NHS
Shropshire
Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277586
E-mail: SHRCCG.CustomerCare@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. Members of the public will be able to ask questions at the discretion of the Chair

Meeting Title	Governing Body Meeting	Date	Wednesday 7 June 2017
Chair	Dr Julian Povey	Time	9.30am
Minute Taker	Mrs Tracy Eggby-Jones	Venue / Location	Seminar Room 5, Shropshire Education & Conference Centre (SECC), Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ

Reference	Agenda Item	Presenter	Time	Paper
GB-2017-06.104	**Apologies** Barbara Beal, Ed Rysdale, Steve James, Rod Thomson	**Julian Povey**	***9.30***	*verbal*
GB-2017-06.105	**Members' Declaration of Interests**	**Julian Povey**	***9.30***	*verbal*
GB-2017-06.106	**Introductory Comments from the Chair**	**Julian Povey**	***9.30***	*verbal*
GB-2017-06.107	**Minutes of Previous Meeting held on 10 May 2017**	**Julian Povey**	***9.35***	*enclosure*
GB-2017-06.108	**Matters Arising**	**Julian Povey**	***9.40***	*verbal*
GB-2017-06.109	Value Based Commissioning Policy	**Michael Whitworth**	***9.45***	*enclosure*
	Clinical and Financial Sustainability			
GB-2017-06.110	Progress Report on Quality, Innovation, Productivity & Prevention (QIPP) schemes	**Claire Skidmore**	***9.50***	*enclosure*
GB-2017-06.111	Complex Care – Settings of Care & Choice Policies	**Nikki Diamond**	***10.00***	*enclosure*
GB-2017-06.112	MSK update	**Michael Whitworth**	***10.10***	*enclosure*
GB-2017-06.113	Midwife Led Unit (MLU) service review – update	**Jessica Sokolov**	***10.20***	*enclosure*
GB-2017-06.114	Gluten Free Prescribing	**Sean Mackey**	***10.30***	*enclosure*

	Corporate Performance Reports			
GB-2017-06.115	Corporate Performance report	**Julie Davies**	***10.40***	*enclosure*
GB-2017-06.116	Contract Performance Report 2016/17	**Michael Whitworth**	***10.50***	*enclosure*
BREAK			***11.00***	
GB-2017-06.117	Quality Report	**Sara Bailey**	***11.10***	*enclosure*
	Strategic Planning Reports			
GB-2017-06.118	Future Fit Programme Director's Report	**Debbie Vogler**	***11.20***	*enclosure*
GB-2017-06.119	Future Fit Joint Committee revised Terms of Reference	**Debbie Vogler**	***11.25***	*enclosure*
	Governance			
GB-2017-06.120	Business Continuity Plan	**Sam Tilley**	***11.35***	*enclosure*
GB-2017-06.121	360° Stakeholder Survey	**Sam Tilley**	***11.45***	*presentation*
	For Information Only/Exception Reporting		***11.55***	
GB-2017-06.122	Finance & Performance Committee	**Keith Timmis**		*enclosure*
GB-2017-06.123	Clinical Commissioning Committee	**William Hutton**		*enclosure*
GB-2017-06.124	Audit Committee	**Willian Hutton**		*enclosure*
GB-2017-06.125	Locality Boards • North Locality Board • South Locality Board • Shrewsbury & Atcham Board	**Shailendra Allen/ Deborah Shepherd**		*enclosure*
GB-2017-06.126	Governing Body Assurance Framework(GBAF)	**Sam Tilley**		*enclosure*
GB-2017-06.127	**Questions from Members of the Public** • At the discretion of the Chair questions from members of the public will be invited • If you would prefer to put this in writing, by 12.00 noon Tuesday 6 June to Dr Julian Povey, Clinical Chair, Shropshire CCG, Somerby Suite, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL or via email SHRCCG.CustomerCare@nhs.net	**Julian Povey**	***12.05***	*verbal*
GB-2017-06.128	**Any Other Business**	**Julian Povey**	***12.20***	*verbal*
	Date of Next Meeting • Wednesday 12 July 2017, time and venue to be confirmed (including Annual General Meeting)			

TO RESOLVE: ***That representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).***

Dr Julian Povey
Clinical Chair

Dr Simon Freeman
Accountable Officer

Shropshire Clinical Commissioning Group

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

HELD IN SEMINAR ROOM 5, SHROPSHIRE EDUCATION & CONFERENCE CENTRE (SECC), ROYAL SHREWSBURY HOSPITAL, MYTTON OAK ROAD, SHREWSBURY, SHROPHSIRE, SY3 8XQ

AT 9.30AM AM ON WEDNESDAY 10 MAY 2017

Present

Dr Julian Povey	*(CCG Chair)*
Dr Simon Freeman	*(Accountable Officer)*
Mrs Deborah Hayman	*(Interim Chief Finance Officer)*
Dr Jessica Sokolov	*(Clinical Director – Women & Children's Services)*
Dr Finola Lynch	*(Clinical Director – Communications & Engagement)*
Dr Steve James	*(Clinical Director - Primary Care)*
Dr Deborah Shepherd	*(Chair – Shrewsbury & Atcham Locality)*
Dr Shailendra Allen	*(Chair – South Locality)*
Dr Julie Davies	*(Director of Performance & Delivery)*
Mrs Barbara Beal	*(Interim Director of Nursing, Quality & Safety and Patient Experience)*
Ms Sam Tilley	*(Director of Corporate Affairs)*
Mrs Anne Dray	*(Interim Director of Corporate Affairs)*
Mr Michael Whitworth	*(Interim Director of Contracting & Planning)*
Dr Ed Rysdale	*(Secondary Care Clinician)*
Mr Keith Timmis	*(Lay Member - Governance & Performance)*
Mr William Hutton	*(Lay Member - Audit)*
Mrs Tracy Eggby-Jones	*(Corporate Services Manager – Minute Taker)*

In Attendance

Mrs Vikki Taylor	*(Locality Director - NHS England North Midlands)*
Mr Graham Shepherd	*(Shropshire Patient Group – Observer)*
Mrs Jane Randall-Smith	*(Healthwatch Shropshire – Observer)*
Mrs Jane Blay	*(Patient Experience Lead) – Minute No. GB-2017-05.087*
Mrs Debbie Vogler	*(Future Fit Programme Director) – Minute No. GB-2017-05.096*

1.1 Dr Povey welcomed members, observers and the public to the Shropshire Clinical Commissioning Group (CCG) Governing Body meeting being held in public. Dr Povey reported that since the last meeting Mr Kevin Morris had been elected as the sixth General Practice representative on the Governing Body.

Minute No. GB-2017-05.081 - Apologies

2.1 Apologies were noted as follows:

- Dr Geoff Davies, Clinical Director – Urgent Care & Finance
- Professor Rod Thomson, Director of Public Health
- Mr Kevin Morris, General Practice Representative
- Mrs Wendy Saviour, Director of Commissioning Operations - NHS England North Midlands

Minute No. GB-2017-05.082 - Declarations of Interests

3.1 Dr Povey reported that the Governing Body Register of Interest was available to view on the CCG's website (http://www.shropshireccg.nhs.uk/register-of-interest).

3.2 Dr Sokolov declared that her father had recently been elected as a member of Shropshire Council and that she would update her declarations of interest accordingly.

3.3 There were no other declarations of interest raised.

ACTION Dr Sokolov to complete new Declaration of Interest proforma.

Minute No. GB-2017-05.083 - Introductory Comments from the Chair

4.1 Dr Povey began by thanking Mrs Dray and Mrs Hayman for their contribution to the work of the CCG over the past few months. Both Mrs Dray and Mrs Hayman were coming to the end of their interim appointments at the CCG at the end of May. Mrs Sam Tilley (Director of Corporate Affairs) and Mrs Claire Skidmore (Chief Finance Officer) had been appointed as the substantive Executive Directors.

4.2 As reported at the previous meeting, Dr Povey advised that the remaining substantive Executive Directors would be commencing in post over the next few weeks.

4.3 Mrs Beal also advised that it would be her last Governing Body meeting, as she had tendered her apologies for the June meeting. Dr Povey recorded his thanks to Mrs Beal for her work as Interim Director of Nursing, Quality & Safety and Patient Experience.

4.4 Dr Povey reminded members of the public that the meeting was being held in public, and that it was not a public meeting, and that it was important to allow Governing Body Members the opportunity to discuss the papers being presented.

4.5 Dr Povey reported that he had reflected on the structure of the meeting and items to be discussed and proposed moving the 'Questions from Members of the Public' to the end of the agenda, with the exception of agenda item GB-2017-05.094 (Review of Quality, Patient Safety and Experience function and report on maternity services at Shrewsbury & Telford Hospital NHS Trust (SATH)), which he advised he would take questions on immediately after it had been presented.

4.6 Dr Povey noted that since the last Governing Body meeting the Secretary of State for Health had announced that an independent desk top review of avoidable baby deaths at SATH would be undertaken. Dr Povey emphasised that Shropshire CCG was co-operating fully with the review as required and that it would be open, transparent and self-critical if it found that improvements and learning could be made.

4.7 Dr Povey, on behalf of the CCG, extended his condolences to the families who had suffered the tragic loss of a baby, or a mother in child birth, and stated that, as a clinically-led organisation, the CCG was committed to preventing avoidable deaths and that It would continue to work with the Trust and providers to ensure that local families had access to safe, responsive and high quality maternity services.

4.8 Dr Povey also advised that the Governing Body would receive a status report on the implementation of the six main QIPP (Quality, Innovation, Productivity & Prevention) schemes, fragile clinical services at SATH and A&E performance.

4.9 Dr Povey was pleased to report that the CCG had achieved its year-end financial control total of £25.9m deficit and noted that all CCGs were required, by NHS England, to hold a 1% reserve, (equivalent to £4.2m for Shropshire). Due to an technical adjustment effecting all CCGs the 1% reserve had been released which had, therefore, reduced Shropshire CCG's deficit from £25.9m to £21.8m. Dr Povey thanked Mrs Hayman and the Finance Team in sustaining the CCG's financial position and advised that a further detailed report would be presented under agenda item GB-2017-05.091.

4.10 Finally, Dr Povey passed on his congratulations to the newly appointed local councillors following the recent elections and advised that the CCG looked forward to working with them to improve the health and social care of the population of Shropshire. Dr Povey highlighted that currently there was a period of purdah, pending the general election on 8 June, and that the CCG would need to ensure it adhered to national election guidance. Dr Povey asked members of the public to take into account the future of healthcare when making their vote.

Minute No. GB-2017-05.084 – Minutes of the Previous Meeting – 12 April 2017

5.1 The minutes of the Governing Body meeting held on 12 April 2017 were presented for approval.

5.2 Dr Povey advised that he had received correspondence from Ms Gill George in relation to two minor inaccuracies relating to the minutes and the questions she had raised during the meeting. The first one related to the circulation of the Better Births guidance (page 10), Ms George advised that she had requested that the guidance be distributed to participants in the review of rural Midwifery Led Units (MLUs) and not to all expectant families. Furthermore, on patient/public involvement in the MLU review (page 11), Ms George advised that she had requested that provision was made to include the three MLU campaign groups from the rural towns, which between them represented almost 5000 local mothers.

5.3 Governing Body Members raised the following minor amendments:

- Page 1 – Dr Povey noted that he was recorded as attending part of the meeting, when he was in full attendance and advised that this had now been changed.
- Page 1 - Dr Lynch noted that the roles of the Clinical Directors were currently being reviewed and that the titles would need to be changed to reflect this once agreed.
- Page 14, paragraph 15.11 – Mr Hutton felt that the wording needed to be clarified to read 'there had been a year-on-year downward trend in performance for every month over the past 3 years'.
- Page 15 – Dr Julie Davies highlighted that the A&E regional escalation meeting had taken place on 20 April not 29 April as stated in the Resolve.

5.4 Subject to the amendments noted above the minutes of the Governing Body meeting held on 12 April were approved as a true and accurate record.

RESOLVE: ***MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the minutes of the meeting of Shropshire Clinical Commissioning Group (CCG) held on 12 April 2017, subject to the minor amendments noted above.***

ACTION **Mrs Eggby-Jones to make minor amendments to minutes of Governing Body meeting held on 12 April 2017.**

Minute No. GB-2017-05.085 – Matters Arising from the Minutes of the Previous Meeting

6.1 An update on the matters arising from the previous meeting were noted as follows:

- **Minute No. GB-2017-04.065 – Matters Arising**

  Dr Freeman advised that the Future Fit Programme Board had not met again since its meeting in February, therefore, the minutes had not yet been approved and were unable to be made publicly available. These would be released as soon as possible.

  Mr Whitworth reported that the Value Based Commissioning (VBC) Policy had been updated to ensure it reflected the latest NICE guidance and advised that it would be presented to the Governing Body meeting in June for formal approval.

- **Minute No. GB-2017-04.069 – Shropshire Health & Care Optimity Review**

  Mr Whitworth reported that a steering group had been established with the Local Authority (including social care and public health), Shropshire Community Health Trust (SCHT) and South Staffordshire & Shropshire Healthcare Foundation Trust (SSSFT). The main programmes of care had been outlined, along with draft governance arrangements. Regular updates on progress would be presented to future Governing Body meetings.

- **Minute No. GB-2017-04.070 – Midwifery Led Unit Service Review**

  Dr Sokolov reported that the project plan had not yet been finalised and that she would present an update at the June Governing Body meeting. Dr Freeman advised that the CCG was unable to undertake any engagement in relation to the review during the period of purdah.

- **Minute No. GB-2017-04.071 – Reducing Levels of Orthopaedic Surgical Intervention Towards National Average by Optimising the MSK Pathway**

Mr Whitworth advised that a report was received at the May Clinical Commissioning Committee (CCC) meeting and that a progress report would be presented to the June Governing Body meeting. Mr Whitworth also noted that the CCG would need to be mindful of purdah in relation to any engagement requirements.

- **Minute No. GB-2017-04.072 – Shropshire Community Services Review**

  Dr Julie Davies advised that there was insufficient detail to present to the Governing Body this month and proposed presenting update reports on a bi-monthly basis starting from June.

- **Minute No. GB-2017-04.075 – Corporate Performance Report**

  Dr Sokolov confirmed that she had spoken to Mrs Beal and Dr Julie Davies in relation to her concerns regarding cancer waits. Dr Julie Davies advised that the issues were being picked up through the Cancer Network and Planned Care Working Group (PCWG).

  Mr Whitworth noted that an update on the Integrated Community Services (ICS) was not contained in the May Contract Performance Report as the data had not been validated following the Contract Review meeting, but gave assurance it would be reported in the June Contract Performance report.

- **Minute No. GB-2017-04.076 – Clinical Commissioning Committee (CCC) report**

  Mr Whitworth advised that an update on SATH's QIPP was not contained within the May report, but would be included in future reports.

- **Minute No. GB-2017-04.079 – Future Fit Programme Director's report**

  Dr Povey reported that although Shropshire CCG Governing Body had approved the Terms of Reference for the Future Fit Joint Committee at its meeting in April, Telford & Wrekin CCG Governing Body had approved a slightly revised version. Therefore, discussion was taking place between both CCGs to ensure that a final version was presented for approval.

  Dr Freeman advised that once the Future Fit decision had been made, it was intended that the Future Fit Programme Board would be dissolved and the implementation taken over by the Sustainability & Transformation Plan (STP) programme. The timeline had yet to be confirmed as it was dependent on the outcome of the independent review and decision-making process.

6.2 Dr Julie Davies gave a verbal update on the following matters arising:

- **Five Year Forward View** – It was noted that the CCG had not yet received formal feedback from NHS England, but an implementation plan had started to be drafted, which would be presented to the Primary Care Commissioning Committee. Dr Davies advised that she would provide an update to a future Governing Body meeting when the feedback was received.

- **Dementia Strategy** – Dr Julie Davies reported that the CCG had jointly co-produced a Dementia Strategy at the end of 2016, with its primary objective to provide better care for those patients living with dementia and for their carers. Dr Julie Davies advised that in order to implement the strategy additional investment would be required, which she acknowledged would be challenging given the CCG's current financial position. Therefore, the CCG was looking at options to release resources from elsewhere in the organisation in order to invest in the implementation of the strategy. In addition, Dr Julie Davies noted that the CCG was currently finalising the service specifications for the memory service.

- **Path House -** Dr Julie Davies reported that the current contract with Path House had ceased on 31 March 2017 and that the Governing Body had approved the provision of an alternative service, to be known as Shropshire Sanctuary. The new service was due to open on 1 April 2017, in Shrewsbury, however, the new provider had had some recruitment issues and would, therefore, not be operational until week commencing 29 May. Dr Julie Davies gave assurance that the 24 hour crisis helpline remained in operation and also access to face-to-face consultation was available in the interim. Dr Julie Davies advised that as part of the new contract transport would be provided for patients in rural areas who were unable to get to the new facility.

In addition, Dr Julie Davies noted that nationally CCGs had received funding from central government for investment in the redevelopment of the urgent and crisis care pathways for mental health. Shropshire CCG would be undertaking analysis and engagement work in relation to this area.

6.3 There were no other matters arising noted.

ACTION

Mr Whitworth to present revised Values Based Commissioning Policy to 7 June Governing Body meeting for approval.

Mrs Dray/Mrs Tilley to present the Risk Management Policy to 7 June Governing Body meeting for approval.

Mr Whitworth to provide regular progress reports on the Optimity Review to future Governing Body meetings.

Dr Sokolov to present Midwifery Led Unit (MLU) review project plan to June Governing Body meeting.

Mr Whitworth to present update on prime provider selection process for optimising the MSK pathway to 7 June Governing Body meeting.

Dr Julie Davies to present progress report on Shropshire Community Services Review to July Governing Body meeting and bi-monthly thereafter.

Mr Whitworth to include update on Integrated Community Services (ICS) in next Contract Performance Report presented to the Governing Body

Mr Whitworth to ensure update on SATH QIPP is included in next Contract Performance report presented to the Governing Body.

Dr Julie Davies to present update on feedback from NHS England following the submission of the CCG's Five Year Forward View to future Governing Body meeting.

Minute No. GB-2017-05.086 – Questions from Members of the Public

7.1 Dr Povey reported that he proposed to take questions from members of the public at the end of the meeting, with the exception of agenda item GB-2017-05.094 (Review of Quality, Patient Safety and Experience function and report on maternity services at SATH), which he advised he would take questions on immediately after it had been presented.

7.2 The following questions were raised at the end of the meeting:

- **Mrs Julia Farrington, Secretary, Shropshire Defend our NHS**

  Mrs Farrington noted that there were ongoing investigations into avoidable baby deaths and asked if there was data available on avoidable adult deaths, if so, how could the information be accessed. Mrs Farrington gave an example of an adult patient death.

  Dr Freeman advised that data on mortality rates for adults was available for patients with conditions under hospital care. Although Dr Freeman noted that mortality data was inherently difficult to interpret.

  In terms of the adult patient death, Dr Freeman advised that the CCG would be happy to receive and investigate the issues surrounding the case as a formal complaint and suggested the family make contact with the CCG's Complaints Manager or alternatively directly with the provider.

- **Mrs Julia Farrington, Secretary, Shropshire Defend our NHS**

  Mrs Farrington also asked if there was any agreed processes or data available on the number of ambulances that had been diverted between Princess Royal Hospital (PRH) and Royal Shrewsbury Hospital (RSH).

Dr Julie Davies reported that a diversion policy had been agreed between West Midlands Ambulance Service (WMAS) and SATH and emphasised that the policy was only implemented if one specific site was experiencing significant pressure and therefore no longer safe to receive patients. Dr Julie Davies advised that this was very rarely implemented and that the CCG's On-Call Director would be notified as part of the process.

- **Mrs Jane Easterley**

Mrs Wright referred to the recent changes to mental health services in Ludlow, in particular the closure of Path House and the local Memory Group. Mrs Wright stated that the CCG had given a commitment at its October 2016 Governing Body meeting that Path House would not close until an alternative service was in place. Mrs Wright noted the earlier update from Dr Julie Davies on Path House, but highlighted that the new provision by Shropshire Sanctuary was a different service in a different town. Mrs Wright asked what patient engagement and consultation had taken place with staff, service users and the public with regards to the changes in this service.

Dr Julie Davies began by confirming that the Memory Group was not a service commissioned by the CCG but by South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT) and was, therefore, unable to comment on future service provision.

With regards to Path House, Dr Julie Davies reported that following a review of Path House last year it was identified it was no longer fit for purpose and did not meet the needs of the whole population of Shropshire. Dr Julie Davies advised that the CCG had extended the contract with the existing provider until 31 March 2017 in order to allow time for an alternative service to be developed. Dr Julie Davies noted that it was the intention for Shropshire Sanctuary to be operational from 1 April 2017, however due to recruitment issues this had been delayed until week commencing 29 May 2017. Dr Julie Davies gave assurance that patients still had access to the 24 hour crisis helpline and face-to-face support 7 days a week. Dr Julie Davies reported that by decommissioning the service at Path House had enabled the CCG to provide transport across the county for patients to access the new service.

Dr Julie Davies advised that she would provide Mrs Wright with the details of the engagement that had taken place with regards to the closure of Path House.

In addition, Dr Julie Davies reported that as part of the Five Year Forward View further investment was expected for improving mental health and that crisis and urgent care was a key priority. Plans would be developed for investing the additional resources locally.

- **Mr John Bickerton**

Mr Bickerton asked how the Future Fit Programme could move forward when the ambulance service was not achieving their response times. Furthermore, Mr Bickerton highlighted that care in the community was also a key component of the programme and that there appeared to be difficulties in this area.

Dr Povey reported that West Midlands Ambulance Service (WMAS) was a key stakeholder in the Future Fit Programme and were involved in the process. With regards to care in the community, Dr Povey reported that the Optimity Review was currently being undertaken to look at health and social care provision and that this work would feed into both the Future Fit Progamme and Sustainability & Transformation Plan (STP).

- **Mrs Sylvia Jones, Clunbury Parish Council**

Mrs Jones advised that following the recent media coverage into a number of issues at SATH, she had obtained information from the NHS Litigation Authority's website on the number of claims made against the Trust in 2015/16, which she noted was very high. In view of the investigation into the avoidable baby deaths, poor A&E performance and number of fragile clinical services, Mrs Jones asked if the CCG was confident that SATH was safe and requested a simple yes or no answer.

Dr Povey, on behalf of the Governing Body, confirmed that services at SATH were safe.

- **Mr Chris Deaves**

  Mr Greaves referred to the QIPP status report and noted that in Figure 2 (page 3) there was a nil figure against the Community Services Review (CSR) and sought clarity with regards this, as Figure 3 (page 4) indicated that there would £5m QIPP savings.

  Dr Freeman reported that an independent review undertaken by Deloittes had identified that Shropshire CCG was overspending on community services by £5m or not generating sufficient value from the current investment. Dr Freeman explained that Figure 2 was nil as the CSR work, and any consultation as a result, would not be completed in-year (2017/18) and therefore no savings released, but that it was anticipating a saving in 2018/19.

  Dr Freeman emphasised that Shropshire CCG was currently spending other CCGs money and that it needed a robust QIPP programme in order to get back to financial sustainability and stay within its funding allocation.

  Mr Greaves referred to the Cost Effective Prescribing Framework(CEPF) outlined in the QIPP report and acknowledged that there needed to be cost effective prescribing, but was unclear what the cost impact would be.

  Dr Freeman clarified that the term 'prescribing' not only related to the prescribing of medicines but to alternatives such as referrals to non-health services, which formed part of the neighbourhood work with the local authority, in order to support patients with ongoing health problems (ie nightsitting service etc).

7.3 Dr Povey closed the meeting to questions from members of the public.

ACTION **Dr Julie Davies to confirm to Mrs Easterley, member of the public, what engagement had taken place with regards to the closure of Path House.**

Minute No. GB-2017-05.087 – Patient Voice

8.1 Mrs Beal introduced Mrs Blay who was in attendance to present the patient voice.

8.2 Mrs Blay reported that she was sharing a patient's experience in accessing non-emergency patient transport services (NEPTS). Mrs Blay advised that the patient was recovering from a Pituitary Tumour which had left him, amongst other things, partially sighted and unable to drive. The patient was, therefore reliant on NHS transport services to attend out-patient appointments at University Hospital North Midlands (UHNM) at Stoke, where his wife had been accompanying him.

8.3 The patient had since been informed that due to changes in the eligibility criteria for NEPTs, his wife would no longer be able to accompany him to appointments. This they felt was partially due to her potential frailty, as she had some mobility issues and often used a walking stick to assist her. This had left the patient very upset and anxious, as his wife not only acted as a valuable escort to guide him through the various clinics and scanning departments, but was often consulted upon in relation to the nature of his condition and to discuss associated treatment options.

8.4 Mrs Blay reported that following a joint approach taken by herself and the CCG's Lead Commissioner the patient's concerns had been raised with the service provider which had resulted in an acceptance that it was in the best interest of the patient to have support from his wife on hospital visits.

8.5 Mrs Blay advised that the patient experience demonstrated how the CCG had listened to the patient's feedback and acted proactively to address their concerns and also showed collaborative working between the Commissioning and Quality Teams and service provider.

8.6 Mrs Beal and Dr Povey conveyed their thanks to Mrs Blay and the patient for sharing their experience.

CLINICAL AND FINANCIAL SUSTAINABILITY

Minute No. GB-2017-05.088 – Status Report on the Six Main QIPP (Quality, Innovation, Productivity and Prevention) Schemes

9.1 Dr Freeman presented an update report on the current position in relation to the six main QIPP (Quality, Innovation, Productivity and Prevention) schemes for the QIPP programme covering the two financial years 2017/18 and 2018/19.

9.2 Dr Freeman reported that in order to aid the CCG's financial recovery during 2017/18 it was required to reduce the year end deficit from £25.96m to £19m. Therefore, the CCG would need to deliver a £17.7m QIPP programme, which equated to 4% of the CCG's total funding allocation. The QIPP programme comprised six main schemes as follows:

- **Complex Care** - There were three elements to this QIPP scheme which together totalled £4.0m and included the introduction of a joint assessment tool (£2.1m), baseline activity review (£1.1m) and extension of the successful hospice at home pilot (£0.8m)

- **Prescribing** - There were seven areas of activity covered by the 2017/18 prescribing QIPP scheme.

  - Prescribing Ordering Direct (POD)
  - Scriptswitch
  - Care home and domiciliary service
  - Board backed approach to medicines management
  - Prescribing restrictions
  - Oral Nutritional Supplements (ONS)
  - Effective approach to local decision-making

  The schemes formed part of the CCG's Cost Effective Prescribing Framework(CEPF) and together were forecasting to deliver a net efficiency saving of £3m in 2017/18.

- **Value Based Commissioning (VBC) excluding MSK** - This scheme was based upon an up to date evidence-based policy which identified areas of healthcare that the CCG would not fund or where particular criteria would apply. The scheme was live and savings were forecast to accrue from April 2017 onwards.

- **MSK Services** - All of the CCG's MSK related schemes had now been consolidated into one programme of work, these were set out in Table 2 (page 5) of the report. The schemes were all live and the forecast reduction in elective, first outpatient and follow up outpatient activity, resulting from both the revised VBC policy and revisions to the Shropshire Orthopaedic Outreach Service (SOOS), intended to improve community care were estimated to achieve efficiency savings of £4.1m in 2017/18

- **Reducing variation in non elective activity** - This scheme seeks to identify at a locality and practice level, variation in non elective activity which could be effectively used to secure a better patient outcome and improve value for money. It was noted that the scheme was still at the planning and design stage and that predicted savings would be realised from October 2017.

- **Community Services Review (CSR)** - The scope of the review was outlined in section 3.6 (page 6) of the report. The work aligned to that being undertaken as part of the Shropshire and Telford and Wrekin Sustainability and Transformation Plan (STP). It was noted that whilst the outcome could not be anticipated for financial planning purposes, the analysis performed by the CCG and Deloittes to estimate efficiency savings, had been recognised in the 2018/19 QIPP programme

9.3 Dr Freeman advised that the CCG was currently forecasting £14.1m in QIPP savings, which left a £3.6m gap to be addressed. There was potential for identified schemes to yield greater savings, and that new initiatives were being explored to provide mitigation against either implementation slippage or financial saving over-estimates.

9.4 Dr Freeman concluded that the 2017/18 QIPP programme now had schemes both in development and in delivery and that in addition to updating the Governing Body, a robust assurance process was in place, with regular progress reports from the newly formed QIPP Planning and Delivery Group (QPDG) to the Executive Team, the Clinical Commissioning Committee (CCC) and the Finance and Performance Committee (F&PC).

9.5 Mr Hutton sought clarity on the scope of the Complex Care baseline activity review. Dr Freeman advised that it involved undertaking a thorough review of all complex care cases in order to data cleanse the system to ensure the CCG was only paying for patients who were its responsibility.

9.6 Mr Hutton asked if it would be possible to include in future reports to the Governing Body a cumulative graph of anticipated savings for each scheme against actual delivery. Dr Freeman advised that this would be presented to the CCG's F&PC, with exception reporting to the Governing Body.

9.7 Dr Povey also sought assurance that the implemented schemes were currently on track and delivering against trajectory. Furthermore, Dr Povey noted that delivery of some schemes were dependent on the support of providers and asked if they were supportive of the CCG's plans. Dr Freeman advised that the CCG would not receive April data until June, but that all indications were, following the implementation of the VBC policy, that there were a significant savings being realised. Dr Freeman also reported that the number of referrals had reduced, particularly in relation to MSK services. Dr Freeman stated that the CCG was working collaboratively with all its providers, including the local authority.

9.8 Dr Freeman clarified that as of the 1 April 2017 the CCG would not be paying for any treatment that did not have prior approval and that the providers had been written to formally to advise them of this. Mr Whitworth explained that there was some activity being undertaken during April and May, which was being carried out under the old policy, but contractually from 1 April the CCG would only be paying for treatment that had prior approval.

9.9 Mr Whitworth also confirmed that a number of Working Groups had been established in relation to the VBC policy in order to ensure streamline implementation, these included communications with GP practices and the provider. Mr Whitworth advised that there were also some technical issues that needed to be addressed, mainly due to prior approval coding, but gave assurance that this would not delay the implementation of the policy.

9.10 Mrs Taylor commended the report and asked if implementation of any of the schemes would be affected by purdah. Dr Freeman advised that there would be no impact to the 2017/18 schemes, but there was potential for the 2018/19 in relation to the Community Services Review (CSR).

9.11 Dr Lynch referred to the CSR (section 3.6) and clarified that the scope of the review in relation to bed-base activity comprised all providers, including nursing homes etc, not just community hospital beds. Furthermore, Dr Lynch explained that the activity, cost and outcomes of the Integrated Community Service (ICS) would be reviewed, but not the ICS itself.

RESOLVE: ***THE GOVERNING BODY NOTED the current position in relation to the six main QIPP schemes and SUPPORTED the actions outlined in respect of each to facilitate a successful transition from development to delivery.***

ACTION **Dr Freeman to present regular updates on QIPP performance to future Governing Body meetings.**

Minute No. GB-2017-05.089 – A&E Performance Report

10.1 Dr Julie Davies presented a briefing paper which provided the Governing Body with an update on the current situation regarding A&E performance and the system wide five priority actions agreed to urgently improve performance.

10.2 Dr Julie Davies reported that in light of continued poor A&E performance locally, Shropshire CCG had undertook a detailed piece of work to understand what had caused the deterioration in A&E performance from 2015/16 to 2016/17. This analysis was then used to get an agreed understanding across the local health and social care system of what the underlying issues were and to identify the key actions required for the system as a whole to focus on to rapidly improve performance initially and then more gradual sustainable improvement going forwards.

10.3 Dr Julie Davies gave assurance that the local system now had an agreed understanding of the issues that had contributed to the deterioration in performance and that this had been used as the basis for identifying the five key actions that would further improve performance towards the achievement of the 95% target in 2017/18. The five priority actions agreed across the system were noted as follows:

- Front Door Streaming/Non-admitted Breaches – estimated impact 4.6%
- Discharge to Assess/MFFD (to include Frailty pathway) - estimated impact 3.5%
- Internal Acute Flow - estimated impact 4%
- Ambulance Handovers - estimated impact 0-1%

- Activity counting Type 3 and 5 included - estimated impact 3.75%

10.4 Dr Julie Davies advised that whilst further work needed to be undertaken to fully embed the discharge to assess approach across the system, to drive down the Delayed Transfers of Care (DTOC) to target levels of 3.5%, the majority of issues contributing to A&E breaches were found to be related to internal flow. Dr Julie Davies reported that she would be leading on the delivery of the Discharge to Assess priority Action for Shropshire CCG.

10.5 Dr Julie Davies stressed that the remaining key area of impact on A&E was workforce, both within the emergency department and elsewhere on the wards within the Trust.

10.6 Dr Julie Davies noted that representatives from the local health economy had attended a regional escalation meeting on 20 April 2017, chaired by the Regional Director of NHS Improvement (NHSI), who noted that there had been significant improvement in recent performance, but acknowledged that workforce challenges at SATH remained a significant issue, not only in improving performance but also in the consistent delivery of that improvement going forwards.

10.7 The expected performance in 2017/18 was calculated at 87.55% with a full year effect of the successful delivery of the 5 key actions on performance of 91.5%. Dr Julie Davies noted that the remaining gap in achieving the 95% position was related to the workforce constraints.

10.8 NHSI had challenged the system to improve performance to show delivery of a minimum of 90% from September onwards. The system's operational leads were meeting during May to further develop the actions plans to see what else could be done within current constraints to further improve performance.

10.9 Dr Julie Davies reported that A&E performance had improved month-on-month from its lowest point in January. The five priority action plans were now being monitored for delivery monthly via the A&E Delivery Board, using a detailed performance dashboard which had several metrics to track the improvement in the front door/back door flow and limited measures on internal flow. Dr Julie Davies acknowledged that this did require further development to include additional metrics from SATH to give more visibility of the delivery of SAFER and the Red to Green methodology to give a comprehensive view of the systems overall performance.

10.10 Updates on the progress against the priority actions and their impact on A&E performance would be included in the A&E section of the CCG performance report from June onwards.

10.11 Dr Sokolov asked if SATH shared the analysis of the issues relating to A&E performance, particularly with regards to workforce, and if so what were they doing about it. Dr Julie Davies reported that the analysis work had been carried out and agreed jointly with the Trust, and it was acknowledged that internal flow and workforce issues were the key areas that were affecting performance. Not only in A&E but across the Trust as a whole, which needed to be addressed.

10.12 Dr Sokolov requested clarity on the terminology 'front door streaming'. Dr Julie Davies explained that at Princess Royal Hospital (PRH) patients who required access to primary care services, were directed back to primary care, but that this was not the case at Royal Shrewsbury Hospital (RSH) as patients were directed to the Walk-in Centre (WIC) co-located next to A&E. Dr Julie Davies advised that new guidance on primary care streaming had been published, which was very prescriptive on how it should be delivered and that following a gap analysis RSH was 85-90% compliant. However, it was noted that work was required at PRH and that it had been awarded £1m capital revenue in order to ensure it met the requirements of the guidance and could offer the same approach as RSH. It was noted that Telford & Wrekin CCG was leading on this piece of work as the lead commissioner.

10.13 Mrs Beal advised that the workforce issues had been picked up through the Clinical Quality Review meetings (CQRM) with SATH and that although the Trust had developed an initial Workforce Plan it did not provide the necessary assurance, this would be kept under review by the CQRM.

10.14 Mr Hutton supported the proposed actions, but questioned if the actions would provide the necessary improvement in performance when it had not delivered previously. Dr Julie Davies acknowledged that the actions identified were the same as previously agreed, but felt SATH had a greater level of acceptance of the challenges it faced, with new personnel, and that there were additional mechanisms in place across the whole health economy to support improvement in performance. Furthermore, the A&E Delivery Board would be held to account for the delivery of the action plan.

10.15 Dr Rysdale referred to the workforce issues at the Trust and acknowledged that there were issues nationally with the recruitment of A&E Consultants, but he also reported that there were issues within Acute Medicine too, and that these needed to be addressed in order to improve internal flow and reduce the length of stay for patients. Dr Rysdale felt it would be helpful to have a comparator year-on-year workforce graph in future reports. Dr Julie Davies confirmed that this was already in progress.

10.16 Dr James also sought assurance that the action plans would achieve the successful delivery in performance. Mr Whitworth advised that as well as the A&E Delivery Board the CCG held regular Executive level escalation contractual meetings with the Trust, which included contracting, activity, performance, finance and quality monitoring, and provided the additional assurance to the CCG's F&P Committee.

10.17 Mr Shepherd also expressed his concern, particularly with regards to streaming patients to the WIC, as he felt that a number of pilots had been trialled over recent years, which had concluded that a maximum of 25% of patients could be treated by the service, but noted that the guidance suggested that this would be 40%. Mr Shepherd felt that even extending the opening hours of the WIC would not provide sufficient patient flow to warrant the cost of paying Band 6 nurses.

10.18 Dr Freeman advised that the national guidance for primary care streaming was mandatory and that the local health economy was required to implement it. Dr Freeman felt that currently patients were receiving a poor A&E service and that in order to improve performance it needed to implement the nationally evidence-based guidance urgently.

10.19 Mrs Beal acknowledged the concerns of Mr Shepherd and advised that evidence showed that primary care streaming had worked effectively in other areas of the country and offered Mr Shepherd the opportunity to visit them. With regards to Band 6 nurses streaming patients, Mrs Beal noted they were Advanced Nurse Practitioners who were at the higher level of their profession and provided valuable contribution to providers and patients.

10.20 Dr Lynch welcomed the report and the work undertaken to address the A&E performance issues. Dr Lynch was concerned that SATH may still not have ownership of the challenges it faced and appeared to suggest that GP admissions was a major contribution to their situation. Furthermore, Dr Lynch highlighted that following a recent unannounced visit to the A&E department, it was identified that 5 patients had been waiting longer than 10 hours and questioned whether the clinical decision-making at the Trust was appropriate. It was noted that this was being addressed through the CQRM.

10.21 Mrs Randall-Smith felt it would be beneficial for the CCG to receive patient feedback following the introduction of primary care streaming in order to understand the impact it may have on them. Dr Julie Davies welcomed patient and public feedback, although highlighted that there would not be a demonstrable difference in service provision at RSH as patients were already streamed to primary care (ie WIC).

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the update report on the current situation regarding A&E performance and the system wide five priority actions agreed to urgently improve performance.***

THE GOVERNING BODY NOTED that Dr Julie Davies and Dr Freeman would continue to monitor delivery of the five priority actions via the System A&E Delivery Board and that Dr Julie Davies would lead on the delivery of the Discharge to Assess priority Action for Shropshire CCG.

ACTION **Dr Julie Davies to include progress against the priority areas and their impact on A&E performance in the A&E section of the CCG's performance report from June onwards.**

Minute No. GB-2017-05.090 – Shrewsbury & Telford Hospitals NHS Trust (SATH) Fragile Clinical Services

11.1 Dr Julie Davies presented a briefing paper which provided the Governing Body with an update on the current situation regarding the services declared as fragile by Shrewsbury & Telford Hospital NHS Trust (SATH) in March and to provide assurance that all necessary actions were being taken to secure safe, good quality services for the patients of Shropshire and as locally as the available provider capacity allowed.

11.2 Dr Julie Davies advised that section 2 of the report outlined the issues and mitigating actions being undertaken by both Shropshire and T&W CCGs to secure safe and good quality services for the specialities SATH had declared as fragile. Dr Julie Davies gave a brief update on these services as follows:

- **Emergency Departments** – A detailed update on A&E performance had been presented under Minute No. GB-2017-05.089.

- **Ophthalmology** – It was noted both CCGs had commissioned a range of services to support access to eye care services across the county, these included a Community Ophthalmology Provider and a range of schemes delivered from Community Optometry practices. As a result there had been a slight improvement in performance

- **Neurology** - SATH had experienced long-standing capacity and workforce issues for several years, and following discussion with commissioners the service was closed to all new referrals from 27 March 2017 for a period of six months. Commissioners had sourced and secured additional capacity from Royal Wolverhampton Hospital Trust during this period. A further tele-conference was scheduled with Walton Hospital on 10 May to secure additional out-reach capacity to support patients accessing care closer to home. The CCGs would continue to work with SATH over the forthcoming months to review pathways and facilitate discussions with other providers to ensure sustainable neurology services in the county for the longer term

- **Dermatology** – SATH had appointed a locum consultant to mitigate the immediate issue within the service. In addition, Shropshire CCG had successfully commissioned a Consultant-led Community Dermatology Service from The Skin Clinic based in Shrewsbury to significantly supplement the capacity available within the county. It was noted that SATH also used The Skin Clinic on a sub-contract basis for the provision of some of their skin cancer services.

- **Spinal Surgery** - Shropshire CCG had facilitated discussions between SATH and Robert Jones & Agnes Hunt Hospital (RJAH), where RJAH had agreed to support SATH by accepting the transfer of the current caseload of patients. SATH would ensure that patients were in agreement for their care to be transferred during this period of unplanned consultant absence. This would be monitored monthly via the Planned Care Working Group (PCWG) with both local Providers

11.3 Dr Julie Davies reported that Shropshire and Telford & Wrekin (T&W) CCGs had been aware of long-standing capacity and workforce issues in the Emergency Department, Ophthalmology, Neurology and Dermatology and had been working closely with the Trust to find suitable, safe, alternative capacity where appropriate. Both CCGs had taken a number of specific actions to mitigate the risks of these fragile services and continued to monitor the situation on all remaining services very carefully via the formal contractual meetings and the Planned Care Working Group (PCWG). In addition to all the specialty specific actions, commissioners were working with the Trust and seeking assurance on their on-going forecast workforce plans, which would be monitored on a monthly basis via the contractual Clinical Quality Review Meetings (CQRM) and reported to the CCG's Quality Committee.

11.4 Both Shropshire and T&W CCGs had requested a three way Executive to Executive meeting with SATH to review all of the issues and to ensure a fully co-ordinated approach and assurance to maintain good quality safe clinical services in Shropshire where a sustainable long term solution could be obtained.

11.5 It was noted that a monthly report was also being provided to the Quality Surveillance Group (QSG), chaired by NHS England (NHSE), and attended by NHSI, Care Quality Commission (CQC) and Healthwatch, to ensure they were kept informed of the on-going position regarding all of the fragile services at SATH.

11.6 Dr Julie Davies stated that Shropshire CCG continued to work closely with Healthwatch colleagues to monitor patient experience and any other concerns identified related to these fragile services.

11.7 Dr James referred to the A&E performance and the implementation of the national guidance on primary care streaming. Dr James noted caution that there was unlikely to be any significant impact on performance at RSH as they currently adhered to very similar guidelines, although acknowledged there would be a greater impact at PRH. Dr James felt that this showed the variation and demonstrable difference in patients presenting at both the A&E sites.

11.8 Dr Sokolov noted the 5 clinical services that had been declared as fragile and referred to SATH's Operational Plan where she highlighted there were a number of other services that were potentially reaching crisis point and asked what processes were in place to monitor these. Dr Julie Davies advised that both the CQRM and PCWGs had early sight of these and would be in a position to anticipate if there was a need to secure additional capacity elsewhere.

11.9 Dr Lynch referred to the Neurology section (2.3.2) where it stated that 'Commissioners had undertaken discussions with SATH to support development of pathways with other private providers but SATH were not been fully supportive of this' and asked if the Trust was in a position to do this. Dr Julie Davies reported that as part of the agreement to secure capacity elsewhere, SATH had given a commitment to the redesign of the pathway.

11.10 Mrs Randall-Smith advised that she had received patient feedback in relation to spinal surgery, where some patients had been referred back to their GP from SATH in order to be re-referred to RJAH. Dr Julie Davies emphasised that this should not be the case and that it had been agreed that the transfer of patients would be done via an inter-provider transfer process. Dr Julie Davies agreed to pick this up directly with the Trust.

11.11 Dr Povey felt that in order to resolve the issues relating to some of the fragile services there would be a need to develop speciality centres and asked if any discussions had taken place with NHSE in this regard. Dr Julie Davies advised that this was being picked up through the regional Quality Surveillance Group (QSG).

11.12 Mrs Taylor reported that she had had discussions with NHSI specifically in relation to neurology services, who were looking at the extent of the issues relating to the recruitment of Consultant Neurologists both regionally and nationally, as it appeared to be problematic in the North Midlands area.

11.13 Mrs Beal confirmed that both CCGs had been asked to submit a report to NHSE on the current position with regards to neurology in the county, which would inform the wider regional discussions.

RESOLVE: ***THE GOVERNING BODY NOTED the briefing paper providing an update on the current situation regarding the services declared as fragile by SATH in March and RECEIVED ASSURANCE that all necessary actions were being taken to secure safe, good quality services for the patients of Shropshire as locally as the available provider capacity allowed.***

THE GOVERNING BODY ALSO NOTED THAT:

- ***Dr Julie Davies would continue to monitor all scheduled care services via the Planned Care Working Group***
- ***Mrs Beal would continue to monitor the workforce plans and the quality and safety of the fragile services via the CQRM.***
- ***Mrs Beal would continue to monitor the Emergency Department staffing levels and have direct involvement in the development of SATH's contingency plans for the provision of A&E services within the county.***
- ***Dr Julie Davies would ensure that the CCG had a commissioning strategy for all the named medical and surgical fragile services to ensure continuity of provision for the people of Shropshire.***

ACTION **Dr Julie Davies to present update on SATH's Fragile Clinical Services to July Governing Body meeting.**

Dr Julie Davies to raise issue of inter-provider transfer of spinal patients to RJAH with SATH.

CORPORATE PERFORMANCE REPORTS

Minute No. GB-2017-05.091 – Financial Report – Month 12

12.1 Mrs Hayman presented the Finance Report which provided Members with an update on the key financial issues as at Month 12, as follows:

- The CCG during 2016/17 revised its original in-year deficit from £9.66m to £25.9million. The CCG had achieved the £25.9m deficit. All CCGs were required by NHS England to hold a 1% reserve, which for Shropshire was £4.2m. A national NHSE technical adjustment effecting all CCGs, involved the release of the 1% reserve, which had reduced the CCG's deficit from £25.9m to £21.8m. The cumulative deficit was now £32.6m.
- Shropshire CCG continued to be in Legal Directions and in formal financial recovery.
- The CCG had entered 2016/17 with a number of known significant risks and had a QIPP target of £10.6m.
- The final position would be presented as part of Annual Accounts.

12.2 Mrs Hayman reported that the draft final accounts had been submitted on 27 April 2017 and were currently being audited. It was noted that the final accounts would be approved at the Audit Committee on 24 May, with final submission due on 31 May 2017.

12.3 Mrs Hayman advised that there had been some areas where the CCG had under or overspent, and that there had been some specific challenges with regards to the contract with SATH and Complex Care packages, both of which had overspent. Mrs Hayman reported that alternative resources had been identified to offset the position which meant the CCG had achieved its year end deficit of £25.9m

12.4 Mr Timmis recognised the work of CCG colleagues in achieving the year-end position and felt that there had been consistent forecasting over the past 6 months. Although it was noted by the F&P Committee that there would be significant financial pressure for 2017/18 and that there would need to be robust forecasting in relation to primary care funding in order for the Primary Care Commissioning Committee (PCCC) to make considered judgements. Mr Timmis also noted his disappointment that there were still a number of legacy issues that had not been resolved.

12.5 Dr Povey thanked Mrs Hayman for her work over the past few months and sought assurance that the improvements to the CCG's finances were not lost during the handover to the substantive Chief Finance Officer (CFO). Mrs Hayman reported that there were robust systems and processes now in place and that she had a handover period with Ms Claire Skidmore, the CCG's new substantive CFO, in order to ensure a smooth transition.

12.6 Dr Povey referred to primary care budget and noted that there had been overspend in the acute sector but an underspend in primary care and sought assurance that future plans for primary care were resourced appropriately. Dr Freeman clarified that the primary care budget did not specifically relate to general practice resources, but all primary care services. Dr Freeman highlighted that there had been an underspend in the budget during 2016/17 as some planned work had not been completed, a review of this was being undertaken. Dr Freeman emphasised that the CCG was not deliberately under-investing in primary care in order to offset overspend in other areas. Furthermore, Dr Freeman noted that a proportion of the underspend would be as a result of the 1% reserve being released.

12.7 Dr Lynch noted that this issue had also been raised at the Primary Care Commissioning Committee, where Members had sought clarity with regards to what would happen to the underspend in primary care and whether this would be put against the CCG's control total. Dr Freeman explained that the underspend had no correlation to the CCG's deficit or legal directions, but related to specific aspects of funding in some elements of primary care. Dr Freeman also stated that GPs were conflicted as primary care providers, but noted that they were Members of the Governing Body in a commissioning capacity.

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the Month 12 Finance report and the key areas of financial reporting.***

Minute No. GB-2017-05.092 – Corporate Performance Report

13.1 Dr Julie Davies presented a briefing paper which provided the Governing Body Members with an update on the CCG's performance year-to-date against the Key Performance Indicators (KPIs) that the CCG was held accountable for with NHS England during 2016/17. Dr Davies noted that the report also provided an overview of assurance on performance achievement against targets/standards at CCG and provider level as appropriate, and the delivery and contractual actions in place to mitigate risks.

13.2 Dr Julie Davies highlighted the following key points:

- **Cancer Targets** - In relation to cancer 2 week breast symptoms, the CCG was likely to achieve the target for the full year, but not achieve the remainder of the key performance standards. Despite the improvement in cancer 62 day RTT (Referral to Treatment) performance with SATH, there had been shared breaches at tertiary centres and out of county providers which had contributed to failure at the CCG level. The CCG was committed to using all contractual levers available to improve this for 2017/18 and a tri-partite meeting was planned with the CCG, NHSE and NHSI in relation to improving performance.

- **Improved Access to Psychological Therapies (IAPT)** – Dr Julie Davies reported that the IAPT targets had been achieved, both in terms of access and recovery.

- **Delayed Transfers of Care (DTOC)** – There had been a continued reduction in the number of delayed transfers of care and Dr Julie Davies felt that this was as a result of the collaborative working with the local authority, particularly with social workers and domiciliary care providers.

- **18 weeks Referral to Treatment (RTT)** – The CCG achieved 89.8% against the 92% target in February. This was made up of 89.8% at SATH, 91.95% at RJAH and 87.7% cumulatively at other providers. The CCG had issued a formal contract performance notice to SATH for failure of delivery of RTT and had requested a formal recovery plan by mid-May. Current draft plans indicated recovery for SATH.

  Performance for Diagnostics waiting time at SATH had recovered on plan and was back above the standard at 99.55% in February due to recovery in MRI and Endoscopy.

  RJAH continued to recover its 18 week position and achieved 91.37% at the end of March. RJAH had no patients waiting over 52 weeks at year end, however the CCG had been affected by 3 over 52 week waiters out-of-county (one each at Wye Valley, Worcester and University Hospital North Midlands) all of which had not be treated by the year end. Wye Valley had also since declared a further 3 over 52 week waiters relating to trauma and orthopaedics and Hereford had declared significant pressure.

  Dr Julie Davies reported that Shropshire Community Health NHS Trust (SCHT) had declared 4 over 52 week waits relating to Audiology. The CCG had requested a position statement from the Trust seeking clarification when the patients would be treated and what the underlying cause of the delay in treatment had been. The outcome would be included in the June Corporate Performance report.

  Full contractual levers had been implemented against the RTT poor performance and the CCG performance lead had requested a forward look of all over 40 week waits with all providers to try and prevent such breaches happening in the future. Dr Julie Davies acknowledged that it was the patients' discretion as to where they received their treatment, however, the Referral Assessment Service (RAS) would be ensuring waiting times were flagged up at the time of booking appointments, in order for patients to make an informed choice.

- **Urgent Care / A&E 4 hour target** – A&E performance remained challenging, although there had been signs of improvement in February, March and April as key actions within the system took effect. The regional escalation meeting held on 20 April with NHSI acknowledged the improvement and encouraged the CCG to continue with its priority actions plans for recovery. Further detailed information on A&E Performance was presented under Minute No. GB-2017-05.089.

- **Ambulance response times** - Given the very poor position the local system was in with regard to ambulance handovers, the system had improved the >1hr responses times at the year-end but had not been able to eliminate them. SATH and West Midlands Ambulance Service (WMAS) were committed to finalising the improvement plan during May and CCG executives had done an observation visit at RSH at peak time to observe the issues first hand.

- **NHS 111** - There continued to be a deterioration in performance for NHS 111 for calls abandoned after 60 seconds, with October 2016 position at 82.6% against 95% target. Dr Julie Davies noted that no performance figures at CCG level were available from the new NHS 111 service provider (Care UK). It was anticipated that this would be available shortly but no timescale had been confirmed from the regional lead

13.3 Mr Timmis referred to paragraph 7 (page 2) where it indicated the CCG was in the lower performance quartile in the Better Care category and requested that the algorithm was included in future corporate performance reports in order to understand the constituent elements. Dr Davies confirmed that it was intended to include this from the June report.

13.4 Mr Shepherd referred to page 3 where it outlined work to develop Urgent Treatment Centres (UTCs) and sought clarity with regards to its remit, as he felt the terminology would be confusing for patients. Dr Julie Davies explained that it was effectively what was currently co-located at the A&E department in RSH and was the terminology used in the primary care streaming guidance, which she acknowledged needed to be made clearer.

13.5 Mr Shepherd also raised concerns with regards to the Hospital Offers (page 3) and referred to the embedding of the Red to Green philosophy and asked for an explanation in this regard. Dr Julie Davies advised that as part of the consultant ward round each patient was assessed to see if the next step in their pathway could be progressed, if so then they would be assessed as being Green, if not they would remain as Red.

13.6 Mr Shepherd stated that a NHS 111 Governance meeting was due to take place next week and he was hopeful that the performance date from the new provider, Care UK, would be presented.

RESOLVE: ***THE GOVERNING BODY RECEIVED the Performance report and NOTED the key standards that were currently not being met and the mitigating actions put in place to recover performance.***

THE GOVERNING BODY AGREED that:

- ***Dr Julie Davies should continue chairing the monthly planned care working group meetings with RJAH and SATH from December onwards to oversee recovery of RTT, diagnostics and Cancer standards.***

- ***Dr Julie Davies and Dr Simon Freeman continuing with the appointment of system urgent care director post on behalf of whole health economy to provide additional capacity to drive improvement in A&E performance.***

Minute No. GB-2017-05.093 – Contract Performance Report 2016/17

14.1 Mr Whitworth presented the Contract Performance report, which summarised the current contractual position at Month 11 for the CCG's four main contracts:

- Shrewsbury and Telford Hospital NHS Trust (SATH)
- Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH)
- South Staffordshire and Shropshire Healthcare Trust (SSSFT)
- Shropshire Community Health Trust NHS Trust (SCHT)

14.2 It identified the main issues relating to delivery of the key contract outcomes including performance against constitutional standards and quality requirements. It also detailed the current actions being taken under the contract with each of the main providers**.**

14.3 Mr Whitworth noted that the major contract report was included as Appendix A and that year-end financial settlements had been agreed with SATH and RJAH. Other work was ongoing with regards to the delivery of the new Improved Access to Psychological Therapies (IAPT) targets for 2017/18. A financial provision had been created to ensure that the CCG was able to meet its mental health investment target for 2017/18 including additional investment for IAPT.

