice and information about access to services and so support them to make informed choices. Our role is to understand how local people prefer to seek and receive information and ensure information is up to date, relevant, impartial and accurate and people can have access to this information regardless of background, disability, age, etc. We aim to work in partnership with the CCG and providers to support them to develop good quality information in the formats that people want and ensure that people can access this information when and where they want to. Another function is to promote and support the involvement of local people in the commissioning, provision and scrutiny of services. We have experience of public and patient involvement and can offer advice and support to partners to do this.

2.4 MLU Review and Consultation

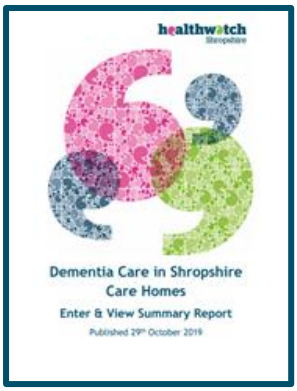
We have offered feedback on consultation documents and our support at events to give the public an opportunity to share their thoughts with an independent organisation and support them to approach the professionals present and ask questions.

3 Enter & View

3.1 Staffing and capacity

We currently have 10 Enter & View Authorised Representatives (ARs - volunteers who have been trained and DBS checked). All new ARs have completed their first visits and some are progressing to leading on visits and reports.

3.2 Visits and reports



Our report into 'Dementia Care in Shropshire Care Homes' was published 29th October 2019. This overarching report highlighted our findings and recommendations following a programme of visits to eight care homes across the county that are registered with the CQC as providing some level of dementia care. As well as gathering feedback from residents and their visitors, we spoke to staff to learn more about the care they provide and looking at how 'Dementia Friendly' the environment was. We also selected homes that have achieved the Gold Standard Framework for End of Life care to try and understand what this means for residents and their families.

https://www.healthwatchshropshire.co.uk/report/2019-10-29/dementia-care-shropshire-care-homes-enter-view-summary-report

We have also published four reports following visits to wards at Royal Shrewsbury Hospital: Ward 27 (General Medicine), Ward 22 (Respiratory), Ward 24 (Cardiology), Ward 23 (Oncology/Haematology)

All published Enter & View Reports are available on our website at:
http://www.healthwatchshropshire.co.uk/enter-view-reports-0

3.3 Follow-up activities

In October 2018 Healthwatch Shropshire published 'The NHS Accessible Information Standard in GP Practices Enter & View Summary Report'. In September Lynn Cawley (Chief Officer) was asked to deliver a session on the NHS Accessible Information Standard to the North and Central Locality Meetings for GP practice staff. These sessions were delivered with Jane Blay, Patient Experience Lead for Shropshire CCG. Across both meetings Lynn and Jane spoke to a total of 182 practice admin staff.

5 You Said We Did

Healthwatch Shropshire have moved to a new website. We are currently reviewing our approach to demonstrating the impact of our work.

https://www.healthwatchshropshire.co.uk/

Example YSWD:

- We were told that End of Life patient records are flagged on a GP system and when relatives speak to 111 they just need to tell the call operators that the patient is in end of life or palliative care, they should then be put straight through to ShropDoc. We explained to a GP practice that all patients and their carers may not be sure of what to say and they undertook to ensure that all patients and carers will be advised on what to say when speaking to 111.

- The findings published in our Maternity and Mental Health Engagement Report have been taken into account by the Local Maternity Service when developing the new Perinatal Community Mental Health Service for Shropshire, Telford & Wrekin.

6 Get in Touch

Please contact Healthwatch Shropshire if you would like more information about the content of this report or to share your views and experiences of local health and social care services in Shropshire.

01743 237884

enquiries@healthwatchshropshire.co.uk
www.healthwatchshropshire.co.uk

Healthwatch Shropshire
4 The Creative Quarter, Shrewsbury Business Park, Shrewsbury, Shropshire, SY2 6LG

7 Summary and Conclusion

HWS remains a four-day service and has a full staff team, however a member of staff will shortly be going on maternity leave so we are in the process of recruiting for maternity cover for this post. We continue to undertake our statutory activities, address our key priorities and raise the profile of HWS.

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-01.016
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	Clinical Commissioning Committee
Date of Meeting:	16 October 2019
Chair:	Sarah Porter

Key issues or points to note:

- **Decommissioning/Disinvestment Policy**
  New policy, which aligns with T&W CCG, discussed and agreement to take to Governing Body to sign off.

- **Health Improvement and Medicines Management**
  Committee approved the strategic direction, operational plans and governance structures for APC (Area Prescribing Committee)

Actions required by Governing Body Members:

- Approve Decommissioning/Disinvestment Policy

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN ROOM K2 AT 9.00AM ON WEDNESDAY 16 OCTOBER 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
Mrs Claire Skidmore	Chief Finance Officer
Dr Alan Leaman	Secondary Care Consultant
Dr Jessica Sokolov	Medical Director
Dr Priya George	GP Board Member
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Nicky Wilde	Director of Primary Care
Mr Kevin Morris	GP Practice Manager Board Representative
Mr Meredith Vivian	Lay Member for Patient & Public Involvement
Emma Pyrah	Head of In Hospital (rep. Julie Davies)
Joe Allan	Head of Quality (rep. Chris Morris)
Mrs Trudy Attfield	Personal Assistant (Minute taker)

In Attendance:

Ms Barrie Reis-Seymour	(Agenda item 19/10/116 – Shropshire Care Closer to Home Update)
Miss Beth Emberton	(Agenda item 19/10/117 – Decommissioning/Disinvestment Policy)
Mr David Whiting	(Agenda item 19/10/118 – Introduction of the FIT Test in Shropshire)
Mrs Lynda Ferron	(Agenda item 19/10/119 – RJAH Clinical Audit)
Mrs Liz Walker	(Agenda item 19/10/120 – Medicines Management Strategy)

Apologies:

Mrs Chris Morris	Director of Nursing & Quality
Mr David Stout	Accountable Officer
Dr Julie Davies	Director of Performance & Delivery
Dr John Pepper	GP Board Member
Dr Finola Lynch	GP Board Member
Dr Julian Povey	CCG Chair
Rachel Robinson	Public Health Director

CCC-19/10/113 Apologies

Apologies were noted as above.

CCC-19/10/114 Members' Declarations of Interest

1.0 Mrs Porter requested that attendees declared any potential conflicts of interest regarding the Committee agenda. There were no declarations of interest.

CCC-19/10/115 Minutes/Actions of Previous Meeting 18.09.19 & 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.

CCC-19/10/116 Shropshire Care Closer to Home Update

3.0 Mr Barrie Reis-Seymour gave an update to members:

3.1 Phase 1 – The FIT teams are in place on both the RSH and PRH sites and all services/teams functional and performing well. A substantive Consultant Geriatrician had now been appointed. Ongoing discussions were taking place with SaTH and the SSP future team regarding the definition of an avoided admission to ensure that everyone was working to the same process. Going forward there would be ongoing monitoring and scrutiny of the performance data received and would then check this against required achievement.

3.2 Discussions were held as to whether admission avoidance was being achieved and the need to understand any gaps in service. Dr Bird talked about a case study problem he had experienced with regard to a patient requiring a community hospital bed and advised that the patient, following complicated discussions with CCC, ended up being admitted to A&E and highlighted that this could have been an avoided admission. Dr Sokolov stated that the FIT team was around managing people who had already arrived at Hospital as they would manage this cohort more speedily and this in turn would hopefully avoid future second admissions into hospital. The wider problems would be covered under other areas of Shropshire care closer to home in managing/implementing areas already agreed to ensure delivery.

3.3 Phase 2 – Case Management is up and running. The case load across all the pilots totalled 475 people. Mr Reis-Seymour reported that the forms were circulated three weeks ago and that there had been a 42% response rate, 7% had declined and 35% had agreed. The 35% were now being actively case managed by the teams. Responses were still awaited from 273 people and he stated that the team was allowing a few more weeks to receive responses due to the staggered implementation. Just over 50% of the individuals picked up had been identified as new and unknown to the Health and Social Care professionals and this had been highlighted as a workforce risk. Currently working with Shropcom on the here and now issues to try to ensure the case management pilots continued to function as effectively as possible.

3.4 It had been agreed at Execs to fund the initial assessments as requested to continue the case management. Dr Lewis raised strong concerns over the Community Trust not providing the expected service and said that she felt that this was not improving and action was required. Dr Sokolov advised that discussions around how best to implement community service plans were ongoing. It was agreed that Mr Reis-Seymour would bring back a report on the SCHT workforce issues around delivering case management including the need, the issues and the planned solutions to enable delivery of the pilots. Mrs Skidmore agreed to also discuss at Execs with regard to actioning going forward.

Action: A report to be brought back to November CCC on SCHT workforce issues around delivering case management including the need, the issues and the planned solutions to enable delivery of the pilots. Mrs Skidmore to discuss concerns at Execs

3.5 Mr Reis Seymour and Ms Wicks had met with Health Education England who were now going to lead, as a neutral post, a system workforce transformation workshop to include the whole system to explore what capacity resource and skill mix existed, taking into account where they needed to get to and they then would carry out the workforce mapping. Concern was noted that Shropcom were not currently engaging with Commissioners.

3.6 Phase 3 - The semi acute community based services – The CCC had agreed the model in principal in June on the proviso that a 3 month impact assessment with the providers was carried out to test out any unintended negative impact as a result of putting the models in place. A paper would be brought back to the November CCC meeting outlining the Phase 3 Impact Assessment Outcomes. Mr Reis-Seymour advised that SaTH was the only provider still to provide requested information and that this was now being escalated to the programme board and possibly the system leader's group. Mr Reis Seymour advised that initial feedback on the models from the workshops had been positive.

Action: A report to be brought back to November CCC on the Phase 3 Impact Assessment Outcomes

CCC-19/10/117 Decommissioning/Disinvestment Policy

4.0 Miss Emberton presented the policy to members and explained that this was a new proposed policy for Shropshire CCG and that this aligned with the Telford and Wrekin Policy which would ensure consistency and collaboration across the County. There is no Decommissioning and Disinvestment Policy in place for Shropshire CCG currently and therefore this meant that there was no standardised process for projects where decommissioning or disinvestment was being explored.

4.1 Mrs Skidmore stated that she supported the framework in principal but expressed concerns that parts of the presented policy were out of date and she suggested that the policy needed to be removed and reviewed. It was agreed that Mrs Skidmore would work with Miss Emberton and produce an up-to-date structured Policy across both CCGs. Members were asked to forward

any comments to Mrs Skidmore/Miss Emberton to include within the new drafted policy. It was agreed that once the new policy had been produced this would be presented to the Governing Body for sign off. Mrs Fortes-Mayer said that she was happy to be involved in producing the policy as needed to ensure that this aligned with the procurement policy.

Action: Members to send comments to Mrs Skidmore/Miss Emberton to utilise within new up-to-date policy. Once agreed this would be taken through Governing Body for sign off.

CCC-19/10/118 Introduction of the FIT Test in Shropshire

5.0 Mr Whiting presented a paper to members outlining the latest recommendations for the use of FIT in primary care for patients with certain symptoms suggestive of colorectal cancer but did not meet the threshold for a 2 week wait referral.

5.1 The cost of the test is low approximately £11 and the cancer alliance would fund the cost of the test for the first two years. There was sufficient evidence nationally and locally to show that this test should be carried out and Telford and Wrekin have already been using FIT for over 2 years.

5.2 Dr Shepherd asked if the referral process could be changed to say that if the patient did not return the test the laboratory would follow up direct with the patient instead of the GP. Mr Whiting agreed that he would look into this.

5.3 Dr Bird highlighted that there was a need to educate GPs/Practices with regard to utilisation of the test. It was suggested that this could be rolled out through Locality meetings.

Mr Whiting noted comments to feedback. Members agreed to endorse the FIT being utilised in Shropshire CCG as soon as possible

CCC-19/10/119 RJ&AH Clinical Audit

6.0 Ms Ferron presented to members the findings of the C2C audit undertaken at RJAH in May 2019 and asked members to approve the recommendations.

6.1 The audit had selected 55 cases at random for activity between November and December 18. Data showed that there were a high number of follow ups, sometimes on a weekly basis, and advised that RJAH were an outlier. Ms Ferron had been working with RJAH on the criteria for follow ups and had identified various options. In line with other CCGs there was a drive to consider moving towards a block contract. The recommendation was to continue the audits, to look at financial implications and to consider block contracting.

Members agreed that they thought block contract would be the best way forward. Following discussions the paper was noted and all recommendations were agreed by members.

CCC-19/10/120 Medicines Management Strategy

7.0 Miss Michell-Harding gave members a brief overview to the Medicines Management Strategic and Operational Framework and members were asked to:

- Approve the strategic direction and operational plans for medicines management to approve the submission to both organisations relevant governance committees for their consideration and approval.
- Support the principle of formalising APC position within the governance structures.

The key points outlined were that Medicines Management had four strategic goals:

1. Aim to understand the patient's experience and empower patients to make choices
2. Evidence based choice of medicines
3. Ensure medicines use is as safe as possible
4. Make medicines optimisation part of routine practice

7.1 Mrs Wilde advised that the Strategy had already been approved at the Telford and Wrekin Primary Care Committee and was also being presented to Shropshire's Primary Care

Committee and Telford's PPQ meeting. The policy had been produced by both Heads of Medicines Management from Shropshire and Telford CCG.

7.2 Dr Leaman stated that he felt that the strategy did not have enough emphasis on cost savings. Mrs Wilde advised that this was not based on cost savings but more a move around quality. Following discussions it was felt that the document was broader that just medicines management and suggested that name should be changed to Health Improvement and Medicines Management

7.3 Mr Allan asked if the strategy had been shared/aligned with other health organisations/providers. Mrs Wilde stated that this was the reason why the APC was required to be the fundamental governance board as this would be the link to ensure all providers were aligned and would be the starting point for priorities for the commissioning team going forward to be able to make this a system wide strategy. It was noted that clearer governance was required going forward.

Members agreed the direction of travel/recommendations taking into account the need to change the name of the strategy and amend suggested wording as agreed.

CCC-19/10/121 Commissioning Intentions

8.0 Mrs Gail Fortes-Mayer presented the final list of Commissioning Intentions that had been shared with Providers detailing the contracting process for 2020/21. The Committee were asked to acknowledge the work that had taken place in developing the commissioning intentions and to note that these now formed part of the contracting process. She advised that the CCG had written out formally to Providers. Members of the Governing Body had been involved in the design and discussions around the direction of travel and delivering against the national priorities set out in the Long Term Plan and around how was going to deliver through local priorities and health needs. Feedback received back from RJAH, Shropcom and SaTH.

8.1 Discussions were held around Primary Care Commissioning and supporting the wider system. It was acknowledged that the document read as though a list of services for Primary Care had been added to the end rather than Primary Care being woven into commissioning intentions. Mrs Skidmore agreed to take feedback away and stated that the document did include the core intentions though the presentation could be revisited.

8.2 Dr Leaman asked how the document had been drawn up as he felt that areas had been omitted on the presented list. It was highlighted that the process was described within the report and that this document was at a headline level only and further detailed information underpinned each section. Discussions were held around how the list had been worked up through the CCC Working Group. Dr Lewis noted that this group had not drawn up the shortlist.

8.3 Clarification was given to assure members that requested items had not been missed. Dr Sokolov stated that the document was not intended to set specific metrics and explained that specifics would be not be lost but developed under these headlines. It was felt that the route needed to be clear as to how the final list had been agreed before the committee could agree and sign up.

8.4 Mr Morris felt that the document was dis-jointed and needed to flow more clearly, giving the primary care content as an example. Mrs Fortes-Mayer agreed to feedback comments to Dr Davies to bring back an amended version to a future CCC.