14.4 Mr Whitworth drew Members' attention to the graphs on pages 4 and 6, which outlined the downward trend in activity referrals at SATH and RJAH respectively.

14.5 Dr Povey noted that there was an underspend on the SSSFT contract and asked if the CCG should request that the funding be spent on providing additional services, particularly as there were pressures in some specialities (ie IAPT). Mr Whitworth advised that the CCG had been tied into the contract with SSSFT previously but reported that discussions were ongoing with the Trust to get greater understanding how the services were provided in order to get the best value for money.

14.6 Dr Povey also that there was a new provider for Child & Adolescent Mental Health Services (CAMHS) and expressed concern that communication on how to access the service had not been circulated to general practices. Dr Julie Davies advised that she was not aware of the issue and agreed, with Mrs Tilley, to pick this up with the CCG's Commissioning Lead.

RESOLVE: ***THE GOVERNING BODY RECEIVED the Contract Performance Report for Month 11 and NOTED the current performance and actions being taken with each of the four main providers.***

ACTION **Dr Julie Davies and Mrs Tilley to take forward concerns raised in relation to communication to practices regarding accessing Child & Adolescent Mental Health Services (CAMHS) with commissioning leads.**

Minute No. GB-2017-05.094 – Review of Quality, Patient Safety and Experience function and report on maternity services at Shrewsbury & Telford Hospital NHS Trust (SATH)

15.1 Dr Povey began by advising that he would take questions from both Governing Body Members and members of the public immediately after the paper had been presented.

15.2 Mrs Beal presented the briefing report, which she advised comprised of two parts, the first part provided Members with accurate and relevant information and assurance regarding the quality and safety of commissioned services from its provider organisations (SATH, RJAH and SCHT) and the actions being taken to address any concerns. Also to inform the Governing Body that the CCG planned to undertake a review of its internal Quality, Patient Safety and Experience Function. Mrs Beal noted that the CCG's Quality Committee had also received and considered the status of these and other providers at its meeting on 25 April 2017.

15.3 The second part of the report provided the Governing Body with an overview and update on the action being undertaken within Shropshire CCG to mitigate risks, learn lessons and gain assurance on maternity services at SATH.

15.4 Mrs Beal stated that it was paramount that the CCG had a level of assurance that the services it commissioned were good quality, were safe, clinically effective with positive patient experience, and that a contractual processes were undertaken with all provider organisations to ensure that assurance was received. This was taken from a variety of sources including each provider's Clinical Quality Review meetings (CQRMs), performance reports, and other relevant information including nationally contractual process entered into by commissioners and service providers.

15.5 Mrs Beal noted that a number of the concerns relating to SATH had been covered earlier in the meeting, particularly in relation to A&E, Neurology and Ophthalmology. In addition, to the CQRM with SATH, Mrs Beal reported that she had recently met with the Trust's Interim Director of Nursing (DoN) where additional assurance was received. It was noted that the new substantive DoN had commenced in post this week. The Care Quality Commission (CQC) report on SATH was anticipated to be released in June 2017, but this had yet to be confirmed, and which would be presented to the CQRM.

15.6 With regards to RJAH, Mrs Beal advised that the Trust had reported three Never Events (NEs) during 2016/17 for wrong site surgery. At the February NHSE Quality Surveillance Group (QSG) it was agreed for a review of all of the Root Cause Analysis (RCAs) relating to these NEs should be undertaken in order to seek assurance that the actions planned and lessons learnt had been undertaken. Mrs Beal reported that the Trust had failed on a number of occasions to complete all the NEs for sign off and assurance and noted there had also been a lack of clinical attendance at meetings. Therefore advice had been sought, and the issue had been escalated to NHSE QSG in April where it was agreed, between them and the CQC, that if the Trust failed to complete the review then a risk review meeting may be required. At the CQRM held on 3 May, the Trust had indicated that it would submit the NE report to both CCGs for review on the 10 May. This would then be considered by the CCGs, NHSI, NHSE, and specialised commissioning on the 11 May and a decision made as to whether a risk review meeting was required.

15.7 Mrs Beal also reported that the West Midlands Quality Review Service (WMQRS) had carried out a review of theatre services at RJAH on 7 February 2017 and there were no immediate risks identified.

15.8 In relation to SCHT, Mrs Beal reported that the Emotional Health & Wellbeing Service had transferred to the new provider (SSSFT) on 2 May 2017 and that NHSI continued to manage the SCHT Sustainability Board with partners to determine options for the future of the Trust with other providers.

15.9 Information on other providers was presented to and considered by the Quality Committee at its meeting on the 25 April 2017.

15.10 Mrs Beal advised that she had considered and reviewed the existing internal quality, patient safety and experience function and that it had been agreed with the Accountable Officer and Executive Team to undertake a root and branch review, building on its strength and examples of best practice and to complete a gap analysis on areas for improvement. The resulting improvement plan would be monitored by the Quality Committee. The primary principles of the review were outlined on pages 5-6 of the report, which would be undertaken in conjunction with finance, contracting and performance departments. Mrs Beal noted that she had secured 2 days external support for the review.

15.11 Dr Povey opened questions from Governing Body Members in relation to part 1 of the report.

15.12 Mr Timmis raised concern in relation to the attitude of the providers with the lack of attendance at meetings and not completing work to agreed timescales. Mrs Beal advised that there had been a change in personnel recently at RJAH and that engagement had improved significantly.

15.13 Mrs Randall-Smith reported that Healthwatch had patient feedback relating to RJAH and was planning on undertaking further information gathering events during the year, which she would share with Mrs Beal.

15.14 Dr Rysdale confirmed that the Quality Committee received and investigated all Serious Incidents (SIs) and that it needed assurance that any key emerging themes or learning was implemented. Mrs Beal stated that serious incident and Never Event investigations were undertaken in-line with national guidance, but acknowledged there was further work required to strengthen the process.

15.15 Dr Lynch welcomed the internal review of the CCG's Quality, Patient Safety and Experience Function and felt it was a good opportunity for the organisation to see where improvements could be made. With regards to clinical attendance at CQRMs, Dr Lynch felt it was important for both the providers and CCG to have clinical representation and ownership of quality issues.

15.16 Dr James and Mr Hutton raised concern with regards to the culture at SATH and the acceptance by staff that patients waiting for more than 10 hours with no decision to admit them was the norm. Dr James asked how the CCG was assured that this was not happening on a regular basis. Mrs Beal acknowledged that the CCG did not have appropriate assurance in this regard and that the issue had been raised at the SATH CQRM and further unannounced visits were planned to seek additional assurance. This would also be reviewed at the SaTH CQRM in May 17.

15.17 Dr Rysdale highlighted that by not making a decision on whether to admit the patient would avoid the need to report a breach, as the clock did not start until the decision to admit had been made. Dr Julie Davies advised that a new urgent care dataset was due to be introduced in October 2017 and that the CCG would then be able to monitor how patients were assigned in the department.

15.18 Dr Sokolov acknowledged that there concerns had been expressed with regards to the quality culture of providers and that it was for the CCG, as the commissioner, to manage the concerns and ensure that there were robust processes in place to monitor the situation so that patients had good quality and safe healthcare.

15.19 Dr Povey referred to the Transforming Care work that SATH was undertaking with the Virginia Mason Institute and asked if this had been considered as part of the CCG's review. Mrs Beal advised that she was not sighted on this area of work and agreed to pick this up at the SATH CQRM to see how this work aligned to current workstreams.

15.20 Mrs Beal presented the second part of the paper which gave an overview and update on the actions being undertaken within Shropshire CCG to mitigate risks, learn lessons and gain assurance on maternity services at SATH.

15.21 Mrs Beal reported that the Governing Body had previously received information and briefing papers regarding processes and actions being taken to attain assurance of maternity services at SATH and that the CCG was working with the Trust, NHSE, NHSI and CQC to address the serious concerns that remained about the level of assurance and due diligence relating to the quality and safety of maternity services.

15.22 Mrs Beal highlighted that, in line with the National Maternity Review, 'Better Births, Improving outcomes of maternity services across England' (2016), the CCG was undertaking a review of its accountability, responsibility and internal quality, patient safety and experience, governance and assurance processes. The 'robust Maternity Services Look Back Review' would be rigorously undertaken at pace to determine the level of assurance the CCG previously sought to the current day. This would enable the CCG to determine whether there was anything else it could/should have done, to learn lessons.

15.23 Mrs Beal emphasised that the CCG was fully co-operating, as required, with the Secretary of State's review of avoidable baby deaths at SATH by NHSI.

15.24 The CCG was also working with SATH, women, their families, local interest lobbying groups and communities on a review of the Midwife led Units (MLUs) across the county. The review was expected to conclude at the end of August 2017 and formed part of a workstream of the Local Maternity System Review. Mrs Beal reported that she was seeking external expert midwifery support for the review from NHS England and possibly the Maternity Alliance and noted that the CCG was unable to engage at present due to the period of purdah.

15.25 In addition, Mrs Beal reported that at the April CQRM both CCGs had offered SATH a contract variation to establish a specific Maternity CQRM from May, In order to enable all parties to focus on the significant work that was needed to be undertaken to improve and assure maternity services. The CCG was expecting a response from the Trust in this regard imminently.

15.26 The CCG had also approached NHSE to seek advice as to whether SATH could be encouraged to participate in the NHSI Maternal and Neonatal Health and Safety Collaborative in 2018/19.

15.27 There were no questions raised by Governing Body Members in relation to maternity services at SATH, therefore, Dr Povey opened the meeting to questions to members of the public relating to this agenda item only. The following questions were raised:

- **Mrs Sylvia Jones, Clunbury Parish Council**

  Mrs Jones asked why there had been routine closures, at short notice, of rural Midwife Led Units (MLUs) in Shropshire in order to staff the obstetric unit at PRH. Mrs Jones particularly highlighted the recent closure of the Ludlow MLU over the weekend, from 8.00pm Friday evening until 8.00am Monday morning. Mrs Jones stated that there were 3 women due to give birth at the unit over the weekend and who were given 3 hours notice of the closure. Mrs Jones tabled a letter on behalf of the father of one of the families whose wife gave birth at home Sunday night, following a fast labour, due to the closure of the unit as there was insufficient time to travel to Bridgnorth MLU. The letter outlined the family's experience during the birth and their request for the Ludlow MLU to remain open so that other families did not have the same experience.

  Mrs Jones asked the CCG to take immediate steps to stop the random closures of the rural MLUs and to recognise that the proposal by SATH to have birthing centres with midwives available on-call would put women and babies at risk. Mrs Jones also noted that the CCG's review of rural MLUs would prioritise value for money over safety of women and babies.

  Dr Sokolov reported that the workforce that manned the MLUs were the same staff, employed by SATH, who covered the Consultant Led Unit (CLU) at PRH. Dr Sokolov advised that currently data showed that 85% of women in the county gave birth at the CLU, as it was anticipated that they would have a complicated delivery and were most at risk of needing a caesarean section. Dr Sokolov noted that at present these women were not receiving one-to-one intrapartum care, due to the workforce issues at SATH, which she felt was unacceptable. Therefore, when there were staff shortages at SATH, the Trust would have to consolidate staff at the CLU where most women were delivering. Dr Sokolov acknowledged that this was not an ideal situation but recognised that it was the only safe thing the Trust could do.

  Dr Sokolov appreciated that the specific patient experience referred to by Mrs Jones would have been distressing for the family involved, however, highlighted that a precipitous delivery could happen at any point as labour could be unpredictable. Dr Sokolov contested the characteristic that cuts were being made without consideration for patient safety and stated that safety was at the forefront of the MLU review, as it had been established as a result of concerns raised by the Trust and patients.

- **Mrs Sylvia Jones, Clunbury Parish Council**

Mrs Jones referred to the Daily Mirror's report on the avoidable deaths of babies at SATH following concerns with foetal heart rate monitoring and noted that a further 12 families had come forward. Mrs Jones reported that concerns had been raised in 2007 and that the CCG's review of maternity services at SATH, conducted in 2013, had concluded that the services were safe and of a good standard, but avoidable deaths had continued. Mrs Jones also advised that in 2015 the CCG, through the CQRM, had given assurances that systems and processes were in place to address the recommendations from the independent review. Mrs Jones felt that these assurances appeared to be the same given by the CQRM now.

Dr Povey confirmed that there had always been a SATH CQRM, but an offer had been made to the Trust to establish a separate CQRM specifically for maternity services. Dr Povey also advised that the purpose of the independent desk top review would be to establish a timeline of events and to establish if the Trust, NHSE and CCG had made adequate responses to the concerns raised and that the outcome of the review and any recommendations could not pre-empted.

Mrs Jones asked if the CCG was confident that it could ensure safe maternity services for local women in the future and asked how it planned to do this.

Dr Povey stated that maternity services were safe for the vast majority of patients and that maternity was by its nature a high risk area and that the outcome of the review would determine whether there were any improvements to be made

Mrs Beal highlighted that the briefing paper sets out clearly the processes whereby the CCG was seeking assurance that the services it commissioned were safe, both from an internal and external point of view, and emphasised that the CCG was fully cooperating with the independent review as required, and would adhere to the findings of the review.

In terms of current services, Mrs Beal stipulated that the CCG was committed to drive at pace with the Trust how it could strengthen the assurance levels, this included the offer of a separate CQRM for maternity services.

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

- ***RECIEVED the information presented in relation to the assurances regarding the quality and safety of commissioned services from the CCG's provider organisations (SATH, RJAH and SCHT) and CONSIDERED the actions being taken to address the concerns.***

- ***NOTED the action being taken by Shropshire CCG to review its internal Quality, Patient Safety and Experience functions.***

- ***RECEIVED the information presented in relation to the actions being undertaken within Shropshire CCG to mitigate risks, learn lessons and gain assurance on the quality, safety and effectiveness of maternity services at SATH.***

- ***SUPPORTED the work to determine how Shropshire CCG could learn lessons and improve the level of assurance it received on maternity services at SATH in order to improve the confidence of the women, their families and the patients and public it served.***

ACTION **Mrs Beal to raise at next SATH CQRM how the Transforming Care work being undertaken by the Virginia Mason Institute aligned to current workstreams.**

Minute No. GB-2017-05.95 – Governing Body Assurance Framework (GBAF)

16.1 Mrs Tilley presented the Governing Body Assurance Framework (GBAF) and reported that since the last Governing Body meeting on 12 April 2017 it had been reviewed by the Executive Team, relevant Governing Body Committees and individual Directors. It was noted that amendments since the previous version were shown in red.

16.2 Mrs Tilley reported that the key change to note was the removal of Finance Risk 1a, which related to the achievement of the CCG's control total for 2016/17 and that any actions relevant to the 2017/18 year were carried forward under risk 1.

16.3 Mrs Tilley also reported that the CCG had received the final GBAF year-end review from internal audit which had confirmed the GBAF review as an 'A' rating, although it was noted that there were still some improvements to be made which the CCG was progressing.

16.4 Mr Timmis, on behalf of the F&P Committee, asked how the governance arrangements of the A&E Delivery Board fed into the CCG. Dr Julie Davies advised that this would be discussed and agreed at the next A&E Delivery Board meeting scheduled for the end of May.

RESOLVE: ***THE GOVERNING BODY RECEIVED the latest iteration of the Governing Body Assurance Framework (GBAF) and NOTED that the process had commenced to regularly review the GBAF risks by relevant Governing Body committees.***

THE GOVERNING BODY NOTED the Internal Audit final GBAF year-end review, which had been assessed as 'A' rating.

STRATEGIC PLANNING REPORTS

Minute No. GB-2017-05.096 – Future Fit Programme Director's report

17.1 Mrs Debbie Vogler, Future Fit Programme Director, was in attendance to provide Members with a verbal update on progress in the following key areas:

- **Independent Review** – It was noted that the initial procurement exercise had not attracted any bidders and a second stage of procurement had been undertaken via a wider procurement framework. However, it was identified that the preferred bidder had a potential conflict of interest. It was, therefore, agreed that a third procurement process be undertaken. Mrs Vogler advised that she was confident that an appointment would be made and that it was envisaged the review would take place during June, with the outcome reported in July.

- **Women & Children's Services Integrated Impact Assessment (IIA)** – Mrs Vogler reported that an additional analysis of the potential impacts and equality effects of changes to women and children services was being undertaken. Mrs Vogler reported that the analytical work had been completed but the engagement work and focus groups could not be progressed at this stage until after the general election, due to the period of purdah, but confirmed that the work would be completed by mid-July.

- **Future Fit Joint Committee Terms of Reference (TOR)** – Mrs Vogler reported that NHS England were providing support to the CCGs in terms of identifying three independent representatives (a Non-Executive Chair and two Clinicians) to sit on the Joint Committee. The TOR had therefore been revised and would be presented to the June Governing Body meeting for approval.

17.2 Dr Povey referred to the membership of the Joint Committee and asked how the independent representatives would be nominated. Mrs Vogler confirmed that NHS England had identified potential candidates and these individuals were currently being approached.

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the Future Fit Programme Director's verbal report on the key areas of the programme.***

ACTION **Mrs Vogler to present revised Terms of Reference for Future Fit Joint Committee to 7 June Governing Body meeting for approval.**

GOVERNANCE

Minute No. GB-2017-05.097 – Healthwatch Report

17.1 Mrs Randall-Smith presented a briefing report which summarised the activities of Healthwatch Shropshire during March and April 2017 focusing on the intelligence received.

17.2 Mrs Randall-Smith reported that the 'Hot Topic' for March and April focussed on dental services, not only in the community setting but also acute services and in care homes. The new 'Hot Topic' for May and June coincided with both Mental Health Awareness week and changes in the way mental health services were provided across Shropshire. Mrs Randall-Smith advised that Healthwatch was interested in hearing about people's experiences of using the wide range of mental health services available, including IAPT, counselling and young people's mental health services,

17.3 Mrs Randall-Smith reported that the Intelligence Committee would meet shortly to analyse the recent feedback received and identify any hot spots and trends. Information sharing meetings had been held during the period and key themes in Shropshire continued to be:

- communication – with patients but also carers and their families
- waiting times - delays in getting appointments
- discharge - both home and into care

17.4 Healthwatch continued to receive feedback on the Midwife Led Units (MLUs) and had shared this with the CCG as part of the MLU review. Mrs Randall-Smith noted that Healthwatch attended the MLU review meetings and Local Maternity System Programme Board. Feedback had also been received on the Consultant Led Unit which had been shared with both the CCG and SATH. In the light of recent press coverage on infant mortality Healthwatch Shropshire, Healthwatch Telford & Wrekin and Powys Community Health Council had arranged a meeting with SATH next week to seek assurance that maternity services at SATH were safe and provided high quality healthcare for mothers and babies.

17.5 Mrs Randall-Smith reported that Healthwatch Shropshire also ran the Independent Health Complaints Advocacy Service (IHCAS) for Shropshire, which provides support to members of the public on raising concerns or making a formal complaint. Mrs Randall-Smith gave an example of a recent complaint that Healthwatch had been involved in relating to access to patient records and advised that the complaint had now been resolved following their intervention and escalation to NHS England.

17.6 Mrs Randall-Smith noted that Healthwatch Shropshire was not a public body and, therefore, not directly affected by the purdah period and had run a communications campaign to raise awareness of the case for change as part of the NHS Future Fit programme. It was also noted that Healthwatch wanted to encourage and facilitate feedback on the programme by raising awareness of existing documents available, but was mindful what it could do during the extended purdah period for the general election.

17.7 During March and April Healthwatch had finalised and published two 'Enter & View' reports on Edgeley House Care Home and Cloverfields Care Home. It was noted that as a result of one Enter & View visits concerns had been escalated to both Adult Social Care and to the Safeguarding team at Shropshire Council and as a result, with support from the provider, significant changes were made to the care packages for two residents.

17.8 Mrs Randall-Smith reported that Healthwatch was planning on undertaking Enter & View visits to GP practices during the coming months. Following discussion at the Primary Care Commissioning Committee, Healthwatch would writing out to all practices in Shropshire during May to explain its powers in terms of Enter & View, the process and to explain the purpose of the visits. Healthwatch would also be engaging with the individual Practice Participation Groups when it visited the practices.

17.9 Mrs Randall-Smith drew Members' attention to the next Board meeting in public scheduled for 2.00pm on 23 May at the Flax Mill, Shrewsbury. Members of the public were invited to attend and ask questions. A drop in session would also be held at 1.00pm, prior to the meeting, in order for members of the public to meet the team and to share feedback on services.

17.10 Dr Julie Davies reported that she would welcome input from Healthwatch with regards to patient feedback on discharge processes in order to ensure it linked with the work currently being undertaken by the CCG and Local Authority.

17.11 Mrs Beal referred to the Research Grant Fund and thought that maternity services could be a future project area. Mrs Beal agreed to pick this up with Mrs Randall-Smith outside the meeting.

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the report which summarised the activities of Healthwatch Shropshire during March and April 2017 following the intelligence received.***

ACTION **Mrs Randall-Smith and Dr Julie Davies to liaise with regards to patient feedback on discharge process to ensure it linked to work being undertaken by the CCG and Local Authority.**

Mrs Randall-Smith and Mrs Beal to liaise with regards to the Research Grant Fund to see if maternity services could be a future project area for funding.

FOR INFORMATION ONLY/EXCEPTION REPORTING

Minute Nos. GB-2017-05.098 to GB-2017-05.102

18.1 The following reports were received and noted for information only:

- Finance & Performance Committee
- Remuneration Committee
- Quality Committee
- Audit Committee

18.2 Mr Hutton presented the Clinical Commissioning Committee (CCC) revised Terms of Reference for approval and reported that there had been some minor changes made to the purpose and membership of the committee. The CCC had approved the changes at their recent meeting and were now being presented for formal ratification by the Governing Body.

18.3 Mr Hutton drew Members' attention to the key points from the Audit Committee, in particular:

- **Internal Audit Reviews** –
  - Financial Reporting – Moderate Assurance. Mr Hutton highlighted that this had been a move from the 'No Assurance' earlier in the year and was a reflection of the hard work undertaken by the CCG to improve the position.
  - Governing Body Assurance Framework (GBAF) – Year End Review – A Level 'A' rating had been confirmed.

- **The Head of Internal Audit opinion for 2016/17** gave the CCG Limited Assurance. This was subject to final confirmation but reflected the positive progress made by the CCG in the last 4 months in closing actions from Internal Audit reviews, ensuring that the GBAF was effective and improving Financial Controls and Reporting.

- **External Audit work on the 2016/17 Accounts** had commenced. The proposed Value for Money conclusion was a Qualified Adverse Opinion, reflecting the scale of the deficit in the CCG, the challenges faced by providers in the Local Health Economy and the current state of Future Fit.

18.4 Mr Hutton also highlighted the recommendation from the Audit Committee that regular updates on the Sustainability & Transformation Plan should be received at each Governing Body meeting in order to provide appropriate assurances on governance and progress.

RESOLVE: ***THE GOVERNING BODY RECEIVED AND NOTED the reports from the Committees noted above and APPROVED the revised Terms of Reference for the Clinical Commissioning Committee.***

Minute No. GB-2017-05.103 – Any Other Business

19.1 Dr Povey advised that he had not been notified of Any Other Business, but noted that it was International Nurses Day.

19.2 There were no items of any other business raised.

Questions from Members of the Public were taken at this point.

DATE OF NEXT MEETING

The next scheduled meeting of the CCG Governing Body is:

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

  Wednesday 7 June 2017 - time and venue to be confirmed.

SIGNED …….. DATE ……

Shropshire Clinical Commissioning Group

ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 10 MAY 2017

Agenda Item	Action Required	By Whom	By When	Date Completed
GB-2017-05.082 – Members' Declaration of Interest	Dr Sokolov to complete new Declaration of Interest proforma.	Dr Jessica Sokolov	Immediately	17.5.17
GB-2017-05.084 – Minutes of Previous Meeting held on 10 May 2017	Mrs Eggby-Jones to make amendments to minutes of Governing Body meeting held on 10 May 2017.	Mrs Tracy Eggby-Jones	Immediately	12.5.17
GB-2017-05.085 – Matters Arising	Mr Whitworth to present revised Values Based Commissioning Policy to 7 June Governing Body meeting for approval.	Mr Michael Whitworth	7 June Governing Body meeting	On agenda – 7.6.17
	Mrs Tilley to present the Risk Management Policy to 7 June Governing Body meeting for approval.	Mrs Sam Tilley	7 June Governing Body meeting	Deferred to July meeting
	Mr Whitworth to provide regular progress reports on the Optimity Review to future Governing Body meetings.	Mr Michael Whitworth	Future Governing Body meetings	
	Dr Sokolov to present Midwifery Led Unit (MLU) review project plan to June Governing Body meeting.	Dr Jessica Sokolov	7 June Governing Body meeting	On agenda – 7.6.17
	Mr Whitworth to present update on prime provider selection process for optimising the MSK pathway to 7 June Governing Body meeting.	Mr Michael Whitworth	7 June Governing Body meeting	On agenda – 7.6.17
	Dr Julie Davies to present progress report on Shropshire Community Services Review to July Governing Body meeting and bi-monthly thereafter.	Dr Julie Davies	July Governing Body meeting	July Governing Body meeting
	Mr Whitworth to include update on Integrated Community Services (ICS) in next Contract Performance Report presented to the Governing Body.	Mr Michael Whitworth	Next Contract Performance Report	

Agenda Item	Action Required	By Whom	By When	Date Completed
	Mr Whitworth to ensure update on SATH QIPP is included in next Contract Performance report presented to the Governing Body. Dr Julie Davies to present update on feedback from NHS England following the submission of the CCG's Five Year Forward View to future Governing Body meeting.	Mr Michael Whitworth Dr Julie Davies	Next Contract Performance Report Future Governing Body meeting	
GB-2017-05.086 – Questions from Members of the Public	Dr Julie Davies to confirm to Mrs Easterley, member of the public, what engagement had taken place with regards to the closure of Path House.	Dr Julie Davies	Immediately	
Minute No. GB-2017-05.088 – Status Report on the Six Main QIPP (Quality, Innovation, Productivity and Prevention) Schemes	Dr Freeman to present regular updates on QIPP performance to future Governing Body meetings.	Dr Simon Freeman	Future Governing Body meeting	On agenda – 7.6.17
Minute No. GB-2017-05.089 – A&E Performance Report	Dr Julie Davies to include progress against the priority areas and their impact on A&E performance in the A&E section of the CCG's performance report from June onwards.	Dr Julie Davies	June Corporate Performance report	On agenda – 7.6.17
GB-2017-05.090 – Shrewsbury & Telford Hospital NHS Trust (SATH) Fragile Clinical Services	Dr Julie Davies to present update on SATH's Fragile Clinical Services to July Governing Body meeting. Dr Julie Davies to raise issue of inter-provider transfer of spinal patients to RJAH with SATH.	Dr Julie Davies Dr Julie Davies	July Governing Body meeting Immediately	July Governing Body meeting
GB-2017-05.093 – Contract Performance Report	Dr Julie Davies and Mrs Tilley to take forward concerns raised in relation to communication to practices regarding accessing Child & Adolescent Mental Health Services (CAMHS) with commissioning leads.	Dr Julie Davies & Mrs Sam Tilley	Immediately	

Agenda Item	Action Required	By Whom	By When	Date Completed
Minute No. GB-2017-05.094 – Review of Quality, Patient Safety and Experience function and report on maternity services at Shrewsbury & Telford Hospital NHS Trust (SATH)	Mrs Beal to raise at next SATH CQRM how the Transforming Care work being undertaken by the Virginia Mason Institute aligned to current workstreams.	Mrs Barbra Beal	As soon as possible.	
GB-2017-05.096 – Future Fit	Mrs Vogler to present revised Terms of Reference for Future Fit Joint Committee to 7 June Governing Body meeting for approval.	Mrs Debbie Vogler	7 June Governing Body meeting	On agenda – 7.6.17
GB-2017-05.097 – Healthwatch Report	Mrs Randall-Smith and Dr Julie Davies to liaise with regards to patient feedback on discharge process to ensure it linked to work being undertaken by the CCG and Local Authority. Mrs Randall-Smith and Mrs Beal to liaise with regards to the Research Grant Fund to see if maternity services could be a future project area for funding.	Mrs Jane Randall-Smith & Dr Julie Davies Mrs Jane Randall-Smith & Mrs Barbara Beal	As soon as possible As soon as possible	

NHS
Shropshire
Clinical Commissioning Group

Governing Body – Matter Arising

Clarification in the Value Based Commissioning (VBC) policy to clearly demonstrate that the CCG is taking due cognisance of the NICE guidance that patients with onset type 2 diabetes should be expedited for bariatric surgery assessment.

The following addition lines from NICE guidance (in red below) are recommended to be added to the VBC policy:

2.4	**Bariatric Surgery**
Intro	People whose BMI is significantly high are more likely to suffer a range of illnesses and have lower lifer expectancy. Bariatric surgery is a highly specialised intervention used in appropriate, selected patients with severe and complex obesity that have not responded to all other non-invasive therapies. The following NICE guidance should also be considered when applying this policy: • *Patient has recent-onset type 2 diabetes with a BMI of 35 or over should be offered an expedited assessment* • *Patient has recent-onset type 2 diabetes with a BMI of 30-35 should be considered for an assessment* • *Patient has recent-onset type 2 diabetes with an Asian family origin should be considered for assessment at a lower BMI than other populations* This policy refers to Tier 4 'Specialised Complex Obesity services' which includes bariatric surgery, and refers to obese II (BMI 35-40) and morbidly obese (BMI 40 and over) patients.
Criteria	Patients will be considered for surgery if they meet the following criteria;
	• aged 18 years or older
	○ patient has BMI of 35 or over for at least 5 years with significant comorbidities OR
	○ patient has BMI of 40 or over for at least 5 years without comorbidities
	AND
	• patient has recently completed a Tier 3 weight management programme for 12-24 months with a stabilisation period of at least 6 months before referral
	OR
	• the patient has BMI of 50 or over

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.110
Shropshire CCG Governing Body meeting: 07 Jun 2017

Title of the report:	QIPP programme update
Responsible Director:	Claire Skidmore, Chief Finance Officer
Author of the report:	Mike Taylor, Interim Senior Finance Project Support
Presenter:	Claire Skidmore, Chief Finance Officer

Purpose of the report:

To report the CCG's delivery of the 2017/18 QIPP programme in the first month of the financial year based upon initial performance data.

Key issues or points to note:

While it is early in the financial year it is important to identify as soon as possible any schemes which are not performing as expected to allow for quick mitigating action. April performance based on data gathered to date is in line with plan, however, current forecasts suggest a small number of high risk schemes that may not deliver the expected level of savings.

The Executive Team are briefed on this position and are in the process of agreeing plans to make good the potential gap. Further information will be available at future meetings.

The QIPP target for 2017/18 is £17.71m but in order to allow for slippage in delivery or lower savings than planned the CCG is not just working to deliver the current portfolio of schemes but is also exploring current schemes for any stretch potential as well as seeking out new opportunities focusing on the newly released NHS England quidance.

The QIPP programme is reviewed monthly by the Finance and Performance Committee. At their meeting on 31 May the Committee expressed satisfaction with progress subject to the formal reporting processes confirming the initial performance data presented.

Actions required by Governing Body Members:

- To note the current position of the 2017/18 QIPP programme.

Governing Body – QIPP Prgramme Update – June 2017

1 Introduction

This is the first report of progress made in delivering the 2017/18 QIPP programme. The current position is based upon early performance data which will be confirmed in due course. The reason for working this way is to get sight of any movement away from plan as soon as possible to allow the best opportunity for corrective action.

Appendix 1 provides an overview of the programme at the end of April, month 1 of the new financial year.

2 Context

Shropshire Clinical Commissioning Group (SCCG) has delivered, subject to audit, the financial outturn agreed with NHS England and so is in a better position than previous years when looking ahead into the new financial year and the challenges to be faced.

The achievement of efficiency savings totalling £17.71m in 2017/18 is key to the CCG's financial recovery plan to return to a sustainable financial position in the medium term.

3 Programme Overview at Month 1

For clearer reporting the programme overview at Appendix 1 does not detail each of the schemes being progressed but consolidates them where possible. For example Prescribing is reported as one number but, as reported last month, there are actually seven schemes being progressed.

The number of schemes can be seen in the appendix and should any move off-plan these will be reported together with any corrective action.

The phasing of the QIPP programme across the year assumed savings of £725,000 in April from the main schemes being taken forwards this year. Subject to formal confirmation the CCG achieved £748,000 and so is on target but does not under-estimate the challenges it faces in delivering the efficiencies required.

QIPP Status Report

NHS Shropshire Clinical Commissioning Group

Date of previous report	None	Date of current report	07-Jun-17

Summary

Overall position:	Initial indications are that the CCG has delivered the efficiency savings planned for April 2017. Positive deep dives scrutinising complex care and contract and community prescribing held by the Accountable Officer.
Pipeline:	Commissioning Leads workshops held and NHS England efficiency saving opportunities under review. Adding to scoping scheme list daily to provide further assurance on delivery of annual target. STP Out of hospital scheme closed but four sub-groups will take this work forwards working across the health and social care economy.
Key risks / issues:	Forecast annual savings reported below of £14.264m recognise the real risks related to contract QIPP the CCG is developing and delivering with providers and around delivery of estimated savings for other schemes.

QIPP Programme Summary	Number of Schemes				Savings - risk adjusted (£000's)			
	Previous	Current	Variance	Trend	Previous	Current	Variance	Trend
Opportunity / Scoping	NA	19	NA	NA	NA	0	NA	NA
Planning / Design / Approval	NA	9	NA	NA	NA	106	NA	NA
Live	NA	9	NA	NA	NA	1,170	NA	NA
Savings Delivery	NA	15	NA	NA	NA	12,988	NA	NA
Closed	NA	9	NA	NA	NA	0	NA	NA
Total		61				14,264		

QIPP savings movement (£000's)

Previous position		Current position
£0		£748

Movement	
Value Based Commissioning excl MSK	102
MSK services	242
Complex Care (3 schemes)	262
Prescribing (7 schemes)	27
RJAH contract (2 schemes)	6
ShropComm contract	109
Total movement since last report	748

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *All QIPP schemes must confirm that there is no negative impact on healthcare and are subject to the full range of impact assessments including clinical quality.*	Yes
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *Each QIPP scheme must have a clinical lead identified.*	Yes
3	Objective 3 - Achieve Financial sustainability for future investment *The QIPP programme is essential to the CCG's successful delivery of the 2017/18 financial targets agreed with NHS England.*	Yes
4	Objective 4 - Visible leadership of the local health economy through behaviour and action *QIPP schemes cannot be delivered by the CCG in isolation. Schemes are required to identify stakeholders and the engagement necessary for successful delivery. Scheme implantation plans will reflect this and be monitored during the year to ensure delivery. Transformational schemes align with the work being undertaken across the county by health and social partners to deliver the Shropshire and telford and Wrekin Sustainability and Transformation Plan.*	Yes
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *The QIPP programme and governance around it provide the opportunity for both clinical and managerial development.*	Yes
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *The two main risks are timetable slippage and lower efficiency savings than forecast. The current schemes are being reviewed for potential stretch and new initiatives identified to mitigate both these risks.*	
2	Additional staffing or financial resource implications *All resource implications are identified by QIPP schemes and taken into account in performance reporting.*	Yes
3	Health inequalities *All schemes are required to undertake a full range of impact assessments which address this issue.*	Yes

4	Human Rights, equality and diversity requirements *All schemes are required to undertake a full range of impact assessments which address this issue.*	Yes
5	Clinical engagement *Clinical Leads for all schemes and reports to the Clinical Commissioning Committee.*	Yes
6	Patient and public engagement *Identifed as requirement for all schemes and the QIPP programme is fully supported by the CCG's Communications and Engagement Team as active contributors.*	Yes

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.111
Shropshire CCG Governing Body Meeting: 7 June 2017

Title of the report:	Settings of Care Policy
Responsible Director:	Barbara Beal – Interim Director of Nursing
Author of the report:	Nikki Diamond - Clinical lead Complex Care Team
Presenter:	Sara Bailey - Lead Nurse Quality & Patient Safety

Purpose of the report:

To present the final draft Setting of Care Policy to the CCG Governing Body and review and approval

Key issues or points to note:

The Settings of Care policy has been developed to provide clarity on what Shropshire CCG is and is not able to fund in relation to complex care.

This Policy has been reviewed by the CCG's adults and children's safeguarding leads as well as by the CCG's Clinical Commissioning Committee and the CCG's Solicitors.

The Board is asked to approve this policy and to note that following approval the policy will be formatted to comply with Shropshire CCG's standard policy template.

Actions required by the Governing Body:

The Governing Body is asked to:

- Approve the Setting's of Care Policy
- Note the once approved the policy will be formatted to comply with Shropshire CCG's standard policy format

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *please provide details relating to objective 1*	
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *please provide details relating to objective 2*	
3	Objective 3 - Achieve Financial sustainability for future investment *please provide details relating to objective 3*	
4	Objective 4 - Visible leadership of the local health economy through behaviour and action *please provide details relating to objective 4*	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *please provide details relating to objective 5*	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *Provide a summary of the risks and any mitigating actions, any legal implications etc*	
2	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	
3	Health inequalities *If yes, please provide details of the effect upon health inequalities*	
4	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	
5	Clinical engagement *If yes, please provide details of the clinical engagement*	
6	Patient and public engagement *If yes, please provide details of the patient and public engagement*	

Shropshire Clinical Commissioning Group

Settings of Care Policy

NHS Continuing Healthcare and Personal Health Budgets

Contents

1 Introduction

This policy describes the way in which the Shropshire Clinical Commissioning Group (CCG) will plan and commission services for people who have been assessed as eligible for an episode of fully funded NHS Continuing Healthcare (CHC) or agree the level of a Personal Health Budget (PHB), if this is an appropriate alternative.

CHC is a package of care (PoC) or placement arranged and funded solely by the NHS for a person aged 18 and over to meet physical and/or mental health needs which have arisen as a result of disability, accident or illness. A Personal Health Budget (PHB) is an amount of money to support an individual's identified care and support needs, planned and agreed between the individual, or their representative and the local NHS team.

The CCG has developed this policy to help inform a common and shared understanding of CCG commitments in relation to individual choice and resource allocation.

As per the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (revised November 2012), the process of assessment and decision-making should be person-centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning process. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into account, along with the risks of different types of provision and fairness of access to resources that are **available**.

The CCG's responsibility for commissioning CHC services derives ultimately from s3 National Health Service Act 2006. This places a duty on the CCG to arrange for the provision, to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it is responsible, of:

- [non-hospital] accommodation for the purpose of any service provided under the Act;
- medical and nursing services; and
- such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as it considers are appropriate as part of the health service.

The CCG is also under a statutory duty to break even financially (s223H).

Accordingly, while the CCG will endeavour to respect the individual's preferences in commissioning CHC services, the CCG is obliged to take into account the cost of services, as well as the clinical risks inherent therein, when planning how to meet assessed needs and making an offer of a package of such services, in order to ensure that the best use is made of the limited resources **available**.

The CCG will commission care to meet clinically assessed care need in an appropriate way. These packages of care are also subject to a cost-effectiveness test, in the same way as all other NHS services are. In deciding what an appropriate PoC is for eligible individuals, the CCG has a statutory duty to consider the overall resource **available** to them to provide services to all the patients for whom they are responsible. In coming to a decision on the PoC for a particular individual, the CCG needs to ensure they are commissioning clinically appropriate and sustainable care within the

available financial envelope, so ensuring that a high quality service is delivered while financial governance is maintained.

It is recognised that a PoC in an individual's own home, or alternative forms of supported living, are often bespoke in nature and thus can often be considerably more costly than the delivery of an equivalent PoC for an individual in an alternative setting (e.g. a care home). The CCG is obliged to seek to balance the realisation of patient choice with the need to work within the financial allocations provided. This policy seeks to assist the CCG to do this in a rational and practical manner.

2 Scope

This policy applies to:

- all CCG staff who are required to make decisions about the packages of care for individuals that are eligible for an episode of fully funded NHS CHC or a PHB
- any staff across the health economy who are contracted to determine eligibility or broker placements under the terms of the NHS national standard contract or a service level agreement
- all adults aged 18 years and over who are eligible for funding of an episode of fully funded NHS CHC or a PHB
- individuals and/or their representative(s) who request a PoC that could be provided in a more cost-effective alternative setting and still meet the individual's clinically assessed care needs in a clinically safe and appropriate manner.

3 Purpose, Aims and Principles

3.1 The Purpose

The purpose of this policy is to:

- define how and when the CCG will support choice of care setting in relation to clinically appropriate packages of care for individuals within the **available** financial envelope and ensure that care is provided equitably across the CCG's patient population
- ensure that the clinically assessed care needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of care to this population regardless of, for example but not limited to, the person's age, condition or disability.

The intentions of this policy are to:

- inform robust, fair and consistent commissioning decisions and their application by the CCG
- ensure that there is consistency in the local area in the packages of care that individuals are offered
- ensure the CCG achieves value for money in the purchasing of packages of care for individuals
- facilitate effective partnership working between healthcare providers, NHS bodies and the Local Authorities (LAs) in the area
- promote individual choice as far as is reasonably possible in the context of the CCG being a public body with finite resources.

3.2 The Aims

This policy aims to assist the CCG to:

- provide guidance for those staff who are designing the PoC with the eligible individual, so that all parties understand that the cost of the POC provided must be proportionate for similar levels of care need regardless of the setting in which the PoC is provided, whilst meeting all of the individual's clinically assessed and eligible health and associated social care needs
- take account of the wishes expressed by individuals and their representatives when making decisions as to the settings of packages of care to be offered
- promote the individual's independence and support individuals to take reasonable risks whilst ensuring that care provided is clinically safe, including through the use of a PHB, taking into consideration the factors set out below:

    - the individual's safety
    - the individual's choice and preference
    - ensuring services are of sufficient quality
    - the individual's right to respect for their personal family and private life, free from unwarranted state interference
    - ensuring services are culturally sensitive
    - ensuring services are personalised to meet individual clinically assessed care need
    - best use of resources for the population of the CCG.

- make decisions about a clinically appropriate PoC in a fair and cost-effective way, within the **available** financial envelope
- understand the CCG's legal responsibilities in commissioning a PoC that meets the clinically assessed care needs of the individual
- meet the responsibilities set out in the law and guidance listed in Appendix B

3.3 The Principles

The principles of this policy are:

a. The CCG understands that many individuals with complex medical conditions wish to remain in their own homes and to continue to live with their families/those important to them with a PoC to aid them to do this.
b. Similarly, the CCG accepts that many individuals might prefer other care options including other forms of supported living or registered care homes.
c. Where an individual or their family/those important to them expresses such a wish, the CCG will investigate whether it is clinically feasible to provide a sustainable PoC for the individual that is consistent with their preferences.
d. The CCG needs to act fairly to balance the resources spent on an individual patient with those **available** to fund services to other patients and the wider health economy.
e. In an attempt to balance the different interests (**available** resources vs meeting the desire for bespoke services at home or in an alternative setting), the CCG is prepared to support a clinically sustainable PoC which keeps an individual in their preferred setting of care, where

the anticipated cost to the CCG is not more than 25% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting. This 25% financial threshold limit will be applied consistently to every PoC by the CCG unless exceptional circumstances apply as defined in section 12 below.

f. Where an individual lacks capacity and a best interest decision has to be made, it will be made in accordance with the financial threshold limit outlined in (e) above.
g. Exceptionality as identified in the policy will be determined on a case by case basis.

4 Mental Capacity and Representation

Where there is reason to believe that an individual may lack the capacity to make a decision relating to the provision of (or change to) their PoC and/or accommodation, a Mental Capacity Assessment (MCA) must be undertaken. If the assessment confirms that the individual lacks the relevant capacity, a 'best interest decision' should be undertaken in accordance with the Mental Capacity Act 2005 and the related Code of Practice. Where appropriate, the CCG will appoint an Independent Mental Capacity Advocate (IMCA) to support the individual in decision making in accordance with the 2005 Act.

In some circumstances in advance of losing capacity, the individual may have given another person formal authority to make a decision on their behalf once capacity is lost. Where the CCG is made aware of this, and a best interest decision is required in respect of an offered PoC, it will ask to see the original or a certified copy of one of the following documents:

- A Lasting Power of Attorney which has been registered with the Office of the Public Guardian. This could be a Health and Welfare Lasting Power of Attorney and/or a Property and Financial Affairs Lasting Power of Attorney depending on the circumstances under discussion.
- An Enduring Power of Attorney which has been registered with the Office of the Public Guardian.
- An order of the Court of Protection appointing the representative as Deputy and the order enables them to decide on the PoC or accommodation of the individual.
- An order from the Court of Protection, in respect of the PoC or accommodation of the individual.

Where one of the above documents is provided to the CCG, it will decide how to involve the bearer in any best interest decisions. The CCG will make this decision in accordance with the Mental Capacity Act Code of Practice referenced in Appendix B.

5 Equality, inclusion and human rights

5.1 Equality commitment statement

NHS Shropshire CCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, seeking to ensure that none are placed at a disadvantage by comparison with others. We take into account current statutory duties, including those enshrined in the Equality Act 2010 and the Human Rights Act 1998, and we promote equal opportunities for all.

This document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances i.e. their age, disability, sex (gender), gender identity or reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and

maternity. This has been considered in the purpose of this policy which includes ensuring that the clinically assessed care needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of that care regardless of, for example but not limited to, the person's age, condition or disability (section 3, page 4).

5.2 Public Sector Equality Duty

This policy has been reviewed in relation to compliance with the Public Sector Equality Duty (PSED) set out in the Equality Act 2010, to have due regard to the need to eliminate discrimination, harassment, victimisation and other prohibited conduct; to advance equality of opportunity; and to foster good relations between those who share a relevant protected characteristic and those who do not.

The protected characteristics of individuals will be considered in the application of this policy with packages of care seeking to minimise potential disadvantages suffered by eligible individuals due to their protected characteristics and encouraging eligible individuals with protected characteristics to participate in public life wherever possible.

The National Constitutional duty for the CCG to respect Human Rights for every individual has been considered in this policy as below:

- The principles of this policy includes the CCG understanding that many individuals with complex medical conditions wish to remain in their own homes and to continue to live with their families/those important to them with a PoC to aid them to do this (section 3, page 4).

5.3 Reasonability

The CCG may consider commissioning on a case by case basis, via a specific purchase, for an individual to be located near specific places in the local community and/or in a place that enables family/those important to them to visit reasonably. This might be a relevant consideration where the CCG's preferred **available** care homes are not within a reasonable travelling distance. This may enable the individual to be accommodated in their preferred area despite the fact that the anticipated cost to the CCG may be up to 25% more than the **available** CCG-preferred accommodation (based on CCG agreed standard rates for equivalent levels of care need). Such requests must be guided by the factors set out in section 12 of this policy. The individual must also understand that where such an arrangement has been agreed this arrangement will be subject to regular review and may change (section 6.1.1, page 8).

6. Identification of Care Provision

Where an individual is eligible for an episode of fully funded NHS CHC, the CCG will commission the PoC that meets the individual's clinically assessed care needs. In other words, the CCG will fund a PoC that is needed to meet the individual's care requirements. This may or may not be in the individual's preferred setting of care.

6.1 The role of the CCG

The CCG must:

- take account of the wishes expressed by individuals and their representative(s) when making decisions as to the setting of care to be offered to individuals
- seek to take into account any reasonable request from the individual and/or their representative(s) in making the decision about the PoC, subject to the factors set out in sections 3 and 12 of this policy
- endeavour to offer a reasonable choice of **available**, preferred providers to the individual
- where the individual wishes to receive their care from an alternative provider, the CCG will consider this preference, subject to it satisfying the following criteria:

    - the individual's preferred care setting is considered by the CCG to be suitable in relation to the individual's care needs as assessed by the CCG
    - the cost of making arrangements for the individual at their preferred care setting would not require the CCG to pay more than they would usually expect to pay having regard to the individual's clinically assessed care needs (and having regard to the average cost of the packages of care offered by the CCG and rejected by the individual)
    - the individual's preferred care setting is **available**
    - The preferred care setting is able to provide the required care to the individual subject to the CCG's usual terms and conditions, having regard to the nature of the care setting for such an individual in receipt of an episode of fully funded NHS CHC.

6.1.1 The CCG and Registered Care Settings

Where care is to be provided in a registered care setting (i.e. one that provides accommodation, such as a nursing home, residential home and some supported living schemes), the CCG will only place individuals with providers which are:

a. registered with the Care Quality Commission (CQC) or any successor - body as providing the appropriate form of care to meet the individual's clinically assessed care needs; and
b. not subject to an embargo by the CCG or LA, including the host CCG or LA if the provider is not located in Shropshire
c. contracted to the CCG to provide nursing care at the standard rate. (Note: Contracted providers are also eligible for the Commissioning for Quality and Innovation [CQUIN] quality premium, subject to achieving the required quality standards);
d. contracted to the CCG to provide care at an enhanced rate, where the CCG determines that enhanced care is required.

The CCG must:

- consider providing a placement in a registered care setting not contracted to the CCG in exceptional circumstances. This will only be approved when the provider complies with paragraphs **a.** and **b.** above.
- approve requests for a preferred setting of care, where reasonably possible, provided that the criteria set out at sections 3 and 12 of this policy are satisfied.
- where a care home that was not originally offered is requested by the individual, consider accepting the individual's preferred setting of care providing it complies with the criteria set out in sections 6.1 and 12 of this policy.
- consider commissioning on a case by case basis, via a specific purchase, for an individual to be located near specific places in the local community and/or in a place that enables family/those important to them to visit easily. This might be a relevant consideration

where the CCG's preferred **available** care homes are not within a reasonable travelling distance [1]. This would enable the individual to be accommodated in their preferred area despite the fact that the anticipated cost to the CCG may be up to 25% more than the **available** CCG-preferred accommodation (based on CCG agreed standard rates for equivalent levels of care need). Such requests must be guided by the factors set out in section 12 of this policy. The individual must also understand that where such an arrangement has been agreed this arrangement will be subject to regular review and may change.

- bear in mind that if an individual or their representative(s) exercise individual choice and prefer a care home in another area, the CCG must consider placing the individual there, subject to the factors in sections 3, 6.1 and 12.

[1] Reasonable travelling distance will be based on a case by case assessment of an individual's circumstances, and must take into account factors such as ability of family/those important to the individual to visit, which may include consideration of public transport links and mobility of the family/those important to the individual in question.

6.1.2 The CCG and preferred provider placements

To assist the CCG in achieving consistent, equitable packages of care, the CCG will endeavour to offer and place individuals with preferred providers. These are those providers that have undergone a procurement exercise with the CCG.

Where a preferred provider is not **available** to meet the individual's clinically assessed care needs, the CCG may make a specific purchase and place the individual with another care provider who meets the individual's care needs. Where such an arrangement has been agreed the CCG reserves the right to move the individual to a suitable preferred provider when capacity becomes **available**, where this will provide better value for money to the CCG. For example, if an individual has a specific care need which cannot be met in the **available** preferred accommodation, the CCG will need to specifically commission accommodation for the individual, potentially through an individually negotiated agreement. The CCG should notify the individual and/or their representative that they may be moved should a suitable preferred provider subsequently have capacity. In such circumstances, the CCG will give a minimum of 28 days' notice to the individual.

Though all reasonable requests from individuals and their representative(s) will be considered, the CCG is not obliged to accept requests from individuals for specific care providers which have not been classed as preferred providers.

Where the CCG deems that a provider is not providing care of an acceptable standard, the CCG reserves the right to move the individual to an alternative provider.

The CCG contracts with different providers to meet the care needs of different service users. Where an individual's assessed care needs change, the CCG may offer a PoC with a different provider. In such circumstances, the CCG will give a minimum of 28 days' notice to the individual.

6.1.3 The CCG and domiciliary care providers

The CCG acknowledges that:

- the provision of domiciliary care for an individual requiring care across the 24 hour period is likely to be more costly than care provided to that same individual in a residential or nursing home placement.
- many individuals with complex healthcare needs wish to remain in their own homes, with support provided in that setting. Where an individual or their

representative(s) express such a desire, the CCG will investigate to determine whether providing a PoC in the home is clinically and financially sustainable.

- However, before it will commission such a PoC, the anticipated cost to the CCG must not be more than 25% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting unless exceptional circumstances apply as defined in section 12 below.
- where the CCG decides to offer domiciliary care to an individual, the individual's home becomes the care providers' place of work. Employee safety is an important consideration in domiciliary packages of care. The individual's home must be a reasonably safe environment in which to work and deliver care to the individual. The cleanliness of the environment, and the nature of interactions between the individual, family/those important to them/carer and the employee are just two examples of factors to be taken into account in considering whether the setting is safe or not.

Where domiciliary care is to be provided, the CCG will:

- benchmark the cost of a PoC against the cost of a suitable PoC in a registered care setting that will meet the clinically assessed care needs of the individual
- when an individual expresses the preference to receive care at home, consider the cost of domiciliary care provision at no more than 25% above the benchmark of the anticipated cost of the provision of a broadly similar PoC in an appropriate registered care setting
- ask family members/those important to the individual if they are willing and able to supplement support and, if they agree, the CCG will assume that family members/those important to the individual will provide the agreed level of support when designing any domiciliary care package. However, no pressure should be applied on them to offer such support as family members/those important to the individual are under no legal obligation to offer care

Please note that, due to the clinical risk of providing the following level of care in a home setting, it should be presumed that this should not be delivered in an individual's own home:

- 24 hour care from a registered nurse. This clinical need would normally be provided for by placement in a nursing home
- hospital-level care. This clinical need would normally be provided within a specialist unit

6.1.4 The CCG and preferred providers

Though all reasonable requests from individuals and their representative(s) will be considered, the CCG is not obliged to accept requests from individuals for specific care providers which have not been classed as preferred providers.

Where the CCG deems that a provider is not providing care of an acceptable standard, the CCG reserves the right to move the individual to an alternative provider.