ACTION: Mrs Fortes-Mayer to feedback comments from discussion with Dr Davies to take forward the Commissioning Intentions to ensure clarity and bring back updated version to a future CCC meeting

CCC-19/10/122 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 20 November 2019 at 9.00am in Meeting Room K2, William Farr House.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.017
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	Finance and Performance Committee
Date of Meeting:	30 October 2019
Chair:	Keith Timmis in the absence of Kevin Morris

Key issues or points to note:

- There were signs of cancer improvements.
- Striving to reduce the deficit
- Working up QIPP/Building strong QIPP for next year
- 20/21 extra 7.5% QIPP based on latest NHSE trajectory
- The state of progress on complex care, with good news after the NHSE meeting, positive news on clearing backlog of council invoices

Actions required by Governing Body Members:

- None

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE COMMITTEE HELD IN MEETING ROOM K2, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL ON WEDNESDAY 30 OCTOBER 2019 AT 11.00AM

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
Mrs Laura Clare	Deputy Chief Finance Officer
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mr David Stout	Interim Transformation Director *(part)*
Dr Michael Matthee	North Locality Chair
Ms Sarah Porter	Lay Member – Transformation

Apologies

Ms Kate Owen	Head of PMO
Mr Meredith Vivian	Lay Member – Patient & Public Engagement

In Attendance

Mrs Chris Morris	Executive Nurse *(part)*
Mrs Faye Harrison	Personal Assistant (minute taker)

FPC-2019.10.106 - Apologies

1.1 Apologies were noted as above.

FPC-2019.10.107 - Members' Declaration of Interests

2.1 No declarations were raised.

FPC-2019.10.108 - Minutes of Previous Meeting held on 25 September 2019

3.1 The Minutes from the meeting held on 25 September 2019 were discussed and amended as follows:

Add additional paragraph to the QIPP section as follows:
It was highlighted that during the last 6 months sufficient progress had not been made with too much focus on discussions and not enough focus on actions. An example which was given was the STP 'Quick Wins' was raised in March 2019 and nothing has happened since.
5.1 – remove word '*severe*'
5.2 – amend paragraph to read: *The forecast at month 5 is that £16.5m with around £1m of added risk assessment predominantly around CHC and Care Closer to Home. Work is still on going to push towards the £19.8m target.*
7.5 – replace single with '*System*'
8.3 – replace possible with '*advisable*'
9.4 – Add action that updated paper on Interim Staff be drafted and brought to the October committee and also to Governing Body.

FPC-2019.10.109 - Matters Arising/ Action Tracker

4.1 The Action Tracker was discussed and updated. The following point was noted:

FPC-2019.07.068 – Performance Report
Mrs Fortes-Mayer to chase up response from Jon Cooke with regards to the ShropCom Out of Hours Contract
Mrs Fortes-Mayer updated members that the output of the review had been received and a letter had been sent to ShropCom stating that we are currently not in a position to support additional resource due to capacity issues which need to be addressed within the financial envelope of the Out of Hours Service. From 1 November the penalty holiday which is applied to the contract from when it started is being moved away from.

FPC-2019.10.110 - Quality, Innovation, Productivity & Prevention (QIPP) Report

5.1 In terms of the overall reporting of the QIPP forecast for Month 6 Mrs Skidmore reported that there was a marginal improvement of around £200,000. However, the risk assessed position has deteriorated slightly and there are still concerns regarding timing and pace particularly around Care Closer to Home. The team are currently going over all projects to check deliverability.

5.2 Prescribing and CHC are currently holding firm in there retrospective forecasts although risk assessments will be required. The areas of most concern are Care Close to Home and MSK; although there is mitigation in place to provide a level of scrutiny to secure a year end figure with RJAH.

5.3 Comment was made around paragraphs 5 and 6 within the report being 'too general' and no assurance regarding the risk level. Going forwards it needs to be made clear exactly what the actions are and how targets are being met. Assurance is required both for this Committee and for the Governing Body. Further discussion was held around this issue and updates were given around the various schemes and the actions which had been taken. It was agreed that clear, consistent messages were needed as members are not always sighted on work which is being done and the progress is not always reflected in the papers.

5.4 At the last Programme Board it was agreed that an extra-ordinary QIPP Board would be arranged for a deep dive into the Commissioning QIPP Schemes. Jon Cooke has been invited to this meeting to avoid duplication across the 2 CCG's.

FPC-2019.10.111 – Complex Care Performance Dashboard Update

6.1 Mrs Chris Morris attended the meeting to update members on the CHC Dashboard. She reported that processes have now been put in place but that it would take at least 18 months to 2 years until the service is back to where it should be.

6.2 The dashboard shows that the numbers are now known and it is aimed to get weekly figures so that staff can look at performance and the difference that this being made. She reported that there was a grip on the activity flow and the conversion rate from referral to treatment is also improved.

6.3 She further reported that they are not delivering the 28 day timeline and that they had a review meeting with NHSE to discuss this. This is related to the staff rates and it is hoped to improve when substantive staff are in post. A follow up meeting has been arranged.

6.4 New Nurse Assessors have been recruited to the Team and should be in post by December; interim staff numbers will decrease as the substantives begin.

6.5 The review and management of appeals has been documented within the report. The backlog of appeals is being addressed and it is hoped that this will be resolved by the end of the financial year.

6.6 The CHC and Finance Teams are working closely together to provide a link across the system. Fortnightly management team meetings are in place to ensure oversight and an improved reconciliation process is also in place. Joint working across both CCG's is also proving helpful.

6.7 Shropshire Council historic invoices were discussed and Mrs Morris confirmed that this is on going as there are further discrepancies. The agreed amount will be paid and discussions on the further discrepancy will continue; it is hoped to have this cleared by the end of the year. Progress is on going around the outstanding Welsh invoices.

6.8 The frequency of bringing the dashboard to the Committee was discussed and it was agreed to bring to the next meeting and go from there. Frequency can be scaled down once the committee are better assured.

Action: Further update on CHC Dashboard to be brought to November Committee where there will be discussion on the frequency of the report

11.55am - Mrs Morris left the meeting

FPC-2019.10.112 – Update on Betsi Contract

7.1 Mrs Fortes-Mayer updated members that the Contract had now been signed.

7.2 There was discussion around the increase in numbers from Wales and it although this is not reflected in the contract it was confirmed that this was included in the allocation adjustment for 'overseas visitors'. These are tracked on a monthly basis.

7.3 The Committee discussed the staff arrangements within the contract as it needs to be ensured the correct representation at meetings is included given the history. Both this Committee and Audit Committee will require appropriate assurance. The message around operational responsibilities has been noted and actioned.

FPC-2019.10.113 – Medium Term Financial Strategy

8.1 Mrs Skidmore highlighted the key headlines which were relevant to Shropshire within the report, however since the report was written things have moved on and the financial position has deteriorated further which impacts on the underlying deficit to be carried forward to future years.

8.2 The model would need to be adjusted to incorporate the deterioration and also any saving assumptions. Financial Improvement Trajectories have been issued nationally to replace the control total therefore an even paced view to get back to balance has been taken. Mrs Skidmore explained this in more detail to members as it is not consistent with previous plans.

8.3 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.

8.4 The overall plan will be discussed at the Senior Leadership Group and cost pressures will be reflected into the system plan. Currently more than half the savings in the plan are unidentified. Discussion was held on the level of savings which could be achieved and the budget for 2020/21; more information would become available as the year progresses.

Monthly Monitoring for Finance and Performance

FPC-2019.10.114 – Finance & Contracting Report

9.1 Mrs Skidmore began by updating members that notes from the recent Workshop had been circulated round the Executives for validation. The plan will be to condense the messages and replay them through the Governing Body. It will be important to align with Telford CCG to consolidate priorities. Decisions which are made at the Governing body need to be clear and consistent.

9.2 Mrs Skidmore moved on to talk about the Month 6 position and reported that they are starting to see positive impacts however, there was some deterioration in the forecast of approximately £1m although this can be rationalised due to the shift in prescribing which is outside of the CCG's control. There was also further deterioration in the acute portfolio and the CHC position. The key messages within the report remain the same as previous months.

9.3 Further discussion was held around the issues with electives and non-electives at SaTH as well as the on-going issues with emergency care. How items are reported needs to be more precise and consistent as well as looking at the scale of the challenge and what needs to be delivered. Commitment from providers is essential.

9.4 There was a query regarding the year to date variants and the disproportionate increase relating to this. Mrs Skidmore confirmed that this is mainly due to Care Closer to Home and the QIPP slippage as it is not expected to deliver.

9.5 Following further queries Mrs Fortes-Mayer confirmed that the West Midlands Ambulance contract had been signed. Mrs Skidmore agreed to look at the volatility in the cashflow figures as the forecast and actual figures are very different; she would circulate something after the meeting to members.

Action: Mrs Skidmore to look at the forecast and actual cashflow figures in Appendix B4 as there appears to be some volatility and circulate an explanation.

9.6 The following explanation was received after the meeting:

Explanation for cashflow variations
June – Additional cash was requested mid-month to pay the increase in provider contract payments (final figures had not been agreed when the cash forecast was calculated);
July – Additional cash required due to BCF payments. The 2019/20 figure was agreed after we had submitted the cash forecast (this also explains the higher

payments than forecast, which included the catch-up months). However, the closing cash balance was £1.9m since cash receipts of £1.6m were received which were not anticipated. These mainly related to receipts from NHSE in relation to GPIT recharges, the exact receipt date of which is difficult to forecast;
August – We drew down less cash than forecast since the cash balance b/f from July was £1.9m as detailed above.

FPC-2019.10.115 – Performance Report

10.1 Dr Davies ran through the report with members and reported that there was still a lack of engagement from West Midlands Ambulance Service particularly around handovers and conveyance. Letters have been drafted from Dave Evans to raise these issues formally but until now there has been no response; this will be raised at the Ambulance Summit.

12.30pm David Stout left the meeting

10.2 On a positive note there is improvement in cancer performance. With regards to RTT it is expected to return to specialty level moving forward although the 26 and 52 week waits need to be taken into account along with patient choice.

10.3 With regards to diagnostics a deterioration has been identified due to issues with endoscopy however this is expected to recover from October onwards. Diagnostics are failing at RJAH particularly around non-obstetric ultrasound therefore extra capacity has been put in place and it is hoped to recover by November.

10.4 Problems with A&E performance are on going particularly challenges with demand and over performance. Local services and community alternatives will need to be considered going forward although this will require further investment.

FPC-2019.10.116 – Key Messages to the Governing Body

- Striving to reduce the deficit
- Working up QIPP/Building strong QIPP for next year
- 20/21 extra 7.5% QIPP based on latest NHSE trajectory

FPC-2019.10.117 - Any Other Business

11.1 Members discussed clinical sessions and interim arrangements. Mrs Skidmore commented that she was content to give headlines to the Committee but that she felt that should in depth discussion be required the Finance Committee was not the appropriate place for this to take place but that she was happy to hold a non-exec discussion outside of the meeting. It was agreed that Mr Morris and Mrs Skidmore would meet to discuss this in more detail.

11.2 Mrs Skidmore informed members that there is an Establishment Control Process in place which is effective for both substantive and interim roles. There are currently 10 interims who are all closely monitored by Directors and all have exit trajectories in place.

11.3 Governing Body roles are all managed through payroll which leaves a small list of sessional payments where GP's and Practice Managers are paid for attendance at Locality Meetings; there is a set rate for this. The total payments for the year are approximately £40,000 and is included in the budget. This leaves 4 individuals who

have specific roles and remuneration is based on the meeting rates and is managed through reimbursement to practice. The roles they perform are to support:

- Commissioning and Transformation
- Medicines management
- Workforce
- IT Lead

Further discussion would be held outside of the meeting.

Date and Time of Next Meeting

Wednesday 27 November 2019, 11am – 1pm in Meeting Room B7, WFH

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-01.018
Shropshire CCG Governing Body meeting: 13 November 2019

Committee Meeting Summary Sheet	
Name of Committee:	Primary Care Commissioning Committee
Date of Meeting:	2 October 2019
Chair:	Mr Meredith Vivian Lay Member – Patient and Public Involvement

Key issues or points to note:

- A recommendation to close the High Ercall branch surgery of Shawbirch Medical Practice as requested by the practice was approved following a presentation to the committee.
- An overview of the process followed with regard to the closure of Whitehall Medical Practice was given by Mr Steve Ellis.
- The 2019 Primary Care Strategy was presented to the committee.
- Mr Morgan presented an update on the Shropshire and Telford & Wrekin STP Primary Care Strategy.
- Mrs Wilde presented a report on working with non-GP Primary Care providers.
- Mr Morgan gave an update on the Shropshire and Telford & Wrekin training hub.

Actions required by Governing Body Members:

- To note the above key points

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 2 OCTOBER 2019

Present

Mr Meredith Vivian	Lay Member, Patient & Public Involvement (Acting Chair)
Mrs Amanda Alamanos	NHS England Primary Care Lead, Shropshire & Telford
Mrs Sarah Porter	Lay Member, Shropshire CCG
Mr Keith Timmis	Lay Member, Performance
Mrs Nicky Wilde	Director of Primary Care, Shropshire CCG
Mrs Claire Skidmore	Chief Finance Officer, Shropshire CCG
Cllr. Lee Chapman	Shropshire Council
Dr Julian Povey	Clinical Chair, Shropshire CCG
Mr Steve Ellis	Head of Primary Care, Shropshire CCG
Dr Mike Matthee	North Locality Chair (representing Deborah Shepherd)
Mrs Helen Bayley	Strategic Lead Nurse for Quality, Telford & Wrekin CCG (representing Mrs Chris Morris)
Mrs Fran Beck	Executive Lead – Commissioning, Telford & Wrekin CCG

In Attendance

Mrs Chris Billingham	Personal Assistant; Minute Taker

Apologies

Dr Colin Stanford	External GP Member
Dr Stephen James	GP Member
Dr Jessica Sokolov	Medical Director
Dr Deborah Shepherd	GP Member, Shrewsbury & Atcham Locality Chair
Dr Finola Lynch	GP Member
Mrs Rebecca Woods	Head of Primary Care for Shropshire and Staffordshire, NHS England
Mrs Christine Morris	Chief Nurse
Mr Kevin Morris	Practice Member Representative
Mrs Sam Tilley	Director of Corporate Affairs
Ms Vanessa Barrett	Healthwatch Shropshire

PCCC-2019-10.069 - Apologies

Apologies received were recorded as above.

PCCC-2019-10.070 - Members' Declaration of Interests

Dr Povey and Dr Matthee both declared a possible conflict of interest relating to Agenda Item PCCC-2019-10.083 – Provision of the GPFV Weekend and Bank Holiday Extended Access Service.

The Committee agreed that as the meeting was a meeting in public there was no need for either of them to leave the room, but also agreed that they should not be involved in any discussion regarding this Agenda item.

PCCC-2019-10.071 – Minutes of Previous Part 1 Meeting held on 7 August 2019 and Matters Arising

The Minutes of the previous Part 1 meeting held on 7 August 2019 were agreed as an accurate record provided several minor amendments were made to job titles, etc. in order to maintain consistency.

Mr Vivian felt that it was important to always refer to the Committee as Primary Care *Commissioning* Committee.

Mr Vivian referred to the Date of Next Meeting which he believed should be 2 October 2019 and not 4 September 2019 as stated. Mrs Wilde advised that the proposed Extra Ordinary meeting scheduled to take place in September was stood down due to lack of available information regarding the topic to be discussed.

The Action Tracker was reviewed and updated as appropriate.

PCCC-2019-10.072 – Public Questions

No questions had been received from members of the public.

PCCC-2019-10.073 – High Ercall Branch Closure

The purpose of Ms Gittins' report was to present information to Primary Care Commissioning Committee (PCCC) to enable a decision to be made on the request from Shawbury Medical Practice to close the High Ercall Branch surgery.

Ms Gittins introduced Ms Jo Clark, Practice Manager, Shawbury Medical Practice who was also in attendance. Key points of Ms Gittins' report were:-

- An Application Notice to close branch surgery premises at High Ercall was submitted to NHS England by Shawbury Medical Centre on 5 August 2019. Formal approval of this application is required from PCCC.
- It is anticipated that the closure will have a minor impact on patients due to the current limited service offered and the close proximity of Shawbury Medical Centre.
- A prescription home delivery scheme and a Practice 'drop off delivery service' will continue for High Ercall patients.
- The Practice use Prescription Ordering Direct (POD).
- The Practice Patient Participation Group are fully supportive of the Practice's request.
- The current main premises have sufficient capacity to provide Primary Care Services for the patient list size.
- Ercall Magna Parish Council understands the Practice's reasons for the proposed closure and has raised concerns about access for patients due to poor public transport links.
- On the basis of the information provided by the Practice in the Application Notice, the Impact Assessment and views of the Patient Participation Group there is no justification to refuse the closure of the High Ercall Branch Surgery.

Ms Clark advised that High Ercall Branch Surgery is seeing approximately 7 patients per week in two one-hour surgeries. In the first six months of this year, 88 patients were seen at the Surgery. 57 of those also attended appointments within the main Shawbury Practice. There are issues relating to the building, which is a non-purpose built bungalow, and it is believed that this would not meet CQC requirements around health and safety or infection control. There is no disabled access.

The Branch provides a limited Primary Care service, which is purely GP consultation. There is no emergency equipment or admin staff on site, and there is no access to drugs. A full service is provided from the main Shawbury surgery.

An Impact Assessment has been completed as part of the report and two issues exist. The first is access to services as patients would need to travel to Shawbury which is 4 miles from High Ercall. The second issue is around access to medication and prescribing which is dispensed from the Shawbury branch and which would continue.

The Practice operates a delivery service and provides a home delivery service as well as a drop off and delivery service at High Ercall Branch. This service would continue in order for patients to receive their medication.

In terms of engagement the Practice has a Patient Participation Group (PPG) who are very supportive of this proposal.

No formal complaints have been received from patients regarding the proposed closure.

Discussion took place regarding communication and consultation with Telford CCG as High Ercall Branch Surgery falls within their area.

ACTION: Mrs Wilde to formally write to Telford & Wrekin CCG advising them of the closure of High Ercall Branch Surgery.

The Committee discussed the level of patient engagement. Mrs Alamanos did not believe that patient involvement had been sufficient to agree the paper at this point in time. The Committee had received no assurance that the PPG's representative in High Ercall was involved. The involvement could have taken place with patients in Shawbury who are not impacted by this decision. Other concerns related to medication being left in an area which is not a Practice setting, another issue upon which the Committee had received very little reassurance. However, Ms Clark confirmed that medication not collected was always taken back to the main Surgery.

Discussion took place regarding the level of patient engagement, and Ms Clark confirmed that only one comment had been received.

The Committee noted the report and approved the recommendations.

ACTION: As a matter of courtesy, Mrs Wilde to write to Healthwatch and HOSC Chairs for information only regarding the closure of High Ercall Branch Surgery.

Mrs Wilde to arrange for letters to be sent direct to affected patients advising them of the closure of High Ercall Branch Surgery.

PCCC-2019-10.074 – Whitehall Medical Practice Closure - Update

The purpose of Mr Ellis's report was to provide Primary Care Commissioning Committee (PCCC) with an overview of the process that has been followed in order to close Whitehall Medical Practice and facilitate patient registration with an alternative GP Practice. Key points of the report were:-

- Whitehall Medical Practice ceased providing patient services as at close of business on Friday 27th September. The Practice closed on Monday 30th September.
- NHS England's Primary Medical Care Policy and Guidance Manual provides details of the process to be followed in relation to Primary Care contracts that are coming to an end and this has been used to inform the process followed by the Primary Care Team.
- Capacity has been secured for all patients to continue to receive GP services.
- All patients who were registered at Whitehall Medical Practice have now either secured a new GP Practice themselves or have been informed of which Practice they have been allocated to and how to register.
- Practices most affected by the closure of Whitehall continue to be supported by the CCG's Primary Care Team.
- The CCG and NHS England's Primary Care Team have been in regular contact with Whitehall Medical Practice to provide support as required.
- All patient letters included details of how to contact the CCG for support in finding a new Practice. All concerns received via the CCG's Patient Advice and Liaison Service (PALS) to date have been responded to.
- NHS England will continue to monitor the patient list at Whitehall Medical Practice until all patients have registered with a new GP Practice.

A review of the process will be considered as part of the internal audit review to be undertaken during Quarter 4.

The Committee noted the contents of the report.

PCCC-2019-10.075 – Estates Strategy

The purpose of the report was to present the 2019 Primary Care Estates Strategy to Primary Care Commissioning Committee, seek input from members, and gain consent to move forward with the recommendations within the strategy.

Mr Brettell requested comments from the Committee, together with any suggested improvements to the Strategy. He also requested Committee's approval of the nine recommendations contained within the report.

Mr Timmis suggested:-

- That the report should contain reference to Brexit and the potential impact upon demographics and patient population.

- That the figures relating to population increase should be checked. The projected population increase of 215,000 did not appear to be accurate.

- That the financial context of the paper should be reviewed in light of the pressure on Estates and the decision making process regarding priorities.

Mrs Wilde apologised for the error relating to population increase, advising that the figure should be 21,000 and not 215,000 as stated.

Mrs Wilde advised that the financial content of the paper was sourced from information obtained from Local Authority projections. Telford & Wrekin CCG are about to commence the same exercise after which both CCGs will consider the financial implications of the strategy. Any comments received from Committee today will be taken into consideration.

The Committee discussed the 3-5 years delivery programme stated within the Strategy and queried whether this should be longer. Mrs Wilde advised that there would be a longer term plan, but in terms of delivery, projects will be categorised into Short, Medium and Long Term. Attention would focus upon delivery of the shorter term projects, whilst planning for the longer term projects.

Other suggested amendments to the report were the inclusion of lease expiry dates on current premises or an anticipated date when the premises may not be fit for purpose, and information regarding the potential impact of the over-65 population on Primary Care.

ACTION: Mr Brettell to amend Point 5 of the recommendations to specifically reflect the Committee's wish to receive assurance that the financial position is fully addressed in the modelling of the Estates Strategy.

ACTION: Mr Brettell to amend Point 5 of the Recommendations to provide an improved explanation of the proposed delivery plan.

ACTION: Mr Brettell to also include reference to proposed large scale developments within the Strategy and their potential impact on GP Practices, e.g. M54 development, Tern Hill, and Ironbridge, and incorporate all other minor amendments suggested by the Committee into his revised report.

The Committee approved the recommendations contained within the report, provided the Committee's recommended amendments are made.

PCCC-2019-10.076 – Primary Care Strategy Delivery and Progress Report

The purpose of Mr Morgan's report was to update Primary Care Commissioning Committee regarding progress on delivery of the Shropshire and Telford & Wrekin STP Primary Care Strategy.

Mr Morgan's latest report - which now includes Communications & Engagement - was taken as read

and questions were invited.

Mrs Porter referred to health inequalities and risks around funding from certain local initiatives and believed it was important that consideration should be given as to how the risk could be mitigated.

ACTION: Mr Morgan to include information relating to health inequalities and risk mitigation in future reports.

Mr Timmis – in his capacity as Chair of the Audit Committee - queried the score allocated to Programme No. 9 "Auditing Delegated Statutory Functions and Governance Arrangements".

ACTION: Mr Morgan to update Mr Timmis regarding Programme No. 9 of the Primary Care Strategy and the allocated Amber Rag Rating.

Mrs Wilde stated that the Programme referred to identifies that our processes and procedures are cross-referencing those procedures against good practice to ensure that the CCG is following good practice. The programme of work is currently being progressed therefore the score is Amber which relates to work being carried out to assess the up to date position.

PCCC-2019-10.077 – Working with Non-GP Primary Care Providers

The purpose of Mrs Wilde's report was to provide Primary Care Commissioning Committee with an update towards delivering the Governing Body 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, which in turn will reduce the pressure on the wider health economy.

Mrs Wilde has agreed to meet with Mrs Woods, NHS England's Head of Primary Care for Shropshire and Staffordshire, before the next Primary Care Commissioning Committee to discuss moving the project forward.

Mr Timmis referred to Paragraph 8 relating to Community Pharmacy and services for smoking and weight management and queried whether this was intended to go some way to mitigating the reduction in services by Public Health. Mrs Wilde replied that this was a national initiative and is viewed as an opportunity for Pharmacy to be involved in such projects and support them, but it is not known how long this would take to be delivered.

Mrs Alamanos replied that implementation of the changes would commence in 2020, and NHS England is currently involved in the consultation process. It is acknowledged that services have been cut by Local Authorities and there is a need to bring those services back into being.

Mr Timmis referred to inaccurate information being given out by both the hospitals and local Opticians regarding Opticians who supply post-operative checks.
Mrs Alamanos will feed this back to NHS England who are aware of this issue and are trying to resolve it.

ACTION: Mrs Alamanos to feed back to NHS England the Committee's discussion regarding inaccurate information being supplied to patients by the hospitals and local opticians.

Mrs Wilde to provide regular updates regarding working with non-GP Primary Care Providers to future Committee meetings.

PCCC-2019-10.078 – Primary Care Finance Report

Mrs Skidmore's report informed Primary Care Commissioning Committee of the financial position of the Delegated Co-Commissioning Primary Care services to Month 5 – August 2019. Key points of the report were:-

- The Co-Commissioning budget for 2019/20 is £1.5m higher than the ring fenced allocation

received.

- At Month 5 spend to date for 2019/20 is reported as £20k under budget.
- The CCG is currently forecasting that spend will be contained within the budget for 2019/20; however it must not be forgotten that this budget is £1.5m above the allocation for the year.
- The CCG & NHSE Finance teams continue to scrutinise all areas of the delegated budgets.

Mr Timmis referred to the possibility of reducing the £1.5m gap and requested that future reports were more explicit about how this could be achieved.

ACTION: Mrs Skidmore to develop the amendments requested by Mr Timmis regarding reduction of the £1.5m gap and include in her monthly report.

PCCC-2019-10.079 – Primary Care Quality & Improvement Indicators / Performance Report

The purpose of the report was to inform Primary Care Commissioning Committee regarding Primary Care performance and quality monitoring.

Work is being carried out to align the templates for submission of papers for both Primary Care Commissioning Committees (Shropshire and Telford & Wrekin) to create a standard format. The revised template will be sent to Committee members prior to the next meeting. Feedback and comments will be welcomed.

Mrs Wilde asked whether information relating to both Shropshire and Telford & Wrekin would be contained within the same paper which will be submitted to both Committees. The Telford & Wrekin Committee held the previous day, at which Mrs Wilde was an observer, had agreed that there would be a single report covering both CCG's. The Committee discussed this proposal and it was agreed that joint papers should be submitted. However, the Committee envisaged that there may be problems when specific decisions were taken relating to one CCG but not the other.

Mrs Beck suggested, and the Committee agreed, that information relating to the other CCG could be appended to reports "for information only". However, papers relating to both CCGs should be issued on the same day.

- The Committee agreed that papers for the next meeting would be prepared in the same format.

- The Committee agreed that further consideration was required regarding combined papers.

The figures within the report were discussed and Mr Timmis referred to the CQC report relating to Severnfields which had rated the Practice "Inadequate". He asked what the next steps were.

ACTION: Mr Ellis agreed to discuss with the Practice the recommendations and actions contained within the CQC report and provide the Practice with support as required.

Mrs Skidmore to feed back to Joint ExecTeam details of the discussion regarding shared reports and alignment of reporting format.

The Committee confirmed that they were confident that quality, performance and processes were improving.

PCCC-2019-10.080 – Break

PCCC-2019-10.081 – Shropshire and Telford & Wrekin Training Hub

The purpose of the report presented by Mr Morgan was to provide a formal report to Primary Care Commissioning Committee on:

- Increased future funding for developing the staffing infrastructure for Training Hubs (TH) which is due in 2020/21

- Positioning the Training Hub in the most effective place to support the workforce aims of the Primary Care Strategy.

The report set out future plans for significantly improving the capacity of the Training Hub to meet the requirements of NHS England. Significant funding is being given to the STP for the Training Hub with effect from April 2020. The report sets out how much funding is being given for infrastructure, staffing costs, and training and development.

The Committee was asked to:-

- Note the work being done to move towards improved training arrangements and increased capacity with effect from April 2020.
- Approve the proposed model as referenced in Paragraph 12 of the report.
- Agree that ongoing monitoring of the Training Hub activity will be included in the Operational Plan update.

The Chair invited questions.

Mr Vivian referred to the funding of £260,000 referred to in the report and asked if those funds were subject to the same governance arrangement as the rest of the Training Hub funding. Mr Morgan replied that this is money that the CCG had been paid for two specific programmes which must be spent in this financial year. The money will be subject to the normal, current governance arrangements.

The Committee:-

- Noted the contents of this report and the level of current and planned investment in relation to Primary Care Training Hubs.

- Approved a formal CCG-hosted Training Hub model for Shropshire and Telford & Wrekin STP area as described in Paragraph 12.

- Agreed that monitoring of the work of the Training Hub will be included in the regular Primary Care Strategy Operational Plan update reports to this Committee.

PCCC-2019-10.082 – Primary Care IT Governance

The purpose of Ms Spencer's report was:-

- To detail the governance process for the Primary Care IT Forum to report to Primary Care Commissioning Committee.
- To detail the decision making structure to ensure there is a clear process that is clearly linked to the STP digital strategy for the development of integration and collaboration of the clinical systems and capabilities across the STP footprint.

Mrs Skidmore expressed concerns regarding sign-off of the document because this is one area of IT but not all of it. Mrs Skidmore would prefer to see the report in the context of totality of the CCG. She also believed that there were some asks contained within the document which the Committee is not set up to do. PCCC is a statutory Committee of the organisation and careful thought must be given to what it is designed to do. However, she was absolutely supportive of Ms Spencer's view that more information around Primary Care IT should be submitted to this Committee, and the Committee should be informed of the risks.

Mrs Skidmore wished to discuss this topic outside of the meeting with Ms Spencer, Mrs Fortes-Mayer and Mrs Tilley in order to give consideration to the broader governance.

Having referred to the PCCC Terms of Reference, Mr Vivian observed that the group did not appear to be able to make recommendations and believed that it should have such powers.

ACTION: Mrs Skidmore to arrange a meeting with Ms Spencer, Mrs Fortes-Mayer and

Mrs Tilley to consider the broader governance of Primary Care IT and to review the document before submission to Joint Exec Team. After consideration by Joint Execs, the paper will be re-submitted to Primary Care Commissioning Committee.

PCCC-2019-10.083 – Provision of the GPFV Weekend and Bank Holiday Extended Access Service

Mr Vivian reminded the meeting that, due to a conflict of interests, Dr Povey and Dr Matthee would not be involved in any discussions regarding this Agenda item.

The purpose of Ms Kinsey's report was:-

- To provide the Primary Care Commissioning Committee (PCCC) with an update on options available to Shropshire Clinical Commissioning Group (CCG) for future provision of the Weekend and Bank Holiday Extended Access Service currently provided by Shropshire Community Health Trust (SCHT).
- To assist PCCC in making a decision regarding action to be taken.