The CCG contracts with different providers to meet the assessed care needs of different individuals. Where an individual's needs change, the CCG may offer a PoC with a different provider.

6.2 The CCG and Personal Health Budgets

Since October 2014, all individuals eligible for CHC and children eligible for Continuing Care have had a "Right to Have" a PHB, save to the extent that this is not appropriate or is otherwise precluded by the statutory framework.

Where the CCG decides to offer an individual a PHB, it will benchmark the cost of such a PoC against alternative packages of care.

A PHB may be provided to an individual in a registered or a non-registered setting of care. It may cover all or part of the care needed by the individual. It may only be used to pay for care agreed by the CCG in the care/support plan.

The requirements for PHBs are laid down in the CCG's PHB Policy:

6.3 The role of the Care Co-ordinator

The individual's Care Coordinator will effect the following:

- discussion of the proposed PoC with the individual and their representative(s) (where the individual gives consent for such a discussion, or where the individual lacks capacity and the representative is properly appointed or can provide information to feed into a best interest decision) including how and where the care and support may be provided.
- identification of different options for packages of care and securing an indication as to which PoC and/or setting of care is preferred by the individual.
- preparation of a written care plan that must clearly identify and articulate the clinical outcomes that the individual wishes to achieve and what actions need to take place to seek to enable those health improvements to be realised.
- using an agreed NHS Funding Request Form, set out the details of the requested PoC and any associated information. The form must be completed in full for every proposed PoC.

7 Availability of care provision

To enable individuals to *receive* the correct PoC promptly, they must be *offered* care as soon as possible. If an individual's first choice from the CCG's preferred provider range is not **available**, they will be offered another CCG preferred provider to ensure provision as soon as possible. The CCG will offer packages of care from preferred providers before any others, unless exceptional circumstances apply as detailed in section 12 below.

If the individual requests a setting of care that is currently unavailable and/or is unwilling to accept the CCG's offer of a PoC, there are several options available to the CCG:

- Temporary placement of the individual with an alternative care provider until the CCG's preferred provider is available. For example, an alternative home care provider, alternative care home, respite care or a community bed
- The individual may choose to go to their own or a relative's home without the assessed PoC until the preferred setting/care provider is available. The terms set out in section 9 of this policy will apply. The individual will, however, retain the right subsequently to change their mind and accept the PoC offered by the CCG. If the individual does not

have mental capacity to make this decision, the CCG will exercise its duties under the Mental Capacity Act 2005 to ensure that a `best interests' decision is made.

- If it has been agreed with the individual that the clinically assessed care needs can best be met through a care home placement, the CCG may choose to provide home care until the preferred care home is available, but cost implications to the CCG must be considered when identifying the level of a PoC to be provided. This will be in accordance with sections 3 and 12 of this policy.

Where the CCG provides an individual with a PoC that is more expensive than the standard cost due to, either unavailability in the market, or the inability of the CCG to commission at the standard cost, the additional cost will be funded by the CCG.

Where such an arrangement has been agreed, the CCG reserves the right to move the individual to a suitable preferred provider when one becomes available where this will provide better value for money to the CCG. The CCG must notify the individual, and/or their representative(s), that their provision may be moved should a preferred provider subsequently have capacity. In such circumstances, the CCG will give a minimum of 28 days' notice to the individual.

If an individual's representative(s) are delaying placement in a care home due to non-availability of a preferred care home provider, and the individual does not have the mental capacity to make a decision themselves, the CCG will have recourse to the Adult Safeguarding Policy, local safeguarding procedures and the Mental Capacity Act 2005, as appropriate.

If the individual is in an acute healthcare setting, they must move to the most appropriate setting of care as soon as they are medically fit for discharge, even if their preferred setting/care provider is not available. The individual's preference must be considered in line with sections 3 and 12 of this policy, when the CCG is deciding which PoC to offer to them. Where the individual's preferred setting is not **available**, but an alternative setting that will meet their clinically assessed care needs is available, they must move and cannot remain in an acute healthcare setting once they are medically stable.

8 Acceptance of care provision

An individual is not obliged to accept an episode of fully funded NHS CHC. Once an individual is eligible and offered a PoC and they choose not to accept this, the CCG must (in appropriate cases) take reasonable steps to make the individual aware that the LA does not assume responsibility to provide care to the individual. The CCG will work with the individual to help them understand their **available** options and facilitate access to appropriate advocacy support. As appropriate, the CCG will have recourse to the Adult Safeguarding Policy, local safeguarding procedures and the Mental Capacity Act 2005.

9 Withdrawal of care provision

The NHS discharges its duty to individuals by making an offer of a suitable PoC to individuals whether they choose to accept the offer or not. The following are examples of how this can work in practice:

- The CCG offers to discharge its duty by providing a PoC for an individual in one or more appropriate care settings, irrespective of whether this is the individual's preferred setting, and that offer is rejected by the individual.
- The CCG offers to discharge its duty to an individual who, to date, has had a PoC in their own home by moving the individual to one or more appropriate care homes (since the

costs of providing such care may be significantly less than providing care for an isolated individual in their own home) but that offer of a care home is rejected by the individual.

Either of the above circumstances may lead to a decision to withdraw services from the individual. The CCG will have recourse to the Adult Safeguarding Policy, local safeguarding procedures and the Mental Capacity Act, as appropriate.

Where an individual exercises their right to refuse, the CCG will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of a PoC.

It may be appropriate for the CCG to withdraw a PoC where the situation presents a risk of danger or violence to, or harassment of, the care staff who are delivering the PoC.

The CCG may also withdraw a PoC where the clinical risks become too high. This can be identified through, or independently of, the review process. Where the clinical risk has become too high in a home setting, the CCG may choose to offer a PoC in a care home setting.

10 Disputes

An individual may dispute a decision by the CCG in relation the PoC offered. Such disputes will be dealt with through the CCG's complaints procedure. If the complaint cannot be resolved locally the individual or their representative can apply to the Health Service Ombudsman.

NHS Shropshire CCG:
William Farr House
Mytton Oak Road
Shrewsbury
SY3 8XL

11 Continuing Healthcare review

A case review should be undertaken no later than three months after the initial eligibility decision, in order to reassess the individual's care needs and eligibility for an episode of fully funded NHS CHC, and to ensure that the individual's clinically assessed care needs are being met. Reviews should take place annually thereafter, as a minimum. The CHC review may identify an adjusted, decreased or increased care need.

If the review demonstrates that the individual's condition has improved to an extent that they no longer meet the eligibility criteria for CHC, the CCG is obliged to cease funding, whether the PoC is delivered in a home or care home setting. In these circumstances, the individual will be informed and where appropriate the Local Authority (LA) will also be informed.

Where an individual remains eligible and is receiving a PoC in their home setting, the CCG will consider the ability of the PoC to be delivered in the home setting, and also the cost effectiveness of this PoC in accordance with sections 3 and 12 of this policy.
Where the individual remains eligible and is accommodated in a care home setting, the CCG will ensure that the care home is able and suitable to deliver this adjusted or decreased care need.

Where the care home is unable to meet this adjusted care need, the CCG will accommodate the individual in accordance with sections 3 and 12 of this policy.

Where there is a decreased care need, the CCG will consider the cost effectiveness of the PoC to be delivered in the current care home setting, and may move the individual to a suitable alternative care provider in accordance with sections 3 and 12 of this policy. In such circumstances, the CCG will give a minimum of 28 days' notice to the individual.

12 Exceptional Circumstances

The CCG is required to achieve financial balance each year. Alongside this, it aims to support a clinically sustainable PoC funded by the NHS which keeps an individual in their preferred setting of care, where the anticipated cost to the CCG is not more than 25% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting.

However, the CCG's policy is that the High Risk and Complex Care Panel should consider requests for CHC funding where the anticipated cost to the CCG is more than 25% above the cost of a broadly similar PoC to be delivered in an alternative setting.

12.1 Exceptional circumstances criteria

In exceptional circumstances, the CCG will be prepared to consider funding provision where the anticipated cost to the CCG is more than 25% above the cost of a broadly similar PoC to be delivered in an alternative setting. Exceptional circumstances will be considered on a case by case basis.

13 Fast track applications

Care provision for individuals assessed using the Fast Track Pathway Tool for NHS CHC will be subject to the same principles as set out in sections 3 and 12 of this policy.

14 Complex Care Panel

Following agreement that an individual meets the eligibility criteria for CHC and/or a PHB and a PoC has been identified that addresses part or all of an ongoing care plan, cases may be referred to the CCG's Complex Care Panel to consider requests for NHS funding. The panel considers:

- a specific PoC
- correct application of the Settings of Care Policy
- the risks inherent in the design of the proposed support/care plan for service users taking up a PHB

The panel has two distinct functions to consider:

i. risk associated with care plans
ii. complex care placements and their cost effectiveness

Appendix A – Definitions

Accommodation: In the context of CHC, accommodation relates to an appropriately registered care setting, supported living setting or the individual's own home.

Care Co-ordinator: The person who coordinates the assessment and care planning process. Care Co-ordinators are usually the central point of contact with the individual.

Care provision: Care provision takes two main forms:

- Care provided in an individual's own home and referred to in this document as 'home-care' or 'domiciliary care'.
- Care provided in an appropriately registered care setting (such as a nursing home or a residential home) and referred to in this document as 'registered care setting' or 'care home'.

CHC: CHC is used in this policy as an abbreviation for NHS Continuing Healthcare which is a package of care arranged and funded solely by the NHS for a person aged 18 and over to meet physical or mental health care needs which have arisen as a result of disability, accident or illness.

Individual: In the context of this policy the individual is the service user that has been assessed and found eligible for CHC.

Personal Health Budget; an amount of money to support identified care and support needs, planned and agreed between an individual or their representative, and the local NHS team.

Representative(s): Representative(s) refers to the person(s) whom it is appropriate for the CCG to consult about and involve in decisions about the provision of CHC/PHB to the individual. The individual receiving healthcare may elect to have representative(s) act with them or on their behalf, or there may be representative(s), formally or informally appointed or chosen, where the individual does not have the mental capacity to make independent decisions relating to the CHC eligibility process or the proposed package of care.

Representatives may be legal representatives, individual advocates, family/those important to the individual, or other people who are interested in the individual's wellbeing.

Where the individual has capacity, they must give consent for any representative to act on their behalf.

A person who has formally been appointed as an Attorney or Deputy has defined responsibilities for the individual. The extent of these responsibilities will vary according to the nature of their appointment.

Local Authority: Local Authority refers to Shropshire Council.

CCG: CCG refers to NHS Shropshire Clinical Commissioning Group.

Provider: Provider refers to the organisation that provides a package of care to the individual.

Preferred providers: These providers have been assessed and accepted onto the Any Qualified Provider framework by the CCG as being able to fulfil the CHC requirements of defined categories of individuals at an agreed cost.

Appendix B – Legal Sources

- Human Rights Act 1998
- Mental Capacity Act 2005 Code of Practice
- National Health Service Income Generation - Best practice: Revised guidance on income generation in the NHS (1 February 2006)
- National Health Service Act 2006 (as amended)
- Guidance on NHS patients who wish to pay for additional private care (May 2009)
- Equality Act 2010
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended)
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (revised)
- Who Pays? Determining responsibility for payments to providers (August 2013)
- Care Act 2014
- NHS Constitution for England 2015

Appendix C – Links to References

- Fast-Track Tool – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213143/NHS-CHC-Fast-Track-Pathway-tool-FINAL.doc

- CHC Framework – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

- Safeguarding Adults Policy – *link to be inserted here*

- PHB Policy – *link to be inserted here*

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.112
Shropshire CCG Governing Body Part 1 meeting: 7 June 2017

Title of the report:	MSK Update
Responsible Director:	Michael Whitworth, interim Director of Contracting & Planning
Author of the report:	Michael Whitworth, interim Director of Contracting & Planning
Presenter:	Michael Whitworth, interim Director of Contracting & Planning

Purpose of the report:
To provide the Governing Body with an update on the MSK transformation QIPP programme.

Key issues or points to note:
2017/18
Two main initiatives:

- Value based commissioning
  - Plan £2.9m, latest forecast £3m
  - Opportunity assessment validated by CCG using national data and externally by Deloitte
  - Referral and underlying intervention rates falling (waiting list backlog reductions have been factored into the plan)
- SOOS – enhanced service model and geographic expansion in second half of the year
  - Plan £1.2m, latest forecast £1.2m
  - Collaborative working with RJAH (clinical meeting to progress enhanced service specification and expansion plan 08/06/17)
  - Significant increase in the proportion of RJAH referrals are being assessed by SOOS

2018/19
Introduction of new community based specialist MSK service

- Project group to be initiated in June 2017 (to include Locality and patient representatives)
- Work is currently being undertaken to review existing and future physiotherapy and (allied services) provision
- Current preferred direction of travel is for a prime provider / accountable care organization – the expectation is that a recommendation will be presented to the September Governing Body

Actions required by Governing Body Members:
To receive and note the content of this report.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.113
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Midwife Led Unit (MLU) service review – update for information
Responsible Director:	Barbara Beal – Director of Nursing
Author of the report:	Fiona Ellis – Commissioning and Redesign Lead, Women and Children
Presenter:	Dr Jessica Sokolov

Purpose of the report:

The purpose of this report is to inform Governing Body of the current position in relation to the Shropshire CCG Service Review of Midwife Led Units in Shropshire, Telford and Wrekin.

Key issues or points to note:

Key issues or points to note:

- Shropshire CCG is leading a service review which focuses on the five Midwife led Units in Shropshire and their relationship to the Community Hubs in Whitchurch and Market Drayton. This review will consider outcomes for patients, safety, quality, staffing, cost and value for money.

- A broad range of information is currently being analysed in order to better understand the needs of women and their families living in Shropshire, Telford and Wrekin and the current choices made and pathways experienced in relation to midwifery-led units. Due to delays in receiving the required activity and finance information, the agreed timescales are at risk of not being met

- In order to address the significant public concern in relation to the MLU review, the MLU review Programme Board are considering how to best assure the public that the review is evidence based and that any changes in service design will have been informed by robust analysis and engagement. Two options are being considered:
  - appointment of an independent midwife to support the service review
  - appointment of an impartial agency to facilitate engagement/co-production activity with women and their families.

Actions required by Governing Body Members:

- To note the action being taken and concerns raised jointly by Shropshire CCG and Telford and Wrekin CCG on the proposed transitional midwifery workforce proposal put forward by SaTH

Shropshire, Telford and Wrekin Midwife-Led Units (MLU) Service Review Update Report

1. Background

1.1. Shropshire currently has five Midwife Led Units (MLUs) in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Telford. These units are supported by two Community Hubs at Market Drayton and Whitchurch and a Consultant led unit at Princess Royal Hospital in Telford. Shropshire is unique nationally in having this number of MLUs for the size of the population.

1.2. The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for the Consultant Unit, community care, postnatal inpatient care for high and low risk cases as well as low risk births. Over the past three years deliveries within the MLUs have declined.

1.3. Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and Shropshire Clinical Commissioning Group (CCG) has responded to this concern by initiating a comprehensive service review to be undertaken jointly with Telford & Wrekin CCG.

1.4. Shropshire CCG are leading a service review which focuses on the five Midwife led Units in Shropshire and their relationship to the Community Hubs in Whitchurch and Market Drayton. This review will consider, outcomes for patients, safety, quality, staffing, cost and value for money.

1.5. The Service Review will deliver a recommendation to the Shropshire CCG Board for a sustainable future model for the provision of Maternity Led Units in Shropshire which provides the best outcomes for the population based on the evidence it has gathered.

1.6. This report provides an update in relation to the Midwife Led Unit service review.

2. Current Position

2.1. The review is currently in Phase 1. This phase consists of information gathering and review, benchmarking, activity and finance review, stakeholder input and public and patient engagement. Due to Purdah, no public engagement has taken place to date. However, a patient representative has been appointed to the Programme Board and is well engaged in the review.

2.2. A wealth of data has been collated from a range of sources, including NHS England, Shrewsbury and Telford Hospitals NHS Trust, Shropshire Public Health and Healthwatch. This information is currently being analysed in order to better understand the needs of women and their families living in Shropshire, Telford and Wrekin and the current choices made and pathways experienced in relation to midwifery-led units.

2.3. Due to delays in receiving the required activity and finance information in order to undertake the information analysis element of the review, the agreed timescales are at risk of not being met.

2.4. There is currently significant public concern in relation to the MLU review. The MLU review Programme Board are therefore considering how to best assure the public that the review is evidence based and that any changes in service design will have been

informed by robust analysis and engagement. Two options which the MLU review Programme Board are currently seeking to secure in order to provide greater assurance around this are the appointment of an independent midwife to support the service review and the appointment of an impartial agency to facilitate engagement/co-production activity with women and their family

2.5. Members of the Board may have seen that SaTH have moved to introduce an, 'adapted midwifery model of staffing to enable, as the Trust have described, 'the midwives attending MLU births as an on-call model in staffing demand, not staffing the MLU buildings, to enable the service to be maintained in a planned and systematic way and also provide prospective escalation cover for the obstetric unit' SaTH have confirmed that that this reflects a growing usage of the Consultant Led Unit and is therefore a response to this rather than a predetermination of the result of the Midwifery Led Unit Review.

3. Next steps

3.1. The needs analysis is due to be complete by 9th June with the Phase 1 report written by 23rd June 2017. It is unlikely that public and patient engagement will have been completed by 23rd June in order to produce the complete Phase 1 report. However, it is likely that the desk top analysis will be complete in time to inform the Phase 1 report.

3.2. The Director of Nursing will seek to secure independent midwife support for this review.

3.3. The Chair of the MLU Review Programme Board will seek to secure an independent organisation to facilitate patient engagement/co-production.

3.4. Following completion of Phase 1, Phase 2 can commence in relation to development of options and options appraisal.

3.5. A further phase will be required to implement the recommendations, of the service review.

4. Recommendations

4.1. That Shropshire CCG Governing Body note the content of this report.

4.2. That Shropshire CCG Governing Body advise of any further action required in relation to the MLU service review.

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1- Deliver a continually improving Healthcare and Patient Experience *The MLU service review aims to identify and implement any required improvements to the current model of service delivery.*	Yes
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *The MLU review Programme Board and associated activities include representation by a range of stakeholders including clinicians and service users.*	Yes
3	Objective 3 - Achieve Financial sustainability for future investment *One of the aims of the MLU service review is to ensure the model of delivery is financially sustainable and delivers value for money.*	Yes
4	Objective 4 - Visible leadership of the local health economy through behaviour and action *This review forms part of the Local Maternity System programme of work, which reports through to the STP.*	Yes
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *The review will consider workforce and staffing.*	Yes
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *Provide a summary of the risks and any mitigating actions, any legal implications etc*	
2	Additional staffing or financial resource implications *The review is currently being undertaken within existing resources, but consideration is being given to the appointment of an independent midwife and an independent engagement organisation to support the review.*	Yes
3	Health inequalities *The review will seek to have a positive impact on reducing health inequalities.*	Yes
4	Human Rights, equality and diversity requirements *The review will seek to have a positive impact in relation to equality and diversity.*	Yes
5	Clinical engagement *Clinical engagement is a key element of this review.*	Yes
6	Patient and public engagement *Patient and public engagement is a key element of this review.*	Yes

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.114
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Gluten Free Prescribing
Responsible Director:	Dr Julie Davies Director of Performance & Delivery
Author of the report:	Mr Sean Mackey
Presenter:	Mr Sean Mackey

Purpose of the report:

For the Governing Body to note the decision made by the Clinical Commissioning Committee in May 17 regards to the discontinuation of Gluten free products on NHS prescriptions within Shropshire CCG.

Key issues or points to note:

- Prescribing gluten-free products costs the NHS in SCCG around £120,000 a year.
- A national consultation by the Department of Health (5) is due to be completed by the 22nd June 17 with a view to actions to be taken around 18 months from now.
- According to the recent DOH Impact assessment: There is no effect on adherence to GF diets for patients diagnosed with gluten sensitivity enteropathies. Where an effect on adherence is considered (in sensitivity analysis and low estimate) the assumed cost effectiveness of GF food is £25k/QALY. Savings to the NHS are reinvested at the margin.

Actions required by Governing Body Members:

Note the contents of this paper.

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience	
	N/A	
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation)	
	Two months of patient and stakeholder engagement to inform of the Clinical Commissioning Committee decision to no longer support the prescribing of GF products on NHS prescriptions	
3	Objective 3 - Achieve Financial sustainability for future investment	
	This policy will save over £120k per annum	
4	Objective 4 - Visible leadership of the local health economy through behaviour and action	
	N/A	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity)	
	N/A	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice	
	No	
2	Additional staffing or financial resource implications	
	N/A	
3	Health inequalities	
	DOH Impact assessment: *There is no effect on adherence to GF diets for patients*	

	diagnosed with gluten sensitivity enteropathies. Where an effect on adherence is considered (in sensitivity analysis and low estimate) the assumed cost effectiveness of GF food is £25k/QALY. Savings to the NHS are reinvested at the margin.	
4	Human Rights, equality and diversity requirements *N/A*	
5	Clinical engagement *Two months of patient and stakeholder engagement to inform of the Clinical Commissioning Committee decision to no longer support the prescribing of GF products on NHS prescriptions Unanimous support for this policy when discussed at all three Loaclity Board meetings*	
6	Patient and public engagement *Two months of patient and stakeholder engagement to inform of the Clinical Commissioning Committee decision to no longer support the prescribing of GF products on NHS prescriptions*	

Review of gluten-free (GF) prescribing policy

1. Introduction

1.1 With a growing population, rising demand for services and a limited budget, Shropshire Clinical Commissioning Group (SCCG), like other NHS organisations, has to review all the services we commission to ensure that we are using NHS funds appropriately and fairly.

1.2 Due to communication from NHS Clinical Commissioning around products that should not be prescribed on the NHS, the CCG has decided to review it's policy on gluten-free products with the intention of advising GPs not to prescribe gluten-free products on NHS prescriptions.

1.3 The Clinical Commissioning Committee in May 17 decided that the CCG should no longer support the prescribing of GF products on NHS prescriptions.

2. Background

2.1 Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Dietary proteins known as glutens, which are present in wheat, barley and rye, activate an abnormal mucosal immune response. Clinical and histological improvements usually follow when gluten is excluded from the diet.

2.2 The treatment of coeliac disease is a lifelong, gluten-free diet. Specific education and information, such as advice and education on alternative foods in the diet to maintain a healthy and varied intake, may increase the likelihood of adherence and a positive prognosis.

2.3 For the past 30 years the NHS has prescribed gluten-free foods to patients who have been diagnosed with coeliac disease. This prescribing started when gluten-free foods were not as readily available as they are today.

2.4 Prescribing gluten-free products costs the NHS in SCCG around £120,000 a year. As commissioners, the CCG has a limited budget with which to deliver high quality local health services which are able to cope with the annual increase in demand for services.

2.5 Currently, patients can be prescribed gluten-free food if they have received a diagnosis of coeliac disease by an NHS professional. In SCCG, the GF prescribing policy allows patients who have received an NHS diagnosis of coeliac disease on prescription a limited number of gluten-free items per month. These standard items include: bread, fresh bread, bread mix, flour, flour mix and pasta only. Children were excluded from this policy.

2.6 NICE Guidance on coeliac disease was issued in September 2015. Whilst recommendations included as part of this guidance are not mandatory, it is recommended (2) that an annual review is offered to people with coeliac disease. This should include considering the need for assessment of diet and adherence to gluten-free diets. NICE also issued "Coeliac disease Quality Standard" in October 2016 (3).

2.7 The Health and Social Care Act 2012 sets out a clear expectation that the care system should **consider** NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality but must balance its demands within the allocated resources.

3. Engaging with patients and stakeholders

3.1 As part of our engagement activity, the CCG is speaking with:

- Coeliac UK,
- Shropshire Local Medical Committee,
- Shropshire Local Pharmacy Committee,
- Healthwatch Shropshire,
- Local dietician specialists,
- CCG's patient engagement group,
- GP Locality Boards

3.2 The purpose of this engagement will be to inform patients and stakeholders of the CCG decision.

3.3 A national consultation by the Department of Health (5) is due to be completed by the 22nd June 17 with a view to actions to be taken around 18 months from now. The documents provided within this link include a comprehensive impact assessment (IA). The IA concludes the following with regards to ending prescribing of GF foods:

There is no effect on adherence to GF diets for patients diagnosed with gluten sensitivity enteropathies. Where an effect on adherence is considered (in sensitivity analysis and low estimate) the assumed cost effectiveness of GF food is £25k/QALY. Savings to the NHS are reinvested at the margin.

3.4 If the decision by the Department of Health after the National Consultation process is to retain GF products on NHS prescriptions, then the CCG would need to reverse its decision.

4. CCGs that have stopped allowing GF products on NHS prescriptions

4.1 Many CCGs, are considering or have already gone down this route including Bath and North Somerset CCG, Norfolk CCG, and Chorley and South Ribble CCG. Links are included in the references at the end of this document.

5. Considerations

- The CCG will embark on an engagement process over the next 2 months with a deadline date of 1st August 17 for GF products to be no longer allowed on NHS prescriptions within Shropshire CCG.
- This engagement process will be to inform patients and stakeholders of the CCG decision.
- Please note the policy statement in Appendix 1.

6. References

1. www.bathandnortheastsomersetccg.nhs.uk
2. https://www.nice.org.uk/guidance/qs134
3. https://www.nice.org.uk/guidance/ng20?unlid=29225289420162417 52
4. https://www.chorleysouthribbleccg.nhs.uk/prescribing-policies
5. https://www.gov.uk/government/consultations/availability-of-gluten-free-foods-on-nhs-prescription

Appendix 1

Suggested Prescribing of Gluten Free Food Policy (4)

Shropshire CCG does not fund the prescribing of Gluten Free (GF) Food.

Summary

In developing local commissioning policies, the CCG will commission only treatments or services which accord with all of the following principles:

Appropriateness

- Effectiveness
- Cost-effectiveness
- Ethics
- Affordability

Shropshire CCG currently spend approximately £120,000 annually on the prescribing of gluten free (GF) food.

Patients with glutensensitive enteropathy, including coeliac disease, should follow a strict GF diet. Prescribing costs of GF food are expected to increase annually as increasing numbers of patients are diagnosed with gluten-sensitive enteropathy. There is also pressure on clinicians to prescribe GF foods for patients with other conditions that are not covered by NHS exemptions.

GF food is expensive when obtained via NHS prescription, and is considerably more costly than the price of purchasing GF food. GF foods are available in supermarkets with a wide variety of choice. In some supermarkets GF staple foods e.g. bread and flour are more expensive than equivalent gluten containing items. However, many coeliac patients can alter their diet to replace bread with naturally gluten-free foods e.g. rice, potato.

Policy Rationale

Shropshire CCG advise that GF will not be prescribed on NHS prescriptions. This policy will ensure equity of service for all residents of Shropshire CCGand will allow the same expectation of what will be provided from the GP Practice or other services.

This policy applies to all services contracted by or delivered by the NHS across Shropshire CCG.

Patients will be expected to purchase GF foods if required. Patients should be signposted to appropriate sources of information on maintaining a healthy gluten-free diet.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.115
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Governing Body SCCG Performance Report 2016/17
Responsible Director:	Julie Davies, Director of Performance & Delivery
Author of the report:	Julie Davies, Director of Performance & Delivery
Presenter:	Julie Davies, Director of Performance & Delivery

Purpose of the report:

To update the governing body on the CCGs performance for the full year 16/17 against the key performance indicators that the CCG is held accountable for with NHS England. This overview provides assurance on performance achievement against targets/standards at CCG and provider level as appropriate, and the delivery and contractual actions in place to address areas of poor performance.

Key issues or points to note:

The attached report sets out Shropshire CCG's performance against all its key performance indicators for 2016/17 full year.

They key standards that were not met for SCCG are :-
Cancer 2wk breast symptoms
Cancer 62day RTT
A&E 4hr target
Ambulance handovers >30mins and >1hr
>52 wk waiters
RTT

Despite the improvement in Cancer performance by our local provider SATH who achieved all the cancer performance targets in 16/17, shared breaches at tertiary centers and out of county providers have contributed to failure at the CCG level. The CCG remains committed to using all contractual levers available to improve this for 17/18.

A&E performance remains challenged but there have been signs of improvement in February, March continuing in April as key actions within the system take effect. However the ongoing workforce issues within the Trust make any improvement fragile. The CCG is raising a new contract performance notice for 17/18 for failure of delivery of A&E target. The recovery plan will be that agreed and monitored by the A&E Delivery

Board.

Given the very poor position the local system was in with regard to ambulance handovers, the system has improved the>1hr responses times at the yearend but has not been able to eliminate them. SaTH and WMAS have now drawn up an improvement plan in May and delivery against this will be monitored via the A&E Delivery Board. The CCG has made £90k of its winter monies available for corridor nurses in SATH from June –September whilst the improvement plan is delivered and whilst a future sustainable model is identified that could be put in place by the autumn to deliver better performance this winter.

RJAH did exit the year with no patients waiting >52wks however the CCG has been further affected by 9 over 52 wk waiters from ShropComm and out of county providers which could not be treated by the year end. All patients were scheduled for treatment in April and May. Full contractual levers have been implemented against this poor performance and the CCG performance lead has requested a forward look of all >40wks waiters at all providers to try and prevent such breaches happening in the future.

The CCG has issued a formal contract performance notice with SaTH for 17/18 for failure of delivery of RTT and requested a formal recovery plan by mid-May. This was received but required further work and is due to be re-submitted at the contract meeting on 1st June.

Actions required by Governing Body Members:

J.Davies to continue chairing monthly planned care working group meetings with RJAH and SATH to oversee recovery of RTT and Cancer standards.

J.Davies / S.Freeman continue to attend A&E Delivery Board to ensure system delivery of the A&E recovery trajectory.

Monitoring form
Agenda Item: GB-2017-06.115

Does this report and its recommendations have implications and impact with regard to the following:		
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *Risk No: 73/16 NHS Constitution*	Yes N/A N/A
2	Additional staffing or financial resource implications *The CCG would fail to get its full Quality Premium Payment if it fails any of its key performance premium indicators.*	Yes
3	Health inequalities *There are potential health inequalities for patients whose care is not delivered within the NHS Constitutional Standards*	Yes
4	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	No
5	Clinical engagement *If yes, please provide details of the clinical engagement*	N/A
6	Patient and public engagement *If yes, please provide details of the patient and public engagement*	N/A

Governing Body

Shropshire Clinical Commissioning Group (CCG)

Performance Report for 2016/17

INTRODUCTION

1. This performance report provides an overview of the key performance indicators (KPIs) that the CCG is held accountable for with NHS England during 2016/17. They are part of the CCG's Improvement and Assessment Framework (IAF) for 2016/17 detailed under the Better Care section and linking in with the six national clinical priorities. These are mental health; dementia, learning disabilities, cancer, diabetes and maternity.

2. The monthly data reported is for March 2017, where data is available.

3. The CCG Improvement and Assessment Framework indicators are taken from the January 2017 NHSE IAF dashboard. NHSE have advised that next release of the CCG IAF dashboard will be at the end of June.

4. The overview provides assurance on performance achievement against targets/standards at CCG and provider level as appropriate, and the delivery and contractual actions in place to mitigate.

DASHBOARD

5. The dashboards below provide details of indicators and their RAG rating against national and local standards within service areas. Following these, there are details of the high risk indicators and the mitigation in place.

6. Where key standards were not achieved in 2015/16, trajectories have been set as part of the Sustainability & Transformational Fund (STF), in the 2016/17 planning round. For Robert Jones and Agnes Hunt Hospital and Shrewsbury and Telford Hospital Trust, these included;

    - A&E 4 Hour Wait
    - Cancer 62 day Waits
    - 18 Weeks RTT Incompletes
    - < 6 Weeks Diagnostics

RANKING AND PEER GROUPS

7. In the NHSE IAF Dashboard, a number of indicators have been ranked for Shropshire CCG in the lowest/poorest performing quartile and under the “Better Care” category.

Reporting any changes in these compared to those reported last month will of necessity be delayed by the postponement of the publication of the Q4 IAF data until the end of June. These will be reported in the next available board report after release of the data – currently this is expected to be the July board meeting.

Shropshire CCG – KEY PERFORMANCE INDICATORS

	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Cancer	Cancer Diagnosed at Early Stage - % of cancers diagnosed at Stage 1 & 2				2014 49.4% (England 50.7%)												
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2015/16	83.3%	85%	82.7%	73.1%	84.0%	84.4%	88.4%	92.5%	88.4%	80.6%	91.6%	72.7%	83.1%	84.5%	83.8%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2015/16	96.6%	90%	95.0%	100.0%	100.0%	88.9%	94.1%	87.5%	90.9%	100.0%	100.0%	93.8%	85.7%	80.0%	93.8%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2015/16	87.3%	No National Standard	85.7%	84.6%	94.9%	80.0%	96.2%	81.0%	93.9%	97.3%	89.5%	86.7%	86.0%	97.4%	89.8%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for suspected cancer	2015/16	94.8%	93%	92.5%	94.6%	93.2%	94.6%	93.7%	93.1%	94.9%	91.9%	93.4%	93.1%	94.6%	94.5%	93.7%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2015/16	94.2%	93%	94.1%	94.0%	90.8%	88.9%	90.4%	92.4%	94.2%	91.1%	93.2%	97.9%	96.3%	87.3%	92.4%
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2015/16	97.6%	96%	98.0%	96.6%	98.1%	98.7%	99.0%	99.5%	99.4%	99.5%	98.1%	98.9%	99.3%	98.8%	98.7%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2015/16	94.6%	94%	94.9%	100.0%	100.0%	100.0%	97.6%	97.9%	94.6%	97.8%	93.8%	94.4%	97.4%	96.7%	97.1%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is anti cancer drug regimen	2015/16	100.0%	98%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2015/16	98.2%	94%	98.0%	100.0%	98.0%	97.9%	94.6%	100.0%	98.4%	100.0%	100.0%	97.3%	98.4%	100.0%	98.6%
	One-year survival for all cancer				2013 70.5% (England 70.2%)												
	Cancer patient experience of responses, which were positive to the question "Overall, how would you rate your care?"	2015	8.7 (England)		2015 8.7 (CCG)												

CANCER

8. As at March 2017, 3 cancer indicators did not achieve the standard in the month:

    - 62 day wait (urgent GP referral), 84.5% against 85% standard.
    - 62 day wait (referral from cancer screening service), 80.0% against 90% standard
    - 2 week wait - Breast, 87.3% against 93% standard

    Two indicators did not achieve the year-end position.

    - 62 day wait (urgent GP referral), 83.8% against 85% standard.
    - 2 week wait - Breast, YTD 92.4% against 93% standard.

9. For the Cancer 2 week wait (Breast) in March 2017 at CCG level, there were 13 breaches - 10 breaches were due to patient choice.

10. SaTH achieved all cancer targets in March and cumulatively, it also achieved all targets. A refreshed cancer improvement plan has been developed to ensure sustained delivery including enhanced partnership working to ensure efficient timed pathways and appropriate capacity in key areas.

11. Analysis reveals the many of the breaches are due either to complex patient pathways or an element of patient choice. Some issues do exist in some of the individual tumour pathways and the CCG is working with SaTH and other providers to improve these. Given the strong level of cancer performance of SaTH as a provider overall, it can be concluded that many of the CCG's performance issues are with providers outside of the county. The CCG is continuing to work with these providers and their respective host commissioners to improve arrangements for Shropshire patients.

12. The cancer dashboard also details 3 further indicators, which are all reported on an annual basis. As national data becomes available this will be updated. These indicators are; diagnosis at early stage 1&2, one year survival and cancer patient experience. 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) – the overall care rating for Shropshire CCG is 8.7 compared to 8.7 for England.

13. There were 6 >104 day breach reported in March. Details of these and earlier reported 104 day breaches are being progressed through the CQRM to identify any key aspects and themes. The February breaches were reported to the CQRM in May for the first time and this requires further work on behalf of both the quality and commissioning leads to ensure there is the correct information for onward reporting to the governing body. The outcome of the reporting for February and March's breaches will therefore be reported to the governing body in July.

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG/SSSFT)	2015/16	**13.1%**	15%	1.3%	1.6%	1.4%	1.3%	1.2%	1.2%	1.1%	1.5%	1.0%	1.5%	1.3%	1.6%	16.1%
	IAPT Recovery Rate (CCG/SSSFT)	2015/16	**49.3%**	50%	45.1%	55.0%	54.0%	56.5%	50.0%	53.7%	57.1%	51.3%	54.5%	50.0%	52.9%	56.5%	54.6%
	75% of people with relevant conditions to access talking therapies in 6 weeks (CCG/SSSFT)	New target 2016 ** SSSFT		75%	98.0%	95.0%	96.0%	97.8%	97.8%	95.1%	98.8%	97.0%	97.6%	98.2%	99.4%	97.0%	97.3%
	95% of people with relevant conditions to access talking therapies in 18 weeks (CCG/SSSFT)			95%	100%	100%	98.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%	99.1%	100.0%	99.6%	99.5%
	50% of people experiencing first episode of psychosis to access treatment within 2 weeks (CCG/SSSFT)	2015/16		50%	50%			88%			60%			75%			**68%**
	Children & Young People's Mental Health Services Transformation	5 Questions: 2 fully Compliant 2 Partially Compliant 1 Not Compliant		5 Questions Fully Compliant	Q1			80.0% Q2									
	Crisis Care & Liaison mental health services transformation	15 Questions: 6 fully Compliant 3 Partially Compliant 6 Not Compliant		15 Questions Fully Compliant	Q1			47.5% Q2									
	Out of Area placements for acute mental health inpatient care - transformation	3 Questions: 3 fully Compliant		3 Questions Fully Compliant	Q1			100.0% Q2									
	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	2015/16	98.2%	95%	99.0% Q1			98.9% Q2			100.0% Q3			97.2% Q4			98.8%

MENTAL HEALTH – IMPROVED ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

14. Performance for IAPT is as follows:

- Roll Out standard 15%. Performance for March is reported locally as 1.6%, an improvement over the previous months, with a full year position of 16.1
- Recovery standard 50%. Performance for Q1, 2016/17 reported at 54.14%; Q2, 2016/17 reported at 54.53%; Q3, 2016/17 reported at 55.94%; Q4 2016/17 reported at 54.7%. Final year position is reported at 54.6%.
- Both waiting time standards are being achieved.

15. There are now three indicators in the Mental Health Dashboard where a service baseline has been set, and progress is due during 2016/17. These relate to children's and young people's mental health, crisis care and liaison and out of area placements.

MENTAL HEALTH – CARE PROGRAMME APPROACH (CPA)

16. As at Q4, 2016/17, 97.2% patients on CPA were followed up within 7days against 95% standard. The final year position is 98.8%

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Learning Disability	Reliance on specialist inpatient care for people with a learning disability and/or autism (per million pop)	Monitoring commenced in 2016/17		Trajectory													
					244.9 75 patients			228.6 70 patients									
	Proportion of people with a learning disability on the GP register receiving an annual health check	2014/15	47% (England)		46.5% (2015/16: CCG)												
Maternity	Neonatal mortality and still births per 1,000 population	2014/15	7.1 (England)		6.7 (2014/15: CCG)												
	Women's experience of maternity services	2015			82.1 (2015: CCG)												
	Choices in Maternity Services	Monitoring commenced in 2016/17			67.3% (2015 CCG)												
Dementia	Maintain a minimum of two thirds diagnosis rates for people with dementia	2015/16	70.5%	67%	69.9%	68.8%	68.8%	69.0%	69.1%	69.3%	69.3%	67.8%	67.2%	67.5%	67.4%	67.8%	67.8%
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2014/15	77%		80% (2015/16: CCG)												

LEARNING DISABILITIES (LD)

17. There are two indicators relating to LD:
    - At Q2, 2016/17, the rate for reliance on specialist inpatient care for people with a learning disability and/or autism per 1m population was reported as 228.6 against a target to be determined (which equates to 70 patients).

18. Nationally people with mild LD are being identified in mental health services as part of the Transforming Care reporting criteria. NHSE is aware, with Commissioners and providers ensuring processes are in place to pick up issues. The CCG has received initial feedback on its bid for capital monies and has been successful in the bid for £68k for the refurbishment of Church Parade, however was informed that for the new build a revised plan for a maximum 6 bedded unit was required. This was submitted on scheduled on the 31st May and has the support of our regional NHSE team. NHSE have confirmed that funding for any patients transferred from NHSE to CCG responsibility will follow but only at the IP rate. Therefore the financial risk remains to the CCG of any additional costs of community solutions that are more expensive than the previous IP package. Use of a new identification tool in 17/18 is expected to improve performance by the end of the 17/18 year.

MATERNITY

19. The maternity indicator position is reported annually. There are three indicators in the dashboard, with data now populated. The Choices in Maternity is RAG rated “blue” as there is no baseline data.

DEMENTIA

20. Dementia diagnosis continues to perform above the national standard.

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Urgent and Emergency Care	Achievement of milestones in the delivery of an integrated urgent care service								2								
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 2014/15	2,168 (England)		Q4 2015/16 527												
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (SaTH)	2015/16	85.6%	95%	84.0%	84.8%	82.4%	86.9%	82.2%	81.5%	78.2%	79.2%	78.0%	73.8%	75.8%	81.6%	80.9%
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (SaTH)	2015/16	0	Zero Tolerance	0	0	0	0	0	0	0	0	1	16	0	0	17
	Ambulance Handover time - Number of handover delays of >30 minutes (RSH + PRH)	2015/16	4242	Zero Tolerance	424	411	552	462	493	552	692	668	709	861	692	609	7125
	Ambulance Handover time - Number of handover delays of > 1 hour (RSH + PRH)	2015/16	580	Zero Tolerance	102	73	97	45	91	103	156	159	156	308	222	88	1600

URGENT & EMERGENCY CARE – A&E 4 HOUR WAIT & AMBULANCE HANDOVERS

21. For March 2017, the SaTH A&E 4 Hour Wait target has not been achieved and is reported as 81.6% (an increase against the previous 6 months) against a 91.2% STF trajectory. This is un-validated data. Although Q1, 2016/17, A&E 4 Hour Wait achieved, subsequent positions from the July position onwards show underachievement with a continuing decline. The final year target has not been achieved and is reported as 80.9% against an 89.8% STF. SaTH achieved 84.5% in April vs its planned trajectory of 77.9%. This was in part due to lower demand and acuity of patients being admitted and also due to a significant reduction in delayed transfers of care (provisional position for SaTH was 2.2% in April).

22. Progress against all key actions was reported at the A&E delivery board but the key impact measures are not yet directly aligned to the actions. This work is in train and will be reported to A&E Delivery board from June onwards. Workforce and variation in demand remain the key issues preventing further improvement in A&E performance.

23. The CCG is leading on the Discharge to Assess action and this is all currently on schedule. The first phase of the demand and capacity planning refresh for complex discharge has been completed and phase two is on track for June. The CCG has reached agreement in principle with the local authority re the funding of pathway 3 capacity and plans to deliver this by the autumn are being worked on by the council to be shared with partners at the next A&E escalation meeting. The system has worked well together to deliver a significant improvement in delayed transfers of care and they are now at their lowest level. The next priority for this work is linked to the Trusted Assessor role and how this needs to be more consistently delivered and further embedded within our whole system ways of working, including care home providers which will be the biggest challenge.

24. There were no breaches for 12 hour trolley waits in A&E at SaTH in March.

25. As at March 2017, there were 609 handover delays for > 30 minutes and 88 for > 1 hour against zero tolerance. Performance for both indicators has improved since December particularly at RSH. The CCG is working with SaTH to ensure that this improved performance is sustained into 2017/18. SaTH and WMAS have now met and agreed draft ambulance handover recovery plan. Delivery of this is to be monitored via the A&E Delivery Board. The CCG has made £90k of its winter monies available for corridor nurses in SATH from June –September whilst the improvement plan is delivered and in addition the CCG is working with T&WCCG to evaluate other systems in England where ambulance handovers are much more effective to identify a future model that could be put in place in the autumn to deliver better performance this winter on a more sustainable basis.

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Urgent and Emergency Care	Ambulance Clinical Quality - Red Performance within 8 mins (WMAS)	WMAS	New metric	75%	ARP Launched 8th June 2016		69.1%	67.3%	68.5%	67.1%	64.6%	65.5%	65.6%	67.2%	65.6%	65.9%	66.5%
		SCCG					45.7%	52.3%	55.9%	52.9%	48.5%	48.0%	49.4%	51.8%	48.6%	50.0%	50.4%
	Category 1 (mm:ss): 75th Percentile	WMAS	New metric		ARP 2.2 Launched 12th October 2016						00:09:14	00:09:06	00:09:10	00:08:57	00:09:09	00:09:01	
		SCCG									00:13:39	00:13:41	00:13:09	00:13:35	00:13:24	00:12:24	
	Category 1 (mm:ss): 90th Percentile	WMAS	New metric		ARP 2.2 Launched 12th October 2016						00:12:08	00:12:04	00:12:07	00:11:55	00:11:49	00:11:54	
		SCCG									00:18:10	00:19:09	00:17:12	00:19:35	00:19:07	00:19:09	
	Category 2 (mm:ss): 90th Percentile	WMAS	New metric		ARP 2.2 Launched 12th October 2016						00:20:22	00:20:12	00:20:57	00:19:44	00:19:43	00:19:00	
		SCCG									00:29:43	00:28:13	00:30:53	00:31:24	00:32:08	00:29:29	
	Category 3 (mm:ss): 90th Percentile	WMAS	New metric		ARP 2.2 Launched 12th October 2016						00:37:34	00:39:41	00:44:08	00:37:53	00:41:35	00:38:32	
		SCCG									00:36:44	00:37:37	00:39:43	00:36:43	00:43:42	00:38:36	
	Category 4T (hh:mm:ss) : 90th Percentile	WMAS	New metric		ARP 2.2 Launched 12th October 2016						01:21:32	01:27:17	01:31:14	01:17:02	01:21:52	01:18:25	
		SCCG									01:04:41	01:10:35	00:53:54	01:01:02	01:04:20	01:01:54	
	Red (mm:ss): 90th Percentile	WMAS	New metric	ARP Launched 8th June 2016			11:26	11:56	11:34	11:50							
		SCCG					17:03	17:00	16:22	17:20							
	Amber (mm:ss): 90th Percentile	WMAS	New metric	ARP Launched 8th June 2016			28:24	32:24	25:19	26:08							
		SCCG					29:26	30:09	29:51	28:17							
	Green (mm:ss): 90th Percentile	WMAS	New metric	ARP Launched 8th June 2016			52:17	56:31	48:59	52:14							
		SCCG					41:12	44:22	42:31	47:46							
	Crew Clear delays of > 30 minutes (RSH + PRH)	2015/16	2958	Zero Tolerance	259	264	367	297	291	365	436	425	428	562	422	346	4462
	Crew Clear delays of >1 hour (RSH + PRH)	2015/16	458	Zero Tolerance	68	38	58	29	48	60	103	120	80	192	129	45	970
	Delayed Transfers of care attributable to the NHS (LA)	2015/16	6517	Reduction 2015/16 Outturn	516	452	378	426	627	477	531	529	692	625	608	481	6342 (Rolling Year)
	DTOC Rate (SaTH)			3.50%	3.8%	3.1%	3.6%	3.9%	5.8%	5.2%	4.4%	3.3%	4.2%	4.2%	3.9%	3.6%	3.9%
	DTOC Rate (RJAH)			3.50%	9.6%	8.5%	7.4%	6.6%	3.7%	4.0%	6.5%	9.0%	9.6%	6.9%	5.3%	4.2%	5.3%
	Population use of hospital beds following emergency admission	Q4 2015/16	1.0 (England)		Q4 2015/16 (data n/a for Q1 2016/17) 0.8 (CCG)												

URGENT & EMERGENCY CARE – AMBULANCE RESPONSE TIMES, CREW CLEAR and DELAYED TRANSFERS OF CARE (DTOC)

23 The ARP pilot is still ongoing in the West Midlands with an evaluation anticipated in July.

24 The crew clear zero tolerance was exceeded for each month during 2015/16, with > 30 minutes showing an average of 247 each month, and >1 hour showing an average of 38 per month. April – March 2016/17 is showing an average of 372 and 81 respectively which reflects the overall deterioration in handover performance. Performance for both indicators has improved for March but remain above the average achieved in 15/16.

25 DTOC - As at March 2017, the number of delays for the final year position is reported as 6342 days delayed (NHS only, Shropshire County LA) against 6517 at 2015/16 position for the same final year period. Delays continue to reduce at SaTH with the DToC rate at 3.6% in March with respect to the 3.9% reported in February. The position at RJAH is also improving at 4.2% against 5.6% in February. Although this is above the 3.5% target most of these patients are highly specialised spinal rehabilitation and require alternate out of hospital care arrangements to be activated by a wide range of CCGs. The Trust is seeking to find an effective solution to this situation with it's out of area commissioners.

Primary Medical Care	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
	Inequality in emergency admissions for urgent care sensitive conditions	Q4 2015/16	2,168 (England)		Q4 2015/16 1,165												
	Satisfaction with the quality of consultation at a GP practice	(Jan-Mar14 & Jul-Sept15) - Published Jan 15	456		458 (Jul-Sept15 and Jan-Mar16) Published July16												
	Satisfaction with the overall care received at the surgery		89.8%		90.8% (Jul-Sept15 and Jan-Mar16) Published July16												
	Satisfaction with accessing primary care		81.3%		82.0%												
	Extended access to GP services on a weekend and evening				Data due December 2016. This will be based on a bi-annual survey undertaken in March and September N.B. Data n/a for Shropshire												
	Primary care workforce: Number of GPs and Practice Nurses (full-time equivalent) per 1,000 weighted patients by CCG				1.1 (2016: CCG)												

Elective Access	Indicator Description	Latest Baseline Position	Outturn/Standard	Standard/Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
	RTT - incompletes (CCG)	2015/16	92.8%	92%	91.6%	92.6%	92.8%	92.1%	91.6%	90.6%	90.2%	90.1%	88.8%	89.0%	88.4%	88.7%	90.6%
	RTT - incompletes (SaTH)	2015/16	92.1%	92%	91.4%	92.7%	91.7%	90.0%	90.2%	88.9%	89.2%	88.8%	87.1%	86.9%	85.7%	85.8%	89.1%
	RTT - incompletes (RJAH)	2015/16	88.6%	92%	88.6%	88.9%	89.2%	88.7%	87.4%	87.1%	87.7%	88.1%	87.7%	88.5%	89.2%	91.4%	88.5%
	No. of 52 Week Waiters (CCG)	2015/16	75	Zero Tolerance	1	3	4	7	9	7	4	3	3	2	4	9	56
	Diagnostic Test Waiting Time < 6 weeks (CCG)	2015/16	0.9%	1%	0.9%	1.1%	0.5%	0.3%	2.1%	2.2%	3.3%	4.5%	3.8%	2.9%	0.5%	0.3%	1.8%
	Diagnostic Test Waiting Time < 6 weeks (SaTH)	2015/16	0.6%	1%	0.5%	0.6%	0.3%	0.2%	1.4%	1.8%	2.5%	4.0%	3.9%	4.6%	0.3%	0.1%	1.7%
	Diagnostic Test Waiting Time < 6 weeks (RJAH)	2015/16	0.2%	1%	0.1%	0.2%	0.3%	0.2%	0.2%	0.2%	0.1%	0.2%	0.1%	0.1%	0.2%	0.1%	0.2%
	Cancelled Operations - no. of patients re-admitted within 28 days (SaTH)	2015/16	5	Zero Tolerance	1			0			0			4			5
	Cancelled Operations - no. of patients re-admitted within 28 days (RJAH)	2015/16	2	Zero Tolerance	1			1			0						2

ELECTIVE ACCESS – 18 WEEKS RTT, 52 WEEK WAITERS, AND < 6 WEEKS DIAGNOSTICS

26 The CCG failed to achieve the RTT target in March (88.7%) against 92% target) which represents a small improvement on the February position. This was made up of 87.8% achievement at SaTH, 92.6% at RJAH and 86.8% at all other providers. This indicates that all providers continue to struggle to achieve the target.

27 Detailed recovery plans have been requested from SaTH for all of the failing specialties and will be monitored at the Planned Care Working Group. These plans will have comprehensive recovery trajectories which will be consistent with those agreed between SaTH and NHSI. SaTH are planning to achieve the standard 1n September 2017 at Trust level.

28 The number of patients waiting for 52 weeks unfortunately increased in March despite RJAH showing zero 52 week waiters. This was due to some patients at Wye Valley Trust and Worcester Acute as well as a number of ENT patients at Shropshire Community Trust. All of these patients had planned treatment dates in April and May.

29 The Shropshire Community Trust 52 week waiters issue revealed a pathway problem for a small number of patients. A full RCA has been completed and is being reported at the June contract meeting. In the meantime discussions between SaTH, Shropshire Community and the CCG have resolved this issue and it should not recur.

30 RJAH performance was 91.4% just short of the target. Recovery is now scheduled for Quarter 3 2017/18 and they remain on plan to achieve this.

29 Performance in relation to the Diagnostic Test 6 week waiting time was above the 99% standard in both February and March indicating a recovery in performance at SaTH.

NHS Continuing Healthcare	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
	People eligible for standard NHS Continuing Healthcare per 50,000 population. Consistent application across the country is the measurement	2016/17 Q2	46.2 (England)		2016/17 Q2 44.8 (CCG)												

Additional Indicators Requiring Focus	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard /Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
	Healthcare acquired infection (HCAI) measure (MRSA)	2015/16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)	2015/16	87	73	6	4	4	3	6	8	7	2	1	7	5	5	58
	NHS111 - Abandoned Calls after 30 seconds			<2.9%	0.5%	1.4%	1.1%	1.8%	1.8%	2.9%	3.2%						1.8%
	NHS111 - Calls answered within 60 seconds			95%	96.6%	91.7%	92.5%	88.5%	88.5%	84.7%	82.6%						

NHS CONTINUING HEALTH CARE (CHC)

31 Performance for CHC at CCG level for Q2 1617 is at 44.8% against a national figure of 46.2%. This national data has been recently published as part of MyNHS dashboard.

HEALTH ACQUIRED INFECTION MRSA AND CDIFF

32 For 2016/17 zero incidences for MRSA have been reported for the CCG.

33 C. Difficile - There have been 58 incidences reported to date in 2016/17 against an objective of 73.

NHS 111

34 There is continual deterioration in performance for NHS 111 for calls abandoned after 60 seconds with October 2016 position at 82.6% against 95% target. Note, as a result of a change in NHS 111 service provider (from Vocare to Care UK) on 8th November, no performance figures at CCG level are available from that date. It is anticipated that this will be available shortly but we are still awaiting a timescale from the regional lead and this has now been escalated to the regional director.