Key points to note were:-

- The CCG will not be commissioning SCHT to deliver a single CCG Weekend and Bank Holiday Extended Access Service after the Telford and Wrekin element of the service is decommissioned at the end of October 2019.
- The current service provided by SCHT will cease for both CCGs at the end of October 2019.
- SCCG has been exploring alternative options for the future provision of this service, including devolving the service to the existing four delivery groups of the Extended Access Service and using LIVI, a digital health solution to provide weekend and Bank Holiday appointments**.**

Ms Kinsey requested that PCCC authorised the Director of Primary Care, Head of Primary Care, and the Chair of PCCC to decide on the most appropriate actions regarding future provision of the service.

Mr Vivian was not comfortable with the lack of audit trail relating to this item.

Mrs Wilde was aware of capacity issues in General Practice. Darwin Health are potentially interested in providing the service, but this has not yet been confirmed, hence the request for delegation to enable certain colleagues to be able to make decisions regarding service provision.

The decision to be made by Committee is whether the gap of 2% in provision of the service can be filled by Darwin Health. This solution fits with all the requirements, including the financial model. The decision of Darwin Health will not be known until later today.

Mrs Skidmore asked if the CCG still wished to purchase 100% of the service. If so, and subject to a decision by Darwin Health this afternoon, the Exec team and Management team must either have the discussion with Darwin or have an option to explore an alternative plan if that is not acceptable.

Mr Vivian asked if the CCG wanted to continue to provide 100% coverage of extended access.

Mr Timmis asked what the NHS England view would be if the CCG was not prepared to provide such cover. Mrs Wilde advised that feedback received from the Regional Transformation Board was that there was an absolute expectation that CCGs will deliver 100% of this target.

ACTION: Mrs Wilde to follow up the proposal and compile an alternative plan if the Darwin solution is not acceptable.

PCCC-2019-10.084 – Broseley Medical Practice – Additional Space

The purpose of Mr Brettell's report was to inform Committee of a longstanding significant premises issue at the Practice in Broseley. This issue must be resolved in order to avoid service risk, and Primary Care Commissioning Committee (PCCC) are asked to agree to the approval of additional reimbursements requested by the landlord to enable the Practice to use additional rooms within the

building.

The Committee must decide if the lack of Finance review paperwork is enough reason for the request to be refused. The view of NHS England is that this request is in breach of the normal Premises Cost Directions as usage of space which has not gone through such process would not be supported.

Mrs Wilde advised the Committee that in 2016 due process was undertaken and at that time PCCC made a decision to approve the use of the rooms subject to financial analysis of the cost effectiveness. Permission was given subject to a piece of work to be undertaken by the CCG at that time. However, there is no evidence as to whether that piece of work was undertaken. As a result of organizational change at that time, the piece of work referred to may not have been completed.

The Committee was asked to decide whether they would support the request for additional rented space which was agreed at PCCC *subject to the appropriate Cost Benefit Analysis.* There is no evidence to confirm whether that did or did not take place.

At the time, Committee wanted to be sure there was a need for use of the additional rooms. The CCG must be mindful that this could set a precedent for other Practices to take space in buildings and then at a later stage ask the CCG for that revenue to be funded.

Mr Brettell wished to draw to the attention of Committee that the new Practice Manager had recently drawn up a new lease.

The Committee discussed whether approval for this additional use and additional funding should be granted. Mrs Skidmore expressed her agreement with the view held by Mrs Alamanos regarding the setting of precedents and believed that it must be made clear that the decision was made as a result of extraordinary circumstances.

- The Committee agreed to underwrite the additional rent requirement from October 2019 subject to receipt of a report by the District Valuer to be submitted to the December meeting, plus an internal CCG evaluation of the Cost Benefit Analysis.

Mrs Alamanos advised that several lease agreements had, in the past, been rejected by the District Valuer as they were not prepared on a standard lease agreement. She asked the Practice and the CCG to be mindful of the correct format when preparing any agreement.

ACTION: Mr Brettell to bring to the December PCCC a report by the District Valuer regarding Broseley Medical Practice, plus an internal CCG evaluation of the Cost Benefit Analysis to enable the Committee to make a decision.

Mr Brettell to bring to the December PCCC a more detailed report and updated Practice Business Plan, including recommendations and a clearer risk assessment.

Mr Brettell to be mindful of the correct format for any lease agreement which is to be submitted to the District Valuer.

PCCC-2019-10.085 – Medicines Management Strategy

The purpose of the report was to inform the Committee of the strategic direction and operational plans for medicines management over the next two years and seek approval for this to be submitted to the relevant governance Committees for consideration and formal approval. The report also sought Committee's view on the current governance structures for medicines management in both organisations and also sought approval in principle for Area Prescribing Committee (APC) to have a formal place in the governance structure for the new commissioning organisation as this is intended as the single point of control for medicines entry to the health economy moving forward.

The report was compiled in order to set the vision of both CCGs for the next five years and was also

being submitted to Clinical Commissioning Committee.

- The Committee reviewed and approved the strategic direction and operational plans for medicines management.
- The Committee approved the submission of the report to both organisations' relevant governance committees for their consideration and approval.

PCCC-2019-10.086 – Primary Care Risk Register

The Committee reviewed the Primary Care Risk Register which had been updated by Mr Ellis.

The Committee were asked to agree the removal of Risk No. 8 relating to the withdrawal of Practices from a range of non-contracted activity undertaken in Primary Care. However, a new provider has now taken on the service.

The Committee were asked to agree to the addition of Risk No. 9 which related to dispersal of patients from Whitehall Practice.

- The Committee agreed the updates to the Risk Register as outlined above.

PCCC-2019-10.087 – NHS England Update

There was no update from NHS England.

PCCC-2019-10.088 – Any Other Business

Cllr. Chapman asked if any discussion had taken place around future plans for the two CCGs and the work involved in aligning reports across the whole of the footprint. He asked if future plans for Primary Care Commissioning Committee were known.

Mrs Wilde replied that representatives from both CCGs are attending the other's Committees in an effort to understand processes within both organisations. Formats of reports are being replicated, and discussions are under way to establish at what point the information for both CCGs is presented in a single report.

PCCC-2019-10.089 – Date of Next Meeting

Mrs Wilde intimated that the next meeting would take place on Wednesday 4 December 2019.

However, Committee members were asked to hold the date of Wednesday 6 November 2019 in diaries in case an Extra-ordinary meeting was required.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2020-01.019
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	Quality Committee
Date of Meeting:	30 October 2019
Chair:	Meredith Vivian, Lay Member - Patient and Public Involvement

Key issues or points to note:

- Workforce at SaTH remains a significant concern with regard to the ability to provide good quality sustainable services. A number of recruitment and retention projects are ongoing.
- There are now less ED Consultants for this winter than last year. The Committee queried whether more cases should be seen in a different assessment area. Officers to explore whether this might be feasible.
- Concerns raised with SCHT over the previous 12 months relating to Looked After Children (LAC). Services are showing signs of improvement.
- Excessive waiting lists for diagnosis of Autistic Spectrum Disorder (ASD) have been fully scoped and plans are now in place to address the back log of assessments required.
- A further inspection has been carried out by NHS England on Infection Prevention & Control systems at SaTH. The Risk Register rating has been updated from Red to Green.
- A higher than expected number of Serious Incidents had occurred in MPFT provision. Analysis indicated that the trend was not significant but the Committee requested assurance for the next meeting.
- MPFT's 'good' CQC rating was reported. It was noted that there were some areas 'needing improvement' including:
  - Safety of care in Urgent Care Services;
  - Risk assessment by Community Child and Adolescent Mental Health Services.
- In its assessment of MPFT, CQC reported 'Outstanding' practice in wards for older people with mental health problems; mental health crisis services; wards for people with learning disabilities, and the Community Health inpatient service.

- Transforming Care Programme (TCP): The Committee heard that the CCG is currently behind the NHS England specialised commissioning patient trajectory for TCP, but it is expected that the CCG trajectory will be met in Q4. The Committee heard that ongoing difficulties around recruitment of a suitably skilled workforce, and significant challenges within Shropshire regarding housing, make the target increasingly difficult.

Actions required by Governing Body Members:

- To note.

Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE
HELD IN ROOM B, WILLIAM FARR HOUSE
AT 2.00PM ON WEDNESDAY 30 OCTOBER 2019

Present

Mr Keith Timmis	Lay Member for Audit & Governance (Acting Chair)
Mrs Sarah Porter	Lay Member for Transformation
Mrs Gail Fortes-Mayer	Director of Contracting & Planning
Mrs Christine Morris	Chief Nurse (2.00 p.m. – 3.00 p.m. only)
Dr Julie Davies	Director of Performance & Delivery
Dr Alan Leaman	Secondary Care Consultant
Ms Lynn Cawley	Chief Officer, Healthwatch Shropshire
Mr Joe Allan	Interim Head of Quality, Shropshire CCG
Mrs Chris Billingham	Personal Assistant; Minute Taker

QC-2019-10.123 (Agenda Item 1) - Apologies
Mr Timmis welcomed members to the meeting.

Apologies were received from Dr Jessica Sokolov, Dr Finola Lynch, and Mr Meredith Vivian.

QC-2019-10.124 (Agenda Item 2) - Members' Declaration of Interests
There were no declarations of interest.

QC-2019-10.125 (Agenda Item 3) – Minutes/Actions of Previous Meeting held on 25 September 2019 and Action Log
The minutes of the previous meeting held on 25 September 2019 were reviewed and approved.

The Action Tracker was reviewed and updated as appropriate.

QC-2019-10.126 (Agenda Item 4) – 0-25 Service
Mr Trenchard's Agenda item was postponed to a future meeting.

QC-2019-10.127 (Agenda Item 5) – Provider Exception Report
The purpose of the report was to provide assurance to the Committee that processes are in place to monitor quality indicators, and escalate and ensure remedial action is in place where poor performance is identified. Key points of the report were:-

- Workforce at SaTH remains a significant concern with regard to the ability to provide good quality sustainable services.
- SaTH's weekly Emergency Department 'Safe Today' calls continue, with a monthly summary being presented at CQRM.
- RJAH reported a Serious Incident in October 2019 relating to patient waits / delays in treatment. The delays were due to patient choice and joint investigations with healthcare providers are planned.
- Concerns raised with SCHT over the previous 12 months relating to Looked After Children (LAC). Services are showing signs of improvement.
- Excessive waiting lists for diagnosis of Autistic Spectrum Disorder (ASD) have been fully scoped and plans are now in place to address the back log of assessments required.

SaTH
A further inspection has been carried out by NHS England on Infection Prevention & Control, and the Risk Register rating has been updated from Red to Green. The issues are still ongoing with CQC.

The weekly Emergency Department (ED) 'Safe Today' calls are improving with data presented and engagement.

Workforce continues to be an issue. A meeting has taken place with the Interim Director of Workforce, the Interim Director of Nursing, the Deputy Director of Nursing and two of the Associate Directors of Workforce. It is proposed to create a new model of four Associate Directors to cover each element of the risk to the organisation.

A number of recruitment and retention projects are ongoing.

Mr Timmis referred to the 'Safe Today' calls and requested assurance that they are sufficiently reliable.
Mr Allan advised that these calls provide a level of detail regarding patients in corridors, patients currently waiting, complaints, etc. The Department is given a daily 'Rag Rating'. A significant improvement has been seen since the update provided to Quality Committee in September.

The Committee discussed the worsening situation with the ED Consultant workforce. There are now less ED Consultants for this winter than last winter. Dr Leaman expressed the view that, to alleviate pressure on ED, at least half of the major cases seen in A&E should be seen in a different assessment area.

ACTION: Mr Allan to provide an update report on issues at SaTH to the November Quality Committee.

MPFT
A number of Serious Incidents (SI's) had occurred, and MPFT had provided an update at CQRM. The SI's had been reviewed and a statistical analysis had been carried out which showed no variation in peaks in terms of SI's and unexpected deaths. Mrs Morris requested that information was brought to the next meeting in order to provide assurance to the Committee of this outcome.

By the end of this financial year those who were in the cohort of patients who have been waiting over 12 months should have been seen. Quality Committee to receive updates on a monthly basis regarding progress.

ACTION: Mr Allan to provide the requested updates to Committee regarding Serious Incidents and MPFT patients waiting in excess of 12 months to be seen.

Shropshire Community Health Trust (Shropcom)
Mrs Morris referred to the letter she had sent to Mr Gregory regarding Quality Committee's increasing concerns regarding the service provided by the Trust. A Strategic Commissioning Board meeting was held with representatives of the Trust at which the points in the letter were discussed. There was a degree of recognition that the Trust could work better with Commissioners in some areas.

Robert Jones Agnes Hunt (RJAH)
RJAH have confirmed that diagnostic rates will be achieved from November onwards.

Issues had existed around non-obstetric ultrasound and the hospital has invested in additional capacity. An improvement is expected from November.

Ms Cawley advised the Committee that she had received information relating to Heatherdene Care Home in Oswestry. The Home has been rated as inadequate and has been suspended by Shropshire Council.
It is unlikely that the CCG has commissioned places in a residential home as CCG commissioned places are normally in nursing homes.

ACTION: Mrs Morris to arrange for the situation at Heatherdene Care Home and any professional relationship with the CCG to be checked.

CHEC (Community Health & Eyecare Ltd)
The Committee discussed the relationship between SaTH and the community provider which continues to present a level of concern, with work ongoing to influence and improve the situation. Several meetings have taken place and the CCG has ensured that appropriate contracts and pathways are in place. No patient-related concerns have been received.

QC-2019-10.128 (Agenda Item 6) – SaTH Quality Oversight Report (SOAG)

Mr Allan's pre-circulated report was taken as read. Much of the content of the report had already been discussed in previous Agenda items as it triangulates much of the information contained in other reports. The report also contained useful information from partners in the wider health economy. Mr Allan will update the Committee on a monthly basis.

QC-2019-10.129 (Agenda Item 7) – MPFT CQC Report

Mr Allan's report provided Quality Committee with an update on the Care Quality Commission (CQC) inspection that took place at Midlands Partnership NHS Foundation Trust (MPFT) from 19 February 2019 to 20 April 2019. Points to note were:-

- MPFT was rated as 'Good' overall, the same rating as that achieved in 2016
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose
- CQC inspectors felt that the Trust had a strong and experienced leadership team, supported by efficient reporting and governance structures
- Overall, clinical services were safe and effectively safeguarded patients from harm
- CQC had identified areas that required improvement. In particular, managers could not provide assurance around the safety of care in the Urgent Care services
- Staff left patients potentially at risk in the Urgent Care services and there was no triage system to determine the priority given to patients attending the two Urgent Care services
- In Shropshire, Telford and Wrekin Community Child and Adolescent Mental Health Services staff did not always complete and update robust risk assessments for each young person and use these to understand and manage risks
- CQC reported examples of outstanding practice in the wards for older people with mental health problems, mental health crisis services, wards for people with learning disabilities and the Community Health inpatient service

Dr Leaman expressed concern around the transportation of patients out of the area because of lack of beds and queried how this could contribute towards achievement of a "Good" rating. Dr Leaman also queried the requirement for an inpatient Adolescent Unit. Dr Davies and Mr Allan responded that scale was an issue and staff could be manning empty wards. However, both agreed that placing such patients in children's wards was not ideal.

ACTION: Mr Allan to raise the CCG's overall rating of "Good" with CQC at the Quality & Safety Group meeting in order to provide clarity on the CQC's benchmark and feed back to the November Committee.

Dr Davies to liaise with Mrs Tilley regarding communication of the outcome of the CQC inspection.

Mr Timmis queried the lack of triage for Urgent Care and any link with SI's and unexpected deaths.

ACTION: Mr Allan to raise the subject of a link between SI's and unexpected deaths at CQRM and establish how this is reflected in the CQC action plan.

QC-2019-10.130 (Agenda Item 8) – National Cancer Patient Experience Results

Mrs Blay's report was written in order to provide the Committee with an overview of the National Cancer Patient Experience Survey 2018 for both CCGs.