Quality Premium - National Priorities	Measure	Latest Data Position	Percentage of QP	Latest position - achieving?
	Improving antibiotic prescribing in primary care	Q3 2016/17	10%	Both Parts
	Cancer		20%	No
	E-Referrals	Q4 2016/17	20%	Yes
	GP Patient Survey	Q3 2016/17	20%	No
	Local Measure 1: % of IAPT patients receiving a course of treatment	Q4 2016/17	10%	Yes
	Local Measure 2: Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population		10%	Yes
	Local Measure 3: % of Diabetes patients receiving the 8 care processes		10%	Yes

Quality Premium - Constitution Measures	Measure	Latest Data Position	% QP Deduction	Latest position - achieving?
	RTT Incomplete	Q4 2016/17	25%	No
	A&E Waits		25%	No
	Max 2 month (62 day) wait from urgent GP referral to first definitive treatment for cancer		25%	No

QUALITY PREMIUM PAYMENTS

35 As at Q3 2016/17 the CCG is achieving 1 National Priority (Antibiotic Prescribing).

As at Q4 2016/17 the CCG is achieving 1 National Priority (E-Referrals).

As at Q3 2016/17 the CCG is failing on 2 National Priorities (Cancer and GP Patient Survey).

As at Q4 2016/17 the CCG is failing on 3 Constitution Measures (RTT Incomplete, A&E Waits and Cancer 62 Day Waits).

Quality Premium Payments at year end position are contingent upon the CCG passing both the Finance and Quality Gateways. Should these gateways fail then payment for any measures achieved is discretionary.

The final position for the other QP indicators will be available in July.

36 NHS Constitution Indicators

Adjustments have been made to standards as a result of the Sustainability & Transformation Fund (STF), and trajectories have been set for two of the Constitution indicators; A&E 4 hour wait and RTT incompletes:

For A&E, SaTH is to deliver 89.9% in Q4 2016/17

For RTT incompletes, RJAH is to deliver 92% in March 2017

RECOMMENDATIONS

The Governing Body to NOTE contents.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.116
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Major Contract Performance Reports - Month 12 (March 2017)
Responsible Director:	Michael Whitworth, Interim Director of Contracting & Planning
Author of the report:	Charles Millar, Head of Contracting, Planning & Performance Meryl Flaherty, Head of Contracts CSU
Presenter:	Charles Millar, Head of Planning, Performance and Contracting

Purpose of the report:

This report summarises the current contractual position at Month 12 for the CCG's four main contracts and highlights key contractual issues for review by the Committee.

Key issues or points to note:

- The yearend settlement with SaTH included a figure of £403,537 identified for successful Contractual Challenges
- Ongoing Quality concerns at SaTH have been raised
- Out of County providers showing substantial over-performance were UHNM, Wye Valley, UHB and Countess of Chester

Actions required by Members:

To note the current performance and actions.

To highlight any areas for future focus in the Contracts report

Appendix A

Major Contract Performance Report

Month 12 (March 2017)

1. Background

This report summarises the position with the CCG's contracts with its main providers and details the actions under the contracts, which are underway.

It should be read in conjunction with the Finance and Contract Report – agenda item 9.1.

Executive Summary

Shrewsbury & Telford Hospitals Trust (SaTH)

- The activity is 2.8% over plan. The main areas of over performance are
  - Emergencies (11.6%)
  - Daycase (7.5%)
  - Critical care (28%)
  - A&E attenders (4.9%)

- A final settlement of £132,200,000 has been made in respect of the 2016/17 position, against a plan of £125,955,426.

Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH).

- The activity is 7.5% over plan. The other two main areas of over performance are
  - PbR Elective (9.7%)
  - PbR Outpatients Follow Up (6.7%)

- A final settlement of £34,152,000 has been made in respect of the 2016/17 position, against a plan of £32,931,836

Shropshire Community Health Trust

- The contract was £225,710 overspent at yearend

South Staffordshire and Shropshire Healthcare Trust

- The contract was £107,994 underspent at yearend

2. Contracts Overview

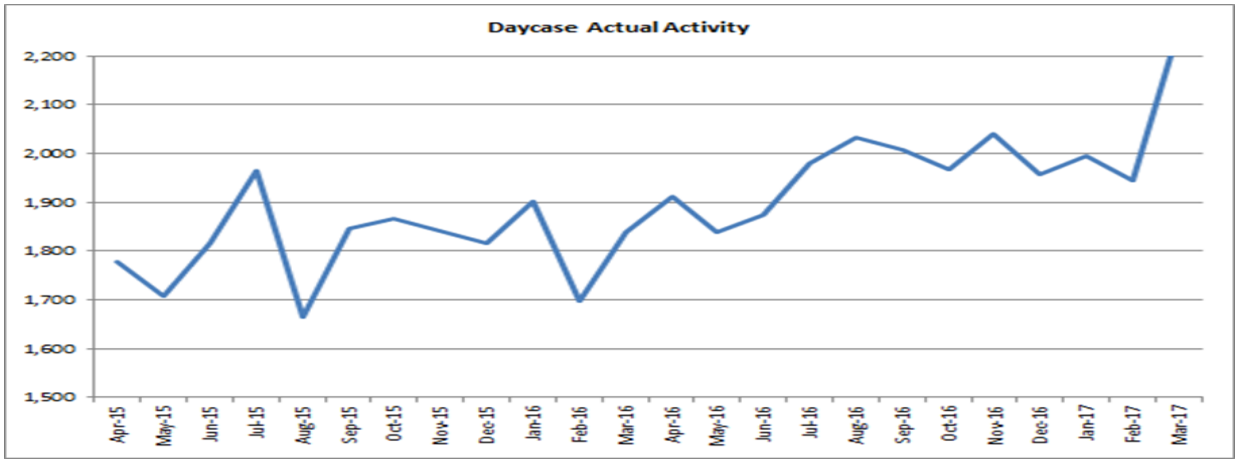
2.1 Shrewsbury and Telford Hospital NHS Trust

2.1.1 Activity

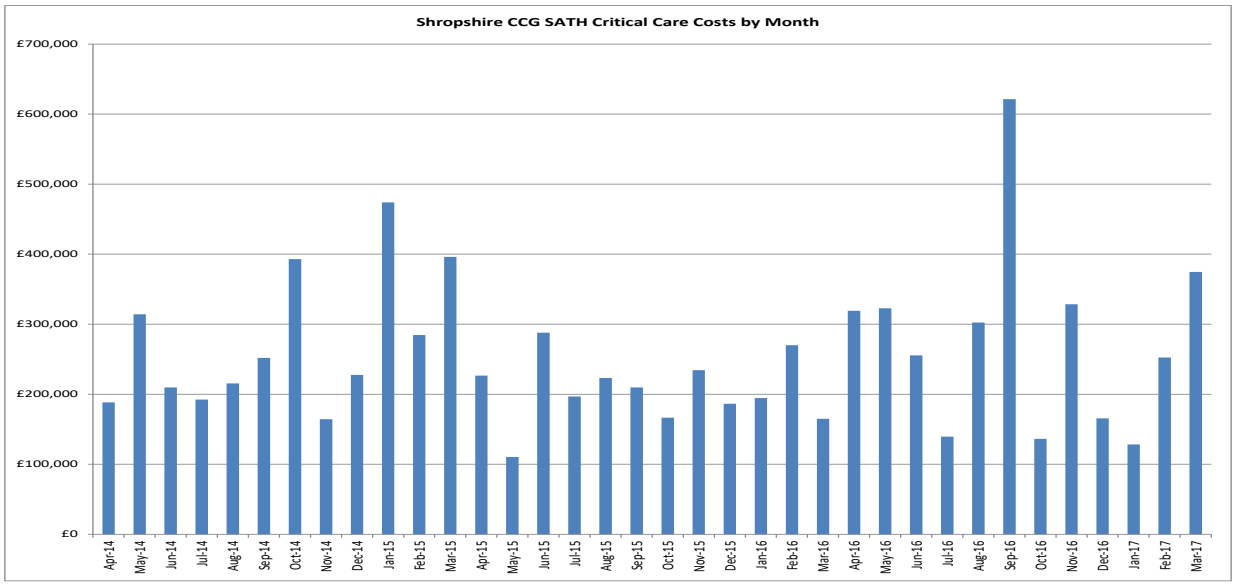
The year to date variance is primarily being driven by Emergency activity of 11.6% over performance. Within this there were 2 months (August and November) when activity was significantly greater than expected. There are no obvious reasons for this. Specialties with higher than anticipated levels of activity include General Medicine, Urology, Respiratory Medicine, and Paediatrics.

Point of Delivery	YTD Plan	YTD Actuals	YTD Variance	% Variance
PbR Day Case	21,014	22,600	1,586	7.5%
PbR Elective	2,781	2,522	(259)	(9.3%)
PbR Emergency	23,492	26,209	2,717	11.6%
PbR Non Elective Other	3,326	3,468	142	4.3%
Non PbR Day Case	1,124	1,213	89	8.0%
Non PbR Elective	171	140	(31)	(18.3%)
Non PbR Emergency	226	258	32	13.9%
Non PbR Non Elective Other	116	144	28	24.1%
Critical Care	2,386	3,053	667	28.0%
PbR Outpatients 1st	46,378	47,701	1,323	2.9%
PbR Outpatients Follow-Up	84,322	83,797	(525)	(0.6%)
PbR Outpatient Procedures	44,942	46,381	1,439	3.2%
Non PbR Outpatients 1st	12,017	11,719	(298)	(2.5%)
Non PbR Outpatients Follow-Up	10,998	10,544	(454)	(4.1%)
Non PbR Outpatient Procedures	5,644	5,398	(246)	(4.4%)
PbR A&E Attendances	54,517	57,214	2,697	4.9%
Total	**313,456**	**322,361**	**8,905**	**2.8%**

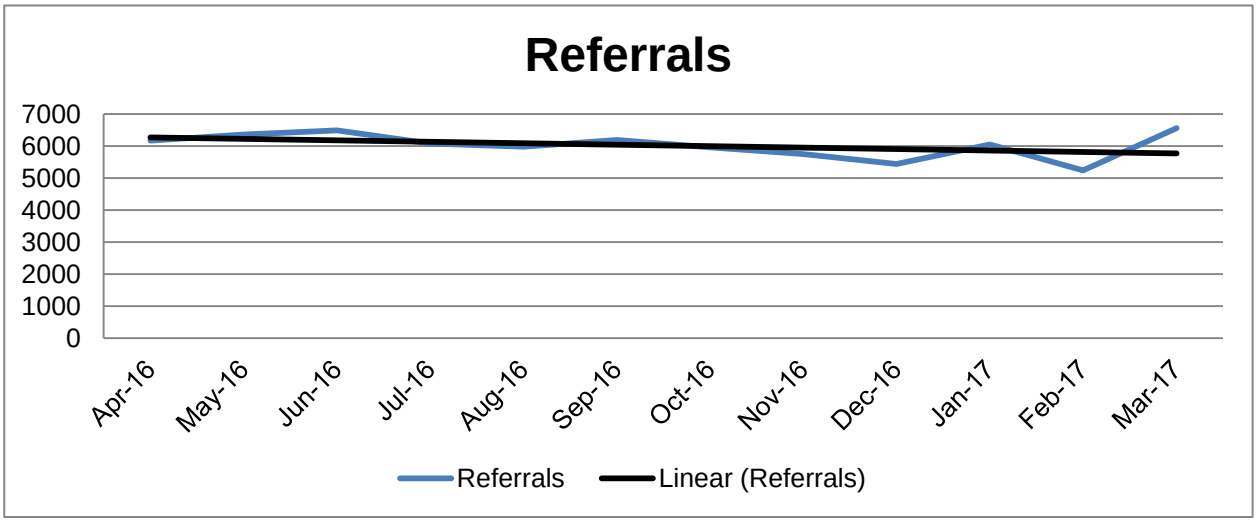
The over performance is activity driven. The charts below show the 24 month activity and cost trend. The charts indicate a gradual increase in activity and cost since April 16. There was a large increase in March 17



Critical care is 28% over plan (a significant amount relates to 1 long stay patient in September).



Referrals to SaTH increased in March, although the trend line is down. Closure to referrals of some services will inevitably be impacting on this. A full analysis of referral data takes place at the Activity and Finance meetings held with SaTH.



2.1.1 Finance

A final settlement of £132,200,000 has been made in respect of the 2016/17 position, against a plan of £125,955,426.

2.1.2 Contractual Actions

2.1.2.1 Contractual Challenges Raised

The CCG was made aware of a problem regarding the Month 11 Freeze Submission from the Trust. The inpatient data had been incorrectly loaded by the Trust onto SUS, therefore a full challenge process could not be run for month 11. The month 12 challenge letter will contain both Month 11 and Month 12 challenges.

Within the yearend settlement, an agreed amount of £403,537 was allocated to successful challenges made by the CCG.

2.1.2.2 Activity Query Notices (AQN)

No new Activity Query Notices have been issued during March 2017.

2.1.2.3 Contract Performance Notices

Two Contract Performance Notices are currently open, for failure to achieve the constitutional target of 18 weeks referral to treatment time (RTT) in a number of specialties and the percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department.

Remedial action plans have recently been submitted by the Trust for all the specialties not achieving the 92% target. The CCG required further updates to the plans. Full discussion takes place at the Planned Care Working Group.

Penalties cannot be applied under the contract as this option has been subsumed within the allocation of the STF (Sustainability and Transformation Fund) from NHS Improvement, which depends on adherence to the agreed STF trajectories. Contractual remedial action plans are in place for these 3 notices.

2.1.2.4 Procedures of Limited Clinical Value (PLCV) / Value based Commissioning (VBC)

The CCG has issued the new VBC Policy to the Trust with application from 1st April 2017. Currently the CCG will not pay for any PLCV procedures that have not received prior approval. All future challenge letters will include the cost of the patients that do not have an approval code for Procedures of Limited Clinical Value.

2.1.2.5 – Quality Issues

The CCG is has become increasing aware of the current quality issues within SaTH. At a recent Joint Commissioning Forum held with Telford & Wrekin CCG, a number of quality issues where raised.

- Closure of the Neurology Service
- Closure of the Spinal Service
- The Ophthalmology Service
- Maternity
- Reports from the WMQRS in regards to Stroke & Theatres
- Workforce Issues

A Joint escalation letter was sent to SaTH with regards these issues and also discussions will take place at the Clinical Quality Review Meetings and further discussions to take place at the Strategic Commissioning Board on 6th June 2017.

2.1.2.6 – Key actions summary from Contract Meetings

- **Blueteq -** Discussion took place around next steps for implementing Blueteq for the CCGs. RJAH require assurance around information governance as Blueteq will hold substantial amounts of PID.
- **Ophthalmology Action Plan** - Task and Finish Group now meets fortnightly, with the next meeting taking place on 1st March, a ‘live’ action plan is discussed and updated at the Group. SaTH had been requested to provide an update on the Plan to the next meeting.

- **Mortality Outlier Alert – Fluid and Electrolyte Disorders** - Concern around number of patients readmitted within 7 days of discharge for a Urinary Tract Infection and what actions the Trust will put into place to address this going forward.
- **Staffing** - With the current workforce challenges facing the Trust, a thorough review of workforce/staffing is required at every CQRM and it will be a standing agenda item.
- **Recent Unannounced Commissioner Visit to Emergency Department and to Review Boarding of Patients** - It was to note the report from the visit was mainly positive, However, even though there had been no recent 12-hour breaches reported, it had been noted during this visit, five patients had spent an unacceptable amount of time within the A&E department (up to ten hours) waiting for a decision.
- **Neurology – Harm and Triage Process** - Commissioners had not seen any quality impact assessments or patient harm proformas prior to the closure of this service.
- **Cancer 104 Day Breaches** - Staff sickness within the Trust Cancer Team remains an area of concern for commissioners as they are still waiting for assurance on the harm proformas from two previous months.
- **Short Synacthen Testing & DeXA Scanning** - charged as a Daycase, challenge has been made these should be charged as an Outpatient Procedure

2.2 Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH)

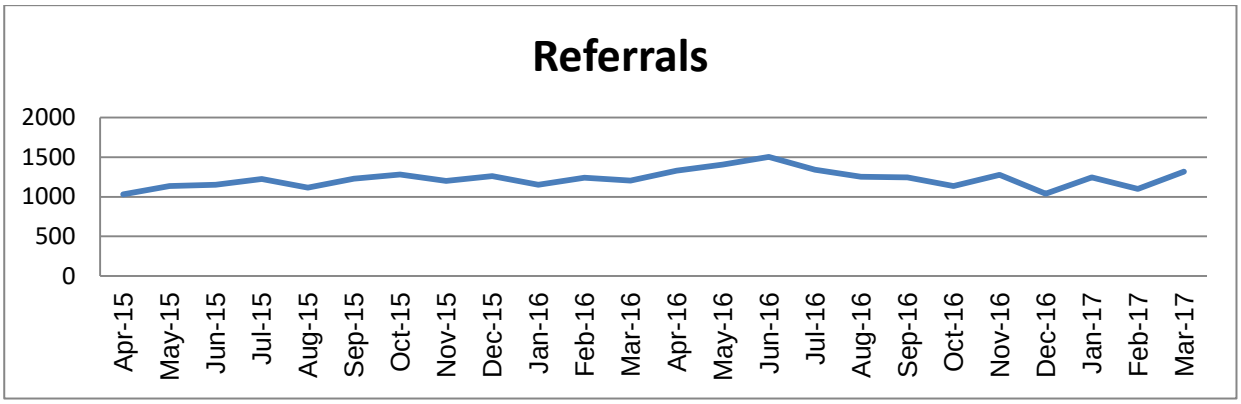
2.2.1 Activity

The year to date variance is primarily being driven by an Elective activity over performance of 9.7%.

Outpatient First attendances have seen a 10.2% underperformance, while Follow Up activity is over by 18.8%. The Trust has recently produced a paper proposing the increasing use of telephone and virtual clinics to reduce the number of follow up attendances. This is being monitored at the Service and Performance Forum. Changes in the tariff structure for 2017/18 onwards will reduce the financial impact of over performance in Follow up outpatients.

Point of Delivery	YTD Plan	YTD Actuals	YTD Variance	% Variance
PbR Day Case	3,233	2,999	(234)	(7.2%)
PbR Elective	2,228	2,444	216	9.7%
PbR Non Elective Other	258	242	(16)	(6.2%)
Non PbR Day Case	137	58	(79)	(57.7%)
Non PbR Elective	114	166	52	45.3%
Non PbR Non Elective Other	1	3	2	150.0%
Non PbR Regular Admissions	245	364	119	48.7%
PbR Outpatients 1st	9,845	8,845	(1,000)	(10.2%)
PbR Outpatients Follow-Up	28,999	34,444	5,445	18.8%
PbR Outpatient Procedures	1,810	1,867	57	3.2%
Non PbR Outpatients 1st	10,680	10,946	266	2.5%
Non PbR Outpatients Follow-Up	24,113	25,717	1,604	6.7%
Non PbR Outpatient Procedures	1,659	1,446	(213)	(12.9%)
Total	**83,322**	**89,541**	**6,219**	**7.5%**

Since June 2016, referrals to RJAH have seen a reversal of the upward trend and have been trending downward since then. There is, however, some indication of a small upturn again in March. This will be monitored over the coming months.



2.2.2 Finance

A final settlement of £34,152,000 has been made for 2016/17 (against a plan of £32,931,836)

2.2.2 Contractual Actions

2.2.2.1 Contractual Challenges Raised

Flex and Freeze is being fully operated in line with the National Secondary Uses Service (SUS) timetable. The CCG will not fund activity that has not been reconciled through SUS or in the case of activity or payments not liable for SUS submission. The CCGs will pay only on reconciliation of Service Level Agreement Manager, data (SLAM) with Patient Level Data.

The challenges are made on freeze data; the amount raised for Month 11 was £20,363. Full discussion takes place at the Finance and Activity Group and further updates regarding the amount achieved will be confirmed in future reports

2.2.2.2 Activity Query Notices (AQN)

No new Activity Query Notices have been issued during March 2017.

2.2.2.3 Contract Performance Notices

A Contract Performance Notice in relation to patients waiting over 52 weeks can now be closed. The Trust had no 52 week waiters at the end of March.

2.2.2.4 Procedures of Limited Clinical Value (PLCV) / Value based Commissioning (VBC)

The CCG has issued the new VBC Policy to the Trust and will be implemented from 1st April 2017. Currently the CCG will not pay for any PLCV procedures that have not received prior approval. The Month 11 challenge letter included patients that do not have an approval code for procedures of Limited Clinical Value, this value was £370,024

2.2.2.5 – Key actions summary from Contract Meetings

- **Blueteq -** Discussion took place around next steps for implementing Blueteq for the CCGs. RJAH require assurance around information governance as Blueteq will hold substantial amounts of PID.

- **Neurology** - RJAH advised that they had been alerted that Royal Stoke may be serving notice on RJAH's use of their consultant for their service due to issues in managing their own demand. No formal notification has yet been received. The CCG is exploring options for alternate service providers.
- **Delayed transfers of Care** - RJAH is exploring an alternative arrangement for rehabilitation of some patients outside of the hospital. This will require funding from other CCGs.
- **Spinal Injury Peer Review** - RJAH advised that the final report was yet to be received. It was agreed this action would be left open pending receipt of the report. RJAH will hopefully be able to supply this for the May meeting.
- **Children in Outpatient Clinics** - RJAH to supply a formal progress report around progress of actions around children in adult outpatient services from CQC Action Plan
- **CQC** - It was noted that the CQC will be returning to RJAH to complete a masterclass with staff around the key lines of enquiry framework. It was understood this was due to take place on 4th May from 12.00 p.m. to 2.00 p.m. at the Lecture Theatre at RJAH. CCG colleagues were encouraged to attend.

2.3 Non Acute providers

2.3.1 Shropshire Community Health Trust

The contract is £255,710k overspent. The majority within inpatients and the Welsh patients in MIU

Area	Activity Plan	Activity Actual	% Variance (Activity)	Value Variance (£)
PBR	31,315	33,064	5.6%	£123,545
Non PbR	516,124	580,648	12.5%	
Total	**501,819**	**562,570**	**12.1%**	**£123,545**
MIU Clinics		**1,208**		**£70,531**
Podiatry AQP				
Non PbR		**1,213**		**£31,634**
Total				**£225,710**

- 25.1% Inpatient over-activity against plan (46) = £44,611
- 4.8% over-activity against plan in MIU (843) = £49,612
- No significant over/ under activity against plan for outpatients but due to under activity in New and over activity in Follow-ups = (£21,346)
- 35.6% over-activity against plan for Welsh patients in MIU (665) = £39,137

The £70,531 non-commissioned MIU activity relates to services that were de-commissioned from the Community Trust with the expectation they would be delivered within Practices but there is a cohort of patients who attend MIU for dressings and other treatments, particularly outside practice hours.

2.3.2 Contractual Actions

No additional ones since last report

2.3.2.1 Contractual Challenges Raised

No Contract Challenges have been raised.

2.3.2.2 Activity Query Notices (AQN)

There is an Open Activity Query Notice relating to Neurology services at Bridgnorth Hospital. The on-going sustainability of this service, including the interdependency with the availability of SaTH clinicians is being discussed with the Trust.

2.3.2.3 Contract Performance Notices

No contract performances notices open at the end of March

2.3.2.4 Key actions summary from Contract Meetings

- **ICS Specification** – Work is being progressed to refine the ICS specification in the light changes in level of input from the local authorities to the service.
- **Interface Issues with SaTH** – Concerns were raised over gaps in pathways were patients moved between Shropcomm and SaTH. The CCG is engaging with both providers to ensure contractual and pathway arrangements are clear.
- **ICS Performance** - CCG raised concerns they had received from a CCC colleague around difficulties accessing the ICS Service. It was unsure whether the difficulties were due to clinical thresholds or service access times and clarity is needed.

2.4 South Staffordshire and Shropshire Healthcare Trust

Activity

The contract is currently 4.7% under the activity target with a £107,994 underspend. The financial adjustment is the application of the 5% cap and collar and the upper and lower tolerances

	Activity plan	Activity Actual	% Variance Activity	YTD Finance Variance	YTD Financial adjustment
Mental Health Services	1,307,675	1,246,346	-4.7%	(£1,644,154)	(£107,994)
Total	**1,307,675**	**1,246,346**	**-4.7%**	**(£1,644,154)**	**(£107,994)**
PICU	600	768	28.0%		
PICU Nurse Specialing *		131			

* Nurse specialling is where a patient requires 2:1 nursing (or more) and is included in the price of PICU.

The marginal rate does not apply to PICU but there is an upper tolerance limit of 20%.

2.4.1.1 Contractual Actions

None since last report.

2.4.1.2 Contractual Challenges Raised

No Contract Challenges have been raised.

2.4.1.3 Activity Query Notices (AQN)

There are no open Activity Query Notices.

2.4.1.4 Contract Performance Notices

There are no open Performance Notices.

2.4.1.5 Key actions summary from Contract Meetings

- **New Model for Learning Disabilities** - It was agreed should report on the new model for Learning Disabilities and the impact this may have.
- **Elimination of Mixed Sex Accommodation** - Commissioners expected a report at the next meeting from a piece of work, which had been undertaken in this area.
- **IAPT** – the trust has been asked to produce a project plan for the introduction of shadow outcome based costing for IAPT as part of the national initiative

2.5 Other Acute Providers

The largest overspend variances year to date are at UHNM, Wye Valley UHB and Countess of Chester. Month 9 saw high Critical Care costs at both UHNM and Wye Valley with obvious implications for the outturn position.

Out of County Acute Contracts	Annual Plan (£)	Outturn (£)	Variance vrs Plan (£)	Variance vrs Plan (%)
Nuffield Health	1,456,269	1,257,633	(198,636)	(13.6%)
The Royal Wolverhampton Hospitals NHST	4,075,299	3,968,073	(107,226)	(2.6%)
Worcestershire Acute Hospitals NHST	4,182,324	4,226,033	43,709	1.0%
University Hospital of North Midlands NHST	3,602,553	4,054,118	451,565	12.5%
Betsi Cadwaladr ULHB	2,925,206	2,883,839	(41,367)	(1.4%)
Wye Valley NHST	3,574,322	3,847,746	273,424	7.6%
University Hospitals Birmingham NHSFT	1,535,654	1,674,325	138,671	9.0%
The Royal Liverpool and Broadgreen University Hospitals NHST	142,546	134,828	(7,718)	(5.4%)
Sandwell and West Birmingham Hospital NHST	254,919	307,899	52,980	20.8%
Countess of Chester Hospital NHSFT	428,639	548,262	119,623	27.9%
Mid Cheshire Hospitals NHSFT	744,134	700,890	(43,244)	(5.8%)
The Dudley Group NHSFT	523,294	515,062	(8,232)	(1.6%)
Birmingham Children's Hospital NHSFT	404,800	431,504	26,704	6.6%
Heart of England NHSFT	232,297	294,803	62,506	26.9%
The Royal Orthopaedic Hospital NHSFT	203,743	184,921	(18,822)	(9.2%)
Total Out of County Acute Contracts	**£24,285,999**	**£25,029,936**	**£743,937**	**3.1%**

2. 6 West Midland Ambulance Service

Activity / Finance

The activity target for this contract was 0.1% over plan, but there is a total overspend of 14k when non activity related expenditure is included.

Finance					Activity				
Annual Plan	Ytd Plan	Ytd Actual	Ytd Variance	Ytd %	Annual Plan	Ytd Plan	Ytd Actual	Ytd Variance	Ytd %
£10,941,984	£10,941,984	£10,956,119	£14,135	0.1%	43,113	43,113	43,174	61	0.1%

3. Recommendations

- The committee is asked to note the current performance and actions.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.117
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	**Shropshire CCG Nursing, Quality and Patient Experience Assurance and Improvement Exception Report for the Quality Committee (QC).**
Responsible Director:	Barbara Beal, Interim Director of Nursing, Quality & Patient Safety
Author of the report:	Nursing, Quality, Patient Safety and Experience Directorate – **Senior Team** Shropshire CCG Editor: **Mrs. Sara Bailey**, Lead Nurse, Quality and Patient Safety Shropshire CCG and Barbara Beal Interim Director of Nursing SCCG
Presenter:	Mrs. Sara Bailey

Purpose of the report

The aim of this report is to provide Shropshire CCG Clinical Commissioning Governing Body with areas of concerns and areas of good practice, attributing each area to the NHS Outcomes Framework which sets out the improvements against which NHS England (NHSE) will be held to account during 2016/17. The information covers the key areas of Effectiveness, Safety and Patient Experience linked to the NHS Outcomes 5 Domains.

The five domains within the NHS Outcomes Framework are:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

Key issues or points to note:

Key issues and provider assurance regarding:

- Accident & Emergency 4 hour Standard
- Ophthalmology
- Maternity Services
- Never Events
- Planned review of Shropshire CCG Quality, patient safety and experience function and the measures taken by the CCG to seek further assurance.

Actions required by Governing Body Members:

To note and understand the key points/concerns/risk raised

To accept this report for information and assurance regarding the steps being taken to improve and monitor the quality and safety and patient experience in commissioned services.

Governance		Yes/ No
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice	
	A summary of the risks and any mitigating actions provided in the report.	Yes
2	Additional staffing or financial resource implications	
	Safe staffing levels submitted by each provider.	Yes
3	Health inequalities	
	None Identified at the time of the writing the report.	No
4	Human Rights, equality and diversity requirements	
	None identified at the time of writing the report.	No
5	Clinical engagement	
	Demonstrated as part of the QAP and across provider and commissioner teams.	Yes
6	Patient and public engagement	Yes
	Patient engagement and experience is sought as part of triangulating assurance regarding commissioned providers.	

1.0 CONTENTS

2.0 Introduction

Good quality healthcare is safe, clinically effective care with a positive patient experience. Quality is central to all aspects of commissioning within Shropshire Clinical Commissioning Group (SCCG) who monitor the quality of healthcare provision through quality indicators, dashboards, national standards and triangulation of data. SCCG is committed to achieving the best possible outcomes for the population of Shropshire.

The purpose of this report is to provide SCCG with accurate, relevant information and assurance regarding the quality and safety of commissioned services. The information presented in this report is taken from a variety of sources including provider Clinical Quality Review (CQR) meetings, performance reports and other relevant information including nationally contractual process entered into by commissioners and service providers. These arrangements are outlined in detail in the NHS standard contracts 2016/17. This report contains a selection of high level key indicators/ standards, which have been identified to be reported upon at this particular point in time. Due to the time frames and internal validation of provider information, there may be slight inconsistency with reporting timescales related to some providers in this reportreported health quality metrics. Regular formal CQR meetings are a requirement of the NHS Contract with Providers.

3.0 Executive Summary

3.1 Shrewsbury and Telford Hospital NHS Trust (SaTH)

Non Delivery of NHS Constitutional Targets - AE 4 hours Standards Urgent Care

The CCG continue to seek assurance from the Trust, triangulating with other sources of information relating to Patient experience, safety and quality, and is working closely with Telford and Wrekin CCG and NHSE.

The CCG has continued to carry out unannounced visits to the Trust since 1st December 2016 during times of high escalation to seek real-time assurance on patient care, safety and experience.

The Trust reported 16 12 hour Breaches on 27th January 2017 at PRH. The system review of these cases identified that no patients had experienced harm as a result of the extended waits and the A&E Delivery Board have received a report on learning to help prevent future reoccurrences.

The CCGs undertook an unannounced visit to review the quality, safety and experience of patients in April 17. During the snapshot visit patients who had been seen appeared to be well informed, maintained with food and hydration and cared for appropriately bearing in mind that they may be in a sub-optimal environment for their care. The observations were mainly

positive but also drew the attention of the attendees to one specific area of concern. Even though there had been no recent 12-hour breaches reported, it had been noted during this visit, there were five patients who had spent a considerable possibly unacceptable amount of time within the A&E department (up to ten hours) waiting for a decision. This was shared at the April 2017 CQRM and the Trust representatives shared this concern. At the May 2017 CQRM the Trust cited the commissioners on the implementation of the care bundle which is now in place for all patients across both ED sites. The Trust have committed to undertaking an audit of the care bundle documentation for a sample of patients, in order to provide a safe level of quality and safety assurance. The analysis of the audit will provide a understanding for the reasons why patients are experiencing long waits in the ED without a decision to admit and what action is being taken by the Trust to mitigate and prevent such long waits and ensure that the patients are safe and not at risk of harm.

A further unannounced visit was undertaken in May 2017 to ED RSH and during this visit the CCG's Quality Lead Nurse was made aware of a young person who had been in the ED for a considerable length of time waiting for a CAMHS assessment and assess to an appropriate bed. At the time of the quality and safety visit the CCG's Quality Lead Nurse was informed the CAMHS assessment had now been completed, an appropriate bed had been allocated and an ambulance was on its way from Birmingham to collect and take the patient. The Trust has reported this as a serious incident and they are undertaking a full root cause analysis.

Others key points:

- 4 patients had a "decision to admit" and were waiting for a bed in the hospital.
- There were no other patients who were experiencing long waits-
- There were no 12 hour trolley breaches.
- There were 3 patients waiting in the corridor waiting with ambulance crew for handover and to be accepted into ED.
- 2 further patients were expected in by ambulance
- Staffing – Additional escalation nurses had been brought in; 1 for the day shift and 1 for the night shift. A further nurse for the night shift to be requested at the 3pm ED meeting.

Neurology

The Trust reported to commissioners that the neurology service was under considerable pressure due to workforce issues. Commissioners have worked with the Trust to divert new referrals to another NHS provider and are seeking assurances in relation to those patients waiting and the potential for harm that may result. At the CQRM in April 2017 it was noted that there had been limited progress and assurance. Commissioners were informed at the May 2017 CQRM that a Task and Finish group is to be set up to by the Trust to monitor; the short, medium and long-term actions detailed in the action plan, quality, patient safety, performance, and to review the quality impact assessments (QIAs). Furthermore, the lack of progress and level of concern has been escalated within the CCG and is being progressed through the Contracting, performance and quality directors with SaTH by both CCGs. These concerns were also reported to NHSE and it whilst it was noted that Neurology is a national issue the CCGs have at the request of NHS E submitted an update report on the level of challenges, concerns, progress and assurance in June 17 to them. NHS E has also escalated the issues in both Shropshire and Staffordshire for advice due to the local, regional and national pressures on the service.

Ophthalmology

The plan for 3 sub-specialty areas to remain closed to new referrals with other provider's remains in place. The CCGs are monitoring the Trust on delivery of the agreed action plan. Concerns remain around the Trusts workforce plan as set out in neurology and will be monitored at the next and subsequent CQRM. It was also agreed with the Trust interim chief nurse that a workforce plan be presented at the next CQRM and assurance sought on a monthly basis. The Trust presented their action plan at the April 17 CQRM and it was noted

that there is limited progress and assurance, as well as a lack of understanding of the Serious Incidents reported. Both of these issues are being addressed through the SI review process and the ophthalmology task and finish group. These concerns were also reported to NHSE as set out above. Subsequently, since the last SaTH Trust Board April 17, SCCG are now in receipt of the report and considering this further with the Trust to determine whether it 'fits' with the CCG commissioning plans in line with the STP, Future Fit, and Five Year Forward Review. At the May 2017 Task and Finish group meeting commissioners were informed a paper on the Ophthalmology services at SaTH is to go to the Trust's Quality and Safety committee in May 2017. The CCG's are expecting to receive this paper on Friday 26th May 2017. This was also noted at the May 2017 CQRM.

The SCCG Governing Body is asked to note that a Joint Strategic Commissioning Meeting between SCCG, T&W CCG is being held with SaTH nhs Trust on Neurology, Ophthalmology, Dermatology, Spinal Surgery and all outstanding West Midlands Quality Review Service (WMQR) reviews to include Theatres, The Critically Ill child and Stroke and TIA services and Maternity Services

Workforce

This continues to be a significant issue for SaTH NHS Trust and its commissioners, therefore there is a specific focus being placed on this by the CCGs and is a standard agenda item on the CQRM from April 2017.

At the May 2017 CQRM the Trust reported that nursing agency usage continues at a high level due to service demand. The Trust are to present a paper to their Executive Directors outlining a number of options and incentives to improve Bank fill rate in order to reduce the reliance on agency workers. Following discussions at this meeting, CCG's are seeking further assurance on workforce issues and more in-depth analysis of the whole workforce profile in terms of medical and clinical and none-clinical groups. This is to be provided at the June 2017 CQRM.

NHSI rules on reporting have changed from April 2017 and the Trust is now required to provide data by type of shift (day, night/Saturday, Sunday/Bank holiday) and to provide details of the 10 highest earning and 10 longest servicing agency workers on a weekly basis.

The Commissioners have requested to be cited on the potential impact of IR35 legislation on off-payroll workers within the Trust to understand the impact that the legislation may have, i.e. the number of workers that may choose not to work for the trust because of the tax implications for them personally. This is to be provided at the June 2017 CQRM.

Maternity services

The Secretary of State has ordered a review of avoidable baby deaths at SATH by NHSI and NHSE. The CCGs are co-operating with the review as required.

The Trust was expected to deliver a review of maternity related SI themes, lessons learned and actions identified at the March CQRM. This did not happen and concerns were escalated to the Interim Director of Nursing at SATH to ensure that this was actioned. This was followed up at the May CQRM, and a specific SI maternity review meeting was held following that on 23rd May 17 (All Directors of Nursing from the CCGs and Trust were in attendance, invites were sent to the GP leads for quality and maternity. The meeting was productive and all parties have agreed the number of outstanding SI (4) and these are under review. It was also agreed that SaTH along with other providers would join a planned SI workshop that the CCGS are arranging. It was also agreed that a senior midwife would attend all future maternity SI review meetings from the Trust and the CCGs are currently sourcing an expert midwife to advise them on these going forward.

The Trust is working with Shropshire CCG on a review of the Midwife Led Units across the County. This is expected to conclude in August 2017 and will be a work stream of the newly established Local Maternity System Programme Board. Due to the planned review by NHSI the meeting planned for the 20th April 17 was paused to enable the CCGs to 'take stock' of the significant maternity services work programmes to ensure 'fit' with the review' and the requirements of NHSI and NHSE. The next meeting was held on the 18th May 17 and all activity and financial data has been received. The CCG are also in the process of securing the expertise of an external expert midwife to support the review, through the Maternity network as suggested by NHSE on the request of Shropshire CCG. The relevant recommendations of 'Better Births' are included in the terms of reference. (Please refer to the full governing report on the MLU for further information)

The CCG continue to support the LMS Programme board and are supporting the development and implementation of the work programme in line with Better Births.

At the April 17 SaTH CQRM both CCGs made a support offer to the Trust to establish a specific Maternity CQRM for 12 months to ensure that there is a significant, sustained and specific focus on maternity services going forward to support. It is considered that there is insufficient time in the current CQRM to enable this to occur. The CCGs had been formally advised w/c 16th May 17 that the Trust had declined this offer and instead offered a one off meeting. This position has now been addressed and agreed by all parties to increase the existing monthly SaTH CQRM by an hour each time for the next 12 months to focus specifically on maternity services and will remain under review.

WMQRS review of the Stroke service

The West Midlands Quality Review Service carried out a review of stroke and TIA services on 2nd February 2017.

Immediate Risks
Non-Thrombolysis Pathway (approx. 87% patients)

a) Care by Specialist Stroke Team

b) Imaging access

c) Access to community-based rehabilitation and support

Routing of referrals of patients with TIA through the Care Coordination Centre

The Trust CEO has responded to the WMQRS with assurances relating to these risks and has subsequently received a response to his queries from WMQRS. The CCGs are awaiting the Trusts action plan to progress these. Commissioners required sight of the Stroke Services action plan and progress, showing the short, medium and long term actions. At the CQRM in May 2017 the Trust informed the commissioners they were in now receipt of the report from WMQRS and they will provide their full action plan and progress on implementation at the June 2017 CQRM. Commissioners have been informed all the immediate risks identified above have been actioned.

WMQRS Review of Theatres

The West Midlands Quality Review Service carried out a review of theatre services on 15th and 16th March.

Immediate Risks were identified in relation to:

- The WHO safer surgery checklist
- The pre-operative checklist

- The checking of anaesthetic machines at RSH

The Trust's CEO has responded to the WMQRS with assurances relating to these risks and the CCGs are awaiting the Trusts action plan to progress these. The Trust CEO received a response from WMQRS to his lines of enquiry.

Commissioners required sight of the Theatres Services action plan and progress, showing the short, medium and long term actions. At the CQRM in May 2017 the Trust informed the commissioners they will provide their full action plan and progress on implementation at the June 2017 CQRM.

Assurances

The CCGs escalated their concerns related to the Trust's ownership and engagement at the CQRM meetings which has been declining in latter months. The Interim Director of Nursing at SATH has given assurances that this will improve with immediate effect. This was followed up on the 11th April 17 and assurances on progress sought. The interim Chief Nurse outlined the review process he has initiated internally and this is being monitored and assurances were sought at the April CQRM. This will be reviewed at the May 17 CQRM

The Care Quality Commission (CQC) report on SaTH NHS Trust is anticipated to be released in June 17 but this is yet to be confirmed. Once released this will be a focus of attention for the SaTH CQRM and SCCG Quality Committee (sub-committee) of the Governing Board and subsequently the board itself.

3.2 The Robert Jones and Agnes Hunt Hospital (RJAH)

Never Events

RJAH Orthopaedic Hospital have recorded and reported three Never Events during 2016/17:

Month Incident Occurred	Number of Never Events reported	Category
July 2016	**1**	**Wrong Site Surgery**
January 2017	**1**	**Wrong Site Surgery**
February 2017	**1**	**Wrong Site Surgery**

At the February NHS England Quality Surveillance Group (QSG) it was agreed for a review of all of the RCAs, actions planned and taken, and lessons learned to be undertaken by the CCGs, NHSI, NHSE and CQC leads to determine whether a recommendation should be made to the QSG for consideration of a risk review meeting. In April 17 the position is that the Trust had, up to the 3rd May 17, failed to submit and complete all Never Events for sign off or assurance. Two off them relate to spinal surgery and one to a procedure on the wrong finger. This was escalated to NHS England QSG April 17 and agreed with themselves and the Care Quality Commission that if the Trust failed to complete the review of the never events for sign off , a high level meeting involving NHS Improvement would be held by the 15th April 17. This has been escalated and following the Clinical Quality Review Meeting with the Trust on the 3rd May 17 the final Never Events report will be submitted to SCCG and Telford and Wrekin CCGs for review. NHS England and NHS Improvement, and specialist commissioning are fully sighted on the position.

Serious Incidents

At the CQRM in May the Director of Nursing presented a thematic review of the Trust's SI processes. An output of this was the request for support from the CCG and NHS E in terms of SI processes. A workshop was arranged and held on 18th May 2017. A representative from NHS E was also invited and attended. This was a informative session and identified the need

for further training in RCA's for all MDT members would be helpful and this would include the wider health economy. The CCG's are currently looking into this as a matter of priority.

Assurances

The CCGs escalated their concerns related to the Trust's ownership and engagement at the CQRM meetings which has been declining in latter months. This was followed up at the May 2017**.**

3.3 Shropshire Community Healthcare Trust

Emotional Health & Wellbeing Service

The transfer of this service to the new provider SSSFT is now taken place

Sustainability

NHSI continue to manage the SCHT Sustainability Board with partners to determine options for the future of the Trust with other providers.

Serious Incidents

The CCG Directors of Nursing have formally written to the Trust to raise concerns about the failure to complete SI on time and to the required standard in line with the national SI Framework. At the CQRM in May 2017 the Director of Nursing informed the members of their review of their internal scrutiny panel and its change in focus to be a lessons learnt panel.

3.4 South Staffordshire and Shrosphire Mental Health Foundation Trust.

Emotional Health & Wellbeing Service

With the transfer of this service to SSSFT the CCG will be seeking assurance at the May 2017 CQRM of the Trusts actions to address the waiting lists, issues around first point of access, delays to seeing consultants once in the service and clarity of the pathways.

3.5 FalckMSL Services non urgent Transport (FMSL)

Serious Incidents

FalckMSL have resubmitted outstanding RCA and action plan to risk team for review at the SI Scrutiny Panel on 18th May.

Joint meeting between FalckMSL and SaTH to discuss outcome of investigations into transfer breaches was held on 10th May. Root causes and themes have been identified and will be discussed with both providers in order to put in place actions for service improvements to mitigate further breaches.

3.6 Marie Stopes International (MSI)

Quality team have received assurance around MSI compliance with Abortion Act in terms of medical assessment/consent (HSA1 and HSA4 forms). The provider has now signed off their Standard Operating Policies for these processes and submitted them to the quality team as requested. The next CQRM will be held on 30th May 2017.

3.7 West Midlands Migrant Health Policy

The CCG's Quality Directorate Team had reviewed this policy in line with their portfolio of work and has identified any actions to address.

3.8 Transforming Care Partnership (TCP)

Shropshire TCP plan shows an overall reduction in in-patient beds from 29 to 14 beds by 2019.

There are 4 SCCG patients and 4 T&W patients in locked rehabilitation beds, this total of 8 means we are currently 1 over trajectory. There are 9 SCCG and 11 T&W patients in Specialised commissioned beds which means we are currently 2 over trajectory. This is due to a patient who has been in a secure bed due to a primary diagnosis of mental health, but has now been diagnosed as having a learning disability. Trajectories are reported monthly to NHSe and it is anticipated that we will be back on trajectory by the end of Q1. However NHSe regional teams are now being asked to monitor trajectories monthly. As we are 3 in total over trajectory, mitigating action plans and assurances are being sought to by NHSE to keep us on track.

Financial update
Confirmation has now been given from NHSe that funding associated with the resettlement of a patient will follow the patient. However, concerns have been raised that the full funding amount will not transferred and hasn't been for those discharged to date.

Indications are that only the cost of the new community placement will be considered for transfer to the TCP i.e. the full cost of the current placement will not transfer.

Discussions are taking place with NHSE to establish what happens if the cost of the community package increases following the initial assessment to seek reassurance that additional funding would be forthcoming from NHSE should this be the case.

The Shropshire footprint is currently forecasting significant revenue costs to both LA's and CCG's. Given current assumptions the two CCGs are facing a cost pressure of £864k which could rise to as much as £2.985 million depending on the flow of funds. The main financial risk is underwriting transitional resettlement without sufficient revenue to cover this.

The TCP Board have continued to discuss the work required to prepare for a discussion on the 'pro's and con's' of having a Pooled budget. A paper has been presented to the TCP Board meeting and shared with SCCG chief finance officer. It is anticipated that a final decision will be taken at the meeting in June, following feedback from the 4 organisations.

Decisions about the Transformation Funding and the Capital funding remain outstanding, although we have now been provisionally informed that we have been put through the first round of applications in order to secure the £68K for the refurbishment of Church Parade but not the £2.68m for the new build. NHSe have suggested putting in a new bid for a smaller development of 6 beds. This application needs to be submitted by the 31st May.

TCP Developments:
LeDer: A contract variation has been taken to each providers CQRM meeting. Quality leads at each organisation have agreed to notify any LD death via the Bristol link and will commit to reviewing LD deaths. Reviewers have now been identified to attend the training from each provider organisation. Shropshire goes 'live' from 1st June. GP's have all been informed. Information sharing is covered under a section 251 agreement. The MoU still needs to be signed off my all providers. This work links into the National Learning from Deaths Guidance which all providers are currently reviewing their mortality policies and processes to ensure they are meeting CQC requirements.

Annual Health Checks
The work to take forward the development of the revised tool continues. CSU Informatics have linked the new tool to EMIS, so a referral will automatically be generated from the GP to the LD team/ CYP team if the score from the health check identifies the need to additional support. The tool will link with the HEF (Health Equalities Framework) and the EHCP (Education and Health Care Plan). Shropshire has also been invited to be a pilot site for the children and young people's version of the HEF which would support the linkage to the EHCP. 3 GP practices in Shropshire and 3 in Telford will pilot the tool in May.

Dynamic Risk Register
Training re CTRs and the importance of raising awareness with colleagues on the 'Patients at Risk of Admission' – PARA register has taken place for professionals from health, social care and education.

4.0 Summary – Provider Quality Assurance- Dashboards and Exception reporting

Monthly quality performance dashboards as shared with the Area Team and are included within this report together with a summary of issues raised by exception.

4.1 Shrewsbury and Telford Hospital NHS Trust (SaTH)

4.1.1 The QAP is referred to the Board Assurance Framework for areas noted as a concern

4.1.2 Monthly Quality Dashboard (*Relative to this type of provider)*

		Jan-16	Feb-16	Mar-16	Trend	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17		YTD 16/17
Never Events		0	0	0	≈	0	0	0	0	1	1		3	0	0	0	0		5
No. of Serious Incidents > 60 days		6	10	13	↓	13	13	14	25	25	25	33	7	8	13	24	18		198
No. of Serious Incidents - Stop the Clock		1	0	0	≈	0	0	0	0	0	0	0	0	0	0	0	0		0
MRSA Bacteraemia		0	0	0	≈	0	0	0	0	1	0	0	0	0	0	0	0		1
C Difficile		3	2	0	↑	1	3	3	0	1	3	2	2	2	0	1	3		21
Pressure Ulcers Grade 2 Avoidable		2	2	0	↑	3	1	1	4	2	1	0	1	0	0	0	1		14
Pressure Ulcers Grade 3 Avoidable		0	1	3	≈	1	0	1	1	1	0	2	3	1	0	0	0		11
Pressure Ulcers Grade 4 Avoidable		0	0	0	≈	0	0	0	0	0	1	0	0	0	0	0	0		1
EMSA Breaches		0	0	0	≈	0	0	8	0	0	0	0	0	0	0	0	0		8
12 hour trolley breaches		0	0	0	≈	0	0	0	0	0	0	0	0	1	16	0	0		17
Mortality Rate	RAMI	80	107	84		86	85	80	82	86	75	112	74	136	TBC	TBC	TBC		TBC

Safety Thermometer - harm free care	96.4	98.4	94	↑	94.1	93	93	96	93.66	93.56%	94.90%	96.33	93.54	95.04	92.54	93.93%	94.17%
Complaints No.	23	25	31	↑	22	24	32	31	41	24	37	41	31	47	45	49	250
VTE Risk Assessments	96.05	96	95.5	≈	95.5	95.5	95.3	95.8	95.5	95.74%	95.4	95.64	95.1	95.31	95.38	tbc	95%

**Data provided by SaTH March 2017*

4.1.3 Safeguarding – Adults

In March 2017 there were ten safeguarding concerns raised involving the Trust – three by other care providers relating to potential deficits in care provided by the Trust and seven by the Trust relating to outside agencies. Of the ten cases, five have now been closed.

4.1.4 Safeguarding – Children

There was one referral made by the Trust to the local authority safeguarding team in March relating to a child. The outcome of their investigation is awaited.

4.1.5 Serious Incidents

There was one serious incident reported in March 2017 relating to a delayed diagnosis. This incident is currently being investigated.

4.1.6 In Service Pressure Ulcers (all grades)

At month 11 the Trust breached the internal targets set at the beginning of the year for in service pressure ulcers that were found to be avoidable following investigation. This has been identified as a serious concern at the SaTH CQRM April 2017. The Trust presented a detailed report on the actions taken and lessons learnt at the May 2017 CQRM.

Some of the factors that may have contributed to the higher than expected numbers include:

- The high vacancy rates experienced by the Trust meaning that agency staff have been utilised who may not have received recent pressure ulcer prevention training
- Recent shortfall in the Tissue Viability team has meant that training has not been available as often as planned however the team will be up to full strength by the end of April
- Equipment such as bedside chairs which have required replacement

Actions include:

- The Workforce Committee receive regular reports relating to the vacancies and actions being taken to address these and Care Groups are required to provide evidence of actions to keep people safe at the Confirm and Challenge sessions
- Recruitment to vacancies within Tissue Viability has been successful
- Bid to Capital Planning Group was successful and enough money has been made available to purchase enough chairs to remove all those that failed the recent audit.

4.1.7 Staffing figures

4.1.8 Infection Prevention and Control

CDI cases are attributed to acute trusts where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

Shrewsbury and Telford Hospital (Data to end March 2017)							
	This Month	In-month Target	*This Month 15/16*	Year End	*Year End 15/16*	16/17 Target	% Under/Over YTD Target
MRSA	**0**	**0**	*0*	**1**	*1*	**0**	**Breached**
CDI	**3**	**2**	*0*	**21**	*30*	**25**	**Achieved**

Source: PHE HCAI web surveillance system

MRSA Bacteraemia

For non-elective areas were below 95% in February, equating to 147 patients missed compared to 132 in January 2017. Planned actions include wards that have missed high numbers of patients being required to urgently review their procedures for ensuring that patients are screened. All wards must ensure that they check the daily list sent by IT to all wards of inpatients that have not been screened. The wards that show the highest numbers of missed screening are the main admitting wards such as the medical and surgical admissions units. *Clostridium difficile*

The year end position (21 cases) is lower than both the Trust's target of no more than 25 reported incidents in the year and the year end position for 2015-2016. However, in March the Trust reported three cases which were above the target of no more than two per month. Investigations are being carried out on all cases but the key trends appear to be delay in isolating patients due to the lack of side rooms and the use of antibiotics.

Outbreaks/Periods of Increased Incidence

One Vancomycin-resistant Enterococci period of increased incidence was reported at RSH site, involving 3 patients and one CDI period of increased incidence, involving 2 patients, was reported at PRH site in March 2017. Post infection reviews are currently in progress and samples of been sent for typing to confirm or rule out cross infection, however, immediate actions have been implemented to reduce the risk of transmission.

4.2.1 Shropshire Community Health Trust (SCHT)

4.2.2 Monthly Quality Dashboard

Monthly Quality Template 2016/2017 - SCHT															
#DIV/0!	Target 16/17	Trend	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD / Apr 16/17
Never Events	0	≈	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of Serious Incidents > 45 days	0	↑	0	1	0	0	0	0	0	0	0	0	0	3	4
No. of Serious Incidents - Stop the Clock	0	≈	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA Bacteraemia	0	≈	0	0	0	0	0	0	0	0	0	0	0	0	0
C Difficile	2	≈	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers Grade 2	0	≈	9	3	6	3	5	8	5	8	8	14	11	11	80
Pressure Ulcers Grade 3 or unconfirmed grade	0	↑	1	1	1	1	1	0	1	0	0	3	0	1	10
Pressure Ulcers Grade 4	0	≈	0	0	1	1	1	0	1	0	0	0	0	0	4
EMSA Breaches	0	≈	0	0	0	0	0	0	0	0	0	0	0	0	0
Safety Thermometer - harm free care	95%	↓	93.47%	97.07%	93.25%	92.51%	92.67%	94.94%	93.22%	94.83%	96.01%	93.21%	95.80%	93.83%	94.23%
Complaints No.		↑	10	11	19	15	5	15	7	8	2	9	5	8	106

VTE Risk Assessments	95%	↑	96.75	98.5	96.95	93.33	98.47	95.04	98.57	95.06	96.53	97.39	90.83	96%		96%

- *Data provided by SCHT March 2017*

4.2.3 Serious Incidents/ Never Events

There has been 2 SI's reported by SCHT on STEIS during March 2017
1 x category 3 pressure ulcer
1 x slip / trip / fall

The CCG Directors of Nursing have formally written to the Trust to raise concerns about the failure to complete SI on time and to the required standard in line with the national SI Framework.

4.2.4 Staffing figures

Staffing figures have been submitted to HSCIC via UNIFY as required. Overall fill rates are over 90% for both days and nights.

4.2.5 Infection Prevention and Control

CDI cases are attributed to the community trust where the sample was taken on the fourth day or later of an admission to a community hospital (where the day of admission is day one).

Shropshire Community Health Trust (Data to end March 2017)							
	This Month	In-month Target	*This Month 15/16*	Year End	*Year End 15/16*	16/17 Target	% Under/Over YTD Target
MRSA	**0**	**0**	*0*	**0**	*0*	**0**	**Achieved**
CDI	**0**	**0**	*0*	**0**	*5*	**2**	**Achieved**

Source: PHE HCAI web surveillance system

Outbreaks/Periods of Increased Incidence

No infection outbreaks or periods of increased incidents were reported in March 2017.

4.3 South Staffordshire and Shropshire Mental Healthcare Foundation Trust (SSSFT)

4.3.1 Quality Concerns - None have been escalated to the CCG Board Assurance Framework.

4.3.2 Monthly Quality Dashboard (Relative to this type of provider)

Monthly Quality Template April 2016/ 2017 - SSSFT														
	Apr-16	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**		**YTD Apr 16/17**
Never Events	0	0	0	0	0	0	0	0	0	0	0	0		0
No. of Serious Incidents > 45 days	0	0	5	1	0	0	1	0	0	0	0	0		N/A
No. of Serious Incidents - Stop the Clock	0	0	0	0	0	0	0	0	0	0	0	0		N/A
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0		0
C Difficile	0	0	0	0	0	0	0	0	0	0	0	0		0
Pressure Ulcers Grade 2	0	0	0	0	0	0	0	0	0	0	0	0		0
Pressure Ulcers Grade 3	0	0	0	0	0	0	0	0	0	0	0	0		0
Pressure Ulcers Grade 4	0	0	0	0	0	0	0	0	0	0	0	0		0
EMSA Breaches	0	0	0	*	0	0	0	0	0	0	0	0		0
Safety Thermometer - harm free care	90.8%*	90.7%*	88.2%	92%	94%	93%	90%	83%	Not available	Not available	Not available	Not available		90.00%
Complaints No.	6	5	2	2	1	1	0	1	3	2	3	3		29

**Data supplied by SSSFT March 2017*

4.3.4 Serious Incidents / Never Events
There were 5 SIs reported during March 2017.
1 x Abuse allegation of adult patient by 3rd party
2 x unexpected death of community / outpatient
1 x Suspected Suicide
1 x slip / trip / fall

4.3.5 Staffing figures

Staffing figures have been submitted to HSCIC via UNIFY as required. Overall fill rates are over 90% for both days and nights

4.4 The Robert Jones and Agnes Hunt Hospital (RJAH)

4.4.1 Quality Concerns - Commissioners continue to seek assurance from the Trust, via CQRm that:

- A review of patients to identify any unintended Harm as a result of delay for appointments of treatment continues.
- Patient experience has been considered and monitored in terms of access

4.4.2 Monthly Quality Dashboard (Relative to this type of provider)

	Jan-15	Feb-15	Mar-15	Target 16/17	Trend	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-16	Dec-15	Jan-16	Feb-16		YTD 16/17
Never Events	0	0	0	0	≈	0	0	0	0	1	0	0	0	0	1	1		3
No. of Serious Incidents > 60 days	1	2	3	N/A	↑	1	1	2	2	3	3	7	0	2	4	6		31
No. of Serious Incidents - Stop the Clock	0	0	0	N/A	≈	0	0	0	0	0	0	0	0	0	0	0		0
MRSA Bacteraemia	0	0	0	0	≈	0	0	0	0	0	0	0	0	0	0	0		0
C Difficile	0	0	0	0	≈	0	0	0	0	0	0	0	0	0	0	0		0
Pressure Ulcers Grade 2	2	2	2	N/A	↓	0	0	0	0	0	0	1	3	1	5	0		10
Pressure Ulcers Grade 3	0	0	1	0	≈	0	0	0	0	0	0	0	0	0	0	0		0
Pressure Ulcers Grade 4	0	0	0	0	≈	0	1	0	0	0	0	0	0	0	0	0		1
EMSA Breaches	0	0	0	0	≈	0	0	0	0	0	0	0	0	0	0	0		0
Mortality Rate - Unexpecte	0	0	0	N/A	↓	0	0	0	0	0	0	0	0	1	0	0		1

d																		
Safety Thermometer - harm free care	94.19	94.12	97.37	95	↓	92.56	92.4	95.73	96.99	91.79	91.54	91.61	88.9	95 %	97.65 %	96.75 %		95.00 %
Complaints No.	7	5	6	N/A	↓	10	9	7	2	14	8	11	11	9	8	7		96
VTE Risk Assessments	100	99.83	100	95%	≈	100	99%	100	99.91	99.81	100.00 %	100	100.00 %	95 %	99.92 %	99.92 %		95.00 %

- Data provided by RJAH March 2017

4.4.3 Serious Incidents

There were three serious incidents reported in February 2017.

- A patient who was admitted for surgery in October 2016 and acquired a grade three pressure sore where the back of their leg was rubbed by the camp splint over the achilles tendon.
- A patient who was transferred from RSH and then fell. A CT scan revealed subdural haematoma.
- Wrong site surgery, reported by the Trust has a Never Event. A patient underwent decompression surgery. In addition to the planned L4/5 decompression, the L3/4 was also opened. Other than a twenty-minute increase in surgical time there was no adverse effect on the patient and no plans for further surgery as a consequence. The incident was reported to the patient verbally and in writing. A full root cause analysis is underway.

4.4.4 Falls

There were sixteen inpatient falls in February 2017 that equates to 2.23% of inpatient activity. There was one further outpatient fall. One fall resulted in a subdural haematoma that is also reported as a serious incident. There were five falls that resulted in low level harm of bruising (2) and skin graze/tear (3). Action: There is ongoing work in this area looking at various themes surrounding falls. Improvements are being made to ensure timely and accurate data is captured from the patient and staff on duty. A process chart is being worked on in relation to the communication and management of outpatient falls. There was one unexpected death in the Trust in February 2017. A surgical patient 23 days after a total knee replacement. Action: A root cause analysis is underway by the Surgical Division and in turn to the Trusts Quality and Safety Committee.

4.4.5 Infection Prevention and Control

CDI cases are attributed to specialist trusts where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

Robert Jones & Agnes Hunt Hospital (Data to end March 2017)							
	This Month	**In-month Target**	***This Month 15/16***	**Year End**	***Year End 15/16***	**16/17 Target**	**% Under/Over YTD Target**
MRSA	**0**	**0**	*0*	**0**	*0*	**0**	**Achieved**
CDI	**0**	**0**	*0*	**0**	*0*	**2**	**Achieved**

Source: PHE HCAI web surveillance system

Outbreaks/Periods of Increased Incidence

No infection outbreaks or periods of increased incidents were reported in March 2017.

4.4.6 Staffing Figures

Staffing figures have been submitted to HSCIC via UNIFY as required. Overall fill rates are over 90% for both days and nights.

4.5 Falck Medical Services Ltd (FMSL)

Serious Incident review
Provider has re submitted the updated RCA and action plan to the risk team for review and closure at SI scrutiny panel meeting on 18th May.

Joint meeting is to be held between Falck MSL and SaTH to discuss the root causes of breaches and agree remedial actions with commissioners. Action plan has been drafted following review of the themes picked out from each breach and its individual root cause. There are recurrent themes which apply to both providers and although these themes have also run through earlier breaches, neither provider appears to have learned any lessons in terms of quick wins around communication.

4.6 Community Ophthalmology CHEC

This is a new provider, commissioned to start delivery of their services May 2017. The first CQRM with CHEC was held on 4th April 2017 to finalise and sign off the contract. 2017 CQUIN offer has been shared with the provider and agreed. No further update available**.**

4.7 Primary care walk-in service (co-located with A&E from IMH Group - formerly Malling)

CQRM and a QA visit are planned for May 2017. No further update available.

4.8 Pain Management Services Ltd

CQRM was held on 25th April 2017 and the CQUIN offer was signed off.

A number of issues have arising from the loss of RJAH pain service.

The process for those patients to be discharged to PMS from RJAH is still to be confirmed. This may be via RAS to protect PID and to avoid discharge back to the GP requiring a new referral to PMS. A joint meeting is to be convened as a matter of urgency between both providers to discuss details in terms of the numbers of the different cohorts of patients discharged from RJAH and pathways, as agreed with commissioners.

Commissioners are aware that there are a number of patient complaints which require action from RJAH and have requested that a formal letter is sent to the Trust to request a meeting to resolve the outstanding issues.

Safeguarding dashboards are to be included in the new contract for quarterly reporting and the next QA visit is scheduled for 18th May 2017.

4.9 Marie Stopes International (MSI)

MSI repatriation of surgical Termination of Pregnancy services to Telford site is now complete.

Quality team have received assurance around MSI compliance with Abortion Act in terms of medical assessment/consent (HSA1 and HSA4 forms). The provider has now signed off their Standard Operating Policies for these processes and submitted HSA1 to the quality team as requested. HSA4 awaiting internal sign off.

Standard Operating Procedure (extended

CQRM planned for 30th May 2017. Clinical Lead (MSI) has been asked to attend the May CQRM for operational overview since repatriation.

4.10 Shropshire Skin Clinic

A contract meeting was held on 31st March to finalise activity and financial issues and also to discuss the CQUIN offer and agree. The provider required clarity on the wording of the 'cost effective prescribing' CQUIN and this has been picked up by the head of medicines management.

4.11 Integrated Out of Hours service (Shropdoc and NHS 111 Care UK)

NHS 111 (Care UK)

The clinical governance meetings for the NHS 111 service will continue and joint meetings will be held between Shropdoc, Care UK and the CCGs going forward. Head of Safeguarding has met with NHS 111 to discuss Safeguarding reporting requirements.

Shropdoc

CQRM held on 6th April 2017. During the meeting, the provider confirmed that they have served 3 months' notice on 1st April 2017 on the out of hours district nursing service provision because they say it is not financially viable for them to provide a service only to Shropshire when T&W have decommissioned their service.
Shropshire CCG commissions this service via Shropshire Community Trust (SCHT) who sub-contracts with Shropdoc. Commissioners have confirmed that discussion between Execs and SCHT to secure continuity of service.

4.12 Physiological Measurements Services Limited

QA visit was undertaken on 9th May 2017 and a report is in progress. A draft CQUIN has been prepared which will be shared with the provider ready for sign off for new contract by 19th May 2017.

4.13 Care Homes and Domiciliary Care providers.

Five quality assurance visits have been undertaken in May 2017. These have been done with the IPC team and supported by Learning Disabilities commissioner and Complex Discharge commissioner. Quality Assurance reports have been submitted to each provider along with recommendations where required.

The process around getting agreement around the content of the service specification and how the CCG will roll this out to all 120 providers across the county remains unclear although there is clear commitment to this from Execs.

Provider engagement remains an issue in the effective monitoring of contracts for this cohort of providers. In the 2015/16 contract, the complex care portal was identified as the route providers were asked to submit their quality returns (dashboard/CQUINs) through, so if we were to include a dashboard (or CQUIN) within the 2017 contract, we would need to look at whether this is the most appropriate portal and have full engagement from providers.

Although the monthly quality return template (dashboard) has been modified, it cannot be included it in the 2017 contract until these concerns have been resolved and appropriate continued resource within the quality team is secured.

Serious Incident reporting

An incident which took place in March but which was reported to the quality team in early May appears to involve issues around the appropriate administration of the CHAS in this particular home. The quality team have asked medicines management (care homes coordinator) to liaise with both the provider and the GP practice in question to identify any learning and provide support where required. In addition to this, the quality team also has some concerns relating to the provider's SI reporting and investigation processes. This will be picked up with them in the recommendations set out in the QA report.

During a QA visit to another provider and potential Safeguarding incident was identified resulting in immediate changes requested from the provider. In addition to these remedial actions, a multi-agency teleconference was held on 11th May to discuss the issues, identify emerging concerns and plan next steps. The provider will continue to remain on the agenda at information sharing forums.

A care homes provider spreadsheet is in place which is monitored and managed by the quality team and which will be updated monthly with intelligence from both inside and outside the CCG. This will inform the senior quality team of emerging concerns/risks which can then be managed appropriately and where appropriate concerns will be escalated to Quality Assurance Panel.

5.0 Infection Prevention and Control

5.1 Shropshire Clinical Commissioning Group

CCG targets are based on cases amongst the population for which the CCG is responsible.

CDI cases are attributed to the CCG whether acquired in acute hospitals (within or outside the local health economy) or within the community and where this is not possible, attributed to the 'lead' CCG for the trust reporting the case. Shropshire CCG is designated the lead organisation for the local acute trust, Shrewsbury and Telford Hospital and Robert Jones and Agnes Hunt Hospital.

Shropshire Clinical Commissioning Group (Data to end March 2017)							
	This Month	In-month Target	*This Month 15/16*	Year End	*Year End 15/16*	16/17 Target	% Under/Over Target
MRSA	**0**	**0**	*0*	**0**	*0*	**0**	**Achieved**
CDI	**5**	**6**	*2*	**58**	*88*	**73**	**Achieved**

Source: PHE HCAI web surveillance system

MRSA Bacteraemia

Out of the 22 CCGs in the West Midlands, Shropshire CCG is 1 of 15 (68%) who achieved the zero tolerance for MRSA bacteraemia in 2016/17.

In 2016/17 one case of MRSA bacteraemia was diagnosed in a Powys resident and was provisionally assigned to Shropshire CCG, However, the post infection review failed to identify any lapses in direct or indirect patient care by local health services which would have contributed to the MRSA infection or would have prevented the MRSA bacteraemia occurring and as a result the case was referred through the arbitration process. The arbitration panel at

NHS England Midlands and East agreed with this decision and finally assigned the case to Third Party and not Shropshire CCG.

Clostridium difficile

Of the 58 cases reported in 2016/17:

- 14 acute trust attributed (diagnosed post 72 hours of admission to hospital), 10 cases in SaTH, 2 cases in University Hospital North Midlands, 1 case in Worcestershire Royal Hospital and 1 case in Torbay Hospital, Torquay.

- 44 community attributed (diagnosed either pre 72 hours of admission to an acute hospital or from samples taken from patients in the community), which includes:
  - 7 relapsed cases (16%), including a case who relapsed twice and therefore accounts for 3 of the 44 community cases
  - 12 cases (28%) diagnosed in Powys residents, 2 of which were inpatients at Welshpool Hospital and 2 were relapsed cases

NB: Relapse cases are positive samples on the same patient more than 28 days apart. These are reported as a separate cases and count against CCG target

Out of the 22 CCGs in the West Midlands, Shropshire CCG is 1 of 9 (41%) who achieved their CDI target in 2016/17.

The table below details Shropshire CCG's performance since 2008 when specific targets for commissioning organisations were first introduced, together with the proportion of CDI cases which were attributed to either the community or an acute trust.

Shropshire CCG						
Year	**National Target**	**Total Cases Reported**	**Acute Attributed**	**Community Attributed**	**% Reduction/Increase in cases on previous year**	**% Reduction since 2008**
2016/17	73	**58**	14 (24%)	44 (76%)	**34%**	
2015/16	73	**88**	26 (30%)	62 (70%)	**22%**	
2014/15	97	**72**	23 (32%)	49 (68%)	**18%**	
2013/14	81	**88**	27 (31%)	61 (69%)	**19%**	
2012/13	97	**109**	32 (29%)	77 (71%)	**1.8%**	**68.3%**
2011/12	98	**111**	39 (35%)	72 (65%)	**18%**	
2010/11	222	**136**	57 (42%)	79 (58%)	**9.9%**	
2009/10	230	**151**	57 (38%)	94 (62%)	**17.5%**	
2008/09	282	**183**	110 (60%)	73 (40%)		

Source: PHE HCAI web surveillance system

The CCG IPC lead Nurse is currently performing an in-depth analysis of all the CDI cases reported in Shropshire residents in 2016/17. Once completed the findings, including common themes for learning will be shared across the local health economy including primary care and will be reported to QPR committee and to the Clinical Quality Review Meetings with Shrewsbury and Telford Hospital for further discussion and assurance.

5.2 *Clostridium difficile* Sanction Implementation

The established commissioner led CDI Appeals Panel across Shropshire and Telford will continue to meet quarterly in 2017/18 to review individual CDI cases which SaTH and RJAH determine through their post infection reviews that no lapse of care occurred within their

control which directly or indirectly contributed to the CDI case. Successfully appealed cases will then not counted against the provider's objective for the purposes of calculation of financial sanctions as set out in Schedule 4G of the 2016/17 NHS Standard Contract.

The CCG IPC lead Nurse has reviewed the panel process, strengthening the reporting requirements from providers of the actions taken when cases submitted to the panel are not upheld. These reports will be shared through the commissioner led Clinical Quality Review Meetings with relevant providers for further discussion and assurance.

Providers are still required to report all cases of CDI fulfilling the current national reporting requirements via the Public Health England Data Capture System and to declare these cases as part of their objective.

5.3 Quality Premium 2017-19 Bloodstream Infections Part a) reducing gram negative bloodstream infections across the whole health economy

The 2017/18 Quality Premium reduction targets for Escherichia coli (E. coli) bacteraemia were published in March 2017.

The table below details the numbers of cases reported in Shropshire CCG and Telford and Wrekin CCG populations during the baseline period January – December 2016 and the required performance in 2017/18.

E.coli Bacteraemia			
	Baseline Data Jan - Dec 2016	**2017/18 Threshold**	**2017/18 Target**
Shropshire CCG	228	10% reduction reported at CCG level based on 2016 performance	205
Telford and Wrekin CCG	106		95

It is believed locally these targets will be a significant challenge for the CCGs to achieve for a number of reasons including:

- Reverse a rising trend E.coli bloodstream infections(BSI) and decrease the number of cases by at last 10% - nationally BSI have been increasing year on year – last year locally Shropshire and Telford reported a 11% increase over previous year.
- A significant number of E.coli BSI are not healthcare related.
- A significant number of the healthcare related E.coli BSI are difficult to prevent as they are linked to neutropenic sepsis (which is mostly about early detection) and infected biliary stents.
- The sepsis CQUIN asks hospitals to raise sepsis screening. This includes taking early blood cultures and is likely to increase the number of bacteraemias through better ascertainment.
- The vast majority of E.coli BSI are diagnosed within 48hrs of admission to the acute trust therefore interventions would need to be in the community i.e. treating urinary tract infection (UTI) more effectively before it becomes a bacteraemia. However, this would involve giving more antibiotics which would run counter to Part b & c of the 2017/18 Quality Premium indicator which requires a reduction in antibiotic prescribing for UTI in primary care.

The Quality Premium also requires the CCG to collect a core primary care data set for all E. coli bacteraemias and make use of the data to identify opportunities and potential interventions to reduce the risk of E. coli bacteraemia in the CCGs population. The CCG IPC lead nurse has developed a tool and devised a process to enable Primary Care to submit the data required to the CCG IPC team - see Appendix 1. The CCG IPC lead nurse has

requested an invitation to attend the locality Practice Manager Forums to discuss the expectations and requirements.

The Local Health Economy IPC Group will be the forum for taking forward specific work streams on the interventions to reduce the risk of E. coli bacteraemia across the whole health economy. At the meeting in March 2017, it was agreed that a local health economy Task & Finish sub-group would be established to focus on the potential interventions to reduce/manage urinary tract infections & urinary catheters in primary and secondary care.

5.4 Healthcare Associated Infection Performance Targets 2017/18

The zero tolerance for MRSA bacteraemia continues in 2017/18.

Due to other pressures on the system NHS Improvement has announced the CDI objectives in 2017/18 are the same as those for 2016/17:

- Shropshire CCG = 73
- Telford and Wrekin CCG = 20
- Shrewsbury and Telford Hospital = 25
- Robert Jones and Agnes Hunt Hospital = 2
- Shropshire Community Health Trust = 2 (Local objective)

The CCG remains committed to a zero tolerance approach to all avoidable infections. We will continue to work in partnership with our the local health and social care providers to ensure a whole-systems approach is taken in reducing the incidence of CDI and other infections and maintain and improve standards of quality and patient safety.

5.4 IPC Quality Monitoring of NHS Providers and Independent Care Sector Providers

The CCG IPC team are involved with all infection related Incidents, post infection reviews and monitoring of subsequent action plans to reduce the risk of reoccurrence.

The CCG IPC team are members of all provider trusts IPC committees. This continues to support our collaborative approach to IPC and provide assurance to the CCG regarding actions taken to comply with IPC standards and the Code of Practice on the prevention and control of infections.

In March 2017 the CCG IPC team participated in unannounced commissioner led quality assurance and patient safety visits to a number of wards at SaTH and two wards at RJAH. The observations of the visit have been formally feedback to the Trusts. The actions to address the quality and patient safety concerns will be monitored through the Clinical Quality Review meeting with both organisations.

As a result of IPC concerns raised during the planned programme of IPC audits or by the wider CCG Quality team and or the CCG and Local Authority Safeguarding teams a number of nursing homes continue to be supported by the CCG IPC team namely Arden Grange, Bradeney House, Cloverfields, Edgeley House, Elmhurst, Hillcrest Manor, Maesbrook, Meadowbrook and The Vicarage.

Supportive resource/packages have been shared with the care home managers and the agreed service improvement plans to raise standards continue to be monitored by the CCG IPC team.

6.0 CCG Quality Team Re-Assurance and Triangulation

The Clinical quality team actively participate and the groups as outlined below to seek quality assurance and triangulation information.

Quality Meeting	SCCG Representation	Frequency of Meetings	Key Messages
Clinical Serious Incident review	Chair DoN/Quality team	Fortnightly	Next meeting: 8th June 2017
LHE Infection Prevention Control Group	Chair IPC Lead Nurse	Quarterly	Next meeting: June 2017
Infection Prevention and Control Committee	IPC Lead Nurse	SaTH Monthly RJAH Quarterly SCHT Bi-monthly	As per Trust meeting schedule
Adult Safeguarding Board	DoN/Quality & Safeguarding Lead	Quarterly	Next meeting: June 2017
Children's Local Safeguarding Board	DoN/Quality & Safeguarding Lead	Quarterly	Next meeting: June 2017
136 LHE Partnership Board	Chair DoN/Quality	Monthly	Next meeting: May 2017
Quality Surveillance Group	DoN/Quality and Accountable Officer	Bi Monthly	Next meeting: 22nd June 2017

7.0 Appendices

Appendix 1- Quality Premium 2017-19 Bloodstream Infections Part a) Explanatory Notes and Primary Care Data Set

Appendix 2 - Infection, Prevention and Control Quarter 4 Report

Appendix 1

Quality Premium 2017-19

Bloodstream Infections

Part a) reducing gram negative bloodstream infections across the whole health economy

Shropshire and Telford and Wrekin

Explanatory Notes and Primary Care Data Set

Version 1 - April 2017

On behalf of:

Shropshire Clinical Commissioning Group
and
Telford and Wrekin CCG Clinical Commissioning Group

Contents:

Background:

In response to Lord O'Neill's Review on Antimicrobial Resistance (May, 2016) the Government has set an ambition to reduce Gram Negative Bloodstream Infections (GNBSIs) by 50% by 2020.

Rationale:

Healthcare-associated GNBSIs pose a significant health risk and threat to patient safety. Escherichia coli (E. coli) bacteraemia is the largest most prevalent group of GNBSI which supports the focus on reducing these bacteraemias over the next 2 years.

The reporting of E. coli BSI is already mandatory via the Public Health England Data Capture System (PHE DCS) and this provided data on which the baseline was established and the reduction targets set for 2017/18.

Reduction targets will be revised nationally for 2018/19 when (through the work done as part of the 17/18 QP) we will understand where and how greater improvements can be supported.

Supporting documents:

Bloodstream Infections Quality Premium 2017-19 Annex - Part a) reducing gram negative blood stream infections across the whole health economy.

https://www.england.nhs.uk/publication/part-a-reducing-gram-negative-blood-stream-infections-bsi-across-the-whole-health-economy/

Threshold:

Part a) reduction in the number of gram negative BSI across the whole health economy. The required performance in 2017/18 must be:

i. a 10% reduction (or greater) in all E. coli BSI reported at CCG level based on 2016 performance data.

E.coli Bacteraemia			
	Baseline Data Jan - Dec 2016	**2017/18 Threshold**	**2017/18 Target**
Shropshire CCG	228	10% reduction reported at CCG level based on 2016 performance	205
Telford & Wrekin CCG	106		95

ii. collection and reporting of a core primary care data set for all E. coli BSI in Q2 - 4 2017/18.

CCGs are expected to use Q1 2017/18 to establish a local approach to capture the core primary care data which will relate to the patient care in the 4 week period pre E. coli BSI.

CCGs cannot submit to DCS directly. PHE are awaiting funding decision to enable changes to DCS functionality to enable CCGs to be able to enter data directly in the future.

In 2018/19 reduction thresholds will be reviewed against the latest activity to ensure the QP supports the maximum appropriate reduction gains. Collection and reporting of a core primary care data set for all E. coli BSI will continue during 2018/19.

CCG Attributing of Cases

NHS Connecting for Health's Demographics Batch Service and Organisation Data Service are used to attribute E. coli bacteraemias. The CCG for each case is attributed, in the following order:

- If patient's GP practice code is available (and is based in England), the case will be attributed to the CCG at which the patient's GP is listed;
- If the patient's GP practice code is unavailable but the patient is known to reside in England, the case is attributed to the CCG catchment area in which the patient resides;
- If both the patient's GP practice code and patient post code are unavailable or if a patient has been identified as residing outside England, then the case is attributed to a CCG based upon the postcode of the HQ of the acute Trust that reported the case.

Data Capture Process:

- NHS trusts report mandatory patient data of all E. coli BSI monthly through the existing PHE DCS and sign off the data by the 15th of the following month;
- The CCG Infection Prevention Control (IPC) team extract the information from the PHE DCS for Shropshire and Telford and Wrekin CCG population the next working day, and merge onto the primary care data set;
- GP Practices are asked to complete requisite primary care data electronically on their patients who have had an E. coli BSI reported in the preceding month;
- Completed primary care data set submitted to CCG IPC team generic email address CCG.IPC@nhs.net by the end of the month.

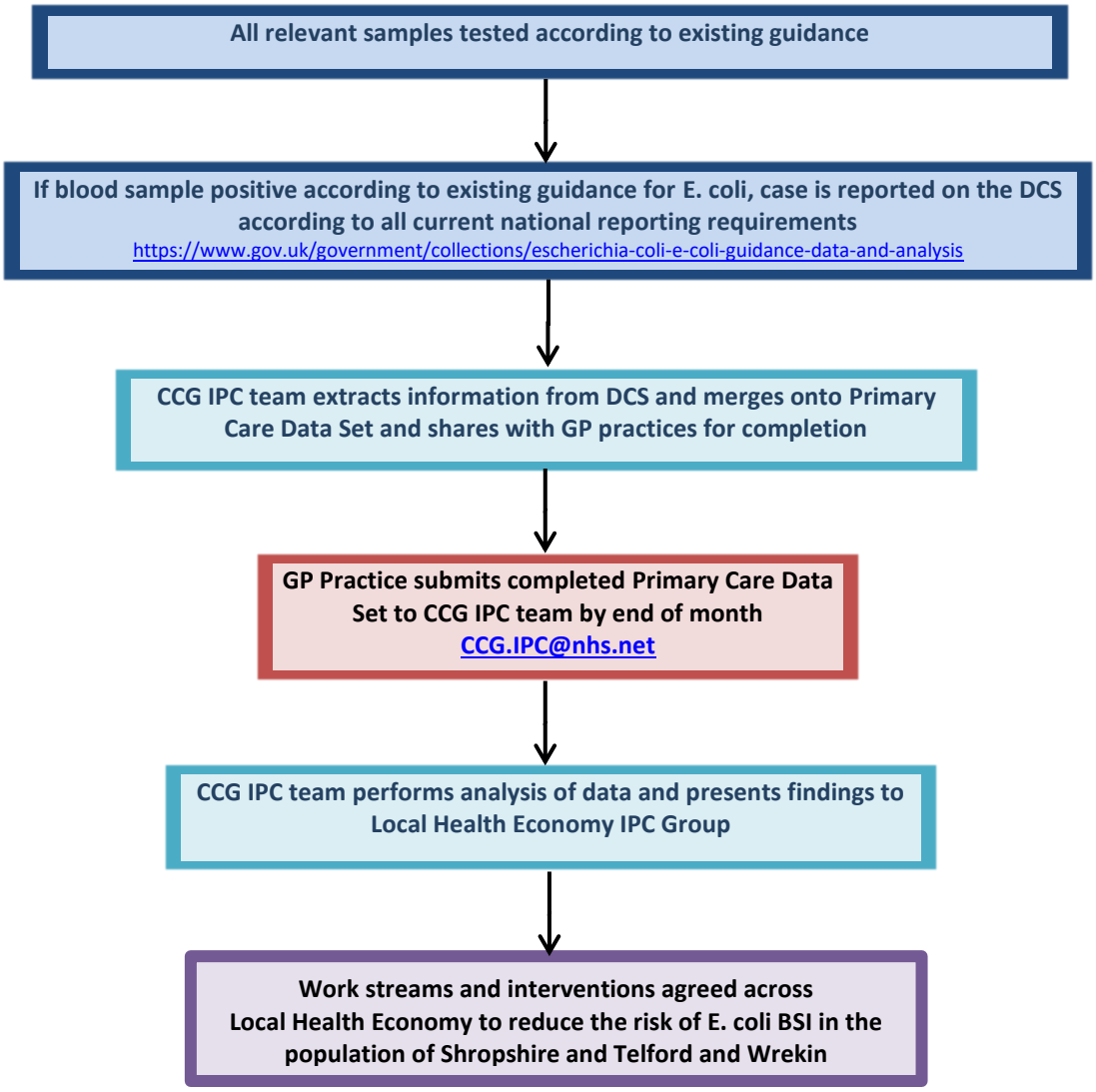
Analysis and Use of Data:

The CCG IPC team will perform analysis of the requisite data through the existing PHE DCS reporting system for E. coli BSI and the primary care data set.

A quarterly report will be presented to the Local Health Economy IPC Group to inform discussions, identify opportunities and potential interventions to reduce the risk of E. coli BSI in the population of Shropshire and Telford and Wrekin.

These reports and the anonymised primary care data set will provide evidence of data capture to NHS England via local assurance processes.

Data Capture Process Diagram:



E. coli bacteraemia Primary Care Data Set

Primary Care Data Set	
Diabetic?	Y/N
COPD?	Y/N
Hospital care 28 days prior to this bacteraemia?	Y/N
Urinary tract infection 3 months prior to this bacteraemia case?	Y/N
Urinary catheter (including intermittent or temporary) inserted, removed or manipulated 28 days prior to this bacteraemia?	Y/N
Surgery 28 days prior to this bacteraemia?	Y/N
Insertion of prosthetic material 12 months prior to this bacteraemia (e.g. joint replacement, pacemaker, heart valve)?	Y/N
Open wounds or ulcer (excluding diabetic foot infection) 28 days prior to this bacteraemia?	Y/N
Diabetic foot ulcer or infection 28 days prior to this bacteraemia?	Y/N
Number of antibiotic courses prescribed by GP 28 days prior to this bacteraemia	
Antibiotic name	
Indication (Reason for)	
Date antibiotic was prescribed	
Duration (how many days)	
Dose (e.g. 250mg)	

Infection Prevention and Control Report

Quarter 4 - 2016/17

1. Introduction

This fourth quarter report details the progress of the CCG Infection Prevention and Control (IPC) team's quality improvement programme across primary care and the independent care sector. The paper covers the period January – March 2017

2. Outbreaks – Independent Care Sector

2.1 Outbreaks

Fourteen gastro-intestinal outbreaks reported within the independent care sector were supported by the CCG's IPC team. None of the outbreaks were confirmed by the laboratory to be caused by norovirus, however due to the clinical signs and symptoms norovirus was presumed to be the causative organism in all outbreaks and treated as such. During these outbreaks no residents were admitted to hospital as a result of diarrhoea and vomiting, dehydration or urinary tract infection.

Five care homes reported an increased incidence of respiratory infections to the IPC team. Three of the outbreaks were confirmed by the laboratory to be influenza A and one confirmed as respiratory syncytial virus.

During all outbreaks and periods of increased incidence of infection the CCG IPC team support care homes to implement policies and procedures to reduce the risk of transmission and to further support the local acute and community trust with patient flow, wherever possible the team also encourage homes to remain open to admissions or transfers back. This approach has been welcomed by the acute trust, particularly during periods of escalation.

2.2 Incidents

The CCG IPC team have provided advice to a number of care homes who were refusing to accept admissions and transfers back to the home as a result of infection or colonisation. In all the incidents this intervention has resulted in the homes agreeing to accept the patients, thereby assisting to alleviate bed pressures within the acute hospital. To support care homes further, the CCG IPC team have reviewed their training programmes to emphasis the practices care homes need to adopt to safely manage patients who are colonised or on antimicrobial therapy.

3. Quality Improvement Programme

The capacity of the IPC team was significantly reduced in 2016, as a result of the retirement of two nurses. However, recruitment of an IPC Specialist Nurse is currently in progress, which will support the development and delivery of the in 2017/18 programme.

3.1 Audit

The audit process is designed to support the independent care sector and general medical practices with compliance in relation to infection prevention, The Health and Social Care Act and to support Care Quality Commission (CQC) registration.
The audit tools used have been adapted by the IPC team from the Department of Health Saving Lives High Impact Interventions and Infection Prevention Society Quality Improvement Tools and focus on patient safety, cleanliness, care of invasive medical devices and direct observation of practices.

At the time of audit the IPC nurse verbally reports any areas of good practice and concerns to the member of staff accompanying them. A written summary report and detailed recommendations in the form of a service improvement plan is developed by the IPC nurse. Services are requested to return the completed service improvement plan within two weeks to the IPC team detailing the actions taken and a timescale for completing any outstanding issues. On return the plan is reviewed by the IPC nurse to ensure sufficient assurance is given to address issues identified and within an acceptable timescale. Support from the IPC team is offered to implement changes required to improve practice.

Services are also encouraged to undertake self-audit to sustain compliance with IPC standards of both the clinical environment and clinical practice.

Within the independent care sector an IPC audit reporting and escalation process has been agreed with Shropshire Council Contracts and CQC.

Independent Care Sector

Nursing Home	Audit Tool	Quarter 4		
		Jan-17	Feb-17	Mar-17
Ellesmere Community NH - Ellesmere	HCAI Prevention	86%		
	Urinary Catheter	50%		
Meadowbrook - Oswestry	HCAI Prevention	55%		
	Enteral Feeding	27%		
	Urinary Catheter	57%		
The Cedars - Albrighton	HCAI Prevention		76%	
	Urinary Catheter		79%	
Maesbrook - Meole Brace	HCAI Prevention		75%	
	Enteral Feeding		92%	
The Mount House - Shrewsbury	HCAI Prevention		84%	
	Urinary Catheter		71%	
Lady Forester - Much Wenlock	HCAI Prevention			85%
Elmhurst - Whitchurch	HCAI Prevention			74%
	Urinary Catheter			64%

Four nursing homes were audited as part of the planned programme during this quarter using the healthcare associated infection (HCAI) audit tool. All four homes failed to achieve adequate standards and will be supported by the IPC team to improve.

Meadowbrook nursing home was re-audited this quarter. Despite a comprehensive support package being delivered by the IPC team, disappointingly standards of IPC at the home had declined and systems shared with the home to manage, monitor and maintain standards had not been implemented. The IPC team will join the wider CCG Quality team and undertake a quality assurance visit to the home in April.

Maesbrook nursing home was also re-audited this quarter and showed little improvement with standards of IPC. The home has now appointed an IPC link nurse who has met with the IPC team to discuss ways of improving standards by using monitoring tools previously shared by the IPC team with the home. The IPC team will continue to offer support and will visit the home to monitor the progress of the service improvement plan.

Elmhurst nursing home was also re-audited and standards of IPC were seen to have improved slightly.

Common issues identified during the audits were staff immunisation records not in line with national guidance, contaminated resident monitoring equipment, no systems in place to monitor

IPC competencies, unsafe sharps practice and personal protective equipment not available at the point of care. The IPC team will support these homes to raise standards and monitor the implementation of the IPC service improvement plans.

Five urinary catheter audits were also carried out at the same time as the HCAI audits. Areas for improvement included completion of urinary catheter care plans, competency assessments for catheterisation and catheter care and a cleaning schedule for catheter bag stands.

Two enteral feeding audits were also undertaken. Areas for improvement include a cleaning schedule for pumps and stands, competency assessments for enteral feeding and storage of reusable syringes in an appropriate container.

A CCG quality assurance visit took place at Hillcrest Manor nursing home in February. It was pleasing to note that the improved standards following the audit undertaken in June 2016 had been sustained.

Due to previous poor compliance with IPC standards Arden Grange, Cloverfields and The Vicarage nursing homes continue to be supported and monitored by the IPC team.

3.2 Training

IPC training has been encouraged and where possible provided by a member of the CCG IPC team to individual medical practices and independent care providers.

The table below details the IPC training delivered January – March 2017.

Provider	Sessions Delivered	Attendance
Independent Care Sector	2	29

In addition:

In March the IPC team participated in the rolling educational programme for care homes arranged by the CCG Practice Support/Medicines Management Team, delivering a training session on the link between poor oral health and common infections including respiratory tract infections. A total of 12 staff from Shropshire care homes attended.

3.3 IPC Link Staff Meetings

A total of 23 practice nurses from Shropshire attended the IPC link forum held in January 2017. The focus of the forum was wound dressings for use with skin tears. An educational talk was given by Mölnlycke Health Care on the types of dressing products available in the local wound formulary, assessment of the skin area and wounds and dressing choice. `

The next independent care sector IPC link forum will be held in April 2017.

4. National & Local Policy/Drivers/Initiatives

4.1 Primary Care Surveillance

The CCG's IPC team continues to monitor 'alert organisms' (MRSA, CDI, E. coli) within primary care. The aim is to monitor specific organisms and share data with CCG Practice Support/Medicines Management Team to support prescribing of antimicrobials in primary care in accordance with local guidelines.

4.2 World Hand Hygiene Day – 5th May 2017

The CCG IPC team is supporting the independent care sector to take part in the World Hand Hygiene Day on the 5th May. Information and resources will be made available on the SPIC website for the sector to use to raise awareness of the importance of hand hygiene to residents, clients, visitors, relatives and staff.

4.3 Catheter Point Prevalence Survey

In May 2016 a point-prevalence survey to determine the occurrence of urinary catheters being used to manage urinary output amongst the nursing home residents in Shropshire and Telford was undertaken. The survey provided a better understanding of the numbers and types of urinary catheters amongst the nursing home population and valuable information into the reasons for urinary catheterisation. The information gleaned was used to support best practice in an attempt to reduce the use of urinary catheters amongst the nursing home population and ultimately the risk of infection.

The catheter point-prevalence survey will be repeated during the summer of 2017 to evaluate if there has been a reduction in the use of urinary catheters. This information will be also be useful when developing plans for delivering the new E.coli bacteraemia reduction targets which have been set at CCG level in 2017/18.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.118
Shropshire CCG Governing Body meeting: 7th June 2017

Title of the report:	Future Fit Update
Responsible Director:	Debbie Vogler Programme Director Future Fit
Author of the report:	Debbie Vogler
Presenter:	Debbie Vogler

Purpose of the report:

The purpose of this report is to:
Provide Board members with an update of progress on Programme delivery since the last meeting.

Key issues or points to note:

There has not been a Programme Board since February 2017 but one is scheduled for 8th June. The main purpose of the meeting will be to review senate and Gateway action plans and to agree the consultation plan and approach.

Work progresses on the independent review, the supplementary IIA and clarifying the Joint Committee arrangements. Independent members of the Joint Committee have been sought with the support of NHSE. These will be confirmed by Boards in their June Governing Body meetings.

The Programme timeline will need to be reviewed due to the delay in appointing the firm to perform the independent review of the option appraisal process. A delay in the decision making and consultation process is assumed. Any revised timeline will of course be potentially subject to change dependent on the outcome of the independent review which is expected to be known in mid July 2017.

Actions required by Governing Body Members:

NOTE the Programme Directors Update

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *The Future Fit Programme is in response to the increasing challenges of providing high quality, safe and sustainable acute and community hospital services.*	YES
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *The Future Fit model is clinically led and the programme continues to engage clinicians through the Clinical design work stream and the Clinical reference group (CRG) meetings. Reports into the GP locality meetings on a regular basis.*	YES
3	Objective 3 - Achieve Financial sustainability for future investment *The Future fit OBC has interdependency with the STP system deficit reduction plan.*	YES
4	Objective 4 - Visible leadership of the local health economy through behaviour and action	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *please provide details relating to objective 5*	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *The Future Fit Programme is in response to the increasing challenges of providing high quality, safe and sustainable acute and community hospital services.*	
2	Additional staffing or financial resource implications *Procurement of the independent review of the Option Appraisal and the additional IIA work will have a financial implication that is an unexpected cost pressure to the programme*	
3	Health inequalities *The impact on health inequalities forms part of the Integrated Impact Assessment work*	
4	Human Rights, equality and diversity requirements *An impact assessment has been carried out in 2016 and was reported to Programme Board in November. Further work is planned for 2017.*	
5	Clinical engagement *The Future Fit Programme continues to engage clinicians through the Clinical design workstream and the Clinical reference group (CRG) meetings. Reports into the GP locality meetings on a regular basis.*	
6	Patient and public engagement *The Future Fit Programme continues to undertake a comprehensive communication and Engagement process which is continually reviewed*	

Programme Director's Report

June 2017

1. Programme Plan – Progress Update/RAG Rated Delivery Dashboard

The purpose of this report is to provide Sponsor Board members with an update of progress on programme delivery since the last meeting. There has not been a Programme Board since February 2017 but one is scheduled for 8th June.

The main purpose of the meeting will be to review senate and Gateway action plans and to agree the consultation plan and approach.

Work progresses on the independent review, the supplementary IIA and clarifying the Joint Committee arrangements. Independent members of the Joint Committee have been sought with the support of NHSE. These will be confirmed by Boards in their June Governing Body meetings.

The programme timeline will need to be reviewed due to the delay in appointing the firm to perform the independent review of the option appraisal process. A delay in the decision making and consultation process is assumed. A paper on a revised timeline is being taken for discussion at Programme Board on 8th June and a verbal report will be provided. Any revised timeline will of course be potentially subject to change dependent on the outcome of the independent review which is expected to be known in mid July 2017.

The table below is a summary RAG rated dashboard of the status of delivery of the key components of the Future fit Programme Plan. It includes a summary narrative of key risks and/or issues.

		Last updated	30th May 2017
		Overall RAG rating	Key Issues/risks
1	**Programme Governance**		The Programme Board agreed that full transition of the governance arrangements to STP governance should not be until the programme moves to project delivery phase, after the consultation process. At that point monitoring of the business case development and implementation will be through the Acute and Specialist services Programme Board reporting to the STP Partnership Board. The Clinical Design and Clinical Reference Groups scope and Terms of Reference (ToR) developed under Future fit will remain as key work streams under the STP. They have now been reviewed to accommodate the wider STP work. The enabling STP work streams for workforce and finance will incorporate any necessary Future Fit activities. The current Communications and Engagement Work stream will extend its remit to accommodate STP. Chief Officer sponsors and executive leads for all the work streams have been agreed.

			There remain significant capacity risks within the programme team currently with a number of recent changes of personnel both in Programme Management and Communications and Engagement Support. Engagement support from existing CCG staff has been agreed. A senior Communications and Engagement lead for the STP has been appointed with the support of NHSE. This individual will also provide some strategic Communications and Engagement advice to Future Fit. Discussions are ongoing with the SROs around future Programme support post September. Support from the STP PMO team is also being explored.
2	**NHS Approvals/ Assurance Gateways**		
	2.1 West Midlands Senate Review		The action plan implementation update report has been received by the Programme Board in June. Progress has been made against most of the 18 actions including: working with the ambulance service in refining the modelling; clarifying the UCC clinical model; considering the necessary IT support; community services alignment; STP governance alignment; public engagement; developing workforce solutions and supplementing the IIA and benefits realisation work.
	2.2 NHS Gateway Review		RED/AMBER rating achieved in November 2016. The action plan implementation update report will be received by the Programme Board on the 6 recommendations in June. The full report has been shared with Programme Board members. Progress has been made on all key areas of focus: the independent review of the appraisal process; communications messages including agreement by the clinical group on UCC nomenclature; sign off and joint ownership of the consultation process; stakeholder relationship development; active risk management within the programme; and transition of FF governance arrangements into the STP process.
	2.3 NHSE Formal Stage 2 Assurance		Process delayed post JC meeting; will likely be rescheduled in August 2017. The Pre consultation Business case will be a key submission into this process and is in draft, as will progress against the gateway actions, the senate actions and the consultation documentation and plan.
	2.4 Pre- Consultation Business Case		This document forms a key element of the NHSE Assurance process. Whilst the document is in draft there remains a number of unresolved elements particularly the source of capital, the more granular detail on the community models emerging from the neighbourhoods and the outcome of other reviews that are outside of future Fit but may have some interdependencies and links to the overall affordability of the acute model and the wider STP.
3	**Options Appraisal/ Preferred Option**		Independent Review: The programme followed NHS procurement policy through two attempts at mini tender exercises on two different management frameworks. Both

			failed to identify a firm to do the work. The first provided no responses and the second provided a single response however the firm identified potential areas where they may be conflicted that the Boards felt could not be mitigated. The CCGs are now able to seek a direct award and have had two proposals. The decision will be made by 9th June and work commence on 12th June for 4 weeks. This single issue is the primary delay in the programme timeline and critical path and will impact on consultation. IIA W&C: Work continues on the IIA and now includes acute clinical and GP input. Approval of the final specification and the costs agreed with the Joint SROs. A number of focus groups and on line questionnaires are designed as part of the process and have had to wait until after purdah. Clinical focus group planned for 27th June to specifically look at impact and mitigation on clinical effectiveness, safety and experience. This has not impacted on timescales for final report which will be available in draft by w/c 10th July. Joint Committee: Meeting took place with NHSE, NHSI and CCGs on 23.2.17 to develop and agree future joint decision making arrangements. A proposal for a reconstituted joint committee with 3 additional independent voting members (2 clinical) was agreed by both Boards in March. ToR now agreed. NHSE have supported the CCGs on proposed independent members and will receive those nominees at their June Boards.
4	**Formal Consultation**		Preparations for consultation continue with the development of the consultation materials including the consultation document, survey questionnaire and a refresh of the programme website. Given the above delay to timelines related to the independent review, following Programme Board and a Joint Committee decision in July, the consultation will also be delayed. The Programme Board are to receive proposals on 8th June on a revised timeline. Joint HOSC and CCG Board development sessions took place in April to develop the approach to consultation. Consultation plan to go to Programme board on 8th June A clinical group met to discuss delivery models for ambulatory and paediatric urgent care and to develop clear and unambiguous public messages. It was agreed between both acute and GP colleagues that the term Urgent Care Centres (UCC) should be the agreed term and all partners should now use this in their engagement with the public. Next steps are to share the outcome of the meeting with wider clinical group through the CRG most likely in early July.

5	**Developing the supporting community model to support required left shift**		Neighbourhoods are leading the community activity modelling work needed for the PCBC to support the assumptions within the acute model. Alignment is needed of Shropshire CCG community reviews, neighbourhood work and the activity modelling output required to support the OBC and PCBC work and approvals in July.
6	**Programme Funding and Budget Management**		Costs pressures have been incurred in recent months associated with the additional work required for the independent review and the IIA supplementary IIA work. Subject to necessary approvals to proceed, the costs of formal consultation will also be a cost pressure in 2017/18. Provisional budgets have been agreed and consideration is being given of integrating some Future Fit functions within the STP programme management office (PMO) including communications and programme management. Proposed budget to go to next Programme Board with monitoring at each subsequent meeting.
7	**SATH OBC/FBC**		Draft OBC approved by SaTH Board in December 2016. Further work required in light of Clinical Senate recommendations for inclusion in final OBC for CCG approval.

Action Status RAG Rating definition	
	Complete
	Delayed - recovery actions planned or in place. Low risk of materially affecting programme delivery and/or timeline
	Delayed - recovery actions planned or in place. Medium to high risk of materially affecting programme delivery and/or timeline
	Deadline not yet reached, delivery on target

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.119
Shropshire CCG Governing Body meeting: 7th June 2017

Title of the report:	Terms of Reference Future Fit Joint Committee
Responsible Director:	Simon Freeman Accountable Officer
Author of the report:	Debbie Vogler Programme Director Future Fit
Presenter:	Debbie Vogler Programme Director Future Fit

The purpose of the report is to formally receive the revised Terms of Reference for the Joint Committee for approval.

Key issues or points to note:

These Terms of Reference set out the revised process by which Shropshire and Telford & Wrekin CCGs will make joint decisions regarding the Future Fit Programme.

At their respective meetings in March 2017, the Governance Board of Telford & Wrekin CCG and the Governing Body of Shropshire CCG ("Governing Bodies") agreed to a revision of the Future Fit Joint Committee Constitution set out in September 2016, to include 3 independent members, one of whom will be the managerial independent Chair, two of whom will be clinicians, and all of whom will be voting.

Since the last meeting two minor changes have been made to these ToR including:

- Clarification in section 3 of the role of the Joint Committee in relation to receiving the recommendation from the Programme Board
- Addition of the T&W round table and Shropshire Patient Group to the observers list in section 4 to reflect what was agreed and in place in December 2016

Actions required by Governing Body Members:

The Governing Body is asked to APPROVE the final revised Terms of Reference for the Future Fit Joint Committee.

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *The Future Fit Programme is in response to the increasing challenges of providing high quality, safe and sustainable acute and community hospital services.*	YES
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *The Future Fit model is clinically led and the programme continues to engage clinicians through the Clinical design work stream and the Clinical reference group (CRG) meetings. Reports into the GP locality meetings on a regular basis.*	YES
3	Objective 3 - Achieve Financial sustainability for future investment *The Future fit OBC has interdependency with the STP system deficit reduction plan.*	YES
4	Objective 4 - Visible leadership of the local health economy through behaviour and action	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *please provide details relating to objective 5*	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice *The Future Fit Programme is in response to the increasing challenges of providing high quality, safe and sustainable acute and community hospital services.*	
2	Additional staffing or financial resource implications *Procurement of the independent review of the Option Appraisal and the additional IIA work will have a financial implication that is an unexpected cost pressure to the programme*	
3	Health inequalities *The impact on health inequalities forms part of the Integrated Impact Assessment work*	
4	Human Rights, equality and diversity requirements *An impact assessment has been carried out in 2016 and was reported to Programme Board in November. Further work is planned for 2017.*	
5	Clinical engagement *The Future Fit Programme continues to engage clinicians through the Clinical design workstream and the Clinical reference group (CRG) meetings. Reports into the GP locality meetings on a regular basis.*	
6	Patient and public engagement *The Future Fit Programme continues to undertake a comprehensive communication and Engagement process which is continually reviewed*	

NHS Shropshire, Telford & Wrekin CCG
Future Fit Joint Committee
Terms of Reference

1. Introduction

These Terms of Reference set out the revised process by which Shropshire and Telford & Wrekin CCGs will make joint decisions regarding the Future Fit Programme.

At their respective meetings in March 2017, the Governance Board of Telford & Wrekin CCG and the Governing Body of Shropshire CCG ("Governing Bodies") agreed to a revision of the Future Fit Joint Committee Constitution set out in September 2016, to include 3 independent members, one of whom will be the managerial independent Chair, two of whom will be clinicians, and all of whom will be voting.

The reconstituted Joint Committee will have the single responsibility of determining agreement or otherwise to the recommendations of the Future Fit Programme Board. The CCGs "joint committee" shall be called the Future Fit Joint Committee (FFJC)

2. Establishment

These Terms of Reference are drawn up in line with:
NHS Shropshire CCG Constitution: Section 6
NHS Telford & Wrekin CCG Constitution: Section 6

In the event of contradiction or dispute, this document should be seen as the authoritative document in respect of the NHS Future Fit Joint Committee functions

The CCGs have agreed to establish and constitute a Joint Committee with these terms of reference to be known as the FFJC.

3. Functions of the Committee

Following the Future Fit Programme Board receiving the outcome of the independent review of the option appraisal process and the supplementary IIA report on Women and Children's services, the FFJC will be convened and on behalf of the two CCGs act as the decision-making body:

(a) To receive the recommendation from the Future Fit Programme Board on the outcome of the option appraisal process for the reconfiguration of Acute Hospital Services.
(b) To confirm which options the CCGs believe at this stage remain deliverable and will therefore form part of the NHSE Stage 2 Assurance Process and the CCGs' public engagement.
(c) To confirm or otherwise the Future Fit Programme Boards recommendation of a preferred option that will be presented to: i) the NHSE Stage 2 Assurance Process and ii) to the public in the CCGs' decision making, including formal consultation where appropriate.

4. Membership

The Joint Committee will be constituted solely of voting members.
The Joint Committee will be chaired by a voting Independent Chair. It is expected that this will be an officer from another CCG outside of area.