The Committee discussed the findings of the survey, and in particular certain results which were outside the expected range and which the Committee considered to be unacceptable. The information will be included in the Quality Report submitted to Primary Care Commissioning Committee, and Mrs Fortes-Mayer will also raise the results of the survey at the forthcoming Cancer Strategy Group.

The extent of the involvement of McMillan Nurses in the service was discussed. Mrs Blay will raise the results of the survey and the involvement of McMillan Nurses in service provision at CQRM.

ACTION: Mrs Fortes-Mayer to raise the results of the Cancer Patient Experience Survey at the Cancer Strategy Group.

Mrs Blay to raise the results of the survey and the involvement of McMillan Nurses in the provision of the service at CQRM.

Mrs Blay to send details of the Cancer Lead Nurse at RSH to Mrs Cawley.

The fact that 33% of cancer patients did not feel that they received the support they needed from their General Practice should be reported to Primary Care Commissioning Committee

QC-2019-10.131 (Agenda Item 9) – Procurement of Out of Hours Contract

Mrs Fortes-Mayer provided the Committee with a verbal update regarding procurement of the Out of Hours Contract.

Details of the review had been built into the contract with Shropcom as part of the procurement process as a result of concerns raised regarding reducing the number of bases across Shropshire. The review took place over an 11 month period from October 2018 until August 2019. Shropcom had requested additional resource and as a result the CCG reviewed the activity profile which was slightly different to that originally planned in the tender document. Overall, activity was down. The review concluded that better profiling and flexing of staff was required rather than additional resource.

Issues had been experienced around the rota but these have now improved and the KPI of 95% rota filling is being delivered.

An area of concern is that this contract forms part of the integrated urgent care across the West Midlands, and the requirement to staff the Clinical Assessment Centre is not being fulfilled. There is no financial penalty to the commissioner or the provider, but the situation is bad practice.

The contractor must also ensure that the technology is in step with the direction of travel for integrated urgent care.

The activity, which may be transferring over to A&E as a result of issues with the Assessment Centres, has not yet been triangulated, and the CCG must address this in order to assure themselves.

The outcome of the review is:-

- There will be no additional resource.
- Additional measures have been put in place. The variable parts of the contract were not applied until the review was complete.
- Key Performance Indicator incentives and penalties were not applied whilst the review was carried out. However, with effect from 1 November 2019 contract penalties will be applied.

Mrs Fortes-Mayer has written to the Trust and awaits their reply.

Mrs Fortes-Mayer provided assurance to the Committee that the situation has not impacted upon A&E. The current difficulties are being experienced as a result of non-elective urgent care.

QC-2019-10.132 (Agenda Item 10) – ReSPECT Briefing

The purpose of the paper was to:-

- Update Shropshire CCG on the revised process for initiating emergency care and treatment in the end of life period
- Outline the ReSPECT process
- Update Shropshire CCG on the rollout of ReSPECT across Shropshire, Telford & Wrekin CCG areas

Mrs Fortes-Mayer advised the Committee that ReSPECT was the recommended summary plan for emergency care and treatment in order to assess and manage patients at the end of life. It replaces the Liverpool Care Pathway and is intended to support the dialogue between all partners across all care settings, and in particular whether Cardiopulmonary Resuscitation (CPR) should be commenced.

Shropshire CCG was successful in receiving a grant from Health Education England which funded the rollout of training and printing of the ReSPECT forms. An electronic version of the form is also available on EMIS. Shropshire Partners in Care (SPIC) have rolled out training across all care settings which has been overseen by the End of Life Care Board and goes live on 31 October 2019.

The Committee discussed the ReSPECT form and agreed that, if possible, it should be amended to give patients the opportunity to specifically express their preference in terms of being cared for at home or in hospital, an option which did not currently appear on the form. Consideration should also be given to prominence of the form in relation to the patient's bed.

ACTION: Mrs Fortes-Mayer to update the November Committee regarding amending the ReSPECT form to enable expression of patient preference, and also give consideration to procedures regarding prominence of the form in relation to the patient's bed.

QC-2019-10.133 (Agenda Item 11) – TCP & LeDER Update

Transforming Care Programme (TCP)

Mrs Bayley's paper provided a brief overview of the TCP programme (now known as the Learning Disability & Autism programme), the current position, and the lessons learned over the past year. The Transforming Care Programme ended at the end of March, as did the funding to manage it. It has become the responsibility of the CCG to deliver the trajectories utilising current resources. Key issues and points to note were:-

- Currently the CCG is not meeting the trajectories set
- Considerable scrutiny continues from NHS England due to the perceived slow progress in discharging of inpatients back into the community
- Housing, culture changes and workforce are the key challenges within the system
- There is now an experienced established TCP team who are working to drive forward the changes required, but a whole system approach is required for true success and sustainability in keeping with LD&A who have challenging behaviours out of secure inpatient settings

For this year, it is not envisaged that the CCG will meet the NHS England specialised commissioning patient trajectory, but it is expected that the CCG trajectory will be met in Q4.

Mrs Bayley's paper outlined difficulties around recruitment of a suitably skilled workforce, and also significant challenges within Shropshire regarding housing. Mrs Morris has requested a meeting with Local Authority Housing Representatives to address the issues.

Similar issues exist all over the country and specific SRO meetings will take place on a monthly basis to monitor the situation. The Senior Responsible Officer (SRO) for Shropshire CCG is Clive Jones, Telford & Wrekin Council. The timetable to resolve the situation will run into next year.

LeDER Update

The LeDER annual report was submitted to the Governing Body in September. As a result, a number of questions were asked relating to greater clarity around certain figures in the report. The report has now been updated and will be re-submitted to the Governing Body meeting in November.

QC-2019-10.134 (Agenda Item 12) – Points to Escalate to CCG Board

- A&E Consultant numbers
- Patient attendance at A&E and management of these patients by the Trust
- Out of Hours service review

QC-2019-10.135 (Agenda Item 13) – Any Other Busines

Dr Leaman requested that, prior to his attendance at the November Quality Committee, Mr Jeffries should supply information relating to the SI's and Never Events at SaTH for each year of the preceding ten years.

Mrs Cawley has tried to establish whether an independent body exists to support patients who are going through a Serious Incident investigation and has arranged a meeting with Dr Edwin Borman, Director of Clinical Effectiveness at SaTH, and other members of the Trust. The Serious Incident Framework is to be replaced by the Patient Safety Framework in 2020. NHS England has contacted all Regional Healthwatch organisations to advise that they must be involved in the Patient Safety Framework to support patients and families.

ACTION: The Committee to monitor implementation of the new Patient Safety Framework which will replace the Serious Incident Framework in 2020.

The Committee discussed the CCG's responsibilities towards Looked After Children as they are currently responsible for the welfare of 400 such children, plus another 400 from outside the area who reside in Shropshire. As Social Services decide whether a child is taken into care, he queried why their care is funded by the CCG and not the Council.

Mr Timmis replied that the CCG is not currently responsible for funding the care implications of such children, but only funding for their health needs. The Internal Audit report gave significant assurance on the CCG's arrangements for Looked After Children.

ACTION: Mr Allan to invite Mrs Braun to attend a future meeting – month to be confirmed – to update the Committee regarding the changes to the arrangements for Looked After Children.

QC-2019-10.136 (Agenda Item 14) – Date and Time of Next Meeting

The next meeting will take place on Wednesday 27 November 2019 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	22 October 2019
Chair	Dave Evans	Time	14:30 – 16:30
Venue / Location	Venue Aldridge Room, Halesfield		

Attendee's

Present:	Dial in attendees:
Dave Evans (Chair) Claire Old Julie Davies Steve Gregory Nigel Lee Paula Clark Clive Jones Paul Shirley Emma Pyrah Fran Beck Jayne Knott (note taker)	No one dialled into today's meeting

1. Apologies: Andy Begley: Cathy Riley: Kim Nurse: Jess Sokolov: David Stout: Jan Ditheridge: Nicky Jacques: Sarah Dillion: Lynn Cawley.

2. Minutes/Actions from previous meeting 24/9/19

Minutes of the previous meeting were approved as an accurate record.

Actions:

1. **Updated bed bridge:** On agenda via winter plan
2. **Sath2Home:** On agenda
3. **Powys LA bed issues:** On agenda – Jason Crowl sent update via email (within papers)
4. **Emergency care dashboard:** On agenda
5. **Escalation Letter-Actions:** Response has been sent – Action CLOSED
6. **Winter Plan: –** on agenda
7. **Ambulance Demand: –** half day summit needed, waiting for response from Anthony Marsh, Dave Evans to chase.

3. Winter Plan:

On behalf of the A&E Delivery Group, Claire Old recommended the winter plan to the A&E Delivery Board.
Plan refreshed each month.
A&E Delivery Group have been through the plan line by line.
No new schemes added to the list
Claire Old had asked for the Flu testing 'point of care' to be added but no bid received yet.
Nothing from Primary Care for additional capacity.
WMAS have concerns around HALO so need to attend either A&E Delivery Group or Board meetings to discuss these concerns.
Intermediate Care in Crisis Response team pilot with LA's, implementation issues noted,

	waiting for proposal due end of this week, concerns it won't be live for beginning of November. Flag as a risk today. Paula Clark updated on capital: Emergency capital – getting works done on Copthorne building completed. 37 beds going into both sites which will take up until Christmas. Relocation of Wrekin MLU adjacent to the Women & Children's building. Vacated space will go to 16 beds initially then to 20 beds ready for next winter. Trauma assessment unit and expansion of SAU at RSH 180 Indian nurses starting over the next few months. RTT at risk for October. As AO Dave Evans suggested sacrificing RTT to deliver better on A&E performance. Edwin Borman has been asked to pick up pathway work. ACTION: Julie Davies to link in with Edwin Borman and pick three pathways that are feeding the front door and do something different. PLCV (procedures of limited clinical value) Stem demand/ pathway to bypass ED. Streaming at PRH appears to be inefficient – can the model be changed – ACTION: Discuss at next SAED G meeting. There is some data around GP practices with highest demand How to stop patients getting through to A&E? Change community behaviour – what can be done differently? Capacity problem with primary care in Telford Ambulance conveyances v walk-ins Gradual step change in conversion rate from ED. Do we understand the reason for change? ACTION: Dave Evans/Clive Jones to discuss Community offer, ask 2-3 GP's to work alongside LA's, community Trust, and voluntary sector around what to do differently. ? Babylon Health, Discussion for SLG. Data needed on what is presenting condition of patients who call ambulance service? UTC/UCC speck to include referral only to ED, one model across both sites. Dave Evans suggested a workshop with other partners and GP's plus T&W LA, to understand what the problem is with primary care, and can things be delivered in a different way i.e. through the voluntary sector, try as a pilot. ACTION: Dave Evans and Claire Old to discuss how to set this workshop up. Shropshire beds to go out to tender. A&E Delivery Board recommend the winter plan. Final set of papers to be issued to each Organisation. Comms plan needs updating with change of names – Replace Paul Watling with Andy Burford. Page 14&16 points of contacts from SaTH to be changed. Arne Rose to be added ACTION: Claire Old to amend Comms part of plan Next escalation meeting 5 Nov. No clear mitigation around beds.
4.	**Future Fit-Update:** Neil Nisbet to attend future Board meeting to update on Future Fit. SOC going to next SaTH Trust Board and 2 CCG Boards in November. Model is challenging.
5.	**Emergency Care Dashboard** Discussed at A&E Delivery group Recommended that a page at the front which has highlights/graphs Further data on winter plan etc will follow the first page. Changes outlined but simplified. ACTION: Charles Millar to do mock up for next Board.

6.	**Workforce Update:** Paper to be circulated to this Board after meeting. 15 ED nurses started in September Biggest change is work done Internationally – 5 arriving in December starting as band 3's then band 5 in March. Jan – Sept 20 per month starting so by Dec 2020 there will be 176 nurses. 7 W/T equivalent Consultants in ED Middle -grade – 16.9 substantive & 12 agency 2 International cohorts of 12, cohort 2, 12 have accepted Cohort 1 have started arriving. 5 here and 7 to arrive between now and April. Cohort 2 – 12 have accepted and will start arriving end of Feb 2020. Significant step change in workforce. Needs to be an annual cycle. Help with cultural issues/communities. Link in with T&W LA for any help.
7.	**Ambulance Demand Update:** No real update since the last meeting. System group has stopped meeting, but this will be re-instated in the future Need the Ambulance summit to engage WMAS and system partners. NHSE/I to facilitate this. ACTION: Dave Evans to chase up with Anthony Marsh.
8.	**Powys Update:** (email update) • PTHB and the Powys Regional Board have received winter Pressure Funding which his being targeted on supporting existing pathways, funding surg capacity and recruitment to D2RA OT roles across the county. There is a small contribution to third sector provision and an allocation to support reduction of care home admissions and flu campaign. • The Patient Flow hub have been working hard to reduce the overall recorded DToCS across Powys and these have reduced from 35 to 20 over two months. They will continue with this focus but start to shift to long ALOS. • Our area of highest pressure is still south Powys in respect to flow, with poor availability of packages of care, social workers and the very high levels of escalation in South Wales and WVT which impacts the south community hospitals more than the North. • There is ongoing work with PCC to improve the efficiency of the domiciliary care market and to right size packages where possible. • Work is ongoing with WAST to reduce community falls transfers and also admissions from care homes. • Improvement work around community hospital flow is continuing with a focus on virtual board rounds and Check, Chase and Challenge approaches be supported by the Flow Hub. • General approach is to improve efficiency and strengthen capacity where possible across the North Powys system for this winter. • As we do not have ';end to end' live data we are keen to understand flow into ED and GP assessment unit which can be usually managed in the community. If this data is being collected by SATH we are keen to understand what this looks like for Powys patients as it will help the redesign of pathways. ACTION – Julie Davies and Nigel Lee to meet with Jason Crowl this Thursday to discuss any further issues not highlighted in the update given.
9.	**UEC Transformation Bidding Letter:** Some of the money that had been asked for now received. Plans now needed around this.

10.	**SaTH2Home Update:** Plan was to work with both LA's to try and wean everyone off the existing model, and LA's to pick up the discharge of patients sooner than the 48hrs. SaTH colleagues have shared budget with Fran Beck. Proposal is could SaTH provide therapy support to do discharge work. Continue to buy the beds, LA will pick up provision and manage. Create a good quality discharge team for all complex patients, which should start to minimise some of the delays where care homes are reluctant to take people after 6pm. Useful if discharges maintained through the same people then relationships would be maintained. Should be managed through the discharge liaison nurses and the hubs and enhanced by therapists. It was said that Prestige were an expensive option. Dave Evans asked for Fran Beck, Nigel Lee, Tanya Miles, Sara Biffen to come up with solution that works that ideally has no financial implications. Local framework in place in T&W for Domiciliary care.
11.	**Any other business:** • 111/Transfer CAS Care UK – decision not to circulate confidential letter. • Escalation letter received today, as the next escalation meeting is before both A&E Delivery Group and Board Claire suggested working on this outside of these meetings. Decide who will do the presentation. • A&E Delivery Group have received the Patient choice policy, and approved for recommendation the Patient choice policy. Claire Old asked the Chair of this Board for approval, this will be circulated. • A&E Local. No clear recommendation that appears deliverable at the moment, but further work to be done. System discussion needed. Concerns around the Critical Care element that 2 ITU/HDU can't be staffed.

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Summary of Actions

Agenda Item	Action required	Owner	By when
3.	**Winter Plan-** • Julie Davies to link in with Edwin Borman and pick three pathways that are feeding the front door and do something different. PLCV (procedures of limited clinical value) • Streaming at PRH appears to be inefficient – can the model be changed – Discuss at next SAED G meeting. • Dave Evans/Clive Jones to discuss Community offer, ask 2-3 GP's to work alongside LA's, community Trust, and voluntary sector around what to do differently. ? Babylon Health, Discussion for SLG. • Dave Evans suggested a workshop with other partners and GP's plus T&W LA, to understand what the problem is with primary care, and can things be delivered in a different way i.e. through the voluntary sector, try as a pilot. Dave Evans and Claire Old to discuss how to set this workshop up. • Claire Old to amend Comms part of plan	Julie Davies Dave Evans/Claire Old Clive Jones	26.11.19
5.	**Emergency Care Dashboard**: Recommended that a page at the front which has highlights/graphs Further data on winter plan etc will follow the first page. Changes outlined but simplified Charles Millar to do mock up for next Board	Charles Millar	26.11.19
7.	**Ambulance demand** Half day summit to be set up.. No response from WMAS so Dave Evans to chase.	Dave Evans	26.11.19
8.	**Powys LA bed issues** – Email update given. Julie Davies and Nigel Lee to meet with Jason Crowl this Thursday to discuss any further issues not highlighted in the update given.	Julie Davies/Nigel Lee	26.11.19
10.	**SaTH2Home -** Dave Evans asked for Fran Beck, Nigel Lee, Tanya Miles, Sara Biffen to come up with solution that works that ideally has no financial implications**.**	Nigel Lee/Fran Beck/Tanya Miles/Sara Biffen	26.11.19

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-01.021
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	North Locality Board
Date of Meeting:	26 September 2019
Chair:	Dr Michael Matthee

Key issues or points to note:

- **Public Health –** Rachel Robinson, Director of Public Health, attended the meeting to give a general overview about the current work and priorities in Public Health. Following previously raised concerns about the loss of the Help2Slim and Help2Quit services she advised that a paper was being written looking into the need of the population and a review was being undertaken to look at governance in hospitals, training and referrals into lifestyle support. A discussion took place about flu vaccinations and the delays in practices receiving these.
- **Locality Chair Update –** It was confirmed that the Membership vote of both CCGs supported the creation of one single strategic commissioner across Shropshire, Telford and Wrekin. An update about the CCG financial position for month 5 was given. It was confirmed that the 111 service would be taken over by West Midlands Ambulance Service.
- **Medicines Management –** Members were shown a presentation and demonstration of the Eclipse Live system and were asked to email their Locality Pharmacist if they were interested in using the system.
- **Respiratory -** Dr Matthee advised that following Dr Lacy-Colson's attendance at the last meeting there was a piece of work ongoing in Shropshire, Telford and Wrekin called CLEAR (**C**linically **L**ead workforc**E** and **A**ctivity **R**edesign programme) which was a national pilot by Health Education England.
- **MECS/CHEC and Ophthalmology –** Concerns were raised about the time taken for assessments and that referrals were being sent back to GPs from Optometrists for the GPs to refer on to Ophthalmology.
- **Radiology –** Concerns were raised about radiology at RJAH as certain referrals were being rejected. Members asked for a list of what the department is actually commissioned to provide.
- **SOOS –** Concerns were raised about SOOS (Shropshire Orthopaedic Outreach Service) referrals for physiotherapy. It was agreed that SOOS and the relevant commissioner should be invited to the next meeting.
- **IAPT –** Cathy Davis attended the meeting to give a presentation about the services that were available outside of IAPT. Concerns were raised about the long waiting times for IAPT and use of phone call consultations which were not always appropriate for all patients. Concerns were also raised about the Crisis Team.

Actions required by Governing Body Members:

- To note the above discussions. No actions required.

Minutes of the

North Locality Board Meeting

Thursday 26 September 2019

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	Attended
Dr Angela Ayers	Clive Medical Practice	*Apologies*
Zoe Bishop	Clive Medical Practice	*Apologies*
Christine Charlesworth	Hodnet Medical Centre	*Apologies*
Dr Jonathan Davis	Knockin Medical Centre	*Apologies*
Mary Herbert	Knockin Medical Centre	*Apologies*
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
Dr Katy Lewis	Westbury Medical Centre	*Apologies*
Helen Bowkett	Westbury Medical Centre	*Apologies*
Dr Ruth Clayton	Whitchurch – Dodington Surgery	Attended
Elaine Ashley	Whitchurch – Dodington Surgery	Attended
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	*Apologies*
David Stout	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	*Apologies*
Sam Tilley	CCG Director of Corporate Affairs	Attended
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	*Apologies*
Rachel Robinson	Public Health Director	Attended
Cathy Davis	CCG Mental Health Lead Commissioner	Attended

Minute No NLB-2019-09.077 [Item 1] - Welcome & Apologies

1.1 Dr Michael Matthee welcomed those present for attending; apologies were recorded as above. He also thanked everyone for being so supportive to Christine Charlesworth during a difficult time and expressed his condolences to Dr Raichura's family and colleagues.

Minute No NLB-2019-09.078 [Item 2] - Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

2.2 Sam Tilley confirmed the kind of interests that Members should be declaring on their forms, such as PCN (Primary Care Network) involvement, personal connections or links to business interests.

Minute No NLB-2019-09.079 [Item 3] - Minutes of Meeting held on 18 July 2019

3.1 The minutes of the meeting held on 18 July 2019 were approved as an accurate record of the meeting and were signed by the Chair.

Minute No NLB-2019-09.080 [Item 4] - Matters Arising from Previous Meeting

4.1 Minute No NLB-2019-02.024 Maternity Audit – Janet Gittins confirmed that four practices had informed her about issues, such as not receiving communication from the maternity team. These had been sent to Fiona Ellis who would be discussing these issues at the contract meeting each month and would be providing feedback to Janet.

4.2 Minute No NLB-2018-10.092 Heart Failure and AF – Katy Lewis had sent apologies for the meeting so was not present to give feedback; this action was deferred to the next meeting.

4.3 Minute No NLB-2019-05.061 Pre-Op Assessments – Members confirmed that they had not received any further requests for pre-op assessments. Dr Clayton had a query regarding patients who were referred for prostate biopsies, consultants had asked for the GP to prescribe Tinzaparin. Dr Matthee advised that this should not be happening and needed to be fed back to the consultant.

ACTION: Janet Gittins to feedback to consultants re issues around them asking GPs to prescribe medication before procedures, this should not be happening.

Minute No NLB-2019-09.081 [Item 5] – New Public Health Director – Introduction and PH Update

5.1 Rachel Robinson attended the meeting to have a general discussion about Public Health. She introduced herself and confirmed that she had been in post since April 2019. She was aware of the significant cuts to the Public Health budgets and concerns about this. She advised that in the future there needed to be a firm evidence base to understand the needs of the population and more work was required on needs assessments. She explained that there were variations across the county and, for example, life expectancy could differ by 10 years depending on where in the county someone lived. More was needed in the community such as social prescribing and prevention.

5.2 Rachel explained that one priority for public health was smoking in pregnancy, and a review of the current service was being completed. Outcomes were poor at the moment and some young women could be at double the rate as in other areas in the county. Other priorities included diabetes diagnosis, weight management and mental health. 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.

5.3 Rachel was originally invited to the meeting due to Members concerns about the loss of the stop smoking and weight management services. She agreed that prevention was very important and Public Health were reviewing this along with smoking in pregnancy services. There would be an options paper following the review looking at governance in hospitals, training across the system and referrals into lifestyle support. A paper was also being written for the CCG in regards to the need of the population for smoking and weight services looking at where the need is and the best evidence and support. Rachel confirmed that a letter would be coming out to everyone to let them know where services are that they can access.

5.4 It was confirmed that flu jabs were commissioned by Public Health England and NHS England (NHSE) but that Rachel would be happy to refer any issues back to them herself. Dr Clayton stated that she was told her practice might not get any flu jabs even though the pharmacies in Whitchurch have had them for weeks, and all her patients were going to the pharmacies instead. Pharmacies also get £1 more than practices even though they don't have to have resus training and equipment. It was confirmed by Members that a number of practices had this same problem. Rachel asked Members to email any concerns about flu vaccines to her so that she could get the information to the right people. Kevin Morris suggested that perhaps PCNs could order these jointly in the future and he was aware that Telford and Wrekin CCG had a wholesaler licence for practices to buy vaccines from the CCG.

ACTION: Members to email Rachel Robinson with any issues in regards to accessing flu vaccines.

5.5 Rachel showed some slides to Members which had figures for life expectancy and differences in the county as mentioned previously. She confirmed that there would be a more place-based approach in the future. She also mentioned that Shropshire had one of the lowest grants in the country and funding had been raised as a problem.

Minute No NLB-2019-09.082 [Item 6] – Locality Update

6.1 Single Strategic Commissioning Organisation - Dr Matthee confirmed that the Membership vote to have one single strategic commissioner had passed positively, though some comments were made about the proposed composition of the new Board. He stated that there would be a Membership meeting arranged in the near future to talk about this. Kevin Morris added that the deadline for the CCGs to make their application to NHS England was Monday 30 September 2019 and that there had been various checkpoints along the way in the process. It was hoped that there would be an announcement about the new Joint Accountable Officer (AO) soon, it was explained that this was a different post to the AO of the single organisation as the new Chair and NHSE would have to appointment the AO for the new organisation. It was anticipated that the new Joint AO, when in post, would start to build their Executive Team and once GP Board members were in place a shadow arrangement would be looked at. The new Chair would need to be in place by the end of December 2019 and new AO by the end of January 2020. Sam Tilley confirmed that there was a robust assurance process with NHSE, and that following the submission there would be a regional panel on 11 October 2019. If the panel feel that the submission was advanced enough this would then go to a national panel at the beginning of November. It was hoped that this panel would then give the permission to go ahead with the plans to form a new single organisation from 1 April 2020; but if not it would be April 2021 with a joint management arrangement in the interim.

6.2 Locality Meetings - Dr Matthee advised that there were no changes to the Locality Boards at the moment. There would still be a need for local commissioning groups to carry on meeting but the format and frequency of these meetings were still to be decided for the new organisation.

6.3 CCG Finances - The CCG financial position in month 5 was not as good as expected due to more activity than anticipated. Kevin Morris advised that activity at SaTH (The Shrewsbury and Telford Hospital Trust) had increased significantly and they were approx. one month over on elective admissions. There was now an estimated in year deficit of £44m. Dr Matthee suggested that the system didn't necessarily need more beds and should look at the way current beds were used.

6.4 111 Service - It was confirmed that the 111 service would be taken over by West Midlands Ambulance Service. Healthcare UK currently run the service but didn't want to carry on. It was hoped that this would help with costs and deployments and reduce the queues at SaTH.

Minute No NLB-2019-09.083 [Item 7] – Medicines Management – Eclipse Live Medication Safety

7.1 Amanda Laing presented information about the Eclipse Live system and gave a demonstration of the system to Members. The presentation included the following:

- Advice and guidance components (Eclipse Live, Radar and Diabetes Complete)
- How it supports patient safety and CQC requirements
- How it works – dashboard, identification of patients with reversible risk
- Impact of Eclipse Live on outcomes
- Alerts and examples of these
- How it is a stand-alone programme or could be partnered with Scriptswitch
- Regions already using the system

7.2 Amanda advised that the system was more of a 'safety net' to manage anything that gets missed by current practice procedures and used a traffic light colour coding system for alerts. It was explained that this system was not the same as PINCER which is run by pharmacists and is designed to reduce workload and make medicines safe, it is seen as a positive to have this for CQC purposes.

7.3 James Bradbury confirmed that his practice only had eight red alerts to begin with and the pharmacist in the practice now runs the searches. He also added that the diabetes module was very useful.

7.4 Members asked about medico-legal implications, Amanda confirmed that all the information displayed by the system was taken from the practice system; it is used for flagging up anything that could have

potentially been missed. Practices were asked to email Amanda Laing if they were interested in signing up to use the Eclipse system as there would be a data sharing tool to sign in order to set the system up at the practices.

ACTION: Members to email Amanda Laing if they are interested in signing up to use the Eclipse Live system.

Minute No NLB-2019-09.084 [Item 8] – Respiratory Update - CLEAR

8.1 Dr Matthee advised that following Dr Lacy-Colson's attendance at the last meeting there was a piece of work ongoing in Shropshire, Telford and Wrekin called CLEAR (Clinically Lead workforcE and Activity Redesign programme) which was a national pilot by Health Education England; Dr Katy Lewis had been involved in the respiratory work. He explained that Health Education England were keen to see how this approach could be used at a system level, and had provided funding for the programme to be run in Shropshire, Telford and Wrekin STP on a whole system pathway. As part of this work the programme would like to look at needs and data from urban and rural practices. Members agreed that this was a good idea and were happy to allow access to data.

ACTION: Members to let Dr Jessica Sokolov know if they were interested in the CLEAR programme and would allow access to practice data – there would be a data agreement to sign.

Minute No NLB-2019-09.085 [Item 9] – Any Other Business

9.1 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.

9.2 MMR Popups - Kevin Morris mentioned MMR pop ups that may now be appearing on patient systems for anyone born after 1 January 1970. After checking some patient paper records Kevin found that some of them had already had the MMR vaccine but this was so long ago that it wasn't recorded on the electronic system. He had now asked the nurses to check records first before booking appointments.

9.3 Radiology - Members asked about radiology at RJAH (The Robert Jones and Agnes Hunt Orthopaedic Hospital) as certain referrals were not being accepted e.g. no x-ray allowed if fall or trauma within 5 weeks or more than 14 days since injury.

ACTION: Janet Gittins to circulate a list of what the Radiology department at RJAH are commissioned to provide.

9.4 Urgent Child Referrals - Dr Matthee mentioned issues he had recently with child referrals and 14 day rule requests; he recently wrote for an urgent appointment but the earliest available was in December; Dr Matthee had to ring the consultant to get the child admitted. Dr Lachowicz advised that there was a rapid access service with an email address; he managed to get an appointment within two weeks. Dr Rogers advised that there was no two week rule for children and these referrals had to be discussed with a consultant. It was confirmed that there was a phone number at the top of the proforma which could be used to discuss referrals and book appointments.

9.5 SOOS - Members discussed problems with SOOS (Shropshire Orthopaedic Outreach Service) referrals for physiotherapy. Sometimes referrals were being accepted but patients are told to go to their local physios who then only see them once. Dr Matthee advised he had reviewed some of the referral letters and some were not detailed enough. Dr Eslava advised that it had to be made clear in referral letters that analgesia had been tried and which analgesia. Members agreed that it would be good to invite SOOS and the relevant commissioner to the meeting to discuss concerns further.

ACTION: SOOS to be invited to the next meeting to discuss concerns and provide information about waiting times, referral criteria, process and what is commissioned.

9.6 Health Visitors - Janet Gittins advised that Members had previously raised issues about health visitors not attending practice meetings. The service has apologised for the incorrect message that some of their staff were giving and it was confirmed that there would be someone to attend quarterly safeguarding meetings. This would be addressed and checked with staff that they are attending. If there were any further issues Members were advised to contact their link worker. Referrals should still be sent to the single point of access email.

ACTION: It was agreed that areas of concern from the meeting to bring to the attention of the CCG Board were ophthalmology referrals, SOOS, flu vaccines, health visitors and help to quit/slim services.

ACTION: Heather Clark to circulate perinatal mental health slides from provider section of the meeting when draft minutes are circulated.

Minute No NLB-2019-09.086 [Item 10] – Services available outside of the IAPT service/gaps and plans to address them

10.1 Cathy Davis attended the meeting to give a presentation on the services available outside of IAPT; her presentation covered the following topics:

- The impact of mental health on spend
- Mental health and the long term plan
- Four strategic ambitions
- Expectation of regulators
- CRISIS and Acute alternatives/complementary services

10.2 Concerns were raised again about the IAPT service and long waiting times. Cathy advised that she was not aware of this as the service had advised her they were not getting enough referrals. Members also raised concern about the use of phone call consultations which were not always appropriate for some patients. Cathy advised that face to face appointments could be requested and the team had a certain number of appointments allocated per month for this.