In addition to the voting independent Chair, the voting members of the Joint Committee shall comprise:

3 Clinicians from each CCG (who would be members of the Governing Body)
2 Lay Members from each CCG
1 Executive from each CCG Governing Body (this will specifically exclude the Joint SROs)
2 Clinicians from outside of area

The Voting Independent Chair and the Voting Independent Clinicians will be appointed by NHSE and approved by both the two CCG Governing Bodies.

Powys Health Board will be invited to the FFJC but will be non-voting. This reflects the Powys health Board's position regarding voting.

Observers at the FFJC will include:
Telford and Wrekin Healthwatch one representative
Shropshire Healthwatch one representative,
Shropshire Patient Group one representative,
Telford & Wrekin Health Round Table one representative,
Powys Community Health Council one representative,
Telford and Wrekin Council one representative
Shropshire Council one representative

All members are required to comply with the NHS Shropshire, Telford and Wrekin CCG Future Fit Joint Committee Principles for Joint Working and Member Code of Conduct.

5. Voting

The voting members (which, for the avoidance of doubt, include any deputies attending a meeting on behalf of the Joint Committee Members) shall each have one vote.
The decision of the Joint Committee would be by majority vote and be binding on both CCGs.

6. Deputies

Any other individual (subject to compliance with the constitution) may deputise for any Joint Committee Member provided that the relevant CCG has made a request in advance of the meeting to the Chair of the Joint Committee to arrive no later than the day before the relevant meeting (or within such shorter period before the meeting as the Chair may in his or her sole discretion decide).

7. Meetings

The Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the Joint Committee. Meetings of the Joint Committee shall be open to the public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend.

8. Quorum

The quorum for a meeting of the Joint Committee shall be that all of the voting members or their nominated deputy of the Joint Committee must be in attendance.

9. Attendees

The Chair of the Joint Committee may at his or her discretion permit other persons to attend its meetings but, for the avoidance of doubt, any persons in attendance at any meeting of the Joint Committee shall not count towards the quorum or have the right to vote at such meetings.

10. Administrative Support

Support for the Joint Committee will be provided by the Future Fit Programme Team. Papers for each meeting will normally be sent to Joint Committee members no later than one week prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

11. Notice

Either CCG may withdraw from these arrangements and revoke its delegation to the Joint Committee at any time by notice given by its Governing Body to the members of the Joint Committee. Neither CCG can retrospectively revoke the constituted JC or its decisions.

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.120
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Business Continuity Plan
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 present the updated Business Continuity Plan to the Governing Body for consideration and approval

Key issues or points to note:

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease, a major transport accident or a terrorist act.

The Civil Contingencies Act (2004) and Health Social Care Act (2012), requires NHS organisations to show that they can deal with such incidents while maintaining services to patients. This work is referred to collectively as 'emergency preparedness, resilience and response' (EPRR) Shropshire CCG's overarching response to EPPR is contained within its Business Continuity plan. This plan has been reviewed and updated and is presented to the Governing Body for approval.

The Governing Body is also asked to note that the review of the Business Continuity Plan is the first stage in a process if comprehensively reviewing Shropshire CCG's emergency preparedness, incident planning and response arrangements. This work will be carried out at pace over the coming weeks and further updates will be presented to the Governing Body.

NHS England have supported the review of the Business Continuity Plan and will be involved in the further work to be carried out.

Actions required by Governing Body Members:

The Governing Body is asked to approve the attached Business Continuity Plan and to note support the additional work to be undertaken

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *please provide details relating to objective 1*	
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *please provide details relating to objective 2*	
3	Objective 3 - Achieve Financial sustainability for future investment This report provides assurance to the Governing Body that the risks to delivery of the CCG's strategic aims and operational targets are being managed	Yes
4	Objective 4 - Visible leadership of the local health economy through behaviour and action *please provide details relating to objective 4*	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *please provide details relating to objective 5*	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice This report provides assurance to the Committee and the Governing Body that the risks included in the GBAF are being managed	Yes
2	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	
3	Health inequalities *If yes, please provide details of the effect upon health inequalities*	
4	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	
5	Clinical engagement *If yes, please provide details of the clinical engagement*	
6	Patient and public engagement *If yes, please provide details of the patient and public engagement*	

Business Continuity Plan

Shropshire Clinical Commissioning Group

CONTENTS

1.0 Introduction

1.1 Business continuity planning forms an important element of good business management and service provision. All business activity is subject to disruptions such as technology failure, flooding, utility disruption and terrorism. Business continuity management (BCM) provides the capability to adequately react to operational disruptions, while protecting welfare and safety.
BCM involves managing the recovery or continuation of business activities in the event of a business disruption, and management of the overall programme through training, exercises and review to ensure the business continuity plan stays current and up to date.

For the NHS, BCM is defined as the management process that enables an NHS organisation to:

- Identify those key services which, if interrupted for any reason, would have the greatest impact upon the community, the health economy and the organisation;
- Identify and reduce the risks and threats to the continuation of these key services;
- Develop plans which enable the organisation to recover and / or maintain core services in the shortest possible time.

This Business Continuity Plan (BCP) describes how NHS Shropshire Commissioning Group (CCG) will discharge its functions in the event of a major incident that causes serious interruption of business operations involving one or more sections/service areas. This is a corporate level BCP which would be implemented when any incident cannot be contained and managed within a single section/directorate/service area.

1.2 Business Interruption can be defined as;

'*An unwanted incident which threatens personnel, buildings, operational procedures, or the reputation of the organisation, which requires special measures to be taken to restore things back to normal'*

1.3 Business continuity management (BCM) is a business-driven process that establishes a fit-for-purpose strategic and operational framework to –

- Proactively improve the organisation's resilience against severe interruption;
- Provide a rehearsed method of restoring the organisation's ability to supply its key services to an agreed level within an agreed time after an interruption;
- Deliver a proven capability to manage a business interruption and protect the organisation's reputation and brand

1.4 Business Continuity Management can be defined as:

"A holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised might cause, and which provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities."
(BS 25999 Business Continuity Management – Part 1 2006: Code of Practice, British Standards Institute)

At the heart of business continuity planning are four key areas:

- Damage/denial of access to premises;
- Non availability of key staff;
- Loss or damage to other resources;
- Loss/damage to IT or data.

1.5 Business continuity is complementary to the risk management framework that sets out to understand the risks to operations or business, and the consequences of those risks. Reference should be made to the organisation's risk management strategy and risk register which relate to corporate and directorate risk assessments that may be considered in conjunction with this continuity planning process.

An effective BCM programme within the CCGs will help the organisation to:

- Anticipate
- Prepare for
- Prevent
- Respond to
- Recover from

Disruptions, whatever their source and whatever part of the business they affect.

The Outcome of an Effective BCM Programme

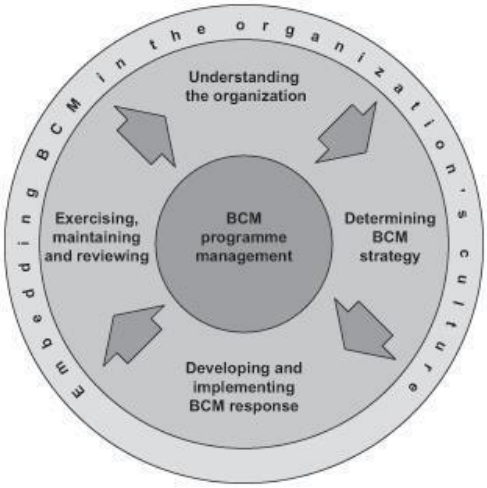
The outcomes of an effective BCM programme within the CCGs include:

- Key products and services are identified and protected, ensuring their continuity;
- The organisations understanding of itself and its relationships with other organisations, relevant regulators or government departments, local authorities and the emergency services is properly developed, documented and understood;
- Staff are trained to respond effectively to an incident or disruption through appropriate exercising;
- Staff receive adequate support and communications in the event of disruption;
- The organisation's supply chain is secured;
- The organisation's reputation is protected;
- The organisation remains compliant with its legal and regulatory obligations

1.6 Elements of BCM Lifecycle

The industry standard, ISO22301 BCM, characterises BCM as a series of six lifecycle elements:

- BCM programme management;
- Understanding the organisation;
- Determining business continuity strategy;
- Developing and implementing BCM response;
- BCM exercising, maintaining and reviewing BCM arrangements;
- Embedding BCM in the organisations culture



DUTIES FOR BUSINESS CONTINUITY AND RECOVERY

There are a number of key document that outline and detail the need for NHS organisations to establish a business continuity management system:

- Civil Contingencies Act 2004
- NHS England Emergency Preparedness, Resilience and Response Framework 2015
- NHS England Business Continuity Management Framework (service resilience) (2013)
- ISO 22301 Societal Security – Business Continuity Management System

This document has been written to align to the NHS England Business Continuity Framework and ISO 22301 requirements

Civil Contingencies Act 2004

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the UK. Part 1 of the act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at a local level. The Act divides local responders into two categories, imposing a different set of duties on each. Category 1 responders are those organisations at the core of the response to most emergencies and are subject to the full set of civil protection duties. Category 2 organisations are 'co-operating bodies'. They are less likely to be involved in the heart of planning work, but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties – co-operating and sharing relevant information with other Category 1 and 2 responders.
All CCGs are listed as category 2 responders.

NHS England Emergency Preparedness, Resilience and Response Framework

The purpose of this document is to provide a framework for all NHS funded organisations to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS standard contracts, the NHS England EPRR Core Standards (2015) and NHS England Business Continuity Framework (2013). The core standards provide the minimum standards which NHS organisations and sub-contractors must meet.

NHS England Business continuity Management Framework (system resilience)

This highlights the need for business continuity management in NHS organisations. It lists the relevant standards and indicates the guidance organisations need to follow. It promotes joint

working arrangements between NHS organisations when planning for and responding to disruptions.

International Standards for Business Continuity Planning

There are a number of national and international standards relating to guidance for BCM that can be found in:

- ISO 22301 Societal Security – Business Continuity Management System – requirements
- ISO 22313 Societal Security – Business Continuity Management System – Guidance
- PAS 2015 – Framework for Health Service Resilience

NHS England have produced a BCM Management Toolkit to help organisations meet these international and national standards. The toolkit has been used to develop this document.

2.0 Purpose and Scope

2.1 Aim of the Business Continuity Plan

This plan aims to ensure that the principles of BCM are embedded throughout the organisation and provides assurance to staff, members, patients, stakeholders and the local population that key services during a disruption event can continue.

2.2 Objectives of the Business Continuity Policy and Planning Framework

The objectives of the Business Continuity Policy and Planning Framework are:

- To ensure a comprehensive BCM system is established and maintained;
- To ensure key services, together with their supporting critical activities, processes and resources, will be identified by undertaking business impact analysis;
- To ensure risk mitigation strategies will be applied to reduce the impact of disruption on key services;
- To ensure plans will be developed to enable continuity of key services at a minimum acceptable standard following disruption;
- To outline how business continuity plans will be invoked
- To ensure plans are subject to on-going exercising and revision;
- To ensure the CCG's Governing Bodies are assured that the BCM system remains up to date and relevant.

The BCM system, addresses those services which are provided by the Teams of the CCG:

- Corporate
- Finance
- Planning & Contracting
- Nursing, Quality & Safeguarding
- Performance & Delivery

2.3 To perform its duty on a day-to-day basis, NHS Shropshire CCG depends upon a wide range of complex systems and resources, and seeks to maintain a good reputation. Inevitably, there is potential for significant interruption to normal business or damage to the organisation's reputation through loss of those systems and resources. NHS Shropshire CCG priorities when faced with a significant interruption (whether actual or impending) will always be to:

- Ensure the safety and welfare of its personnel and visitors;
- Endeavour to meet its obligations under legislative requirements;
- Secure replacement critical infrastructure and facilities;
- Protect its reputation;
- Minimise the exposure to its financial and reputational position;
- Facilitate a return to normal operations as soon as practicable.

2.4 The scope of this BCP will centre on conformity with ISO23301, legislative requirements within the Civil Contingencies Act (CCA) 2004 and NHSE guidance, as set out earlier in this document.

3.0 Categorisation and prioritisation of services

3.1 Successful business continuity planning includes the ability to define the essential business services of the organisation and must be identified at all levels. These can be broken down into critical, vital, necessary and desired. Determining and categorising services in this way is the responsibility of heads of service within the organisation.

3.2 **CRITICAL** services must be provided immediately or the loss of life, infrastructure destruction, loss of confidence and significant loss of revenue will result. These services will require continuity within 24 hours of interruption.

3.3 **VITAL** services are those that must be provided within 72 hours or loss of life, infrastructure destruction, loss of confidence and significant loss of revenue or disproportionate recovery costs will result.

3.4 **NECESSARY** services must be resumed within two weeks or considerable loss, further destruction or disproportionate recovery costs could result.

3.5 **DESIRED** services could be delayed for two weeks or longer, but are required in order to return to normal operating conditions and alleviate further disruption or disturbance to normal conditions.

3.6 This is a list of the possible interruption factors that represents the potential impact for the organisation;

- Loss of life or inacceptable threat to human safety;
- Disruption of essential services;
- Loss of public/stakeholder confidence;
- Loss of vital records;
- Loss of expertise;
- Significant damage or total loss of infrastructure;
- Significant loss of revenue or public funds;
- Disproportionate recovery costs.

3.7 Within the organisation the interruption factors may include;

- Access to or the ability to operate normal services from a site which can be either fully or partially interrupted due to an incident occurring e.g. fire, loss of utilities;
- IT systems are interrupted or the network fails, causing significant disruption to either a single or more department;
- Failure of service provision arising from a key 3rd. party supplier or provider organisation;
- Greatly reduced staffing levels e.g. severe weather condition, flu pandemic;
- Loss of telephone communications.

And as a result there is impact upon:

- Health and safety
- Possibility of either adverse financial or reputational damage.
- A requirement to relocate to alternative working premises or service delivery resources.

4.0 Business Impact Analysis (BIA)

4.1 The CCG has undertaken an analysis of what services are considered **CRITICAL** services and these are as listed below. This takes into account which services should have priority, which services will be the most difficult to resume, the minimum resources to resume a service and an indication of the timeline in which it should be accomplished:

- **Communications (IT, Telephony and Media Communications)**
- **Complex Care - including Children's complex packages of care and Mental Health/Learning Disability**
- **Continuity of commissioned services**
- **General Practice IT (this function is provided by Shropshire Community Health NHS Trust)**
- **Safeguarding children and vulnerable adults**

- **Serious Incident Management**

Appendix II sets out a number of scenarios which could be encountered by the CCG, impact on staff groups and actions

4.2 A key element for consideration of a BIA is the maximum tolerable period of disruption and a recovery time objective. Timelines are crucial when establishing 'cut-off' points and setting targets. The 'timeline's' extracted from BS 25999 are as follows;

- **Maximum Tolerable Period of Disruption (MTPoD)**
  'Duration after which an organisation's viability will be irrevocably threatened because of the adverse impacts that would arise as a result of not providing that service (function) or performing that activity'
- **Recovery Time Objective (RTO)**
  'Target time set for –
  - *Resumption of the service (function) after an incident; or*
  - *Resumption of a performance or activity after an incident; or*
  - *Resource recovery after an incident*

Note – the Recovery Time Objective has to be less than the Maximum period of disruption…'

For 'critical' functions, the maximum periods of disruption have been suggested to be ***4 hours to 24 hours***, depending upon the service or function.

4.3 The following services fall into the **VITAL, NECESSARY** and **DESIRED** services and the specific length of time the service can be suspended has been defined:

PRIORITY AND DEFINITION	**CCG activities**
Priority One Functions – An essential function needing to be restored within 0-24 hours	• These are listed under 4.1
Priority Two Function – An important function needing to be restored within three working days	• Complaints, PALS and MP letters handling • Payroll function (time sensitive to payroll schedule - Payroll is administered by NHS Midlands and Lancashire CSU but requires CCG input) • Mental health/learning disabilities packages of care • Contract management • Infection prevention and control
Priority Three Function – A function needing to be restored within seven working days	• Independent Funding Requests • SI datix reporting The below functions are administered by NHS Midlands and Lancashire CSU on behalf of the CCG but require CCG input • Freedom of information requests • Elements of Financial systems
Priority Four Function - A function which can be restored progressively after seven working days	All other functions

5.0 Activating the Corporate Business Continuity Plan (BCP)

5.1 When something has happened that impacts on critical business functions, the following activation sequence will normally be used when informing staff of the activation of this plan: Standby phase, Implement phase, Stand Down phase

- *'Standby'* will be used as an early warning of a situation which might at some later stage escalate and thus require implementation of this Plan. This is particularly important if an interruption occurs towards the end of office hours and staff may need to be asked to stay at work until the situation becomes clear. Standby means the EDDR Lead and On-call Director are made aware of potential business continuity issues and actions taken to mitigate their impact.

- *'Implement'* is the immediate activation of this plan.

- *'Stand Down'* will be used to signify the phased withdrawal of the activation of the plan e.g. the standing down of the incident room.

In activating this plan, buildings, facilities or other resources, including staff need to be managed. This Plan lists the critical functions that need to be maintained, and sets out emergency steps to manage the incident. Generally, the chain of events will be;

- An alert is raised and brought to notice by any member of staff to their Director or Head of Service. The Director will inform the Accountable Officer/Deputy, On-Call Director and the Accountable EPRR Lead Officer/Deputy.
- The Accountable Officer /Deputy, On-Call Director and Accountable EPRR Lead Officer/Deputy will consider the appropriate response and whether to activate this BCP in full or in part. Figure 1, considers the activation levels.

Figure 1 – Plan activations

Incident dynamic Reported to AO/ Deputy and Director Team	**Activation** Potential considerations for Plan activation	**Business Continuity Incident Response Team (BCIRT)** Strategic, Tactical, and Operational responsibilities
The incident is **contained to single Department or Locality <u>and</u>** able to be managed effectively to conclusion by that Department/Locality	- 'Declare Locality /Department Business Continuity Incident' - Initiate **Directorate** BCP	**Establish Locality/Dept BCIRT to include** - Director or Deputy as **Locality/Dept** Lead Officer - CCG On Call Director - Communications Officer - Building Manager - HR lead - Finance Officer - IT lead - Administration coordinator;
The incident affects **more than one Locality/Department**	- 'Declare Corporate Business Continuity Incident' - Initiate **Corporate** BCP	**Establish Corporate BCIRT** - AO//Deputy as Strategic Lead - CCG On Call Director - Communications Officer - Building Manager - HR lead - Finance Officer - IT lead - Administration coordinator; - Loggist

5.2 Criteria for escalation

- Increase in geographic area or staff affected (Pandemic, flooding etc.)
- the need for additional internal/external resources
- increased severity of the business interruption
- increased demands from government departments, the service or commissioned service
- heightened public or media interest

5.3 In the event of the activation of the BCP, the Accountable EPRR Lead Officer/Deputy will identify an Incident Room (IR), form the Incident Response Team (IRT), giving a general status report for the IRT to consider appropriate actions.

5.4 **Criteria for de-escalation**

- Reduction in internal resource requirements
- Reduced severity of the incident
- Reduced demands from government departments, the service and commissioned service
- Reduced public or media interest

6.0 Responsibilities for BCP

6.1 **The Accountable Officer/ Deputy** has overall responsibility for emergency response planning and for ensuring that an effective BCP is in place, ensuring the continuation of critical functions and overseeing de-escalation until normal services are restored to their pre-incident capacity, in the minimum timeframe possible.

6.2 **Accountable EPRR Lead Officer/Deputy / CCG On-Call Director**

The Accountable EPRR Lead Officer/Deputy / CCG On-Call Director is responsible for;

- Leading the IRT;
- Collate incident assessment and situation report **(Appendix I)**
- Deciding on action to be taken based on type of disruption / event affecting staff, space or supplies **(Appendix II)**
- Facilitating meetings (**Appendix III,** suggested agenda format for first meeting);
- Informing the Executive Team and liaising with senior management;
- Overseeing the activation of the plan;
- Managing the Incident Room (IR) for continuing activities during an incident response or locating an alternative IR where necessary within the CCG footprint; or as necessary under mutual aid arrangements at Telford & Wrekin CCG.
- Coordinating recovery;
- Leading the lessons learned and compiling final report.

6.2.1 **Department Manager working in conjunction** Accountable EPRR Lead Officer/Deputy **/ CCG On-Call Manager**

The Department Manager is responsible for;

- Ensuring a suitable IR is available;
- Overseeing and coordinating the assignment of alternate facilities where required;
- Liaising with the CCG's Director of Corporate Affairs and finance lead regarding asset registers of equipment, insurance and reporting arrangements of damage assessment;
- Liaising with NHS Property Services where there is damage to infrastructure;
- Liaising with Emergency agencies where appropriate;
- Ensuring the security of employees and buildings during the incident response with the CCG's Director of Corporate Affairs;

- Liaising with the senior governance officer (health and safety), Commissioning Support Unit (CSU), to assess safety and fire risks where appropriate;
- Working with the finance lead to adhere to emergency expenditure and procurement procedures.

6.3 Communications Manager

The Communications Manager is responsible for;

- Developing an information and media response plan;
- Preparing for and advising senior management on crisis communications messaging surrounding disruptions to critical and vital services
- Internal and external communications management
- Highlighting reputation risk advising on reputation damage limitation
- Exercising crisis communications principles.

6.4 Human Resources

The CCG Department Manager, Accountable EPRR Lead Officer/Deputy and HR lead are responsible for;

- Having available a list of up-to-date contact list of current employees, agencies that can supply temporary staff, a list of recently retired staff, all to support essential services during a human resource shortage;
- Liaising with the senior governance officer (health and safety), CSU, to ensure there are no risks to the health and safety of staff where appropriate;
- Liaising with Occupational Health (CSU) to secure post-incident counselling where appropriate;
- Advise on anticipated personnel concerns e.g. payroll, child care, transportation;
- Liaising with operational areas and the Information Governance Manager, in identifying, prioritising and protecting all paper vital records.

6.5 Finance Lead

The finance lead is responsible for;

- Ensuring that appropriate insurance is available;
- Ensure asset registers are available;
- Ensuring appropriate staff are authorised to make emergency expenditures when required;
- Liaising with the appointed IRT Director/Deputy to ensure that emergency expenditure and procurement procedures are adhered to;

6.6 Senior Information Officer (SIRO)

The SIRO is responsible for coordination of;

- Ensuring that IT systems are recovered in business critical areas where necessary;
- Liaison with operational areas and ensuring IT systems are recovered within time objectives set or set up if staff have been relocated;
- Ensuring IT policies have been adhered to when storing/backing up information;
- Liaison with the finance manager where assets require replacing due to loss/damage;
- Maintenance of a list of suppliers and qualified contractors for emergency procurement;
- Liaison with operational areas and the Information Governance Manager, in identifying, prioritising and protecting all vital electronic information.

6.7 **Administration Coordinator/Loggist will be identified by the Accountable EPRR Lead Officer/Deputy.**

The Administration Coordinator is responsible for:

- Liaising with the Accountable EPRR Lead Officer/Deputy (CCG On Call Director)
- Ensuring available resources in the IR e.g. hard copies of plans, stationary, writing materials, flip chart, telephone, computer and printer.
- Taking notes
- Type final reports

7.0 Communications

Effective communications are crucial. It is essential to disseminate accurate and timely information to staff, partners, stakeholders and where necessary the public during the response to a business interruption. The CCG On-Call Director/ Accountable EPRR Lead Officer/Deputy will liaise with the communications manager as needed to ensure effective, on-going communications. This will be overseen by the On-Call Director/ Accountable EPRR Lead Officer/Deputy in charge. A checklist is given at **Appendix IV.**

8.0 Incident Room (IR)

The purpose of the IR is to provide a place where the CCG can implement and co-ordinate the organisation-wide initial response and recovery operations; to provide a single point of contact for requests for assistance allowing the IRT an immediate overview of the organisation-wide response and to provide an area for information collation and preparation of any briefings

The IR for the CCG is at CCG headquarters at **William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL**. The CCG On Call Director / Accountable EPRR Lead Officer/Deputy would need to identify the right room and designate it as the 'incident room' e.g. Director's office, a meeting room.

In the event that William Farr is not useable the back-up IR can be organised at Telford and Wrekin CCG / Shropshire Council Offices as appropriate. The suggested equipment to be kept in the room can be seen in **Appendix V.**

9.0 Debrief

At the conclusion of the incident, the Director with responsibility for Emergency Preparedness, Resilience and Response/Business Continuity will lead a debrief session and coordinate preparation of a report on the incident **(Appendix VI)**, to include issues identified by the debriefing process. This should take place between 24 hours and fourteen days following the incident. The report will be considered at a meeting of the IRT and submitted to the Audit Committee together with any recommendations and action plan. The report should be submitted to the Governing Body for approval.

10.0 Training, exercises and monitoring

Training

11.1 Members of the on call rota and the IRT will be trained in line with the required competencies for their role.

Exercises

The CCG will undertake annual table top exercises to test this plan

11.2 The accountable officer for EPPR will Review this policy on an annual basis and in relation to emerging guidance and policy updates, The accountable officer for EPPR will also ensure appropriate monitoring of training and exercises, identifying and addressing any gaps.

11.0 Emergency Preparedness, Resilience and Response (EPRR)

As noted in the introduction, Business Continuity and EPRR are closely linked. As Category 2 responders the CCG does not have the resilience infrastructure that a Category 1 responder would have. However, the CCG ensures that it meets the core standards required of it through the following actions:

- The Director of Corporate Affairs is the accountable officer for EPRR
- The Director of Corporate Affairs and Deputy are members of the Local Health Resilience Partnership Group and the Health Emergency Planning Officers Group (HEPOG) respectively, and are the first point of contact in the CCG for EPRR. Attendance at EPRR workshops and other events is part of this remit and relevant information is fed back to personnel within the CCG as needed
- The CCG has an on call rota of senior, experienced and trained individuals in place to manage unexpected surges of activity within Shropshire and Telford and Wrekin that are not classified as Major Incidents. They link with the Head of EPRR, NHSE, North Midlands for support in the event of Major Incidents taking place
- NHS England Regional Team has in place a full Major Incident Plan and the CCG utilises this in the event of an Incident rather than having a separate Plan, as this ensures integration of response
- The CCG takes part, as needed, in EPRR exercises within Shropshire and across the Telford and Wrekin and Staffordshire areas.
- The CCG's Head of Communications and Engagement is the organisation's strategic communications lead and is also a member of the West Mercia Local Resilience Forum's Communications Workstream
- The CCG has signed a Memorandum of Understanding for the mobilisation of NHS resources in the event of a significant Public Health Incident or Outbreak
- Should the CCG require specialist EPRR expertise it would request NHS England, to assist and advise

Appendix I

Incident Assessment and Situation Report - METHANE

Report details	
Date:	Time:
Name of person completing form	
Name of people contributing	
METHANE SUMMARY What are the facts about the incident?	
Major incident declared?	
Exact Location	
Type of incident	
Hazards – present or suspected	
Access – routes that are safe to be used	
Number – type and severity of casualties	
Emergency services present and/or those required	
Other facts	
What are the assumptions about the incident?	
What additional information is required?	
Warning and informing	
What agencies/partners/public are involved in the incident? Who has been informed (when and by whom, if known?)	
Do we need to inform or request actions of other individuals/services/partner organisations?	
Risks	
What are the main risks and consequences of the incident?	
What are the knock-on effects to other services and/or partner organisations?	
Media	
Will the incident attract media interest? What is the current situation with the media? Are actions required?	

What agencies are involved in the incident? Who has been informed (when and by whom, if known?)
Do we need to inform or request actions of other individuals/services/partner organisations?

Appendix II - Business Continuity Action

TYPE OF DISRUPTION / EVENT	**1. Access denial to work area (any reason including fuel crisis) or utility failure (electricity, heating, water) or flooding**
Impact On Shropshire CCG	Shropshire CCG would be unable to provide its critical functions as listed within section 4.1 of this Business Continuity Plan and would also need to suspend non-critical functions until normal services could be resumed or alternative premises or access to premises was established.
Risk Rating of this Event	**MEDIUM / LOW**
Contingencies Available	Shropshire CCG staff are mainly based in one location: William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL **CRITICAL Services** In short term incidents, if the interruption is due to utilities failure, lack of access to the building or damage to the building or work area the following arrangements can be put in place: • Use a different building at the current location (there are several buildings on the same site) • Identify alternative premises to relocate these staff in the short term through partnership discussions with Telford and Wrekin CCG and Shropshire Council as appropriate • With the approval of their line managers, staff may be able to work remotely from home (via VPN access if appropriate). **VITAL, NECESSARY** and **DESIRED Services** In short term incidents, if the interruption is due to utilities failure, lack of access to the building or damage to the building or work area and an alternative arrangement cannot be found the following arrangements can be put in place: • staff may be given time off at the discretion of their line managers • staff could be asked to take annual leave or flexi time whilst they are unable to attend their designated place of work or an alternative site • if reasonable efforts have not been made to attend work or if the interruption is caused by the lack of access to fuel or severe weather the CCG's policy on annual leave, flexible working and special leave policies will be effective subject to negotiation.
Initial Actions During Event	• Complete 'Incident Assessment and Situation Report' • Verify the information and identify the anticipated timescale of the interruption. • Discuss and agree access to alternative locations to relocate staff on a temporary basis as above if required. • The On Call Director / Accountable EPRR Lead Officer/Deputy will have an up-to-date contact list of current employees and via the CCGs cascade arrangements this list should be used to communicate with affected

<table>
<tr><th>TYPE OF DISRUPTION / EVENT</th><th colspan="2">1. Access denial to work area (any reason including fuel crisis) or utility failure (electricity, heating, water) or flooding</th></tr>
<tr><td></td><td colspan="2">staff by email or text or phone as appropriate, based on whether the incident is ‘in hours’ or ‘out of hours’
If fuel shortage or severe weather (e.g. snow):
• Confirm continuation of critical functions.
• Implement flexible working arrangements for staff.
• Communicate decisions to staff via appropriate communications channel.</td></tr>
<tr><td rowspan="5">Communications & Management Contacts
Detail trigger points for events and list management contacts</td><td>Cordon established:</td><td>Building has to be evacuated – notify staff of evacuation if in hours via email / text message to relevant staff group. If out of hours and cordon is to remain in hours, then notify staff by text message.</td></tr>
<tr><td>Damage or flooding to buildings:</td><td>Notify relevant staff via cascade of closure of building and alternative site to be used via email / text message in hours and via text message only out of hours.</td></tr>
<tr><td>Utilities failure:</td><td>Notify staff who work at the affected location of alternative working arrangements and timescale of interruption and when normal arrangements are proposed. Provide number for staff to call to provide an update on progress or advise staff to check on the CCG website for information.</td></tr>
<tr><td>Severe Weather:</td><td>Activate cascade to all staff as above. Provide flexible working arrangements to all staff ensuring critical functions are maintained. This will be aligned to the CCG’s policy annual leave, flexible working and special leave policies subject to negotiation</td></tr>
<tr><td>Fuel Crisis:</td><td>Activate cascade to all staff as above. Provide flexible working arrangements to all staff ensuring critical functions are maintained. NHS Regional Team will activate the Fuel Shortage Response Plan and issue temporary authorisation to staff who qualify under this scheme.</td></tr>
<tr><td>Actions In Relation To Staff - Include details of contact lists held and the communications process with members of staff.</td><td colspan="2">Activate staff communications cascade
NOTE: Senior Managers are required to have access to this information for the staff in their respective sections. The On Call Director / Accountable EPRR Lead Officer/Deputy will have an up-to-date contact list as a backup.</td></tr>
<tr><td>Actions In Relation To Space - Include details of accommodation for visitors</td><td colspan="2">• Limited accommodation for staff providing critical functions could be provided at Telford and Wrekin CCG / Shropshire Council or by using VPN access from home.
• Hot desk facilities will be provided for staff but this may mean sharing facilities.</td></tr>
</table>

TYPE OF DISRUPTION / EVENT	1. Access denial to work area (any reason including fuel crisis) or utility failure (electricity, heating, water) or flooding
and staff workplace areas.	• Space will be identified in alternative sites to allow for meetings with visitors to proceed.
Actions In Relation To Supplies & Services - Include details of supply lines and actions following loss of service or utility.	• Suppliers will be notified by staff responsible for ordering essential supplies of any alternative location arrangements for deliveries. • If utility services fail within specific sites it will be the responsibility of NHS Property Services to liaise with the utility provider on progress and timescales for restoration of services.
Planning Vulnerabilities & Gaps	• If the incident affects patient facing services as well as commissioning functions, priority will be given to patient facing services in terms of alternative sites.
Proposed Remedial Actions	None
Other Actions/Comments	• Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. • Ensure all Shropshire CCG staff are aware of this plan and what is expected of them during incidents.

TYPE OF DISRUPTION / EVENT	2. Loss of established systems (IT, specialised software, email and Telecoms)
Impact On Shropshire CCG	Shropshire CCG would be unable to provide its **CRITICAL Services** as listed within section 4.1 of this Business Continuity Plan and would also need to suspend **VITAL, NECESSARY** and **DESIRED Services** until normal services could be resumed.
Risk Rating Of This Event	**MEDIUM/LOW**
Contingencies Available Regarding This Disruption/Event	**CRITICAL Services** In short term incidents, where loss of IT functionality is expected to be more than 24 hours and up to one week, the following actions need to be put in place: • Use a different building at the current location (there are several buildings on the same site) • Identify alternative premises to relocate these staff in the short term through partnership discussions with Telford and Wrekin CCG and Shropshire Council as appropriate • With the approval of their line managers, staff may be able to work remotely from home (via VPN access if appropriate).

TYPE OF DISRUPTION / EVENT	2. Loss of established systems (IT, specialised software, email and Telecoms)	
	VITAL, NECESSARY and **DESIRED Services** Shropshire CCG staff providing **VITAL, NECESSARY** and **DESIRED Services who** rely on IT functionality and are unable to be relocated and are not able to work remotely from home via VPN, then they may be given time off at the discretion of their line manager. All other staff not depending on IT functionality could operate manual paperwork systems until normal IT services are re-provided by the Commissioning Support Unit.	
Initial Actions During Event	If IT functionality is disrupted and critical services are required: • Contact Midlands and Lancashire CSU who provider IT functionality • Establish likely timescale of loss of functionality. • Discuss workstation availability at alternative sites for staff that provide critical functions. Alternatively agree staff working from home. • Contact Midlands and Lancashire CSU to arrange software installation and remote connections where necessary. • Where possible notify staff in person if incident occurs in hours or by text message if incident occurs out of hours.	
Communications & Management Contacts - Detail trigger points for events and list management contacts.	At sudden onset of IT failure which has been verified with Commissioning Support Unit. Including likely timescale of interruption	Implement the communications cascade to staff at affected sites via text message (assuming no email available).
	At sudden onset of Telecoms failure which has been verified with Commissioning Support Unit. Including the likely timescale of interruption	Implement the communications cascade to staff at affected sites via text message (assuming no email available). As and when the telecoms functionality at sites are affected this normally affects telecoms also as the system is Voice Over Internet Provider (VOIP). Use of media may be required to get message to staff and visitors and Midlands and Lancashire CSU will be required to support this.
Actions In Relation To Staff - Include details of contact lists held and the communications process with members of staff.	Activate staff communications cascade NOTE: Senior Managers are required to have access to this information for the staff in their respective sections. The On Call Director / Accountable EPRR Lead Officer/Deputy will have an up-to-date contact list as a backup.	
Actions In Relation To Space - Include details of accommodation for visitors and staff workplace areas.	Staff will obtain IT support as detailed above. Visitors will be advised on change of any locations.	
Actions In Relation To	• Contact Midlands and Lancashire CSU and maintain contact with them regarding progress on re-establishment	

TYPE OF DISRUPTION / EVENT	2. Loss of established systems (IT, specialised software, email and Telecoms)
Supplies & Services Include details of supply lines and actions following loss of service or utility.	of service. • Commissioning Support Unit will contact all CCGs of IT/Telecoms issues which attract an Amber or Red rating via their IT Systems Incident Plan. • Notify all relevant stakeholders of the interruption to Telecoms – via mobile phones.
Planning Vulnerabilities & Gaps	• Midlands and Lancashire CSU may establish service to other services prior to Shropshire CCG and therefore the interruption may be extended due to prioritisation.
Other Actions / Comments	• Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. • Ensure all Shropshire CCG staff are aware of this plan and what is expected of them during incidents.

TYPE OF DISRUPTION / EVENT	3. Restricted staffing levels for any reason (including Influenza Pandemic and travelling difficulties due to extreme weather conditions)
Impact on Shropshire CCG	Shropshire CCG would be unable to provide its **CRITICAL Services** as listed within section 4.1 of this Business Continuity Plan and would also need to suspend **VITAL, NECESSARY** and **DESIRED Services until** normal services could be resumed or where sufficient staff are available to cover these functions. All CCG staff are encouraged to have the annual influenza vaccination where appropriate.
Risk Rating Of This Event	**MEDIUM/HIGH**
Contingencies Available Regarding This Disruption/Event	• Using staff redeployment, all critical functions are required to be maintained in this situation. • In the first instance, staff available who cover VITAL, NECESSARY and DESIRED services roles and with suitable skills within Shropshire CCG would be made available to cover the identified critical functions. If necessary, additional resources from Telford and Wrekin CCG would be sought to support the critical functions. • In extreme weather situations, flexible working arrangements will be implemented including working from alternative bases for up to one week or working from home remotely via VPN access. This will be aligned to the CCG's policy annual leave, flexible working and special leave policies subject to negotiation
Initial Actions During Event	• Review staffing numbers and critical functions to be maintained across the CCG in a Pandemic. Monitor position daily as this will be constantly changing. • Where necessary suspend VITAL, NECESSARY and DESIRED services **if** staffing levels are hit substantially – review daily. • Provide staff for redeployment to CRITICAL services across the CCG – also make staff available with appropriate skills for primary and secondary care where necessary. • Notify staff of decisions to suspend work and redeploy staff where necessary. Keep all staff informed of the situation in relation to the Pandemic. • Annual leave and flexi leave may be cancelled. Staff who attend work with flu like symptoms will be asked to

TYPE OF DISRUPTION / EVENT	3. Restricted staffing levels for any reason (including Influenza Pandemic and travelling difficulties due to extreme weather conditions)	
	go home to protect the health workforce. • In extreme weather, cascade weather information to staff. Activate flexible working arrangements where necessary to be in place for up to one week. If situation persists review arrangements in place and monitor the impact to critical functions. This will be aligned to the CCG's policy annual leave, flexible working and special leave policies subject to negotiation	
Communications & Management Contacts - Detail trigger points for events and list management contacts	Pandemic is announced and staffing numbers are affected. Daily reporting of staff situation indicates an impact on services provided.	• Cascade to staff that Business Continuity Plan arrangements are being implemented, including suspension of non-critical functions where appropriate, redeployment of staff to cover the critical and essential workload and support of the pandemic flu response. • Cascade information to staff via email contact lists and text message.
	Extreme weather warnings received.	• Cascade information to staff via email contact lists and text message
	Extreme weather happens/ schools/ nurseries close/ road networks affected/ public transport affected.	• Cascade to staff via email and text message (text message only if incident commences out of hours). • Implement flexible working arrangements for staff, working from alternative sites, working from home. • Staff unable to access an alternative location to work or unable to access work remotely will be asked to take annual leave. This will be aligned to the CCG's policy annual leave, flexible working and special leave policies subject to negotiation. • Staff needing to look after very young children due to nursery closures will be required to take annual leave if alternative carer arrangements cannot be found. This will be aligned to the CCG's policy annual leave, flexible working and special leave policies subject to negotiation
Actions In Relation To Staff - Include details of contact lists held and the communications process with members of staff.	Activate staff communications cascade NOTE: Senior Managers are required to have access to this information for the staff in their respective sections. The On Call Director / Accountable EPRR Lead Officer/Deputy will have an up-to-date contact list as a backup.	
Actions In Relation To Space - Include details of accommodation for patients, visitors and staff workplace areas.	• Under flexible working arrangements for severe weather situations, staff should already have notified their line manager of the nearest base they can attend or whether flexible working arrangements have been agreed.	

TYPE OF DISRUPTION / EVENT	3. Restricted staffing levels for any reason (including Influenza Pandemic and travelling difficulties due to extreme weather conditions)
Actions In Relation To Supplies & Services Include details of supply lines and actions following loss of service or utility.	• The CCG's Medicines Management Team will be critical in maintaining appropriate access to antivirals during a pandemic.
Planning Vulnerabilities & Gaps	- If these situations arise during key staff holiday times, then the impact on staffing levels would be experienced earlier than in the times when staff would normally be at work (e.g. summer holiday periods, Easter and Christmas).
Proposed Remedial Actions	- None
Other Actions / Comments	- Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. - Ensure all Shropshire CCG staff are aware of this plan and what is expected of them during incidents.

Appendix III

FIRST MEETING AGENDA - MEETING OF BUSINESS CONTINUITY (PLANNING) TEAM
DATE, TIME AND PLACE:
ATTENDEES: CHAIRED BY:

No	Item	Action	Action By Who	Action By When
1	**Analysis of Impact** - Review Service Impact Analysis Sheets - Brief team on nature, severity and impact of disruption. - Identify information gaps - Agree immediate action necessary - Adjourn to take immediate action as needed - Agree time to reconvene			
2	**Confirm Roles** - Agree roles and responsibilities of staff during the disruption. - If required revise roles and determine if additional staff/deputies are required. - Identify additional team members that may be required - Stand down members not required			
3	**Confirm Key Contacts at Scene of Disruption** - Main points of contact for ongoing information updates			
4	**Logs** - Ensure personal logs in place. (Written record of significant events and all communications)			
5	**Recovery Management** - Review recovery priorities - Determination of support requirements.			
6	**Welfare Issues** - Have members of staff, visitors or third parties been affected? - What is their location? - What immediate support and assistance is required? - What ongoing support and assistance might be required?			
7	**Communications** - Who should we inform? - Are Communications managers required / present? - Professional Public Relations/Media advisors required? - Determine which, if any external regulatory bodies should be notified. - Determine any internal communications that need to take place (other sites, affected services etc.			
8	**Media Strategy** - Determine the media strategy to be implemented. - What is the story? What is the deadline?			
9	**Legal Perspective** • Determine what legal action or advice is required.			
10	**Insurance Position** • Determine whether insurance cover is available and if so, how best to use the support it may provide.			
11	**Next meeting** • Date, time, place and attendees of next meeting			

Appendix IV

Business Continuity Communications (internal)

During the response to a business interruption it is important that staff are kept fully informed of progress. Staff directly affected by a business interruption will obviously be very concerned about the impact upon them personally. Staff not directly affected by a business interruption also need to be kept informed of progress as they may be impacted upon e.g. they may need to take on additional work, be relocated to alternative accommodation, etc. A clear, concise and accurate flow of information is essential; it will ensure that all staff are fully aware of developments and can work together to ensure that the organisation overcomes the interruption. The severity of the business interruption will influence the level of detail and amount of information which needs to be issued to staff.

The business Accountable EPRR Lead Officer/Deputy/On Call Director will liaise with the Head of Communications and Engagement as needed to ensure effective, on-going communications and will cover, as a minimum:

1 Are the normal day-to-day communication links with staff still in place? If yes, these should be used to issue information to staff.

2 If normal day-to-day communication links are no longer in place, use any agreed fall-back procedure for issuing information to staff.

3 In the case of a business interruption, the Accountable EPRR Lead Officerand Executive Team will continually monitor staff instructions and ensure that all staff are aware of the current situation and plans.

4 If information needs to be relayed to the public then this should be arranged with the Head of Communications and Engagement.

Appendix V

Equipment in the Incident Operating Room / Incident Response Room

The IOR/IR room should include;

- Workstation and computer
- Access to a dedicated generic Email account and backup account Comment – need individuals using generic account to be identified)
- Access to an A3 colour printer
- Access to a Fax machine
- Access to a photocopier
- Sufficient telephone lines
- A stationery pack
- White boards and pens/flip charts and pens
- Log books (call logs/decision logs)
- Hard copy plans (Business Continuity Plan, Major Incident Plan, Office On-Call, directories and maps). these should be maintained in the On Call File held by the Director of Corporate Affairs.
- Note - Portable items to be secured in known accessible place for transfer to the Incident Room.
- A copy of all key paperwork should be maintained off site.

Appendix VI

Debrief Template Post Incident

Incident Date: **Outline of Incident:**

This debrief template provides the framework for undertaking a structured De-brief and will assist in the development of the post incident Report which will cover –

- What was supposed to happen?
- What actually happened?
- Why were there differences?
- What lessons were identified?

Issues	**Response**
How prepared were we?	
What went well?	
What did not go well?	
What can we do better in the future?	
Is there a need to modify the plan / training?	
Other Issues	
Communications	
Equipment	
Human resources	
Planning and briefing	
Other issues	

Completed by: **Date:**

Shropshire Clinical Commissioning Group

MINUTES OF THE
FINANCE & PERFORMANCE COMMITTEE
HELD IN ROOM B, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL
ON WEDNESDAY 26th APRIL AT 12.30PM

Present

Mr Keith Timmis (Chair)	Lay Member
Mrs Deborah Hayman	Interim Chief Finance Officer
Dr Jessica Sokolov	Deputy Clinical Chair
Mr William Hutton	Lay Member and Audit Chair
Mr Michael Whitworth	Interim Director of Contracting & Planning
Dr Julie Davies	Director of Performance & Delivery

In Attendance

Mr Mike Taylor	PMO Lead
Mr Charles Millar	Head of Planning, Performance & Contracting (1.45pm – 2.15pm)
Mrs Faye Harrison	Personal Assistant/Minute Taker

Apologies
None received

FPC-2017-04.034 (Agenda item 1) - Apologies

1.1 No apologies were received.

1.2 Mr Timmis began by informing members there had been some confusion over the membership of the Finance and Performance Committee and who needed to attend. He clarified that it had been agreed to keep this as a small group and that larger workshop sessions would be offered to the Governing Body as part of the Board Meeting.

FPC-2017-04.035 (Agenda item 2) - Members' Declaration of Interests

2.1 There were no declarations of interest.

FPC-2017-04.036 (Agenda item 3) - Minutes of Previous Meeting held on 29th March 2017

3.1 The minutes from the previous meeting were agreed as being a true and accurate record.

FPC-2017-04.037 (Agenda item 4) - Matters Arising/Action Tracker

4.1 The Action Tracker was discussed and updated as appropriate. Please see attached Action Tracker.

4.2 The A&E Delivery Board was discussed and Dr Davies informed members that Simon Freeman had agreed to be the Vice Chair of the Committee. Dr Davies agreed to add an A&E Delivery Board section into the Performance Report to provide an update to the F&P Committee each month. She further reported that the Board reports directly

to NHSI and NHSE although members felt it needed to have some formal authority so that issues can be escalated effectively.

Action:	**Dr Davies/Mrs Hayman to discuss the A&E Delivery Board at Executive Team with regard to where the committee reports**

Action:	**Dr Davies to include an update from the A&E Delivery Board in the Performance Report for F&P**

4.3 Mr Whitworth informed members that the Strategic Commissioning Forum was due to be held in June and that he felt it would be beneficial to bring an update to this committee. It was agreed that he would bring an update before the end of July depending on the timing of the meeting. Further updates would be required to go to other committees.

Action:	**Mr Whitworth to bring an update from the Strategic Commissioning Forum before the end of July.**

FPC-2017-04.38 (Agenda item 5) - Workplan

5.1 The Workplan was discussed and it was agreed that the FRP Deep Dive should now come to the June Meeting as Claire Skidmore, new CFO won't be in post until 1st June; this will mean that the Complex Care Deep Dive can now come to the May Meeting. Dr Davies agreed to speak with Nikki Diamond around the change of date.

Action:	**Dr Davies to speak to Nikki Diamond regarding the Complex Care Deep Dive which will now come to F&P in May.**

5.2 The Workplan will be re-circulated to members for any updates.

Action:	**Mrs Harrison to circulate the Workplan to members asking for any further updates**

FPC- 2017-04.039 (Agenda item 6) – QIPP Deep Dive

6.1 Mr Mike Taylor, PMO Lead attended the meeting to discuss the QIPP schemes. Members agreed that QIPP should be a standing item on the agenda for an update each month.

Action:	**QIPP update to be added to the agenda as a standing item.**

6.2 Mr Taylor began by talking through the paper with members and highlighted the draft report asking members for feedback/comments on the report content and layout. Mr Timmis highlighted that there were some discrepancies in some of the figures e.g. the total savings target in the report and commented that they needed to be consistent throughout.

6.3 The more detailed report is to be presented to the QIPP Performance and Delivery Group and Mr Taylor could bring a shorter summary to this meeting if required. Members agreed that the more detailed report was required currently as they felt it was helpful to see the detail but that moving forward this could be changed to the summary as things progress.

6.4 Mr Timmis enquired as to whether there were some gaps in the report around Clinical Leads and Mr Taylor reported that he was due to pick this issue up with Julian Povey later in the week. Mr Taylor hoped that it would be known who the scheme leads would be by the end of May. It will be the Executives' responsibility to identify the leads; Dr Davies reported that until the substantive Directors were in post capacity was an issue as she is currently covering other areas of work outside of her own. This could be identified as a risk although it was agreed it didn't need to be added to the BAF yet but that this will be monitored.

6.5 Mr Taylor highlighted to members that schemes had been identified for NHSE to get the assurance that is required with a greater degree of detail on both the activity and finance.

6.6 There are currently Deep Dives on-going for Coding and Counting Outsources Projects, Methods Analytical are looking at further QIPP opportunities and Optimity is working on the STP Community. In order to make the savings some schemes will over deliver and some will under deliver but it is hoped that these will balance out to make the £17m of savings by the end of the year. Mrs Hayman highlighted that Simon Freeman would be carrying out a series of Deep Dives on the bigger projects such as CHC, MSK and Prescribing.

6.7 Mr Timmis enquired about missing and poor data in some schemes and whether this needed to be recorded as a risk. Mr Taylor reported that an assessment of all the schemes had been carried out and taken to Executive Team as a concern. Mr Timmis felt that these needed to be highlighted in the document as a risk.

6.8 Mr Timmis asked for more detail on the feedback from NHSE and Mr Whitworth reported that no formal feedback had been received although Paul Watson did acknowledge that a lot of work had been carried out over the last few months and significant improvements had been made.

6.9 Dr Davies provided further update on the projects that would be progressing to the Clinical Commissioning Committee next month.

6.10 Mr Whitworth updated that for future meetings there needs to be specific reference to Rightcare. Feedback has been provided to NHSE on applications of scoring systems.

6.11 Mrs Hayman reported that there is a regional approach to doing QIPP; there is a MOO (Menu Of Options) Event taking place to create a network for all CCGs within the Midlands and East region.

6.12 Governance structures were discussed and Mr Taylor highlighted until the substantive structure is in place this is a work in progress. Mr Timmis commented that he felt this needed to be more definitive to improve the risk position.

6.13 Dr Davies discussed the admin support for the PMO and reported that Sam Tilley is going to map all of the admin requirements in order to provide appropriate cover.

6.14 Mr Whitworth reported that he had been involved in a conference call with NHSE regarding non-elective activity in Primary Care and reported how this would be progressed in the early stages of development. Some of the SaTH QIPP would need to be focused on non-elective admissions.

6.15 Mr Taylor reported that the PMO would focus on the schemes with the large savings such as the Community Services Review which is hoped to deliver £5m of savings in the next financial year.

6.16 Members discussed and approved the QIPP Planning and Delivery Group Terms of Reference; any feedback should be sent directly to Mr Taylor.

FPC-2017-04.40 (Agenda item 7) – Monthly Monitoring for Finance and Performance

Finance Report

7.1 Mrs Hayman reported that the £25.9m controlled total had been met; this includes the £4.2m 1% reserve. The annual accounts have been agreed and submitted.

7.2 Mrs Hayman wanted to draw member's attention to the delegated primary care information. She reported that the position reflects that the total hasn't delivered to the level that was expected and assessments have been made about how this might be done.

7.3 Mr Timmis highlighted that it wasn't accurately reflected in the report that this is a forecasting failure and is not about making decisions. He wanted a focus for next year that a better system is put in place in order to improve working practice and provide assurance and would need to be a key area of focus for the Finance Department.

7.4 Mrs Hayman informed members that they had been made aware of the underspend in Month 10 although this had not been highlighted to the Primary Care Commissioning Committee until April and that further focus would be required on this moving forward.

7.5 It was agreed that there needed to be a clear form of words used in the statement of accounts which is then followed in every document consistently. Consistent messages to staff would also be important.

7.6 Mr Timmis commented that from a Finance Management point of view this committee required assurance about how better forecasting in Primary Care will be delivered.

7.7 Mr Hutton suggested that another column for adjustments be added to the table to which Mrs Hayman agreed.

Contracting Report

7.8 Mr Charles Millar joined the meeting for this report. He commented that they are looking at restructuring the activity plan to reflect the areas with the biggest pressures and also look at the longer-term trends.

7.9 Mr Whitworth drew members' attention to the referrals graph and discussed the increase in referrals and activity management. Moving forward this would require a much more escalated view to address the backlog.

7.10 Mrs Hayman commented that it may be more beneficial to have 2 lines on the graph for this year and the previous year rather than running one on to the other as the comparisons will be more obvious.

7.11 Mr Timmis enquired whether the challenges and the VBC would be resolved by the end of the year and Mr Whitworth reported that the reconciliation process has been agreed and the plan is that those which have not been resolved will be escalated to the Executive Directors. There will be a "settlement" on a regular basis during the year, probably quarterly.

7.12 Mr Whitworth reported that he had recently attended a meeting with RJAH and following this a letter had been sent out with a clinical focus to providers mainly aimed at SaTH as their meeting hadn't gone so well. There needs to be a month's notice for VBC changes and monthly or quarterly updates will be provided. The assumptions need to be made clear and consistent.

7.13 Mr Timmis enquired about the SSSFT activity which is less than planned. Mr Whitworth reported that there had been discussion with T&W CCG around this and there has also been active engagement from Shropshire CCG.

7.14 It was reported that the WMAS activity was at around a cost of £265,000. The way they recorded the data has changed which makes it difficult to hold them to account.

Performance Report

7.15 Dr Davies reported that there are concerns with the Ambulance performance as there are concerns around both category 1 and category 2. Dr Davies informed that she had further concerns about the relative response times and this needs to be looked at from a quality point of view also. Unfortunately there isn't enough CCG capacity to carry out this piece of work presently but this is something which can be looked at in 2018/19. Mr Timmis summarised that as there is very little that can be done with the present contract this can be followed up from a patient safety/quality perspective. Dr Davies agreed to pick this up with Barbara Beal.

Action: Dr Davies to pick up patient safety/quality issues around WMAS with Barbara Beal

7.16 It was agreed that the two priorities were to develop a secondary response for the PRU and to work with SaTH around ambulance handover delay.

7.17 Dr Davies reported that notice had been served on the Physician Response Unit for the service to be decommissioned.

7.18 Dr Davies reported there is increasing concern relating to RTT. The papers which were being submitted to the Planned Care Working Groups are not up to standard, the papers are arriving late and the detail in the specialty recovery plans is sporadic. She reported that at the meeting scheduled for the following day she will be formally asking for a detailed recovery plan at a Trust total level and also at a sub-specialty level. Telford CCG will also be asked to join for an overall recovery plan. Dr Sokolov raised further concern about SaTH's ability to future plan and manage the situation.

7.19 Dr Davies further reported that RJAH have confirmed that the final over 52 week patient was treated in March and they are forecasting no 52 week wait patients in April or May. They did identify that there would be a slight increase in their incomplete position due to the spinal issue at SaTH and a patient transfer case.

7.20 Dr Davies informed that diagnostics had recovered in February and the submission of their business case to which alterations have been made with additional capacity now provided.

7.21 With regard to A&E the Trust have shown an improvement particularly on their non-admitted breaches.

7.22 There was a meeting held on 20th April with NHSI, chaired by Dale Bywater which went well. It was accepted that changes and improvements had been made however it was made very clear that any performance less than 90% was not acceptable. The recovery trajectory which had been submitted which showed a 2017/18 delivery of 86.55% and they have been asked to re-write this.

7.23 It was agreed at the A&E Delivery Board that a detailed action plan would be worked on to monitor progress.

7.24 Dr Davies raised concern that HALO's had been lost from mediation although Mr Bywater has asked for an alternative to be identified. They will be looking to fund this through winter monies. Dr Davies reported that models used by Lincolnshire and Sherwood are currently been looked at.

2.30pm Mr Millar left the meeting

FPC-2017-04.041 (Agenda item 8) – Governing Body Assurance Framework

8.1 Mr Timmis enquired as to what needed to happen regarding the 'old financial year' and 'new financial year' on the document and Mrs Hayman confirmed that the 'old year' would gradually be removed from the document.

8.2 Mr Timmis further enquired regarding assurance to the F&P Committee that the risk is being minimised as some of the evidence was not available.

8.3 Mr Timmis asked for the Directors to look at their relevant risks and update accordingly.

FPC-2017-03.042 (Agenda item 9) - Any Other Business

9.1 There were no items of other business to discuss.

Meeting closed 2.30pm

Date of Next Meeting
Wednesday 31st May 2017, 12.30pm, Room B, William Farr House

Signed……

Agenda Item – GB-2017-06.123
CCG Governing Body – 7.6.17

Shropshire Clinical Commissioning Group

MINUTES OF THE CLINICAL COMMISSIONING COMMITTEE (CCC)
HELD IN ROOM 2, OAK LODGE
AT 11.00AM ON WEDNESDAY 15TH MARCH 2017

Present

Mr William Hutton	CCC Chair, CCG Lay Member
Dr Simon Freeman	Accountable Officer
Dr Julian Povey	GP Member, CCG Chair
Dr Jessica Sokolov	GP Board Member
Dr Julie Davies	Director of Performance and Delivery
Mr Kevin Morris	Chair, North Shropshire Locality
Mr Michael Whitworth	Interim Director of Contracting and Planning
Dr Ed Rysdale	Secondary Care Consultant
Dr Irfan Ghani	Public Health Consultant (Representing Professor Rod Thomson)
Mrs Sarah Smith	Personal Assistant, Minute Taker

Apologies

Mrs Deborah Hayman	Interim Director of Finance
Professor Rod Thomson	Director of Public Health for Shropshire

In Attendance

Mr Chris Evans	Consultant Orthopaedic Surgeon in Arthroplasty, RJAH (Agenda Item 5)
Mrs Paula Jefferson	Divisional Manager for Medicine, RJAH (Agenda Item 6)
Ms Nia Jones	Deputy Director of Operations, RJAH (Agenda Items 5 and 6)
Mrs Nina White	Head of Transformation and DIPP Definition (Agenda Items 5 and 6)
Mrs Emma Pyrah	Senior programme Manager for Futurefit (Agenda Item7&8)
Miss Gemma McIver	Commissioning and Redesign Lead for Reablement and Rehabiliation (Agenda Item 7)
Ms Sam Tilley	Head of Planning and Partnerships (Agenda Item 9)
Mrs Anne Dray	Interim Director of Corporate Affairs (Agenda Item 11)

1. Apologies

Apologies were received from Mrs Deborah Hayman and Professor Rod Thomson.

2. Members' Declaration of Interests

There were no declarations of interest.

Mr Hutton welcomed members and attendees to the Clinical Commissioning Committee (CCC).

3. Minutes of Previous CCC Meeting

Matters Arising

3.1. CCC Meeting held on 15th February 2017

The minutes of the last meeting were agreed to be a true and accurate record subject to the following amendments:

Page 4 – Minute Number 17/27 (Agenda Item 7) Musculoskeletal (MSK) - It was agreed to take out the highlighted section relating to the Interface Team

Page 8 – Minute Number 17/34 (Agenda Item 14) Methods Analytics – Dr Freeman requested that the paragraph related to the Aristotle system should be corrected to read " Dr Freeman began by raising concern within the organisation that the current systems appear not to be used".

3.2 Matters Arising – Actions from Last Meeting

Developing a timeline in relation to MRET, Readmission, Winter Monies – Dr Davies advised this work was still ongoing and it was anticipated this would be complete by the end of March. It was agreed this item come back to the April meeting.

ACTION: Dr Davies and Mr Whitworth to work together to develop a timeline in relation to MRET, Re-Admissions and Winter Monies. This item would be brought back to the April CCC meeting.

Chief Finance Officer to be added to CCC TOR and taken to Governing Body for approval - This action was complete and the CCC TOR item was on the agenda today.

Dr Sokolov and Dr Freeman to draft letter to South Staffordshire and Shropshire Healthcare NHS Trust (SSSFT) regarding the withdrawal of Primary Care Liaison Mental Health Workers – This action was complete and was followed up by a letter. Some concerns had been raised with regard to the withdrawal of Primary Care Liaison Mental Health Workers and members noted Dr Sokolov and Dr Povey would be meeting with the Medical Director of SSSFT. It was noted that an update would come back to the April CCC meeting.

ACTION: Dr Sokolov and Dr Povey to meet with the Medical Director of SSSFT. An update would come back to the April CCC Meeting.

Mr Whitworth to provide update around MSK and SOOS Improvement Plan at the next meeting – Mr Whitworth asked for this item to be deferred until the April Meeting.

ACTION: Mr Whitworth to bring back an update around MSK and SOOS Improvement Plan back to the April CCC Meeting.

Dr Freeman and Dr Sokolov to write to Clive Wright and Simon Wright to highlight that all pilot schemes need to come to the CCC for approval before being initiated – Dr Freeman advised this would be confirmed at the next meeting.

ACTION: An update on pilot schemes would be given at the April CCC meeting.

Mr Menzies to circulate draft TOR to members whilst clinical and legal advice is sought – Dr Davies advised this work was ongoing and legal advice was being sought. Dr Davies noted daily contact was being made to try to get this work completed.

Community Services Review TOR to be brought back to March CCC – Dr Davies advised she was following this work up on a daily basis and asked members if this work could be signed off under Chairs Action due to some concerns regarding the pace of this work. Members agreed this work could be delegated to Dr Freeman and Dr Povey for them to meet to discuss this work before the next CCC meeting. It was agreed the updated work around Community Services Review TOR would be circulated to members for approval and final sign off.

ACTION: Dr Freeman and Dr Povey to meet to review work around Community Services Review TOR and an update would be circulated to members for final approval and sign off.

Demand Management (Emergency Admission Variation Scheme) – Mr Whitworth reported that the Demand Management (Emergency Admission Variation Scheme) had gone to the Shropshire CCG Board Meeting. Mr Whitworth advised work was ongoing with demand management and he was currently awaiting data to progress this work. Mr Whitworth gave his apologies and asked if this item could be deferred until the April CCC meeting. He advised Mr David Harry was working with Business Intelligence to produce the required information.
Dr Povey asked about getting letters out to Practices with regard to Enhanced Services for next year and suggested sending a list to Practices detailing what pieces of work the CCG were doing. Members discussed Local Enhanced Schemes and Direct Enhanced Schemes and Dr Freeman advised that LES and DES went to the Primary Care Commissioning Committee (PCCC). Mr Whitworth suggested having a consolidated list. Mr Morris noted that a letter had already gone out to Practices with regard to CHAS noting this scheme was continuing and this would be reviewed within the next 12 months.

Mr Whitworth reported that the Demand Management Scheme had changed from a general intensive scheme to focussed support for specific initiatives to be developed by the three localities. Mr Whitworth concluded that work was ongoing with Demand Management and once the appropriate data had been received and digested, an update on progress would come back to the April CCC meeting.

ACTION: Mr Whitworth to bring an update regarding Demand Management (Emergency Admission Variation Scheme) back to the April CCC Meeting.

Dr Davies and Dr James to draft letter to Practices around the Medicines Optimisation QIPP attaching a template for the plans which they will be required to submit in order to gain funding – Dr Davies advised this work would be taken to the Executive Team Meeting on 27 March for discussion and advised this item would come back to the next CCC meeting.

ACTION: Dr Davies to bring an update around Medicines Optimisation QIPP template back to the April CCC meeting.

Call Centre Plan around Repeat Prescriptions to be brought back to March Meeting – Dr Davies advised work was ongoing with the call centre plan around repeat prescriptions. Mr Hutton noted this was potentially a large piece of work and it was agreed this item would come back to the April CCC meeting.

ACTION: Dr Davies to bring an update around Call Centre Plan and Repeat Prescriptions back to the April CCC meeting.

Dr Davies and Mr Whitworth to work together on the draft joint membership for SaTH QIPP – Mr Whitworth advised this work was progressing and links were being established between GPs and Shrewsbury and Telford Hospitals NHS Trust (SaTH) clinicans to progress the identified priority areas. Mr Whitworth highlighted ambulatory care services and a planned service visit by Dr Geoff Davies and Dr Steve James.

Dr Freeman and Dr Sokolov to set up meeting with Phillip Dunne, MP regarding MLU – Dr Freeman advised a meeting was in the process of being set up for this.

Dr Davies to liaise with Brigid Stacy, NHSE regarding clinical oversight of MLU Review - Dr Davies advised she had been unable to attend the last Quality Surveillance Group (QSG) meeting and noted she would be following this work up with a phone call to Brigid Stacey tomorrow.

Clive Wright to be invited to CCC to discuss upstream investment and prevention – Members agreed Clive Wright should be invited to the April CCC Meeting.

ACTION: Members agreed Clive Wright be invited to the April CCC Meeting to discuss upstream and investment and prevention.

Frail Elderly to be brought back to a future meeting – Dr Davies advised this would come back to the April CCC Meeting.

ACTION: Members agreed Frail and Elderly item would be put on the April CCC Agenda.

GP Five Year Forward View to be brought back to the March CCC – Members noted this item was complete and did not need to come back to a future CCC meeting.

Dr Sokolov and Dr Freeman to agree how to pick up with NHSE the position regarding the GP 5 Year Forward View – completed.

Healthy Lives – Healthy Lives to be brought back to a future meeting once the review is complete – Dr Freeman advised that no paper should come to the CCC without having been through and seen by the Executive Team meeting. The Healthy Lives paper had not been through the appropriate route.

Quality Premium Local Choices to be brought back to a future meeting (possibly late summer) – Dr Davies noted this paper would come back to CCC in August 2017.

ACTION: Members agreed the Quality Premium Local Choices Item would come back to the August 2017 meeting.

4. Update from the Accountable Officer

Dr Freeman advised he had significant concerns with regard to the degree of progress with QIPP mobilisation and delivery of some of the actions. Dr Freeman commented a discussion on QIPP had taken place at the Executive Team meeting which had produced a plan of action, however, Dr Freeman still had concerns over which QIPP schemes were currently being progressed and which work was assigned to which staff. Members noted that QIPP resources was being reviewed. Dr Freeman commented that Paul Watson had expressed a view that the CCG had good ideas, but the next stage was about translating them into hard actions.
Dr Freeman reported the letter from Mr Paul Watson had been discussed around work priorities. Dr Freeman advised he anticipated that some of the areas of work could be completed by the end of March 2017 with the focus on the essential pieces of work. The next meeting with Mr Watson was at the beginning of April.

Dr Freeman raised concerns with the Sustainability Transformation Plan (STP) advising this did not currently accurately reflect the Shropshire work programme Dr Freeman commented that unfortunately he was unable to attend the next STP meeting, however, Dr Freeman would be writing a letter to brief the STP on his thoughts. Dr Freeman advised that Mr Clive Wright had initiated the Optimity Review to support the development of the Shropshire out of hospital STP programme.

Dr Freeman welcomed Dr Irfan Ghani's presence at the meeting and commented that Shropshire needed a clear health management plan. Dr Freeman highlighted the need for both commissioners and care providers to have access to robust population level needs and utilisation intelligence.

Dr Freeman updated members on the work around the Community Services Review and advised that there had been issues over the availability of detailed information. Dr Freeman reported there were no financial deliverables in 2017/18 for this review, however, based on the external review there was an assumption that greater value for money would be delivered in 2018/19.

5. 17/42 Virtual Follow Up (Agenda Item 5)

Mr Chris Evans, Consultant Orthopaedic Surgery in Arthroplasty, Robert Jones and Agnes Hunt Hospital (RJAH), Ms Nia Jones, Deputy Director of Operations, RJAH and Mrs Nina White, Head of Transformation and QIPP Definition attended to present this item.

Mrs White advised the purpose of the report was to present a proposal received from the RJAH to replace attendance at RJAH for follow up and x-ray with a virtual appointment and x-ray. The proposal advocated two face to face follow up appointments (6 week and 1 year follow ups) for all patients who have had primary hip and knee replacements and the use of virtual follow up appointments for those patients requiring long term follow up (3 and 5 year review). An x-ray would be undertaken and then a telephone consultation if required.

Mr Whitworth advised he had discussed the proposal with Mrs White and Chris Tomlinson who were supportive of this. However, Mr Whitworth asked for clarification about whether the initiative would increase overall activity or just deliver the same amount in a more effective way. Mr Chris Evans advised that over the last 10 years there had been multiple pathway iterations for managing long term follow-ups. The expectation was that the move to virtual clinics would not increase activity volumes in itself and that the pathway was being driven by the latest evidence based guidance. Mr Evans highlighted the key issue of missed silent failure of joints and that this was both dramatic for

patients and very expensive for the NHS. Mr Evans advised the proposed follow up pathway would provide a degree of security to consultants that the joints they had fitted were still functioning as they should. Mr Evans added that the early signs of failure for some patients were often very subtle.

Mr Evans commented the virtual clinic model had been looked at for a long time with the CCG and Mr Evans advised this proposal met the needs of both RJAH and the CCG. There is potential for reducing unnecessary follow ups with consultants, whilst reducing the CCG costs. Mr Whitworth asked about prevalence of silent failures and if there was any data on this. Mr Evans confirmed that to get data on this would be difficult as it depended on how long a patient lived. Mr Evans went on to describe scenarios with regard to patient follow ups and problems that could arise after surgery, he advised that with regard to infection, most infections which were relative to surgery would represent itself within 2 years. Mr Evans said that infection from seeding at time of surgery was unlikely but it was possible to have infection from bacteria, confirming patients could also get late secondary infections. Mr Evans went on to talk about non-infected failures of hip and knee replacements and noted that 80% would present with some symptoms, however, if patients were seen by RJAH which had previously been seen elsewhere, there was a possibility their symptoms may had been classed as relatively mild, and would have had no diagnosis. Mr Evans said it is all about making a correct diagnosis and confirmed that 20% of patients would present in a mode where the situation was worse than expected. Mr Evans commented that anybody with a metal device needs careful observation and eventually all parts used will fail.

Dr Povey asked for clarification in relation to the figures stated in the paper with regard to the 450 patients a year who have follow up appointments. Mr Evans confirmed RJAH were discharging more patients currently. Ms Jones advised the data in the paper was historical and from patients who had received replacements perhaps 5 years ago and whom now would be requiring follow ups and work this year. Ms Jones noted in terms of a profile on how this might look going forward, and with the appropriate management this would improve going forward. Dr Povey asked about face to face consultations and rather than using a consultant, it was suggested using a physio for these consultations. Mr Evans advised patients being seen by a consultant is always the best option and the most cost effective, but the involvement of other trained health professional could also be appropriate in some instances.

Members acknowledged the virtual follow up service would need to be run by experienced Allied Health Professionals who have knowledge of this work.

Ms Jones commented that not all patients would require regular follow ups. For example a patient who had received one hip replacement would be discharged when fit, although the other hip would need doing at some point but the patient would still be discharged. Mr Evans said GPs should not ignore a patient complaining of pain if they have had had hip and knee replacements.

Dr Povey asked if RJAH were positive about this proposal. Mr Evans said he spoke on behalf of the arthroplasty team whom were all supportive. Mr Evans noted this proposal had been discussed at length and with the included safety caveats, all consultants were happy with this way forward. Members noted that the virtual clinic model had previously been done in Coventry and Warwick although it had slightly more face to face time scoring.

Mr Evans and Ms Jones left the room.

Mr Whitworth said he felt it was extremely positive that clinicians from RJAH were attending the

CCC meeting. Dr Povey commented that engagement with clinicians should be encouraged.

There was general support for the proposal. However, concerns were raised about the overall growth in the number of follow-up attendances. Mr Whitworth advised this work around follow ups was in line with good national public practice, however, the above planned levels of follow-ups was something the contracting team was reviewing. It was noted this was a national issue which had resulted in changes to the National Tariff Payment System and lower tariffs for outpatient follow-ups.

Dr Freeman suggested exploring a volume cap based on best practice. Dr Davies advised that RJAH had previously had a huge backlog of follow ups and this proposal was part of systematic proposal to establish clear evidence based pathways for follow-ups.

Dr Freeman advised the CCG needed more information in relation to follow ups. Dr Rysdale commented that age was often an important factor in follow-up rates and should be considered in any analysis.

Mr Whitworth recommended members approve this item. Members approved the proposal but requested that outpatient follow up rates are regularily reviewed.

6. 17/43 DMARDS (Agenda Item 6)

Mrs Paula Jefferson, Divisional Manager for Medicine, RJAH (managing the rheumatology team) and Ms Nia Jones, Deputy Director of Operations, attended the meeting with Mrs Nina White to present on this item.

Mrs White confirmed the purpose of the report was to present a proposal received from RJAH in response to a decision made at the Clinical Assurance Panel (CAP) in May 2016 where it was agreed to; Commission a service where by the clinical responsibility for the initiation of DMARDS for patients with inflammatory arthritis is held by a specialist rheumatology service.

Mrs White advised that currently RJAH could not deliver the required service and that some GPs were initiating DMARDS and the patients of other GPs were being referred out of area. Mrs White advised that RJAH were now in a position to deliver the service and proposal. Mr Whitworth added that Mrs Trish Campbell had been involved in this work from a pharmaceutical perspective and supported the initiative.

Dr Sokolov commented that currently the pathway was not clear and that this could cause significant problems. However, Dr Sokolov added that the proposal paper wasn't clear about potential issues, for example if a patients' bloods were abnormal, then should a GP speak to a rheumatologist of the DMARD service nurse. Mrs Jefferson confirmed this service was mainly nurse led, however, a helpline would be available. It was also reported that if the proposal was approved, the rheumatology database would be purchased and this would flag up abnormal results. Also if patients had any concerns they could also call the helpline.

Members discussed information in the paper which was historical and about the questionnaire done by Practices about initiating DMARDS. Mrs Jefferson reported that RJAH would be investing in additional nursing staff and the database. Patients under RJAH would use this service and it would be anticipated that patients in Shropshire would be referred to this service unless choosing another provider as is their choice.

Dr Povey asked about stabilisation and highlighted that some patients may require more than 8 weeks monitoring of DMARDS. Mrs Jefferson confirmed that some patients do need to switch drugs or stop drugs and so will need to be monitored for longer. Mrs White added that for clarification purposes and from Mrs Trish Campbell's perspective, with regard to prescriptions, this potentially needs to be identified at the beginning of the process regarding the amount of time of monitoring. Mrs Jefferson agreed that in the NICE guidance it suggests patients are monitored every 4 weeks and if all is going well with the bloods done every 2 weeks, the prescription is for just 4 weeks and the patient is monitored again. The nurse can then hand over the shared care to the GP.

Dr Sokolov thanked Mrs Jefferson for her hard work in getting this proposal done. Mrs Jefferson advised that in terms of timelines, RJAH would recruit the nurse and purchase the database and would look at starting this service and having this in place for patients by end of November 2017.

Dr Povey raised repatriation of patients and the associated costs. Mr Whitworth advised the CCG were currently paying price per patient. Members discussed the number of Practices that initiated DMARDS and about the Practices that did so at no cost. Discussion was held on patients which went out of the County for this service and issues were raised about whether it was cost neutral. Dr Povey noted this was an excellent system and a better service but it needed to be looked at in terms of whether it was cost neutral.

Mr Hutton thanked Mrs Jefferson and Ms Jones for attending and they left the meeting.

Dr Freeman stated that there was a clear need to understand the financial implications of the proposal and that it could not be approved until that was available. Mr Whitworth agreed that the costings needed to be looked at and also how much the CCG were currently paying at out of area providers.

It was agreed that this proposal should be looked at again with regard to cost pressures and finances and should be forwarded to Deborah Hayman for her advice as to whether this proposal was workable and cost neutral or whether it should be done as a QIPP scheme. Dr Freeman advised it was about bringing clinical thinking and financial control together. Mr Whitworth suggested this paper come back to the April CCC Meeting. Members agreed.

Dr Freeman thanked Mrs White for the report and advised this was a good piece of work, however it just needed an extra level of financial review. Mrs White asked if there could be a Chairs Action on this proposal to get this through quicker. It was agreed this could be done if Dr Freeman and Dr Povey were involved in this. Members agreed Chairs Action could be taken on this work provided Dr Freeman and Dr Povey were able to schedule a time to be informed and updated of its progress.

ACTION: It was agreed the proposal be forwarded to Mrs Deborah Hayman for her advice with regard to costings and agreed this paper come back to the April CCC Meeting.

7. 17/44 PRU Options Paper (Agenda Item 7)

Miss Gemma McIver and Mrs Emma Pyrah attended for this item. Dr Davies presented this item and advised members that Mrs Pyrah had recently returned from her secondment. Dr Davies confirmed the CCG was not in a position to take this work forward with the ambulance service

despite best efforts from the CCG and members acknowledged the consequences of de-commissioning.

Miss McIver summarised the paper and noted the PRU was developed as a priority scheme within the A&E Recovery Plan 2015-16 for reducing admissions in >75 year olds. Previous updates presented to Executives had detailed the success of the scheme from July – September. The PRU was however suspended by West Midlands Ambulance Service (WMAS) on 13 September 2016. Despite many efforts to mediate and re-implement the PRU it was agreed through an options paper originally presented in February 2017 that decommissioning the service was now the most viable option. Discussion was held about suitable alternative employment for the individuals concerned and Dr Davies advised she was meeting with the two doctors this week.

Members considered the Worcester model and it was highlighted that the CCG would need to look at the evidence for this model as to how effective the scheme was. Dr Rysale suggested there was good evidence for the model, however other members said there was conflicting evidence regarding the effectiveness of a secondary response. Dr Davies proposed that the PRU service be de-commissioned.

Members agreed with the proposal and it was approved to de-commission the PRU service.

ACTION: Members agreed the de-commission the PRU service and Miss McIver would write a notice to SaTH to advise.

8. 17/45 IMH Contract Review (Walk in Centre/A&E Service RSH) (Agenda Item 8)

Mrs Emma Pyrah attended for this item and the following points were noted:

Mrs Pyrah advised the Primary Care Walk-In Service co-located within A&E at RSH was now in year 3 of operation via IMH Group (formerly Malling Health). The purpose of the review was to determine the extent to which the IMH contract delivers best value for money and delivering the benefits aspired for in 2014 when the decision to relocate was made and if not, to describe potential options for delivering better value in the future.

Mrs Pyrah reported there were 5 alternative options for review with which option 4 was the preferred option. Mrs Pyrah advised the options put forward were the most pragmatic approach to achieving and progressing towards an integrated front door within the current national policy and local landscape the CCG were operating in (Futurefit).

Members agreed the paper needed more work and Dr Freeman advised the paper needed more clinical working through. Mrs Pyrah said it was about getting a more flexible model and highlighted that SaTH had an incentive to make this clinical model work as it is was included in their Outline Business Case (OBC) in that they need a functioning Urgent Care Centre. Dr Davies advised the CCG could use the opportunity to work on this with Telford & Wrekin CCG

Mr Morris asked about timescales and whether this work could fit in with Telford and Wrekin CCG's work. Dr Freeman advised that Simon Wright was supportive of this work.

It was agreed Dr Davies would bring an update back to the April CCC meeting in relation to the progression of the new front door. Dr Davies advised Dr Steve James was also involved with this work and with commissioning and plans.

Dr Freeman left the meeting.

ACTION: Members agreed that further work was required and it was agreed Dr Davies would bring an update back to the April CCC meeting.

9. 17/46 MLU Terms of Reference (Agenda Item 9)

Ms Sam Tilley attended for this item and she took members through the report. Ms Tilley noted the report was to update CCC members on the progress of the review and for the Committee to consider the revised Terms of Reference for the review and the revised Terms of Reference for the associated Programme Board following the receipt of legal advice.

Ms Tilley reported the Terms of Reference (TOR) for the Midwifery Led Review had been presented in February 2017 and the CCG had received legal input into these documents with a revised Terms of Reference now being presented at today's meeting with the revisions in colour. Ms Tilley asked members to consider and approve the paper and reported that in addition to this work, an update was included on actions that were being taking forward for example around the table top project plan.

Dr Povey asked about the patient/service representatives in the TOR. Ms Tilley advised this had been deliberated on and the consensus was that one single service user representative would not be best way forward for a robust process. Ms Tilley noted Healthwatch were included in the TOR.

Members discussed patient representatives further and it was suggested that a representative from the Shropshire Patient Group (SPG) should be included. It was also agreed to add in the title of the Clinical Lead for Women's and Children's within the document. Members agreed and Ms Tilley agreed to amend the TOR.
Members approved this paper subject to the above amendments. Ms Tilley confirmed the CCC would receive updates on this item at future meetings.

ACTION: It was agreed Ms Tilley amend the TOR to include amendments discussed and regular updates would come back to future meeting.

10. 17/47 Clinical Commissioning Committee Terms of Reference (Agenda Item 10)

Dr Davies presented this item and reported that she had met with Mrs Anne Dray, Mr Whitworth and Mrs Deborah Hayman to discuss the CCC TOR and to clarify the Committee's purpose. Dr Davies advised the TOR had also been taken to the Executive Team meeting where they had had discussions about the CCC purpose.

After considerable discussion it was agreed to take out the wording "To develop" and amend it to read "Overseeing QIPP and strategy development" rather than develop as the CCC did not develop QIPP schemes.

Members went on to discuss quoracy and it was noted under the new TOR the meeting today would not have been quorate, but as this TOR was due for approval today, fortunately the meeting was quorate under the old TOR. Dr Davies added that the Secondary Care Clinician had been added to the TOR.

Dr Sokolov asked if ensure could be removed as it did not need to be in the paragraph twice and it would then read more clearly if grammar was also amended.

It was agreed the TOR should be changed to read "Oversee the development of and approve QIPP schemes". Dr Davies said she would amend the TOR with the points raised and then she would circulate them to members for approval, before being taken to the April Governing Body Meeting for final approval.

ACTION: It was agreed Dr Davies updated the CCC TOR with amendments discussed and would circulate to members for their approval.

11. 17/48 Governing Body Assurance Framework (Agenda Item 11)

Mrs Dray attended for this item and took members through the Governing Body Assurance Framework and the following points were highlighted:

Mrs Dray advised the BAF had gone through the Governing Body and Mrs Deborah Hayman was working on this document and the wording.

Under number 4, 74/16, on page 1 - Transformation – members noted STP had a role in this. It was agreed actions around STP be added and Dr Freeman's name should added to risk owner section. It was noted the BAF was a fluid document and the actions had now gone through. Members agreed to have a standing item on this and also an STP update.

Mr Hutton reported that there were also other pieces of work for example with the MLU that come under transformation section not just STP. Mr Whitworth suggested having a dashboard that links to standing items such as the STP, Transformation and QIPP programmes. Members agreed there was a need for a Transformation Dashboard and it was agreed to take this suggestion to the Executive Team meeting. Mrs Dray said would note this action (to ask the Executive Team to develop a Transformation Dashboard) and Mrs Dray would add a line to the Transformation section to reflect this and other strands of transformation work.

Under number 5, 75/16, on page 2 – Communications and Engagement – Mrs Dray advised this section was very fluid and things were constantly changing with this. Mrs Dray said work was ongoing.

Dr Povey asked about PPECC and Mr Whitworth advised a checklist would be useful to look at and to see what the CCC needed to be aware of in relation to Communications and Engagement plan so that the CCC had a level of assurance. It would be good to have all these major pieces of work on a checklist to see if they have they got communications and engagement in place.

Mrs Dray reported that with regard to the PMO they were all standard documents and templates. Quality Impact Assessments should also be part of the standard set of paperwork. Mrs Dray agreed to change wording to Standard Documents for CCC to include communications and engagement

plans and other in QIA etc.

Mr Whitworth and Mrs Dray advised it was important that the appropriate wording was used in each scheme in relation to QIPP and communications and engagement. Then once or twice a year a stocktake would be useful. Mrs Dray said it was about ensuring the appropriate sentence was put under each scheme and then a periodic check to be added.

Under Number 6, 75/16, on page 2 – CCG Workforce Resilience and Trust – Mrs Dray reported this was around the restructure plan. Mr Hutton suggested putting staffing implications as another heading. This linked to the points made above.

Under Number 10, 71/16, on page 3 –Impact of social care funding challenges – Dr Povey asked why this section was at risk. Mrs Dray advised this document was very fluid and things have changed with this. Mrs Dray noted this section needed to be extended to include more detail in here, however, at the time this was at risk previously.

Mrs Dray commented on the STP programme and neighbourhood plans and noted this was being looked at and its impact and how the CCG influenced the resources spent.

12. Any Other Business

Access to Services - SSSFT
Dr Sokolov advised this had been resolved under the matters arising section.

IT systems
Dr Sokolov raised an item with regard to IT systems and mentioned this had been discussed at the Open House GP Meeting this morning.

Dr Sokolov commented IT was down to be discussed at the Executive Team meeting and members agreed that procurement of such things should be discussed further.

Workforce Information from A&E
Mr Whitworth updated members on workforce information from A&E. He advised he had spoken with Mrs Chris Morris from Telford & Wrekin CCG. Mr Morris had advised that the Contract Quality Review meeting received regular workforce reports. However, the new Deputy Director of HR was now providing more detailed reports. Mr Whitworth had been advised that there had been no worsening of the position and a number of factors were improving
.
Mr Whitworth reported that the target was for ten consultants over the two hospital sites, however, it had not been possible to recruit to these levels and the Trust was currently operating with 5 consultants. However, with regard to nurses Mr Whitworth confirmed the numbers reported were up to full complement and there were currently no vacancies. There had been concerns about the training requirements for middle grade staff, however, it had been reported that these had been addressed.

Mr Whitworth commented that detailed reports could be sent to members and Dr Davies would ensure a full summary/briefing went to the Quality Committee (QC) as well as the CCC meeting.

Members agreed that Mrs Chris Morris should attend CCC and QC to give an update on this and also a staff member from SaTH. Mr Whitworth said he would progress this work with Dr Rysdale.

ACTION: It was agreed Mrs Morris would attend the CCC and Quality Commission (QC) meeting with a member of staff from SaTH to give an update on A&E Workforce.

13. Date of Next Meeting

Wednesday 19 April 2017, Time and Venue to be confirmed.

The meeting closed at 13.20

SIGNED …….. DATE……

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.124
Shropshire CCG Governing Body meeting: 7 June 2017

Title of the report:	Key Points from 24 May Extraordinary Audit Committee Meeting
Responsible Director:	Sam Tilley - Director of Corporate Affairs
Author of the report:	William Hutton – Audit Chair
Presenter:	William Hutton – Audit Chair

Purpose of the report:

To highlight to the Governing Body key issues arising from the 24 May 2017 Extraordinary Audit Committee to receive and approve the 2016/17 Annual Report and Accounts.

Key issues or points to note:

1. The audited final 2016/17 Annual Accounts and Annual Report for the CCG were reviewed by the Audit Committee and approved for submission to NHS England confirming the year end cumulative deficit of £32.6m in line with previous forecasts. This is comprised of £10.8m cumulative deficit brought forwards from 2015/16 and an in year deficit of £21.8m. These totals are unchanged from the draft accounts reviewed by the Audit Committee in April.
2. The draft Audit Finding report from our External Auditors highlighted a number of points including:
   - 2.1 Charges to expenditure and write-off of income totalling £3.5m arose during 2016/17 as a result of the issues identified when finalising the 2015/16 accounts.
   - 2.2 Concerns about remaining weaknesses in internal controls around accrual of CHC expenditure and the review / write-off of uncollectable debt.
   - 2.3 Confirmation that £588k debt will be paid by Shropshire Council
   - 2.4 Outstanding reviews of continuing healthcare claims have led to a contingent liability for the CCG of £674k being recorded.
   - 2.5 There is a potential liability of £450k in relation to continuing healthcare from Wolverhampton LA. This is being disputed by the CCG and as a result no provision has been made.
3. A qualified Regularity Opinion has been issued as a result of the failure of the CCG to meet statutory financial targets.
4. The adverse Value for Money conclusion is confirmed as a result of the failure to meet the statutory financial targets, the significant current and cumulative deficit, concerns about the ability of the CCG to deliver its Financial Recovery Plans and

weaknesses in partnership working particularly in relation to Future Fit.

5. The Head of Internal Audit Opinion for 2016/17 is confirmed as Limited Assurance.

Actions required by Governing Body Members:

The Audit Committee recommends the following actions:

1. Note the contents of this report and recognise the hard work from the Finance Team and other CCG staff in ensuring that the finalising of the 2016/17 Annual Accounts and Annual Report progressed smoothly.
2. Note the potential liabilities in relation to Continuing Healthcare from 2016/17 that could lead to additional cost pressures during 2017/18.

Minutes of the North Locality Board Meeting held on

Thursday 9 March 2017

The Venue at Park Hall, Oswestry

Shropshire
Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277595

Minutes

Name	Practice/Organisation	Signature
Dr A Booth	Baschurch	Attended
Nicolas Storey	Baschurch	Attended
Dr G Davies	Clive	*Apologies*
Zoe Bishop	Clive	*Apologies*
Dr N Von Hirschberg	Ellesmere	Attended
Jenny Davies	Ellesmere	Attended
Dr N Raichura	Hodnet	*Apologies*
Christine Charlesworth	Hodnet	*Apologies*
Dr William Grech	Knockin	*Apologies*
Jean Grech	Knockin	Attended
Dr Mike Matthee	Market Drayton	*Apologies*
Michele Matthee	Market Drayton	*Apologies*
Dr Santi Eslava	Oswestry Cambrian Medical Centre	Attended
Kevin Morris (Chair)	Oswestry Cambrian Medical Centre	Attended
Dr S Lachowicz	Oswestry Caxton	Attended
James Bradbury	Oswestry Caxton	Attended
Dr Y Vibhishanan	Oswestry Plas Ffynnon	Attended
Sue Evans	Oswestry Plas Ffynnon	Attended
Dr A C W Clark	Shawbury	*Apologies*
Jane Coles	Shawbury	*Apologies*
Dr Emma Smart	Wem / Prees	Attended
Richard Birkenhead	Wem / Prees	Attended
Dr Katy Lewis	Westbury	Attended
Helen Bowkett	Westbury	*Apologies*
Dr T W Lyttle	Whitchurch – Bridgewater	*Apologies*
Morven Jones	Whitchurch – Bridgewater	*Apologies*
Dr M Abey	Whitchurch – Claypit Street	*Apologies*
Elaine Egerton	Whitchurch – Claypit Street	*Apologies*
Dr R Clayton	Whitchurch – Dodington	Attended
Elaine Ashley	Whitchurch – Dodington	Attended
Paul Goulbourne	Patient Participation Group	Attended
Roy Aldcroft	Patient Participation Group	*Apologies*
Dr Simon Freeman	Accountable Officer	Attended
Dr Julian Povey	CCG Chair	Attended
Dr Jessica Sokolov	Deputy CCG Chair	Attended
Sam Tilley	Head of Partnerships & Planning – CCG	Attended
Tony Menzies	Project Manager [Item 7]	Attended
Sean Mackey	Head of Medicines Management – Primary Care [Item 10]	Attended
Richard Kubilius	Commissioning Lead for Mental Health [Item 11]	Attended
Sandra Stackhouse	CCG (Minute Taker)	Attended

1. Welcome and Apologies

Mr Morris, Chair, welcomed and thanked those present for attending. A special welcome was extended to Dr Simon Freeman, Accountable Officer and Dr Emma Smart, Wem and Prees Medical Practice. On behalf of the Locality Board, Mr Morris also thanked Dr Grech, who had been unable to attend this meeting, and Mrs Grech for their involvement in the locality's work and wished them both all the best for their retirement. Mrs Mary Herbert would be taking over from Mrs Grech as Practice Manager at Knockin from 1st April. Apologies were recorded as above.

2. Members' Declarations of Interests

There were no declarations of interests received for items to be discussed on this meeting's agenda other than those already noted on the register.

Members were reminded that everyone needed to complete and sign the new Declaration of Interests form, which had been previously circulated and further copies tabled. In addition to Locality Board Members all GPs, Practice Managers, Practice Nurses and staff who held a potential conflict with CCG business were also required to complete and return the form either to Mrs Stackhouse or to: tracy.eggby-jones@nhs.net

Action: All Members, Practice Managers, Practice Nurses and practice staff who hold a potential conflict of interest with CCG business to complete and return a new signed Declaration of Interests form and return to Mrs Stackhouse or to: tracy.eggby-jones@nhs.net

3. Minutes of Meeting held on 26 January 2017

The minutes of the previous meeting held on 26 January 2017 were accepted as a true and accurate record and were signed by the Chair.

4. Matters Arising not covered on the Agenda

Mr Morris read through the actions included in the minutes of the last meeting and action table and the following verbal updates were given:

[12.3] Any other business: Violent and aggressive patients – Mr Morris referred to the ongoing issue which had been raised about this cohort of patients, particularly those who had been rotating around the three Oswestry practices after they had been dismissed from one of the practices following unreasonable behaviour. Mrs Evans reported that Chief Inspector Sarah Chaloner had been invited to the Practice Managers' meeting to discuss further but unfortunately she had failed to attend. Mrs Tilley offered to follow up when she attended the next Community Safety Partnership meeting.

Mr Storey referred to the official protocol for the removal of Violent and Aggressive patients from practice lists, which had been included on a Primary Care Support England (PCSE) bulletin guidance, which explained PCSE had taken over from NHS England in managing this process. Mr Storey explained this advice did not address the difficulty of the returning patients at the Oswestry practices but requested the following to be formally included in the minutes:

"If you need to request the immediate removal of a violent or aggressive patient from your practice list, please email us at dedicated email address for this service: pcse.immediateremovals@nhs.net

Requests will be processed within 24 hours of receipt. Please note that this email address should only be used for patients that require immediate removal from your practice list following violent or aggressive behaviour, and where the police have been involved. For all other patient removals, please email:PCSE.enquiries@nhs.net

NHS England is currently defining a national process for how the patient removal service should be delivered."

Mr Morris advised that practices should call the police in the first instance to which Mrs Evans also added that this was in addition to the rule that practices were required to inform the patient that the practice was going to contact the police to give the patient every opportunity to leave the practice premises first.

Action: Mrs Tilley to follow up police attendance at the next Community Safety Partnership meeting.

Members to note guidance contained in the PCSE bulletin available on the link provided above.

Dr Sokolov, Dr Davies and Ms Telford to continue to raise issue of violent and aggressive patients with NHSE representatives at the Primary Care Working Group meetings.

[11.] Locality Assurance Framework – Mr Morris believed Dr Matthee had datix reported the case of the patient being informed they had pancreatic cancer at beg-December and finally had an endoscopy on

10 January. The test result had been normal but the patient was still awaiting follow-up and was unsure of their present prognosis.

[12.2] Apixaban – Included on this meeting's agenda under 'Any other business'.

5. Locality Chair's Update: Locality Board Chair - Mr Morris announced that a majority vote had been received from Members in favour of the nominated representative, Dr Tim Lyttle of Bridgewater Medical Practice, Whitchurch to be North Locality Chair. Dr Lyttle had apologised he was not able to attend the meeting but had confirmed he would be unable to take over the role until July and so in the interim period, Mr Morris, Dr Povey and Dr Sokolov would share the Locality Chair role for the next two meetings. Mr Morris wished to record his congratulations and best wishes to Dr Lyttle in the role.

6. CCG Chair's Update: STP and Neighbourhood Work – As requested by Dr Lyttle a dedicated item on the neighbourhood work would be brought forward and included on the agenda for the April meeting (since rescheduled to 4th May).

Action: Mrs Stackhouse to include a dedicated item on the neighbourhood work on the agenda for the next meeting as Dr Lyttle had been unavailable to discuss further at the March meeting.

Mr Storey raised he had read the STP and referred to Dr Sokolov stating at the last meeting that the output of the STP would be in the neighbourhood work. Mr Storey highlighted that in the STP the capital expenditure projection by that Board was focussed on secondary care, and after attended the LMC meetings in February, suggested this matter should be logged as an issue on the Locality Assurance Framework. This would ensure this issue would be discussed each month so that primary care had input into the neighbourhood work.

Dr Freeman responded by explaining that the use of the word 'left-shift' had created the wrong impression. The plan was not to take a large number of patients from the acute hospital and place them in primary care. The aim was to develop solutions to avoid patients being admitted into hospital where they could be successfully treated elsewhere in the community. An example, was given about looking at falls management to reduce the £16m cost of trauma in MSK. There was evidence that effective core strategies could reduce trauma and one of the neighbourhood solutions might be to look at a full service to avoid falls, which would be of benefit to the patient and the health and social spend. It was more about avoiding things happening rather than maintaining sick people in the community. The neighbourhood work was currently underdeveloped and a group of health economists, called Optimity, had been commissioned to look at this work. Dr Freeman agreed this issue should be added to the LAF and considered the messaging so far had been wrong and the CCG needed the Members' help to develop solutions properly.

Action: Mrs Stackhouse to include on the LAF the STP and the neighbourhood work, which at present was underdeveloped and would be raised at future meetings.

7. Children's Safeguarding – It was reported that Mr Coan had received some feedback following his attendance at the last meeting. Members were reminded to feedback comments or suggestions on the draft template form and/or ways of improving the system for child protection conferences direct to: davidcoan@nhs.net

10. Dementia Strategy – A reminder for Members to forward feedback to Mr Downer or if practices wished to receive copies of the Dementia Strategy for their reception areas to contact Mr Downer direct to: pete.downer@nhs.net

11. Locality Assurance Framework – June Telford had been informed of the concerns regarding PCSE's management of files and had been asked to escalate to NHSE. Mr Morris reported this was work the LMC was currently involved in also. It was believed that most practices would have received a letter which explained they would be entitled to £250 for the inconvenience caused if files were delayed or mislaid.

12. Any other business – Mrs Ashley had previously raised the changes to the Mental Health Services and as a result, Mr Richard Kubilius, Commissioning Lead for Mental Health Services had been invited to attend to give an update on the present position.

Dr Sokolov further reported she had met with the Medical Director of SSSFT that morning and a few of the issues had been discussed but some still needed to be worked out particularly around the lack of consultant cover for the north locality. The Medical Director had appeared genuinely regretful that the Primary Care Liaison workers had been withdrawn abruptly and had agreed to try and reinstate them as soon as possible. The plan was to have a joint review of community services in future.

12.3 Productivity, Quality and Optimisation Scheme (PQOS) – Mr Mackey had clarified a peer review of antibiotics towards the PQOS was still outstanding. Mr Mackey had accepted that the peer review would not be carried out at this meeting but at the next meeting.

5. Accountable Officer's/Clinical Chair's Update

Finances – Dr Freeman reported there were two large financial issues: the amount of money spent on elected surgical orthopaedics and when benchmarked with other comparable health economies, Shropshire CCG was approximately £12m higher. Shropshire also had a very expensive, unproductive community services contract and was over-spending by approximately £5-7m. £20m out of the £26m deficit for this year was tied up in those two issues and the CCG needed the help of the GPs and practices to correct this as they were seen as the basis of CCGs. To enable this work going forward, the CCG planned to significantly develop and provide resources to enable the localities and practices within it to generate and implement ideas.

Dr Freeman and Dr Povey had attended that morning the monthly financial meeting with Dr Paul Watson, Midlands and East Regional Director, NHSE. It had been agreed that Shropshire's overspend for the following year would be £20m. The difference between £20m and £26m deficit for this year was that when growth was added in the CCG needed to generate a £18m savings programme and six major schemes had been developed. Not all these schemes involved general practice, for example, Complex Care, and pricing issues, however, with MSK and PLCV, the CCG required the help of GPs and practices by following Dr Chris Tomlinson's model of utilising alternatives to surgical intervention and by enacting the PLCV policy by submitting referrals to RAS who would either approve or decline them. There was a second stage for consultants to decide whether a procedure was required but these would need require a prior approval code first. There was also a piece of work being carried out on community services, which would be covered under Item 7. The CCG was also looking at reducing the £53m prescribing budget and a new prescribing incentive scheme would also be discussed under Item 8 whereby there was potential for practices to receive back approximately £3 per patient.

Dr Lewis commented that some of these savings involved drugs like Apixaban, where the majority of patients were being discharged from the acute trust on expensive Novel Oral Anticoagulants (NOACs) instead of Warfarin and there was no good clinical reason why the patients should be on those drugs. GPs were under a lot of pressure and it was very difficult to switch the patients back when they had been told by the hospital they should be prescribed NOACs. Dr Lewis advised she had highlighted this concern but nothing so far had been done and the situation was becoming worse. Dr Freeman promised the CCG could help to resolve this issue and it would be taken back to the commissioners to look at and invite some GPs to take part in discussions with the acute trust.

Action: Mr Mackey to be requested to look into the issue of patients being prescribed NOACs.

Dr Lewis advised she had previously highlighted a further major cost that breast cancer patients were being prescribed by the oncologist bisphosphonates at a cost of £128 per month. When Dr Lewis had queried this with the Trust they had sent a paper to Dr Lewis, which she had already read, in which it stated there was no significant difference between the drugs. It was agreed it would be much better to have a CCG member of staff not a GP talking to the hospital. Dr Freeman advised Members to log issues such as this and advised Dr Lewis to forward this concern to him and the CCG would do its best to act on behalf of the localities to resolve this issue.

A further area of work would be to look at clinical variation in emergency admissions in some specialities, which would not be based on targets but would be conducted via peer review work. It was agreed this would be useful as was carried out a few years' ago when practices had been forwarded their list of top admissions and had been asked to verify attendances. Following this exercise, Dr Lewis pointed out there had been a large amount of double-counting and if it had had been taken back to SaTH at the time this could have saved quite a lot of money.

Dr Freeman referred to SaTH's C2C policy and the claim that referrals were only done under exceptional circumstances. However, it had been revealed that above the average number of C2C referrals had taken place. Members were asked the question how they would feel if a prior approval code was required and it needed to be referred back to the GP. It was agreed this would put an unreasonable strain on general practice. GPs were generalists and not specialists and it was felt that it would inappropriate for a GP to overrule a specialist. It also raised patients' expectations and was very difficult for the GP to disagree if a patient had been advised by a consultant they needed to be seen by a specialist.

Dr Freeman referred to the future appointment of the Locality Managers who would work in the localities for the Locality Chairs to support the practices in these areas of work. Any feedback on ideas for cost savings from providers would be welcome.

Dr Vibhishanan said she was encouraged to hear what had been discussed but pointed out that her practice had been raising issues via the datix system for a considerable amount of time. Dr Freeman acknowledged this point and said the CCG would review the datix reports already logged.

Mr Morris referred to Dr Lewis' statement that the locality did used to discuss a lot of data before, ie top big spends and some practices were using Aristotle at present but was aware it was not the ideal system. Dr Freeman advised the CCG had purchased another system called Stethoscope which could be demonstrated to the locality. The system was web based and allowed for filtering at different levels but not at patient level. The system would facilitate practice comparisons and a demonstration of the system would be organised for the next or subsequent meeting.

Action: Mrs Stackhouse to request a demonstration of the Stethoscope system at the next meeting.

Dr Booth asked if Dr Tomlinson was going to produce a pathway because as far as he was aware there was not one to follow at present. Dr Freeman advised the pathway under consideration at present was that all MSK referrals would go into SOOS, which would triage the referrals and if surgical intervention is needed, choice will be offered at SOOS. Dr Booth advised it would be useful for primary care to have a pathway of how the CCGs wished referrals to be managed before patients are referred to SOOS. Some other CCGs had some really good pathways and Dr Booth tended to follow those. Following a brief summary by Dr Sokolov of what the MSK interface service would entail, Dr Freeman said he would ask Mr Michael Whitworth and Dr Tomlinson to attend the meeting to discuss the SOOS pathway.

Action: Mr Michael Whitworth and Dr Chris Tomlinson to be invited to attend the meeting to discuss further the SOOS pathway.

Dr Povey thanked Mr Morris for his time spent in the role of North Locality Board Chair and also announced that Mr Morris had put his name forward to be a Member of the CCG Governing Body, which would require support from the Locality and would be discussed under Item 11.1.

It was also excellent news that Dr Simon Freeman's substantive appointment as Accountable Officer, had been confirmed by Simon Stevens, CEO, NHS England.

6. Locality Chair's Update

6.1 PQOS Review of Antibiotics – Mr Morris asked how Members wished to run the peer review at the next meeting. Mr Bradbury reminded Members practices had been given a choice on which area they audited. Practices only needed to carry out a peer review on the antibiotic use within practices because of the short timeframe that had been given. It was suggested and agreed practices would focus on UTIs so that the parameters could be compared across practices at the next meeting. Mr Bradbury agreed to co-ordinate and Mrs Stackhouse was asked to include an item on the next agenda.

Actions: Members to review their practice data on antibiotic use in UTIs for sharing with Member practices for the peer review session to take place at the next meeting.

Mrs Stackhouse to include a dedicated item on Peer Review of Antibiotic Use of UTIs.

6.2 Diagnostic, Assessment & Access to Rehabilitation (DAART) Centres – Feedback was requested over the DAART services owing to the high costs (circa £1,200 per patient) involved in running the centres. Members' viewpoints were that they used either the Oswestry or Shrewsbury centres. Dr Vibhishanan reported her practice used the Oswestry centre, not every week but did refer patients for such services as transfusions. Dr Lachowicz considered it was an excellent and quick service, however, was concerned that it did not offer a complete service.

Dr Freeman offered further clarification that one of the DAARTs was costing more per patient than the total allocation of the NHS per patient and so work would be carried out on reviewing the DAART service. If Members felt the service was valuable but considered it could be offered in a different way that is more cost-effective, the CCGs would look to GPs to help to design that service and how it should be run.

7. Community Services Review

Mr Tony Menzies, Interim Project Manager, attended to give a brief overview for Members about the Shropshire Community Services Review outlining the background and strategic context. The declared primary goal of Shropshire CCG was to improve the long term health of the population. This needed to be achieved in the context of Shropshire's ageing population, rurality, associated access issues and a recurrent overspend of £26m this year and £20m next year.

It was explained that the local health economy would focus its efforts to develop place-based care, increased community care and greater integration/working with partners. The scope of the review would cover the following areas county-wide: community beds; Diagnostic, Assessment & Access to Rehabilitation (DAART) Centres; and Minor Injury Units (MIUs). The only service that would be informing the community beds area would be the Integrated Community Service (ICS), therefore, the performance of that service would be looked at but it would not be reviewed as a service.

This would be a clinically led review by two GP board members, Dr Jessica Sokolov and Dr Finola Lynch and the governance would be via a programme board that would be chaired by joint clinical leads, Dr Sokolov and Dr Lynch and would include representatives from SCHT, SaTH, the local authority, the CCG and patients and carers groups. The remit of this group was to put forward recommendations and any commissioning decisions would be made by Shropshire CCG Governing Body.

With the process there would be a sub group of the Programme Board which would be a Clinical Reference Group, which would score potential options and identify a preferred option; and ensure clinical leadership supporting the clinical redesign of services across organisations to meet the needs of the local population. Members of this group would comprise clinical leads, two GPs from each locality, and SCHT and SaTH clinicians. The process was explained and a detailed delivery plan, including an engagement and communication plan, was currently being developed. An email would be circulated from Dr Sokolov and Dr Lynch to each practice and Practice Manager asking for two GP volunteers from each locality to sit on the Clinical Reference Group, which was due to meet on 30th March to discuss more detail on the process. We are trying to move forward on the 30th March on the Clinical Reference Group, which will go into a lot more detail on the process. Backfill would be provided at the sessional rate. At this point Drs Vibhishanan and Lewis expressed an interest in becoming involved but said they needed to check with the practice first.

When asked what work had been so far carried out, Mr Menzies confirmed the activity data was available and the MIUs had been looked at but no hard financial data had yet been obtained. A conversation ensued regarding the costing of community beds and having the right patients in the right beds. Dr Lachowicz commented that he found that patients would go anywhere for a community bed because it meant that they did not have to go into the acute hospital. Dr Sokolov acknowledged this point and said this was the kind of area that the review would need to explore because there had been extra capacity available recently which had not been taken up. There would be different reasons for that but it suggested that the present system was not necessarily the best one.

Action: Practices to consider the request for two GP volunteers to assist with the Clinical Services Review.

Mrs Stackhouse to circulate Mr Menzies' PowerPoint slides for information for Members.

8. Prescribing Update

Mr Sean Mackey, Interim Head of Medicines Management – Primary Care, attended to give prescribing updates on the following areas, hard copies of which were tabled:

- April-December 2016 Prescribing Spend Growth discussing the CCG actual cost growth in percentage and figures.
- Practice NICE per APU for April to December 2016 showing individual practice figures.
- North Locality Practice Actual Cost Growth for the current month, last 3 months and current financial year.
- April-December 2016 BNF chapter actual cost/spend growth.