10.3 Members talked about concerns they had with the CRISIS team such as issues with them not coming out to see patients, saying it is too far to travel and also issues with police telling a patient to call their GP when they threatened their own life. This was not appropriate and needed to be addressed.

10.4 Cathy stated that voluntary sector cafes and night time cafes were being looked at with Designs in MIND and how to expand this to all of the localities. Members advised that the BEAM café in Shrewsbury was very good and would like to have one in the North Locality.

10.5 In reference to the action from the previous meeting about the Trailblazer schools, Cathy advised that the schools had just been signed into the programme and that she would be able to find out which schools these now were and share this with Members. She explained again that the Trailblazers were for secondary CAMHS low level work in schools; their training started in January and the service would be fully operational in 12 months.

ACTION: Cathy Davis to share list of Trailblazer schools.

Cathy Davis to attend the locality meeting again in 6 months' time to provide an update on the IAPT service.

Minute No NLB-2019-09.087 [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-2019-09.088 [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 NLB-2019-09.089 [Item 13] - Date of Next Meeting

13.1 The next meeting will take place on: **Thursday 28 November 2019** 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 24 October 2019 (PLT)
- Thursday 28 November 2019, The Venue at Park Hall, Oswestry
- 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 Michael Matthee, Joint North Locality Chair

NHS
Shropshire
Clinical Commissioning Group
Agenda item: GB-2020-01.022
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	Shrewsbury and Atcham Locality Committee
Date of Meeting:	19th September 2019
Chair:	Dr D Shepherd

Key issues or points to note:

- Workshop on communication issues with SaTH. What works well eg electronic clinic letters; practice generic email addresses; what does not work well, and how to improve eg electronic discharge summaries, out of date GP names, outpatient prescription requests, significant event reporting and responses
- Transforming Midwifery Care. Presentation on progress with this programme
- Medicines management update. Update on issues with prescribing in CAMHS; presentation on Eclipse prescribing safety and quality support system
- Update on progress towards a single strategic commissioning organisation
- Update on communications with Health Visitors

Actions required by Governing Body Members:

- None

Minutes of the

Shrewsbury & Atcham Locality Board Meeting

Thursday 19 September 2019

Board Meeting Room, Severn Fields Health Village,
Sundorne Road, Shrewsbury, SY1 4RQ

NHS Shropshire Clinical Commissioning Group

Member Name	Practice	Attendance
Dr D Shepherd (Chair)	CCG Locality Chair & Locum GP	Attended
Dr J Pepper	Belvidere	Attended
Caroline Davis	Belvidere	*Apologies*
Dr M Fallon	Claremont Bank	Attended
Jane Read	Claremont Bank	Attended
Dr E Baines	Marden	*Apologies*
Zoe George	Marden	Attended
Dr Julia Visick	Marysville	*Apologies*
Izzy Culliss	Marysville	Attended
Dr Sarah Watton	Mytton Oak	Attended
Adrian Kirsop	Mytton Oak	*Apologies*
Dr R Bland	Pontesbury	*Apologies*
Heather Brown	Pontesbury	*Apologies*
Dr B Roberts	Radbrook Green	Attended
Angela Treherne	Radbrook Green	*Apologies*
Dr P Rwezaura	Riverside	Attended
Tracy Willocks (Vice Chair)	Riverside	*Apologies*
Dr D Martin	Severn Fields	Attended
Tim Bellett	Severn Fields	Attended
Dr L Davis	South Hermitage	Attended
Caroline Brown	South Hermitage	*Apologies*
Dr E Jutsum	The Beeches	Attended
Kim Richards	The Beeches	*Apologies*
Jo Beason	Whitehall	*Apologies*
Dr K McCormack	Worthen	Attended
Cheryl Brierley	Worthen	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Chair	*Apologies*
David Stout	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	Attended
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
Alison Jones	SaTH GP Liaison Officer	Attended
Amanda Laing	CCG North Locality Pharmacist	Attended
Dr Jessica Sokolov	CCG Medical Director	Attended

Minute No S&ALB-2019-09.086: 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-2019-09.087: Item 2 – Members' Declarations of Interests

2.1 There were no further interests declared for items included on the agenda.

2.2 Dr Shepherd advised that following review of the declaration of interest forms some inconsistencies were found. The guidance page from the policy was circulated to Members to show the types of interests that should be declared; Dr Shepherd added that partners or senior managers of practices should declare their role at their practice as a conflict of interest and asked that new forms were completed if this had not already been declared. It was confirmed that Heather Clark would send email reminders to Members when their declarations were due to be reviewed; if no changes were required it would now be possible to email back a response to confirm this. If changes to declarations were needed, a new form would need to be completed showing all current declarations.

Minute No S&ALB-2019-09.088: Item 3 – Minutes of Meeting held on 18 July 2019 and Actions

3.1 The minutes of the meeting held on 18 July 2019 were agreed as a true and accurate record of the meeting and were signed by the Chair.

3.2 All actions from the previous meeting had been completed and updates provided with the meeting papers.

Minute No S&ALB-2019-09.089: Item 4 – Matters Arising

4.1 No further items were raised for discussion.

Minute No S&ALB-2019-09.090: Item 5 – Workshop: Communications with SaTH

5.1 Alison Jones, GP Liaison Officer from SaTH (The Shrewsbury and Telford Hospital NHS Trust) attended the meeting to talk about communication between practices and SaTH and how it could be improved. Members were asked to discuss what was working well and not so well for communication between clinicians and health professionals, between admin teams and between GP engagement at SaTH and primary care. The following were the main points discussed:

5.2 **Communication between Clinicians/Health Professionals**

Working well:

- Anything sent electronically e.g. discharge summaries.
- Rolling out of electronic clinic correspondence – all specialities should be using this by April 2020.
- Education – study days, training and events to share best practice.
- New and improved SaTH website for service information.
- Referrals in and out, when done right it works well.
- Advice and guidance.

Not working well:

- E-discharge summaries – quick and fast but are no good if content isn't sufficient. The new intake of doctors were now receiving training on this. GPs need to know about investigations and results of x-rays, what the patient attended with and what has been ruled out. It would also be useful to know what the patient had been informed of so far and if they were aware of the medication they need and when to start taking it.
- Hospital colleagues are sending patients to GPs for tests, SaTH is working on getting them to give patients form with information about where to get this done.
- Electronic letters – consultants are being encouraged to start these with highlighted key GP information or highlight that no action is needed.
- Letters were still being sent to GPs that were no longer at practices therefore a data cleansing exercise was needed. Nicky advised this could be raised through the Quality Committee.
- Language and tone of letters needed to be improved.
- Outpatient prescription requests – With electronic clinic letters being rolled out there should no longer be any need for handwritten prescription requests. If medication is needed urgently, this should be prescribed in clinic, either from the hospital pharmacy or on an FP10, as most appropriate. Members felt that they should no longer receive outpatient prescription requests from April 2020, when electronic clinic letters should have rolled out to all specialities. Jenny and Deborah to follow this up with Alison Jones in January to monitor progress towards this.
- Patient records – SaTH still have handwritten records; this is on the CCG risk register.
- Feedback from lab teams – use of practice professional lines for urgent incidents, lab staff had been advised never to leave messages if urgent and to keep trying or use the emergency option on the GP phone line.
- Datix and lack of engagement from SaTH in responding to these – Alison Jones links in with Jane Blay from Shropshire CCG. There were now more members in the patient safety team and all issues were now formally logged and outcomes reported back from SaTH to the CCG.

- Clinicians not appreciating each other's problems – resources, staff, time etc., there is a need to try to share best practice and learn from each other.
- Breach reporting process – SaTH now can't follow through all breaches and share full information because of GDPR (General Data Protection Regulation) – there was concern about sharing of information without patient consent.

ACTIONS:
CCG to look into issue around GDPR and sharing of information to investigate SaTH breaches.

CCG to raise through Quality Committee the issue around out of date GP information (in response to letters being sent to GPs no longer at practices).

Jenny/Deborah to follow up with Alison Jones in January 2020 regarding progress towards electronic clinic letters and phasing out of outpatient prescribing request forms.

5.3 **Communication between Admin Teams**

Working well:

- Fax machines – encouraging all to use nhs.net and phase out fax machine use.
- Correct and appropriate use of practice generic emails.

Not working well:

- SaTH teams need to have more generic group nhs.net accounts set up and have a directory of email addresses.
- It would be helpful to have consultant emails and PA emails on the website or directory.
- Secretaries should not be advising patients to contact their GP to expedite referrals.

5.4 **Communication between GP Engagement and Primary Care**

Working well:

- Newsletter to Practice Managers every month.
- Streamlining communication to primary care.

Not working well:

- Using practice managers as 'posties' to send information to – Alison is now using TeamNet via Jenny Stevenson as she is unable to log on to this herself.

Minute No S&ALB-2019-09.091: Item 6 – Transforming Midwifery Care

6.1 Dr Jessica Sokolov gave a presentation to Members about the proposed model for midwifery care in Shropshire, Telford and Wrekin. The presentation included the following:

- Recap on reasons for change (including data on location of births and usage of current sites)
- Proposed new model of midwifery care (including what was staying the same, maternity hubs and birthing options)
- Options appraisal methodology and outcome
- Number and location of Maternity Hubs and the criteria for these
- Access Impact Assessment Summary
- Consultation Plan, approach and next steps

6.2 Dr Fallon asked about deliveries at the Shrewsbury site. Dr Sokolov advised that at the moment the site was being maintained, but the CCGs had committed to having a site in both Shrewsbury and Telford. At some point in the future when FutureFit plans are put in place the consultant-led site would be moving to Shrewsbury.

6.3 Dr Bale asked what the feedback had been like in the other localities. Dr Sokolov advised that whilst some of the proposals were not liked, Members fully understood the reasons for the decisions made and the evidence-based approach used.

Minute No S&ALB-2019-09.092: Item 7 – Medicines Management Update

7.1 **CAMHS Prescribing Update**

Clare Michell-Harding advised that the results from the CAMHS (Children and Adolescent Mental Health Services) searches suggested that there were 575 children (183 in Shrewsbury) aged 0-18 on mental health drugs that need shared care agreements; this search was also extended to certain other drugs to check that none had been missed. Approximately 65% of the patients did not have a shared care agreement or had an out of date agreement, and about a third of patients didn't have the required physical health monitoring. Just under a third of patients didn't appear to be under the CAMHS service. 11% of patients had the required monitoring completed but this was only discovered once the records

were looked at, therefore a piece of work was needed with MPFT (Midlands Partnership NHS Foundation Trust) about how these details are shared with practices.

7.2 The Medicines Management Team explained they would be presenting MPFT with the findings and working closely with their Chief Pharmacist. The team had also agreed to work alongside the LMC (Local Medical Committee) to keep them updated on the long term plan for these patients. Clare Michell-Harding advised that all concerns and comments would be fed back and as soon as the team knew what the short term plan was this would be communicated to practices; the long term plan had already been presented to the locality in a previous meeting. Dr Fallon asked if MPFT would cope with all the extra patients; it was advised that they did not have capacity for this which is why a plan would be put in place.

7.3 **Eclipse Live System**

Carrie Jenkins and Amanda Laing presented information about the Eclipse Live system and gave a demonstration of the system to Members. The presentation included the following:

- Advice and guidance components (Eclipse Live, Radar and Diabetes Complete)
- How it supports patient safety and CQC requirements
- How it works – dashboard, identification of patients with reversible risk
- Impact of Eclipse Live on outcomes
- Alerts and examples of these
- How it is a stand-alone programme or could be partnered with Scriptswitch
- Regions already using the system

7.4 Dr Fallon explained that he had been using the system in his practice and found it very useful. He stated that at first there were quite a few alerts but these became fewer as the system was used. The system highlights high risk patients using a traffic light colour system so practices could concentrate on the red alerts first. A question was asked about the clinical risk and responsibility once an alert had been raised. Dr Fallon explained that the information was taken directly from practice systems and was not new data, so practices should already be aware of these patients.

7.5 Practices were asked to email Carrie Jenkins if they wanted to sign up to use the system as there was a data sharing tool to sign in order to set the system up at the practices. A day would be needed to complete the first data extract and a day would also be provided for training.

ACTION: Members to email Carrie Jenkins if they are interested in signing up to the Eclipse Live System.

Minute No S&ALB-2019-09.093: Item 8 – Locality Chair Update

8.1 **Care Closer to Home**

Dr Shepherd advised that all practices in phase two were now up and running and had received positive feedback with most patients signing up. A number of patients had been identified who had not previously been known to community services, who could now be provided with support to maintain their health and wellbeing.

8.2 **Clinical Commissioning Committee**

A new major service redesign for respiratory services was discussed at the Clinical Commissioning Committee which had been prompted in part by the work completed by the North and Shrewsbury and Atcham Localities.

8.3 **Single Strategic Commissioning Organisation**

The CCG Membership vote had taken place for the new organisation proposal which was positive and showed support for the dissolution of the two current CCGs to form one CCG, and agreement in principle for the suggested set up of the new Governing Body. A question was asked about the equal GP representation from both areas on the new Board; it was confirmed that this was a starting point to get things up and running and may not necessarily be how it would be in the future. Dr Shepherd added that she could not envisage it to be a problem. The next step in the process would be for the CCGs to submit their application to NHS England by the end of September, there would then be regional and national panels to consider the application.

8.4 A question was asked about loss of jobs at the CCGs. Dr Shepherd stated that there was a requirement for the CCGs to have a 20% reduction in running costs and it was expected that if there were to be job losses these would be mostly at a senior level in the Executive Teams and CCG Boards. Staff may be moved around to other roles but redundancies would be unlikely for people in lower grades. The CCGs were also still waiting for confirmation from NHS England for the appointment of the new Joint Accountable Officer. In the meantime the CCGs would need to arrange the election of the new Board Members and decide with members how the new organisation would operate.

8.5 Dr Julian Povey and Dr Jo Leahy, Chairs from the CCGs, had been working on a first draft of the new single CCG constitution and would be arranging a meeting with the Membership from both CCGs to discuss this in late October or early November. Dr Shepherd suggested that for the meeting Members think about how they would like decisions or voting to be determined – whether by practice, by GMS/PMS/APMS contract or by patient numbers, for example. Also to consider how they would like to engage with the new organisation e.g. some form of Locality meeting, or other format. It was explained that currently Shropshire CCG had three locality meetings and in Telford they had one GP Forum.

8.6 **Weekend Extended Access Service**

Nicky Wilde advised that Shropshire Community Trust, who the CCG commission the Weekend Extended Access Service from, had given notice on this service and the CCG were looking at potential solutions to this; the options would be presented to the Primary Care Commissioning Committee in October. Emails had already been sent out to existing access hubs and Primary Care Networks for interest.

8.7 **Health Visitors**

Dr Shepherd and Jenny Stevenson met with Yvonne Gough following concerns raised at the last meeting about health visitors. It was confirmed by Yvonne that there would be someone to attend practice safeguarding meetings on a quarterly basis. These meetings would not be the best place for referring new cases or concerns, but should be for discussion of ongoing cases; new referrals should be sent to the single point of access. Jenny Stevenson advised that she would be collating all the key contact names and numbers to go on TeamNet such as nominated practice link workers. Link workers will be asked to make contact with practices to set up the quarterly meetings. It was also clarified that a single practice link worker may not be responsible for all patients at a particular practice and that patients would be shared out between the team.

ACTION: Jenny Stevenson to collate health visitor key contact names and details to be shared on TeamNet.

Minute No S&ALB-2019-09.094: Item 9 – Open Discussion / Provider Issues

9.1 No further items were raised for discussion.

Minute No S&ALB-2019-09.095: Item 10 – Primary Care Update

10.1 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-2019-09.096: Item 11 – Commissioning Update

11.1 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-2019-09.097: Item 12 – Any Other Business

12.1 Dr Jutsum raised that The Beeches Medical Practice were still receiving letters from opticians asking the GP to refer to ophthalmology. Jenny Stevenson to pick this up with the practice for more information.

ACTION: Jenny Stevenson to liaise with The Beeches Medical Practice regarding letters from opticians asking the GP to refer to ophthalmology.

Minute No S&ALB-2019-09.098: Item 13 - Date and Time of Next Meeting

13.1 The next formal meeting will be held on **Thursday 21 November 2019** in **Severn Fields Health Village, Sundorne Road, Shrewsbury, SY1 4RQ** commencing at **2.00pm.**

13.2 Further meeting dates:

Thursday 21 November 2019
Thursday 19 December 2019
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-2020-01.023
Shropshire CCG Governing Body meeting: 15.01.20

Committee Meeting Summary Sheet	
Name of Committee:	South Locality Board
Date of Meeting:	04 September 2019
Chair:	Dr Matthew Bird

Key issues or points to note:

- **Single Strategic Commissioning Organisation -** An update was given about the move towards a single commissioning organisation; the CCGs had appointed Deloitte as the organisational development partner and the Joint Accountable Officer interviews had taken place. Shropshire practices would be asked to vote on 17 September 2019 to show whether they were in support of the dissolution of the CCG and creating a new organisation across Shropshire, Telford and Wrekin.
- **PINCER -** Sandeep Pahal, Medicines Optimisation Lead from West Midlands Academic Health Science Network attended the meeting to give a presentation about PINCER (**P**harmacist-Led **I**T-based I**n**tervention to reduce **C**linically important medication **Er**rors).
- **RightCare Data -** Gail Fortes-Mayer talked through a presentation about NHS RightCare and how it could be used to identify strengths and weakness within the system. It was agreed that the practice and locality level RightCare data would be circulated for practices to review.
- **PLTs –** The date and venue of the upcoming PLT was discussed. Concerns were raised about the value of these PLT session for practice admin staff. Discussion took place about this and Members felt that it would be more useful for admin staff to stay at their practice and work on their Bluestream modules.

Actions required by Governing Body Members:

- To note the above discussions. No actions required.

Minutes of the

South Locality Board Meeting

Wednesday 4 September 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	Attended
Dr Adrian Penney	Bishop's Castle	*Apologies*
Sarah Bevan	Bishop's Castle	*Apologies*
Dr Gwen Potter	Bridgnorth	Attended
Dude Newell	Bridgnorth	Attended
Dr Mathai Babu	Broseley	*Apologies*
Nina Wakenell	Broseley	Attended
Dr Bill Bassett	Brown Clee	Attended
Vicki Brassington	Brown Clee	*Apologies*
Dr Alex Chamberlain	Church Stretton	*Apologies*
Emma Kay	Church Stretton	Attended
Dr Paul Thompson	Cleobury Mortimer	*Apologies*
Mark Dodds	Cleobury Mortimer	*Apologies*
Dr Juliet Bennett	Clun	*Apologies*
Peter Allen	Clun	Attended
Dr David Appleby	Craven Arms	Attended
Susan Mellor-Palmer	Craven Arms	Attended
Dr Shailendra Allen	Highley	*Apologies*
Sudhanshu Consul	Highley	*Apologies*
Dr Catherine Beanland	Ludlow – Portcullis	*Apologies*
Rachel Shields	Ludlow – Portcullis	*Apologies*
Dr Graham Cook	Ludlow - Station Drive	*Apologies*
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	*Apologies*
In Attendance	**Organisation/Role**	**Attendance**
Dr Julian Povey	CCG Clinical Chair	*Apologies*
David Stout	CCG Accountable Officer	*Apologies*
Nicky Wilde	CCG Director of Primary Care	Attended
Tom Brettell	CCG South Locality Manager	Attended
Heather Clark (Minute Taker)	CCG Personal Assistant	Attended
Clare Michell-Harding	CCG Senior Project Lead Pharmacist	Attended
Shola Olowosale	CCG Locality Pharmacist	Attended
Gail Fortes-Mayer	CCG Director of Planning and Contracting	Attended
Sandeep Pahal	Medicines Optimisation Lead – West Midlands Academic Health Science Network	Attended
Dr Ward (observing)	GP Albrighton Medical Practice	Attended

Minute No SLB-2019-09.079: 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-2019-09.080: 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.

2.2 Dr Bird reminded Members of the importance of keeping their declarations of interest up to date. The policy was circulated with the meeting papers and states that declarations must be updated every six months. Miss Clark confirmed that she would send email reminders to Members whose declarations were out of date and if there were no changes from the last form Members could email back with "No Changes". If changes to declarations were needed then a new form would need to be completed.

2.3 Dr Bird also mentioned that it appeared that many Members were not declaring any interests at all, but that all Members should really have at least one conflict of interest and should be declaring which practice they work for. Members who had not declared this may be asked to complete a new form.

ACTION: Heather Clark to email reminders to Members with out of date declarations, and those who have not declared any.

Minute No SLB-2019-09.081: Item 3 – Minutes of Formal Meeting held on 11 July 2019

3.1 The minutes of the meeting held on 11 July 2019 were agreed as a true and accurate record and were signed by the Chair.

Minute No SLB-2019-09.082: 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-2019-05.054 – SilverCloud – There had been a misunderstanding with the action for Anne O'Shea to provide a log in for Members to look at SilverCloud. Anne had advised Tom that she could not provide a log in for individual practices but could facilitate for practices to have a look at the system.

ACTION: Members to let Tom Brettell know if they are interested to take a look at the SilverCloud system.

Minute No SLB-2019-07.072 – Perinatal Mental Health – Members were advised that the new service would be starting on 30th September 2019, and that there were some training opportunities and events coming up. The GP Champion for the service is Dr Caroline Freeman, who is a GP at Shawbirch in Telford and Wrekin CCG.

ACTION: Tom Brettell to circulate information about training and events for new Perinatal Mental Health Service.

Minute No SLB-2019-07.073 – Commissioning Intentions – Tom Brettell advised that he had not received any ideas for the CCG commissioning intentions yet but that Members could still send any ideas through to him.

ACTION: Members to send any ideas for next year's commissioning intentions to Tom Brettell.

Minute No SLB-2019-07.077 – Trial of New Meeting Room – Tom Brettell had looked at alternative venues to hold the locality meetings in the south west and made a few suggestions to Members. Members agreed to keep the meeting in the usual room at the Mayfair Centre in Church Stretton, but trialling Dr Bird sitting at the other side of the table to help with the acoustics in the room.

Minute No SLB-2019-09.083: Item 5 – Locality Chair's Update

5.1 Dr Bird advised that he had attended the Shrewsbury and Atcham Locality Board meeting to observe and noted that their meeting was held in a different order with a general discussion at the beginning of the meeting and he felt that this was helpful. As such, Dr Bird asked if anyone had anything to discuss or raise; Susan Mellor-Palmer mentioned an issue with ophthalmology referrals and that numerous patients who had been seen by an optician and confirmed to have cataracts were then being referred back to the practice for the practice to make a referral to CHEC (Community Health and Eye Care Limited). Nicky Wilde advised that this had been raised as it should not be happening and that practices were within their

rights to not accept the referrals back. She explained that Julie Davies, Director of Performance and Delivery had asked for live examples, Tom Brettell advised that he would share this information with Julie as he had some examples already from practices.

ACTION: Tom Brettell to share examples with Julie Davies of Optometrists referring back to GPs to refer on to CHEC.

5.2 Dr Bird advised that the Independent Review Panel process looking into FutureFit was still ongoing and that he had not yet been made aware of the outcome for this.

5.3 The CCG had appointed Deloitte as the Organisational Development partner working towards a single organisation. Shropshire practices will be asked to vote and Nicky Wilde advised that there would be some communication coming out to practices about this and the vote would be taking place electronically on 17th September 2019. The CCG will be asking for the nominated person at the practice to be available from 8am until 3.30pm. If availability would be a problem on that day, practices were asked to inform the communications team and they would liaise with the nominated person. There will be three questions asked of Members: Do you agree with the dissolution of the CCG? Do you agree to having a new organisation across both Shropshire and Telford and Wrekin and a question about the number of GPs on the new CCG Board. The nominated person can be whoever the practice partners have chosen. Dr Bird noted that from the last locality meeting there was no sense of resistance to the process or proposal but that if anyone had concerns it would be good to know about them before the vote takes place. Dr Bird added that interviews had taken place for the new Accountable Officer but there was no news about this yet as the CCGs were still awaiting NHS England approval.

5.4 Dr Bird gave an update from the Primary Care Commissioning Committee where a discussion about Whitehall Medical Practice took place, the practice was due to close on 27th September 2019. A planning application for the new premises at Pauls Moss in Whitchurch had been turned down but had now been amended and resubmitted. There was also an update provided about Primary Care Networks and the CCG had offered support as they start to develop. Also the Primary Care Strategy was being developed as a joint document with Telford and Wrekin CCG, the Primary Care Teams from both CCGs were now working more closely together with joint meetings and papers.

5.5 Dr Bird stated that a proposal had been put together for Primary Care Quality Assurance visits, and that some practices had had their visits from the CCG already. Concerns had been raised previously that this was an extra workload and another burden. Nicky Wilde advised that the way the visits are conducted wasn't mandatory and could be altered and feedback had already been taken into consideration with a new form with Chris Morris (Chief Nurse) to approve. It was confirmed that a practice could request a visit rather than waiting for one to be arranged. Dude Newell added that Bridgnorth practice found the visit to be quite useful with guidance and a light approach.

5.6 Shropshire Care Closer to Home – Phase one, Frailty Intervention Teams, were now in place at both the Royal Shrewsbury Hospital and Princess Royal Hospital five days a week. Phase two, Case Management, had been delayed as Case Managers had only recently been appointed and were completing training. Dr Potter asked how much GP input was expected for the service, Dr Bird advised that this should be minimal and shouldn't increase GP workload. Dr Potter added that the practice was invited to weekly MDT meetings but this would not be possible. Nicky Wilde explained that GPs were not required to go and that some practices were more involved than others.

5.7 Dr Deborah Shepherd was working on a pilot for non-medical referrers to request x-rays. SaTH (The Shrewsbury and Telford NHS Hospital Trust) had received the pathway and asked for it to be in their standard format but did not provide any feedback to change the pathway.

Minute No SLB-2019-09.084: Item 6 – PINCER

6.1 Sandeep Pahal, Medicines Optimisation Lead from West Midlands Academic Health Science Network attended the meeting to give a presentation about PINCER (**P**harmacist-Led **I**T-based I**n**tervention to reduce **C**linically important medication **Er**rors). The presentation was circulated to attendees prior to the meeting and included the following topics:

- Why is there a need for PINCER?
- What is the PINCER Intervention?
- National PINCER Dataset
- The PINCER Tool
- Evidence Base for Each Indicator
- PINCER Evidence
- What is the impact of PINCER?
- Intervention Evidence at Scale

- National Rollout of PINCER
- Chart Online Comparative Analysis
- Information Governance Assurances
- GP Contract
- NICE Medicines Optimisation Guideline
- CQC Appraisal

6.2 Sandeep confirmed that the searches and training were completely free, and across the region all CCGs had signed up to PINCER apart from Redditch and Bromsgrove CCG; they were going through a merger so this had been put on hold for now.

6.3 Clare Michell-Harding advised that training had been planned for CCG locality teams to support with this work. She added that there were also some pharmacists embedded in practices at the moment who may prefer to support with this work themselves. The team were also piloting Eclipse Live, though this system doesn't have to have pharmacist input; it has a wider number of searches and runs in the background all the time. PINCER is the whole methodology for improving the system whereas Eclipse is more of a "mop up system". PINCER has dedicated 6 or 12 monthly searches and so the two systems complement each other. Shropshire CCG will be adopting both systems. Links will be sent out to practices to register and to sign the Data Protection Agreement; these will be sent to the Practice Manager unless the team are told otherwise.

Minute No SLB-2019-09.085: Item 7 – RightCare Data

7.1 Gail Fortes-Mayer talked through a presentation about NHS RightCare to explain to locality members what drives commissioning and the data behind it. The presentation covered the following areas:

- What is NHS Right Care
- The Right Care methodology
- Variation by programme
- CCG headline variation in: detection, NEL (non-elective) admissions, bed days, long stay patients, elective admissions, primary care prescribing
- Midlands and East system wide opportunity analysis
- Where to look: Respiratory, CVD (cardiovascular disease) and MSK (musculoskeletal)
- Planning guidance 2019/20
- Next steps for the locality

The charts and data were discussed and explained to Members and longer discussions took place around the three identified areas where potential savings could be made (respiratory, CVD and MSK).

7.2 Concerns were raised about the waiting time for routine respiratory appointments which were 3-5 months. Clare Michell-Harding advised that there were discussions ongoing at STP level looking at respiratory across the STP. Concerns were also raised about coding issues. Members also thought that getting patients in to see heart failure nurses was difficult and ended up going through the consultant. Dr Bird added that he thought the fast track referrals for cancer were working well and wondered whether this could be considered for other areas.

ACTIONS: Gail Fortes-Mayer to share practice and locality level RightCare data.

Once received, Practices to discuss RightCare data within their practice teams and responses/ideas to be sent to Tom Brettell for discussion at a future locality meeting.

Minute No SLB-2019-09.086: Item 8 – Primary Care Update

8.1 The monthly Primary Care Update had been circulated to Members prior to the meeting it was highlighted that the last session for the GP Retention Fund and Resilience Training was on 25th September 2019.

8.2 Gail Fortes-Mayer advised that the HSCN network would be replacing the N3 connection giving practices across the system ability to network and improved bandwidth, ensuring that it is future-proof. Redcentric was the successful bidder during procurement and the contract was being worked through. Site visits had been completed by CSU staff and practices will be informed in plenty of time when the switch over will take place. Tom Brettell added that there were many conversations taking place about the most rural practices and finding solutions where there were not fibre optic connections currently.

Minute No SLB-2019-09.087: Item 9 – Commissioning Update

9.1 The monthly Commissioning Update had been circulated to Members prior to the meeting and there were no further questions about this.

Minute No SLB-2019-09.088: Item 10 – Any Other Business

10.1 October PLT – Discussion took place about the next PLT session, the venue of which would be Shrewsbury Town Football Club. At the moment this was a whole locality PLT. Concerns were raised about the value of the admin side of the PLTs and work was ongoing to make this more valuable. Discussion took place about this and Members felt that it would be more useful for admin staff to stay at their practice and work on their bluestream modules. Dr Bassett mentioned the guidance on the NHS safeguarding app that would be good for a protocol.

ACTIONS: Tom Brettell to send email out to Practice Managers re what has been agreed for the PLT/admin staff.

Tom Brettell to let David Coan at the CCG know about the safeguarding app.

Minute No SLB-2019-09.089: Item 11 – Date of Next Meeting

11.1 The next formal meeting will take place on: **Wednesday 6 November 2019** at **Bridgnorth Medical Practice** at **3.30pm.**

11.2 Dates of future meetings:

Thursday 3 October 2019	PLT
Wednesday 6 November 2019	Bridgnorth Medical Practice
Thursday 9 January 2020	Mayfair Centre, Church Stretton
Wednesday 5 February 2020	Bridgnorth Medical Practice
Thursday 5 March 2020	Mayfair Centre, Church Stretton

Signed: …….. **Date:** ……

Dr Matthew Bird, Locality Chair