Cost effective Prescribing Framework:

- The Productivity, Quality and Optimisation Scheme (PQOS) money that practices have been used to receiving yearly will now receive £273k upfront payment under SLA with 50% available from April and a further 50% in May based on successful submission of an action plan.
- Confirmed allocation of Individual Practice Prescribing budgets based on age, sex and temporary resident originated prescribing units (ASTRO-PUs).
- Further payment of the proportion of the £273k - up to £2 per patient if the CCG underspends the prescribing budget overall and if the individual practice underspends its budgets. (This would mean possibly an additional maximum payment of approximately £600k in addition to the £273k if sufficient savings are made. Currently the CCG's planned forecast is for £4m savings in prescribing budget out of the £20m savings to be made next year.)
- Monthly monitoring of prescribing data and QIPP indicators.
- Locality lead pharmacist supervision.
- Potential £600k investment (only paid out if sufficient underspend).

Dr Freeman added the CCG had limited the improvements that any one practice had to make in percentage terms and was trying to be equitable across the county to reflect where practices were and the degree of effort that required them to change.

Dr Lewis also raised that ScriptSwitch might be a very good system for the non-dispensing practices but if GP in a dispensing practice actually agreed to everything, the practice would start losing money. Dr Freeman explained that Mr Mackey had been addressing those specific issues by talking to the pharmacists about switches that would reduce costs. Work was also on-going on addressing some problem areas with some specific practices but this needed to be done on a case by case basis. If practices would help the CCG achieve the required savings then the CCG would be able to help the practices.

Mr Mackey reported the north locality stood at 4 per cent reduction the previous year and so overall practices had underspent which was considered a tremendous achievement. Practices would start receiving letters with the pack of information about the following:

Prescription Ordering Direct (POD):
- Call centre approach to managing patient requests for repeat medications. Call centre based centrally, which will hopefully be set up for three practices by end-June.
- Managed repeats not allowed through community pharmacy.
- Based upon the Coventry and Rugby CCG model set up three years' ago as highlighted in the HSJ.
- Reduction of 8-12% prescription volume in Coventry based upon 30 practices.
- Telford and Wrekin CCG started same in November 2016.
- Conservative estimate of £1m savings for the first year of POD in Shropshire.

The CCG had considered feedback from the localities on dietetics and the nutritional sip feeds and currently the CCG was spending approximately £1.6m per year. From the beginning of May, all care homes would be informed of the new process whereby if a GP is asked to prescribe sip feeds for a care home, it will have had to go through the dietetics service first. A publicity campaign would be channelled through a You Tube video, media campaigns, Facebook competitions, etc. If a clinician did decide to prescribe a sip feed they were requested to do a 'must score' and have followed the Food First pathway so the patients have been given the information leaflets. There was a minimum of £400K savings by introducing this process.

Care Homes Medicines Optimisation service:
- Service to cover the 130 Care Homes.
- Training.
- Clinical patient reviews.
- Link to POD.
- Wastage reductions.
- See patient within 48 hours of admission to/discharge from Care home.
- Savings of £675k.

Prescribing policies:
- Common medicines for minor ailments: Paracetamol; Hayfever preps for over 18 year-olds, etc.
- Oral Nutritional supplements – Care Homes refer to Dietician; MUST scores and "Think food" for 1 month.
- Review of Area Prescribing Committee and Board agreement on managing non-adherence to recommendations.
- Scriptswitch.
- Hospital drug pathway reviews.
- Bluteq.
- Hospice contract review.

Possibilities:
- Wound product DN basis. Pilots will be run to take away from GP prescribing. District nurses will hold stock at their bases, will order direct and distribute to patients single dressings at a time rather than boxes.
- New Stoma contract.

Mr Morris added that Cambrian Medical Practice had previously been overspent in this area and now were underspent by switching to supply no more than one week's worth of dressings, which had reduced the practice's overspend by £26k.

Mr Mackey commented that Shropshire was different to other areas with the issue of consultants recommending expensive drugs to patients. Normal practice would be the consultant initiated and the patient monitored until stabilised and then primary care would take over the responsibility in providing that drug. It was hoped that in the next few months the Area Prescribing Committee would agree a unified formulary. This formulary would clearly state a red drug would not be prescribed by the GP but if it was an

amber drug, after the patient was monitored, there would be shared care arrangements in place. More information would be available about this at the next meeting.

During a short question and answer discussion the following points were made and confirmed:

Dr Lewis raised a concern regarding patients who were required to take Paracetamol on a regular basis and only being able to purchase small supplies at a time from pharmacies or supermarkets. Mr Mackey confirmed this cohort of patients would not be affected.

Mrs Grech asked if primary care could be given information guidance on CCG Medicines Management letterheaded paper which could be handed to patients. Mr Mackey explained part of this would be linked in with the Patient Advice and Liaison Service (PALS) and the Medicines Management Team that will include a telephone number to call those services rather than the practice.

Mr Goulbourne asked if the patient access system on the website would still be available as well as the call centre. Mr Mackey confirmed patients could still order directly through the practice but would not be able to order through the pharmacy. It would be the patient's choice to go direct through the practice or the call centre, which will operate through a freephone number Mon-Fri 9-5, which may be extended into weekends.

Dr Vibhishanan enquired as to the process for patients who received free prescriptions and Mr Mackey advised there was an NHSE funded service through community pharmacy, which would be promoted by the CCG.

Action: Practice Members who would like to receive further information on the above incentive schemes, including dispensing practices, to contact Mr Mackey: smackey@nhs.net

Mrs Stackhouse to circulate the PowerPoint slides for information for Members.

8.1 Apixaban

Further to the discussion under Item 5, Dr Lewis reported she had nothing further to add because she had heard nothing and believed no action had been taken. Dr Lewis had continued to monitor her patients and not one patient had been discharged on Warfarin; all had been discharged on Apixaban apart from two who had been given Rivaroxaban.

Dr Lewis' concern was that there was one reversible agent for one NOAC but not for any of the others. It was considered if consultants were going to prescribe a NOAC then they should at least prescribe the one which had a reversible agent. In other areas of the country patients were being encouraged to self-monitor if taking Warfarin. It was not advocated that Warfarin was without its own risks but the side-effects and complications of taking NOACs was at present unknown.

9. Update on Mental Health Service

Mr Richard Kubilius, Mental Health Commissioning Lead, had been invited to attend to give an update and help Members understand the recent concerns raised regarding the current status of the mental health service and to feedback from meetings attended on behalf of the CCG on what it wishes to commission as a health organisation.

Mr Kubilius said he had been aware there had been several changes, particularly around the withdrawal of the Primary Care Liaison (PCL) role that had not been communicated very well by the South Staffordshire and Shropshire Foundation Trust (SSSFT). There had not been any engagement from the Trust around the PCL role and various issues had been raised with them, such as learning disabilities; consultant psychiatrists and primary care liaison remodelling engagements; what the pathways were going to look like; the single point of access and how that was going to affect primary care. Mr Kubilius had today attended the contract meeting and one of the things he had suggested was for representatives of the Trust to attend all the Locality Boards and present their pathways. It was not intended to present an overview but would be a significant piece of work with the detail behind so the localities could have an oversight and comment on them.

Dr Clayton asked if this was going to happen before 1st April. Mr Kubilius confirmed it had been decided there would be a staggered approach to influencing the pathways owing to it being too large a task. The first stage would be the single point of access which is where all referrals for secondary mental health care would go. There would be a single telephone number that would be operating from 8-8 with trained call handlers as well as clinical staff and psychiatric support. Outside of those hours it would be a trained call handler from 8pm-8am with access to support from the crisis resolution health treatment team. Mr Kubilius was aware there were various issues around mental health and would find it beneficial for Members to feedback to him in order to gather those together to be able to challenge the Trust on the way the CCG wished to do business rather than vice-versa.

Dr Sokolov advised that she had met with Dr Abid Khan, Medical Director of SSSFT who had made a commitment of reinstating the PCL members of staff in the short-term whilst a joint review was carried out in what was needed in the community. It had been made very clear that what had happened so far was under-resourced and the CCG were not happy and should be moving things forward in a more productive manner. It was considered a step forward for Dr Khan to undertake that commitment on behalf of the Trust and Dr Sokolov urged Members to follow up to ensure the Trust adhered to their promise.

Mr Kubilius gave a short update on Attention Deficit Hyperactivity Disorder (ADHD). Patients at the present time were being referred to Dudley and Walsall for assessment and diagnosis, where there was a shared care agreement in place. If the patient had taduated on a dose they would review the medication but would not initiate treatment.

Dr Clayton questioned how patients were managing to get to Dudley as Dodington Surgery's patients had been bounced back and given an online questionnaire to complete. Mr Kubilius explained that the current process was not formally commissioned but was carried out on a case by case basis. From 1st May CAMHS would be a 0-25 emotional and well-being service so patients would not actually be able to see a physician at 25 years but there was a meeting scheduled on 20th March to expedite a new service locally that would be an ADHD clinic that would assess, diagnose and treat. Mrs Ashley added that Mr Kubilius had been very helpful to Dodington Medical Practice.

Mr Morris thanked Mr Kubilius for attending. Mr Kubilius further explained that he would like to attend all the locality board meetings to begin a wider engagement about what people actually wanted around mental health services in general and not necessarily around a specific area. In addition to work the Trust had already carried out, there was a lot of redesign work to do and this is where it should be commissioner-led and general practice input would be invaluable in order to get the right level of engagement. Areas to be looked at were: the rehabilitation pathway; the urgent in crisis care pathway which will include the RAID, the hospital liaison team; and learning disabilities. Members' feedback and input would be really helpful.

Action: Members requested to provide feedback on areas of concern to Mr Kubilius on email: r.kubilius@nhs.net

Mr Kubilius and representatives of the Mental Health Service to attend future Locality meetings.

10. **Good things/bad things – Locality Assurance Framework**

The Locality Assurance Framework (LAF), an excel spreadsheet used to log and track queries and issues of concern from the localities, had been updated and tabled. The outstanding issues regarding COMPASS and CAMHS had been retained on the log until these issues had been resolved hopefully by the new service provider. Members were asked to verbally raise positive and negative issues and the following points were raised:

Good thing

- Mrs Grech was pleased to report Knockin Medical Practice had received their in-house counselling service back. Mrs Ashley pointed out that Dodington Surgery had received an email the day before about a review to see whether the service was continuing. Mrs Grech confirmed she had not received an email.
-

Bad things

- Dr Lewis reported a number of issues, which had already been datixed. Over the Christmas/New Year period, on four separate occasions, paramedics had been called out to patients and had decided that the patients did not need to go to hospital and the patients directly suffered as a result. On one occasion it had resulted in the death of a patient. The patient had collapsed and when the ambulance arrived had seen the patient was disabled and treated the patient as suffering from a fall and had left the patient to use their stairlift and buggy. Dr Lewis had been asked to see the patient the following day when she had found the patient was blue, had no real swallowing reflex, was dribbling, had slurred speech and was clearly needing admission. The patient died of aspiration pneumonia probably secondary to a stroke.

  Action: Mrs Tilley was requested to look into the four datixes logged and investigate progress to date with follow-up of these issues.

- Dr Vibhishanan reported an unusual issue which it was considered fitted in with the Shropshire Community Services Review. Dr Vibhishanan had received a phone call from People to People informing her that they had one of the practice's patients who had been admitted following a dislocated ankle fracture in January. The patient had been discharged at the beginning of February to a nursing home rather than residential because of the personal care they had needed but because they had been unwell had only had their catheter removed 3-4 weeks into their stay at the nursing

home and had received no physio. The People to People representative had said the care was expensive and wanted the GP to find the patient a community bed. Dr Vibhishanan said she had not been asked this before and had consulted with ICS who had said they had received the same phone call. It was considered it was not the GP's responsibility to find a placement for a patient who had been discharged from acute care. Mr Morris added that his practice had received a case very similar but was unaware of the details other than People to People had spoken to one of the practice's Community Care Co-ordinators.

Action: Mrs Tilley was requested to discuss further with Mrs Gemma McIver/Mrs Tanya Miles.

Mrs Stackhouse to add this issue to the LAF to be monitored at the next/subsequent meeting.

- Dr von Hirschberg passed on a CAMHS related issue on behalf of one of his partners where a teenager had been referred to CAMHS and had been referred to family therapy. When the teenager saw the consultant, they had been concerned to hear the service was being decommissioned and organised by SSSFT but could not give any timescales and was unsure whether they were ever going to be seen. Dr von Hirschberg was requested to forward the details of this issue to Mr Kubilius (email: r.kubilius@nhs.net)

Action: Dr von Hirschberg was requested to forward details of GP Partner's concerns to Mr Kubilius.

- Dr Lachowicz said he had understood patients would be contacted by RAS about their referral in order to make a choice of where to go to receive treatment and informed of what the waits might be but had found after speaking to some patients this was not the case and so patients inevitably would choose the closest trust. Regarding the Neurology service in particular, Dr Lachowicz had received a letter from the neurologist informing him there were not going to see the patient and suggested the patient should be referred elsewhere. Dr Povey advised this issue was already being addressed with SaTH.

- Mrs Ashley reported Dodington Surgery had received a referral from the optician who required a patient to be seen urgently within two weeks. This was then referred to RAS who had confirmed it needed to be forwarded directly to the acute trust and was not one that the optician referred directly. A Practice Managers' Update was then received on 6th March which said there was confusion around eyes, so if it was 48 hours the optician referred but if it was a referral for within a two week wait, these needed to sent direct to the bookings team and if it was over then it should be sent to RAS. The bookings team were then contacted but said they had not been aware. Dr Povey confirmed he had queried this advice with Ms Wendy Southall who had confirmed this advice was correct.

Action: Mrs Ashley to email details of this issue to Wendy Southall, Commissioning Lead for Ophthalmology and Claire Roberts, Ophthalmic Advisor.

- Mrs Ashley referred to Dodington having a psychiatric patient and with no psychiatrist available, Dr Clayton had agreed to do a weekly visit to one of her complicated psychiatric patients. Dr Sokolov advised she had been in discussion with representatives of the service that day who had appointed a psychiatrist that week so there should be cover. The point had been made that the CCG needed to understand the provision of service that was in place to cover sick leave as it appeared the service was very fragile. Dr Povey advised Mrs Ashley and Dr Clayton to raise this issue with Mr Kubilius (email: r.kubilius@nhs.net)

Action: Mrs Ashley/Dr Clayton to email details of this issue to Mr Kubilius.

- Dr Clayton reported that because the primary care liaison (PCL) worker had left the practice, she had written to IAPT asking them to see the patient and had received a rude letter back asking why Dr Clayton had referred in writing. Dr Sokolov agreed with Dr Clayton this was a different level of care and the pcl workers were going to be reinstated, however, practices were being asked to allow for the trust to locate the workers and put back into post ensuring the provision was equal across the county.

- Mr Morris reported that at a recent staff training event the question was asked if the PEARS service was available to the under-18s or was there a limit for the PEARS service for ages. According to SpecSavers they would not see anybody under 18 but it is actually commissioned as a no-age limit service. Ms Wendy Southall was going to write out to those concerned participating in the scheme, copying also to practices, to confirm there was no lower age limit.

- Dr Clayton warned Members that when practices were requesting extra blood tests from the lab, there was no new system whereby practices had been asked to fill in forms. The Haematology Team would like to receive feedback from practices the names of the member/s of staff who were requesting forms to be completed beforehand.

11. Any other business

11.1 Nomination of Governing Body Board Practice Member

At this point Mr Morris left the meeting room.

Dr Povey reported Dr Colin Stanford was retiring and one of the six GP practice representatives on the CCG Governing Body Board would be available. It was explained that in the Constitution where self-nominees stood to be elected on the CCG Board, they needed to be nominated and supported by one of the Locality Boards. It was agreed that Mr Morris was supported by the majority of Members, however, it was raised by Mrs Sue Evans that she had not understood there had been a vacancy for Members to apply for. Following discussion during which it was explained that Dr Povey had forwarded two communications to practices inviting expressions of interest, it was accepted there had been a misunderstanding and the deadline for nominations would be extended from the initial closing date. Mrs Anne Dray, Interim Director of Corporate Affairs would forward a communication inviting expressions of interest for the role, which ideally would be working four sessions a week, and support from Members would then be sought for any new nominees. If required a membership-wide election would follow across all localities, which would be conducted remotely by email.

During discussion, it had also been explained that if the successful candidate was a Practice Manager, they would still bring a lot of expertise to the role of how commissioning decisions impacted on practices and eight of the nine Board roles were GP Members who would cover the clinical work.

Action: Mrs Anne Dray to circulate a further communication inviting expressions of interest for the CCG Board Member role.

Members requested to consider expressions of interest for the CCG Board Member role.

Mr Morris re-joined Members and recommenced chairing the meeting.

12. Date of Next Meeting

Mr Morris advised dates for forthcoming meetings might need to be changed going forward. The yearly programme would include 12 meetings, three of which would be PLT sessions and one joint localities meeting. The idea was that the PLT sessions would include an element of commissioning. Mrs Izzy Culliss, Practice Manager from the Shrewsbury and Atcham locality was looking at the dates for all three localities. Hopefully the majority of these dates would remain the same but Mrs Stackhouse would forward to Members any changes as soon as they were finalised. The next meeting had been arranged to take place on:

Thursday 4 May at Market Drayton Medical Practice
[Please note the above new meeting date replaces the previous date of 27th April as a result of the GP National Institute of Health Research (NIHR) meeting, which was being held on the same date.]

Future Dates for North Locality Board Meetings

- Thursday 8 June, The Venue at Park Hall, Oswestry
- ~~Thursday 13 July, Market Drayton Medical Practice~~ (rescheduled to 27 July)
- Thursday 27 July, Market Drayton Medical Practice
- Thursday 7 September, The Venue at Park Hall, Oswestry
- ~~Thursday 12 October, Market Drayton Medical Practice~~ (to be rescheduled)
- Thursday 26 October, Market Drayton Medical Practice (to be confirmed)
- Thursday 23 November, The Venue at Park Hall, Oswestry
- Thursday 25 January 2018, Market Drayton Medical Practice

(All meetings to commence at 2.00pm preceded by a light lunch at 1.30pm.)

Signed: ……... **Date:** ….....4 May 2017.....……
Dr Geoff Davies, Acting Chair

Actions from the North Locality Board Meeting held on 9 March 2017

Minute No.	Action Required	By Whom	By When
2. Members' Declarations of Interests	All Members, Practice Managers, Practice Nurses and practice staff who hold a potential conflict of interest with CCG business were requested to complete and return a new signed Declaration of Interests form and return to Mrs Stackhouse or to tracy.eggby-jones@nhs.net	All Members and Practice Staff who have potential conflicts	As soon as possible
4. Matters Arising [12.3] Any other business Violent and aggressive patients	To follow up police attendance at the next Community Safety Partnership meeting.	Mrs Tilley	As soon as possible
	To note guidance contained in the PCSE bulletin available on the following link: pcse.immediateremovals@nhs.net	ALL	On-going
	To continue to raise issue of violent and aggressive patients with NHS representatives at the Primary Care Working Group meetings.	Dr Sokolov, Dr Davies Ms Telford	On-going
6. CCG Chair's Update: STP and Neighbourhood Work	To include a dedicated item on the neighbourhood work on the next agenda to include Dr Lyttle in discussion.	Mrs Stackhouse	May / June mtg
	To include on the LAF the STP and the underdeveloped neighbourhood work, which would be raised at future meetings.	Mrs Stackhouse	On-going
5. Accountable Officer/Chair's Update	Requested to look into the issue of patients being prescribed NOACs.	Mr Mackey	As soon as possible
	To request a demonstration of the Stethoscope system at the next meeting.	Mrs Stackhouse	Next or subsequent meeting
	Mr Michael Whitworth and Dr Chris Tomlinson to be invited to attend the meeting to discuss further the SOOS pathway.	Mrs Stackhouse	Next or subsequent meeting
6. Locality Chair's Update 6.1 PQOS Review of Antibiotics	To review their practice data on antibiotic use in UTIs for sharing with Member practices for the peer group review session to take place at the next meeting.	ALL	4 May meeting
	To include a dedicated item on Peer Review of UTIs.	Mrs Stackhouse	Next meeting

7. Community Services Review	To consider the request for two GP volunteers to assist with the Clinical Services Review. To circulate Mr Menzies' PowerPoint slides for information for Members.	All Members Mrs Stackhouse	As soon as possible As soon as possible
8. Prescribing Update	To contact Mr Mackey if they would like to receive further information on the incentive schemes. To circulate Mr Mackey's PowerPoint slides for information for Members.	All Members Mrs Stackhouse	As soon as possible As soon as possible
9. Update on Mental Health Service	To provide feedback on areas of concern to Mr Kubilius (email: r.kubilius@nhs.net) Mr Kubilius and representatives of the Mental Health Service to attend future Locality Board meetings.	ALL Mr Kubilius	As soon as possible / On-going As soon as possible
10. Locality Assurance Framework – Bad Things	To look into the four datixes logged and investigate progress to date with follow-up of issues. To discuss further with Mrs Gemma McIver/Ms Tanya Miles re requests received from People to People. To add this issue to the LAF to be monitored at the next/subsequent meeting. To forward details of GP Partner's concerns regarding the CAMHS case to Mr Kubilius. To email details of issue regarding optician referrals to Ms Wendy Southall, Commissioning Lead for Ophthalmology and Claire Roberts, Ophthalmic Advisor. To forward details of issue of lack of psychiatric cover for patient to Mr Kubilius.	Mrs Tilley Mrs Tilley Mrs Stackhouse Dr von Hirschberg Mrs Ashley Mrs Ashley	As soon as possible As soon as possible Next meeting As soon as possible As soon as possible As soon as possible
11. Any other business **11.1 Nomination of Governing Body Board Practice Member**	To circulate a further communication inviting expressions of interest for the CCG Governing Body Practice Member role. Members requested to consider expressions of interest for the CCG Governing Board Practice Member role.	Mrs Dray ALL	As soon as possible As soon as possible

South Locality Board Meeting

4.30pm, Thursday 30 March 2017

The Mayfair Community Centre, Church Stretton

Shropshire Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277595

Minutes

Name	Practice/Organisation	Signature
Dr Matthew Bird	Albrighton	Attended
Val Eastup	Albrighton	Attended
Dr Dale Abbotts	Alveley	Attended
Lindsey Clark	Alveley	Attended
Dr Adrian Penney	Bishop's Castle	Attended
Sarah Bevan	Bishop's Castle	Attended
Dr Stuart Wright *(Chair)*	Bridgnorth	Attended
Sandra Sutton	Bridgnorth	Attended
Dr Shailendra Allen	Broseley	Attended
Louise Linning	Broseley	*Apologies*
Dr Bill Bassett	Brown Clee	Attended
Vicki Brassington	Brown Clee	*Apologies*
Dr Jennifer Howard	Church Stretton	*Apologies*
Emma Kay	Church Stretton	Attended
Dr Paul Thompson	Cleobury Mortimer	Attended
Mark Dodds	Cleobury Mortimer	*Apologies*
Dr David Appleby	Craven Arms	*Apologies*
Susan Mellor-Palmer	Craven Arms	Attended
Dr S Selva	Highley	*Apologies*
Theresa Dolman	Highley	Attended
Dr Juliet Bennett	Knighton and Clun	Attended
Hilary Fowles	Knighton and Clun	*Apologies*
Peter Allen	Knighton and Clun	Attended
Dr Catherine Beanland	Ludlow Portcullis	*Apologies*
Julia Thompson	Ludlow Portcullis	Attended
Dr Graham Cook	Ludlow (Station Drive)	Attended
Dr Jennie Bailey	Much Wenlock & Cressage	Attended
Sarah Hope	Much Wenlock & Cressage	Attended
Dr Richard Shore	Shifnal & Priorslee	*Apologies*
Sheila MacLucas	Shifnal & Priorslee	*Apologies*
Sylvia Pledger	PPG South East	*Apologies*
Roland Johnson	PPG South West	*Apologies*
Dr Simon Freeman	Accountable Officer [Items 1-8]	Attended
Dr Julian Povey	CCG Clinical Chair	Attended
Dr Steve James	Clinical Director of Information and Enhanced Technologies, CCG	Attended
Dr Colin Stanford	Clinical Director of Better Care Fund, CCG	Attended
Michael Whitworth	Interim Director of Contracting and Planning, CCG	*Apologies*
Sean Mackey	Interim Head of Medicines Management – Primary Care [Item 9]	Attended
Tony Menzies	Interim Project Manager, CCG	*Apologies*
Mr Andrew Tapp	Medical Director for Women and Children Services, SaTH [Item 8]	Attended
Kate Shaw	Associate Director of Service Transformation, SaTH [Item 8]	Attended
Sandra Stackhouse	Committee Clerk, CCG (Minute Taker)	Attended

Minute No South.2017.26: Item 1 – Welcome & Apologies

Dr Stuart Wright, Locality Chair, welcomed and thanked Locality Board Members for attending. A special thank you was noted to Hilary Fowles for her past involvement and who was retiring from general practice on

31st March. New Practice Managers, Sarah Bevan, Bishop's Castle Medical Practice and Peter Allen, Clun Medical Practice were welcomed and introduced to Members. Apologies received were recorded as above.

Minute No South.2017.27: Item 2 – Members' Declarations of Interest

There were no additional declarations of interests received for items included on this meeting's agenda.

Minute No South.2017.28: Item 3 – Minutes of the Previous Meeting and Actions

The minutes of the meeting held on 15 February 2017 were agreed as a true and accurate record and were signed by the Chair.

Minute No South.2017.29: Item 4 – Matters Arising

Dr Wright referred to the notes of the last meeting and actions included in the appendix to the minutes. It was agreed the points listed had either been actioned, or were on-going issues or included as items to be discussed on this meeting's agenda. The following matters arising from the last meeting were discussed:

[2.0] Members' Declarations of Interest – There were still a number of Declaration of Interest forms outstanding and Mrs Stackhouse asked if those Members who had not returned theirs to please do so as soon as possible. The auditors were chasing the CCG for the return of these forms and the deadline had already been extended. There was still a requirement to complete if Members had no interests and it was requested to include the word 'nil' or 'none' as per the guidance included in the Conflicts of Interest policy.

Action: Members requested to return outstanding Declaration of Interest forms to Mrs Stackhouse: sandrastackhouse@nhs.net

[6.0] Community Mental Health Team (CMHT) – Dr Freeman confirmed Dr Jessica Sokolov, Deputy Clinical Chair had spoken with the Medical Director at South Staffordshire and Shropshire Foundation Trust (SSSFT) who had agreed to reinstate the service but then it had been realised how difficult this was and had retracted on the agreement. Dr Sokolov had since written to SSSFT regarding the change in the CMHT service and a meeting had been arranged for Dr Povey and Dr Sokolov to meet with the Trust. It was highlighted this issue was a source of high levels of frustration across Shropshire.

Dr Penney explained that a meeting had been held at Bishop's Castle with four SSSFT members of staff who had informed the practice that there was going to be a new system. Reassurance had been given that the in-house weekly CMHT counsellor was to remain in post, however, was withdrawn with one-day's notice at Christmas and was replaced by a fortnightly drop-in session at the Community Centre, which appeared to work well. This service had now been withdrawn without notification and the practice had no access as the CMHT stated they would have to wait until 1st April when a new SPR was be set up. The CMHT consultant had felt that any contact with practices was being deliberately severed to impose an algorithm based on an urban model of service, which they could not fit into. Dr Penney explained he had been trying to refer an adult patient that day but had been told there was one CMHT worker working in the south today and one the following day. Social workers had also been withdrawn by the Council. It was highlighted there were significant concerns with potential safety issues and there was no access of referring into the system from Monday.

It was agreed that Members were finding it increasingly difficult to get patients seen and were unaware of the new referral arrangements and service provision from SSSFT. Dr Wright asked if it could be fed back that GPs were very unhappy with the current CAMHS provision, COMPASS and the ability to get young adults seen. Dr Povey agreed he would ask Mr Kubilius to forward an urgent communication out to Members confirming the new arrangements and service provision provided by SSSFT. It was also requested if Mr Kubilius could be invited to attend the next meeting to discuss further.

Dr Bird raised an issue with the process through the COMPASS/CAMHS single telephone number when trying to access the adult safeguarding team. Dr Bird had considered there was a block after calling the COMPASS number as he had not heard back from them. After chasing the safeguarding team they had been unaware of the initial call but as soon as Dr Bird had spoken to them they had provided excellent service and re-housed the patient that night. Dr Povey said he would refer Dr Bird's concern to Mr Paul Cooper to address the issue.

Dr Bailey reported a further issue with the Improving Access to Psychological Therapies (IAPT) service especially regarding a patient who could not use the telephone service. Dr Bailey had telephoned IAPT to ask for their email address so that the patient could email them as previously advised they could do. It was considered the person who had answered the call had been very impolite and advised it was no use emailing

IAPT as they would not do anything and to advise the patient they needed to overcome this and to telephone direct. It was confirmed to Dr Povey the practice did have a telephone recording system and this might prove useful to share with IAPT.

Dr Thompson asked if a newsletter of service changes in the CCG could be produced on a single A4 sheet, for ease of reference for GPs. It was acknowledged that practices did find out separately various sources of information but it could be embarrassing if a GP did not have the information to hand in the presence of a patient. Following a short conversation, it was confirmed that some changes of service involved Public Health at Shropshire Council also. Dr Povey said he would ask for a commissioning directory to be produced which would include both the CCG's and the Council's commissioning contacts, together with an organisational structure and contact details that would be available on the CCG's website.

Action: Dr Povey to ask Mr Kubilius to forward an urgent communication to all CCG practices confirming the new referral arrangements and service provision from SSSFT.

Dr Povey to ask Mr Kubilius to urgently look into the concerns that had been highlighted with potential safety issues.

Mr Kubilius to be invited to the next meeting to further discuss the changes in service. Mrs Stackhouse to include an item on Mental Health on the next meeting's agenda.

Dr Povey to ask Paul Cooper to look into Dr Bird's concerns regarding accessing the adult safeguarding team.

Dr Povey to request Mrs Jenny Stevenson, Membership Communications and Engagement Lead to produce a newsletter of service changes of both the CCG and Council on a single page and also to make available on the CCG's website an organisational structure and contact details.

Minute No South.2017.21 Item 9 – Dementia Strategy – Dr Wright believed Mr Pete Downer had received some feedback for consideration of the final version of the Dementia Strategy. Mrs Stackhouse reported she understood Mr Downer was still collating feedback from the localities and needed to attend the Shrewsbury and Atcham Locality meeting before the Strategy was finalised and copies could be produced for display in surgeries.

Minute No South.2017.24 New NHS Community Echocardiogram Service in Ludlow – Dr Freeman read out feedback received from Mr Michael Whitworth who had reported that the service was originally commissioned by the PCT on a national AWP contract 2012 and the provider had been delivering from Oswestry since that time. There was also rolled out delivery from Severn Fields Medical Centre in Shrewsbury. As SaTH was still not providing the service at RSH, the provider after agreeing the referrals, had chosen to deliver from a further site in Shropshire to ensure less travelling for patients. Based on referral data, Ludlow had been identified as an appropriate area to provide this service in the south. This was not a directive from CCG, it was a patients' echocardiogram service and the CCG held quarterly performance meetings with the provider and patients' feedback had rated the service as good.

Mrs Thompson commented that she had understood Dr Beanland had queried why the service had not been based at Ludlow Hospital. Dr Cook said he was unaware why the service was being run from his surgery as he had not been involved in the setting up of the service other than the surgery did have capacity to host. Members welcomed the service and it was confirmed referrals needed to go through the Referral Assessment Service (RAS).

Minute No South.2017.30: Item 5 – Locality Chair's Update

Retirement of Dr Stanford – Dr Colin Stanford was retiring from the CCG and general practice as of 31st March. On behalf of the Board, Dr Wright wished Dr Stanford a long and happy retirement and thanked him for both his contribution to the Locality Board and also for his involvement in the wider locality work. In response, Dr Stanford thanked everyone for supporting him over the last six years, when the South Locality Committee was initially set up.

Resilience Monies – Dr Wright referred to a previous discussion regarding resilience monies. NHSE had decided to divide the sum of money into quarters, which was currently sitting in four practices across the county. The plan was to have that money, which was approximately £85K-£90K repatriated centrally back to the CCG to be demarcated on a capitation basis, which equated to approximately 26p per patient to be used for developing collaborative working. There was also a further pot of money because the CCG was going to have its own baseline around £1.50 per patient and it needed to be worked out how that funding would be used for new models of working to stabilise general practice, which was still in discussion.

Once the new Director of Primary Care was in post it would be very different as she would be able to establish her team and a deputy. There would also be the three new locality managers so it would be very different from that point. It was highlighted that although the split of the funding into four different pots by NHSE was unusual, Members expressed concern that it had not been split into three for the three localities and also had chosen four practices as the holding accounts without any due warning. Dr Povey assured Members that each locality would decide on how the money was spent.

Resignation of Dr Wright as Locality Chair

Dr Wright thanked Members for their support over the last three years and confirmed he was now standing down as the Locality Chair and the next step was for the Locality Board to elect a new Chair.

Election of new Locality Chair

As far as Dr Wright was aware, there was one standing candidate: Dr Shailendra Allen unless there were any further nominations received. Dr Bennett announced there might possibly have been an expression of interest from one retired partner from her practice who was not present at the meeting. Following a short conversation when the criterion of eligibility to stand and the election process was discussed, it was pointed out that there had been sufficient opportunity for Members to come forward. The vacancy had been well trailed and clearly marked on the agenda that had been previously circulated. Dr Bennett confirmed the self-nomination from Knighton and Clun could not be confirmed at the meeting.

It was agreed proceedings should continue and Dr Wright nominated Dr Allen, seconded by Dr Cook.

As a new Member of the group, Dr Allen was asked to give a short introduction when he explained that he had been working in Telford for more than 10 years having started in Shropshire as a partner in Market Drayton in 2004, resigning in 2006 to go to Telford combining three of the surgeries together. Over the years the Trinity group of surgeries emerged, with Dr Allen's surgery becoming larger with 17,000 patients and he joined Teldoc. There was an imminent merger of three practices: Oakengates, Lawley and Trinity making the population size 40,000 on one contract and was also working with Wellington on the federated model to enable modern working for a locality having 54,000 patients. Dr Allen had joined Telford and Wrekin CCG in October 2016 and clarified his position on being critical of the joint committee but was not opposed to having one A&E or having one planned care site. Dr Allen's personal opinion had been that before going out to consultation, there needed to be solid evidence so there would be no repercussions of not having evidence behind the decision. Dr Allen would look forward to collectively working with Members to achieve the same vision for the locality.

At this point, Dr Allen stepped out of the meeting room whilst the election took place.

Dr Wright asked Members to cast one vote per practice in the election of Dr Allen to succeed Dr Wright as South Locality Chair, the result of which was as follows:

All those in favour:	4
All those against:	0
Number of abstentions logged:	9
Total number of practices represented at the meeting:	13.

Out of 15 practices - Shifnal and Priorslee and Broseley were not represented.

A short conversation followed when a potential conflict of interest was queried if Dr Allen remained a Member of the Telford and Wrekin CCG Board. Dr Povey explained he had had extensive conversations with Dr Allen who, if elected, would immediately tender his resignation from Telford and Wrekin CCG.

A further query was raised regarding Dr Allen's involvement in Teldoc. Dr Povey explained that Dr Allen had reduced his involvement to just the finances and expansion but this involvement was no more than any Member being an integral part of their own practice. Dr Allen had been a partner in Broseley since January and would be a partner at Highley from 1st April.

At this point, Dr Allen was invited to re-join the meeting.

Dr Wright, on behalf of the Locality Board, congratulated Dr Allen on being elected as Chair and Dr Allen was invited to take over chairing the meeting.

Minute No South.2017.31: Item 6 – Clinical Chair/Accountable Officer Update

Dr Povey, Clinical Chair, thanked Dr Wright for his leadership of the locality and involvement in the CCG. Dr Wright had undertaken a lot of work over the past few years and Dr Povey was very grateful to him.

Dr Povey gave brief updates on the following:

Board Structure – There had been some main changes to the CCG Governing Body Board. The majority of Clinical Directors had served their three-year terms and it was explained that two locality chairs, Dr Wright (as discussed above) and Mr Kevin Morris (North Locality Board Chair) had stepped down from their roles. Mr Morris was succeeded by Dr Tim Lyttle, GP in Whitchurch. Dr Deborah Shepherd had been elected to take Dr Alan Otter's place as the Locality Chair for Shrewsbury and Atcham, who had also recently retired.

Both Dr Povey and Dr Steve James, Clinical Director had also reached their three year terms and to avoid six members out of nine standing down at the same time both Drs Povey and James had been allowed to extend their terms of office by two years and one year respectively. This would enable a staggered election over the next few years. The other members of the Board were: Dr Jessica Sokolov, Deputy Clinical Chair; Dr Finola Lynch, salaried GP from north Shropshire; and Dr Geoff Davies, GP partner at Clive.

Following Dr Stanford's retirement, there was one Board vacancy for a Practice Representative and after writing round to practices, one self-nomination had been received from Mr Kevin Morris. At the recent North Locality Board meeting there had been a comment received from one Member that the letter had not been clear enough and they had not understood there had been a vacancy to apply for. As a result, Dr Povey had written round extending the deadline by 72 hours and there were now two Members who had put themselves forward for the election. The other candidate was Mrs Sue Evans, Practice Manager, Plas Ffynnon Surgery, Oswestry. Once the short portraits of the nominees had been received an election would be conducted requesting one vote per practice.

Dr Freeman had been appointed as the substantive Accountable Officer. A new full team of Directors had also been appointed, who would be joining the CCG at different times over the next three months depending on their notice, who were as follows:

- Dr Julie Davies was continuing in her role as Director of Commissioning
- Nicky Wilde, Director of Primary Care (from Telford & Wrekin CCG)
- Gail Fortis-Meier, Director of Contracting
- Sam Tilley, Board Secretary and Director of Corporate Affairs
- Dawn Clark, Director of Quality and Nursing (from Bath and North East Somerset CCG)
- Claire Skidmore, Director of Finance (from Wolverhampton CCG).

Dr Simon Freeman, Accountable Officer, explained Dr Povey and himself had spent a considerable time over the last few weeks taking part on the interview panel for the new substantive Director posts. It was considered a very positive step forward now having a substantive team in place and to build the directorates and structures below them.

Finance – It was hoped the CCG would achieve the year-end deficit total of £26m, which had been a huge achievement. Part of this work had entailed agreeing the £8m of legacy disputes with Shropshire Council.

QIPP Schemes - Going into next year the CCG needed to save £17.7m out of a budget of £450m and six major schemes of work had been developed to enable this. One of these was Complex Care, which did not involve GPs but was really about managing a historically badly managed service.

A discussion would be held under Item 9 on prescribing where the CCG was looking to reduce its prescribing budget by approx £3m. The current budget was approximately £53m, which was an approximate 5-6 per cent saving but it was believed this was achievable.

The largest issue in the county but not so evident in the south of the county was the over-intervention in elective orthopaedics in the region of £12-20m and so this entailed a lot of work to reduce this.
There was also a piece of work looking at Procedures of Limited Clinical Value (PLCV) whereby consultants are required to seek prior approval codes prior to undertaking activity. That was proving quite difficult but there had been large reductions experienced in orthopaedic procedures recently. Both referrals from GPs and completed episodes were expected to fall. Further work was also focussing on: follow-ups; high cost drugs switching; and bio similes, with £5k estimated savings.

Practice Visits – Dr Freeman had visited Knighton and Clun and Bishop's Castle practices recently and was hoping to visit as many practices as possible in the coming year. The practices were at the forefront of the CCG and the CCG was looking to support them with innovation and ideas that achieve savings.

Sustainability and Transformation Plan (STP) – A short update was given and it was suspected that in future there would be a move towards single accountable care organisations for STPs and single strategic commissioners. An example was given of the four CCGs in Derbyshire moving to a single Accountable Officer and management team and a joint committee for the CCGs. Currently there was no plan to do this in Shropshire and the remit was to rebuild the CCG's financial position.

Dr Povey reported that a meeting had been held with representatives from OHP. It was seen as a very positive development that practices were beginning to come together and one of the aims was to allow practices in the OHP to have a seat on the STP. Although the CCG commissioned primary care, it was very different from working with primary care. It had been considered the STP had been too acute provider focused and should have looked at what work should be done in the community. The CCG was keen to drive the message that work coming into the community was not work coming to general practices but was about asking the acute trust and other providers to work in a different way. The CCG had started to re-set Future Fit, Community Fit and STP with a piece of joint commissioning work with Shropshire Council by Optimity, which was looking at the process so far and how best to continue.

A lot of this work would come through the Community Services Review (CSR) and the neighbourhood work that was being carried out with Shropshire Council. That was always going to be difficult in Shropshire than in inner city areas because of the distances between the practices. This was a work in development and the OHP model was very positive but there were different ways of doing it as well.

Minute No South.2017.32: Item 7 – Shropshire Community Services Review

Mr Tony Menzies, Interim Project Manager, had been unable to attend at short notice and so in his absence Dr Freeman gave a brief overview of Mr Menzies' presentation on CSR, hard copies of which had been included in the meeting packs.

Dr Freeman explained the context in that when the CCG was placed in legal directions, NHSE had reviewed its finances and one of the reviews involved Deloittes looking at its community services expenditure. Effectively this was the CCG's contract with Shropshire Community Health Trust (SCHT), which was approximately £40m of which circa £10m was paid on services that operated out of community hospitals, ie DAARTs, MIUs, rehab beds. The recommendation by Deloittes to NHSE was that the CCG was either paying £5-7m too much or was generating £5-7m too little value out of those services.

The CCG had now been asked to undertake a review of those services with a review to reducing the SCHT contract by £5m in 2018/19. The scope of the review, including public consultation, would cover the following areas county-wide: community beds; Diagnostic, Assessment & Access to Rehabilitation (DAART) Centres; and Minor Injury Units (MIUs). It would be a clinically led review by two GP board members, Dr Jessica Sokolov and Dr Finola Lynch and the governance would be via a programme board that would be chaired by joint clinical leads and would include representatives from SCHT, SaTH, the local authority, the CCG and patients and carers groups. The remit of this group was to put forward recommendations and any commissioning decisions would be made by Shropshire CCG Governing Body.

Dr Freeman explained that the CCG was not trying to suggest MIUs should cease but it was questioned why there were MIUs in some areas and not in others, such as Clun. As an example, in the Oswestry MIU, 70 per cent of patients received no treatment so the localities needed to openly discuss how this service could be offered more efficiently than it was currently.

A sub group of the Programme Board would be a Clinical Reference Group, which would score potential options and identify a preferred option; and ensure clinical leadership supporting the clinical redesign of services across organisations. Members of this group would comprise clinical leads, two GPs from each locality, and SCHT and SaTH clinicians.

Dr Penney added that he did not there had been a meeting where this had not been discussed and similarly at the Local Medical Committee (LMC) and welcomed this review. Dr Penney, however, referred to a meeting that had taken place at the Community Hospital the previous week with the staff who were likely to have to relocate whilst refurbishment was carried out. The new Assistant to the Director of Quality at SCHT, Ms Alison Trumper had been in attendance and had referred to the CCG undertaking a community review. Ms Trumper had said she had attended two meetings and claimed the CCG did not know what they were doing and had not expressed a desired outcome. It had also been suggested that Shrewsbury's problems were a result of GPs closing at 5pm and not offering people appointments so they presented at A&E. Dr Penney considered this had been unacceptable behaviour particularly in the presence of vulnerable staff and had reinforced the desire that primary care should be involved in the community review.

Dr Freeman added that nationally there was no evidence that expanded GP opening hours had any impact on A&E attendances or admissions. The only evidence that existed was that properly funded practices giving holistic care to patients had lower levels of admissions and attendances, which was expected.

Dr Wright reported that he had put his name forward to sit on the review panel and the first meeting had taken place that day. The other GP representative from South Shropshire was Dr Catherine Beanland. It was agreed this review would be difficult but it needed to be clinically led with support of clinicians across the CCG. Dr Wright was hopeful there would be further information to feed back at the next meeting.

Action: Mrs Stackhouse to include an item the Community Services Review on the next meeting's agenda to discuss feedback.

Minute No South.2017.33: Item 8 – Transformation Update

Mr Andrew Tapp, Medical Director for Women and Children's Services and Consultant Gynaecologist; and Kate Shaw, Associate Director of Service Transformation, SaTH attended to share a brief update on the Sustainable Services Programme (SSP) and the wider relationship with the Future Fit programme with a reminder of the key elements of the clinical model. There was also an update on the plans of the proposed emergency and planned care sites as described in the Outline Business Case (OBC). Hard copies of the PowerPoint presentation slides were tabled, which covered the following key points:

The options for consultation – balanced hospital sites:
Option B (Emergency Care at PRH, Planned Care at RSH)
Option C1 (Emergency Care at RSH, Planned Care at PRH) – identified as the preferred option by the Future Fit Programme Board (October 2016)
There had been previously a third option separating Maternity and Paediatrics but following a number of external reports identifying this option created significant clinical risk both to mothers who are critically unwell and particularly to children also.

Programme update on Future Fit and for the Trust. Dr Freeman did add at this point that he felt it was important that SaTH understood Shropshire CCG's Governing Body Board's position in that it did not think there was a need for either an independent review or a further impact assessment. The majority of services would not be changing, however, particularly in the way in which the Telford position was presented to the Department of Health Gateway Review, the recommendation was an independent review to be undertaken, which was likely to cost circa. £150K for the two reviews. As a result, Shropshire CCG would have to pay £100K and it had a £26m deficit.

Mr Tapp in response said SaTH would take the comment back to the SaTH Board. SaTH saw their role as supplying information as quickly as possible to be able to fulfil the concern of how much it would cost in relation to that and to point the direction for what information that would be useful for them to have.

Dr Freeman added that the Constitution of the Joint Committee had been changed so that no one CCG held the right of veto. The Committee would comprise two independent clinical members that would be appointed by NHS England and NHSi with one independent voting chair who was likely to be an Accountable Officer from a non-related CCG.

Sustainable Services Programme – improving patient experience and flow
Planned Care Site and Emergency Site
Also discussed were concerns around the bed base; and the plan for ambulatory emergency care.

During the question and answer session that followed Dr Bird queried how many beds in total would there be and not clinical spaces. Ms Shaw answered that it depended on whether Women's and Children's was included. If there were 736 now does include critical care at the moment and we go up to 802 so includes the additional critical care capacity and it includes the additional ambulatory emergency care. The difficulty is it does get complicated around beds, trolleys, clinical spaces, day case beds because the current model of care that we have got, as you will all know is quite hampered by our estates and our environment so sometimes we have got beds when we could do with day case or trolleys or ambulatory care or whatever it might be so that total number is trying to realign that appropriately. So people that are currently in an inpatient bed will not be in an inpatient bed, they will be in an ambulatory space so I can send something round which actually splits it down if that help. We are not necessarily comparing like with like because we are talking about a new model five years down the line and we are quite away from that because we have got a very traditional model at the moment.

Mr Tapp highlighted the other element was that it was live data from 2012/13 and the data from 2015/16 was different and this year's data would be different again. There was a prediction of a demographic change and the patients that were now in hospital were in different settings rather than being in the traditional bed on a

traditional ward as opposed to the emergency ambulatory care centre. Most patients attended for planned care and so the majority of work would stay in the appropriate site that had that role.

Dr Thompson raised if there was an issue with workforce in Shropshire, would there be capacity within the workforce to increase these numbers and maintain staffing positions in the community services.

Ms Shaw explained that a piece of work was progressing which rather than focussing on the numbers of doctors, nurses and clinical staff, it was looking at the skills and competencies that was required to deliver the care for particular patient groups at that particular time. It was acknowledged there was a challenge to fill gaps in what have been traditional doctor roles and the most experienced nurses were being considered to backfill those roles. Work was being carried out around the new associate nurse to enable the changes to happen with the most senior nurses. There was a large piece of work to be carried out as part of the STP around the total workforce but it was not without risk.

Mr Tapp added that duplication on both sites did not help SaTH's workforce and there were real pressures on medical workforce coming into the county at all tiers. However, from experience when areas of the service were stabilised, for example, in abdominal surgery and Women's and Children's, there usually were no problems in senior medical recruitment.

Mr Allen referred to the STP and asked how far had SaTH planned and was SaTH willing to work with GPs to move care into the community as much as possible to enable a balance of community and hospital care and not financially penalise primary care.

In response, Ms Shaw assured Members there was a huge commitment to work with GPs around the pathways and the work on the neighbourhood groups under the STP should be the vehicle in getting some of that work progressed because it needed to be considered as a system. It was particularly important to take into consideration the demographic growth area and what might be in the next 5-10 years.

Dr Freeman explained that the Shropshire neighbourhoods work was not fully developed and the CCG had commissioned a group of health economists called Optimity to advise on taking this work forward.

Action: Members were invited to contact the SaTH Transformation Team if they required further information by emailing: transformation@sath.nhs.uk or by telephoning: 01743 261183.

Mrs Stackhouse to circulate electronic copies of the Transformation update presentation for information for Members.

Minute No South.2017.34: Item 9 – Prescribing Update

Mr Sean Mackey, Interim Head of Medicines Management – Primary Care, attended to give updates on the following using presentation slides, a hard copy of which was tabled:

- Prescribing spend April 2016-January 2017.
- Prescribing spend per ASTRO-PU (APU) April 2016-January 2017. (Based on a weighting list size, looking at the spend divided by the number of patient denominators adjusted for age, sex, and temporary residence status at the practice so this did not include deprivation, QOF scores.)
- Prescribing Practice spend April 2016-January 2017.
- Prescribing BNF Chapter spend April 2016-January 2017.

Cost Effective Prescribing Framework:

- Practice would receive the monies under the PQOS scheme for the last financial year but also available would be a £273K upfront payment under SLA with 50% available from April and a further 50% in May based on successful submission of an action plan on how a practice was going to reduce expenditure over the next 12 months. Subject to the locality approving those action plans, a further 50% of that £273K would be available in May to claim against. Practices would be able to use that money if they wished to support the deficit in the funding for those pharmacists in practice.
- Confirmed Individual Practice Prescribing budgets, the process of which is going to be approved at the Formulary Committee on Monday taking into account high cost drugs, deprivation by looking at the tick box on the back of a prescription – a percentage of those prescriptions that are for low income; age, sex, and temporary resident (astro-PU) status profile of a practice; nursing home residents and learning disability residents lists also and modelling this to provide an expected budget for 2017/18.
- Further payment of up to £2 per patient if the CCG underspends the Prescribing budget overall and individual practice underspends their budgets.
- Monthly monitoring of prescribing data and QIPP indicators.

- Locality lead pharmacist supervision, underneath the pharmacists will be technicians who will be around to do the switch work and audit work in order to save money to support you. For the South, the Locality Lead will be Shola Olowosale, Primary Care Support Pharmacist.
- Additional to the £273K there was the potential of £600K investment (only paid out if sufficient underspend) for the whole PQOS.

During the question and answer session that followed, it was confirmed the only clawback of monies would be if practices did not sign the action plans or did not engage with the process over the year. As part of the action plan there would be drug switches and it was understood from practices this would be quite difficult so this was being looked at. Practices would receive guidance by email, together with a list of suggested drugs, which would be adapted for dispensing practices.

Prescription Ordering Direct (POD) scheme: Sixteen practices had already agreed to join this scheme and it was hoped to have approximately 21 practices operating through the POD by the end of the year. Meetings have been held with the Practice Managers of the three localities also. Overall there are approximately £4m savings to be made and as a reminder, the POD scheme entailed:

- Call centre approach to managing patient requests for repeat medications.
- Managed repeats not allowed through community pharmacy.
- Based upon the Coventry CCG model as highlighted in the HSJ. Open 9-5 Monday-Friday.
- Reduction of 8-12% prescription volume in Coventry based upon 30 practices.
- Telford CCG started same in November 2016.
- Conservative estimate of £1m savings for the first year of POD in Shropshire.

Care Homes Medicines Optimisation service:

- Service to cover the 130 Care Homes.
- Training.
- Clinical patient reviews.
- Link to POD.
- Wastage reductions.
- See patient within 48 hours of admission to/discharge from the care home, led by Ceri Wright? Our technician.
- Savings of £675K.

Prescribing policies:

- Common medicines for minor ailments: Paracetamol; Hayfever preps for over 18 year-olds, etc. A list of products that the CCG would prefer not for GPs to prescribe anymore will be circulated to practices.
- Oral Nutritional Supplements (ONS). From 1st May care homes will not be able to request from the GP nutritional supplements without having carried out MUST scores and the "Think food" for 1 month. Care Homes are to be referred to the Medicines Optimisation Team and Liz Bainbridge and the dietetic team will determine whether it is appropriate that patient has a sip feed.

Other schemes:

- Review of Area Prescribing Committee and Board agreement on managing non-adherence to recommendations.
- Scriptswitch.
- Hospital drug pathway reviews.
- Bluteq.
- Hospice contract review.

Possibilities:

- A pilot was going to be carried out to move wound care away from general practices. At the moment this was being considered at Bridgnorth and another location. District Nurses were going to have stock at their bases and supply from that stock. What had been seen locally and nationally is that approx 20% wastage could be saved in the cost of the products but would also mean that the workload in practices was reduced. This proved popular with the district nurses as it would also mean they would not be waiting for prescriptions to be generated from a practice.
- New Stoma contract.

Practices will be supplied with their own BNF list for their practice and would also be able to choose one/two areas where they believe there are significant savings and how they planned to do that. The Medicines Optimisation Team (MOT) was hoping to work with practices on various models, potentially with pharmacists working through NHSE funding.

In answer to a question raised by Dr Bird, Mr Mackey confirmed the same rules applied as for PQOS but in addition, it had been agreed through the CCC, practices could also use the money on the deficit from NHSE funding for clinical pharmacists. This would be for an employed person whereas before it had been for sessional staff. An example would be if a practice decided to recruit a pharmacist as part of collaborative working, then NHSE would provide funding of £60K over three years for one pharmacist for a 30,000 list. Practices could also spend the money on staff already employed to give them additional time to do the work because it was on a temporary basis and was not recurrent monies.

Dr Stanford suggested for the work about the care homes in particular and prescribing for older people at home. There had been some medical literature in the GM magazine about how doctors could help patients make the right decisions about their care and their treatment, for example, the inappropriate prescribing of statins particularly towards the end of life. Dr Stanford suggested it might be useful to support GPs in providing the links to such articles or research.

Mr Mackey agreed and explained this was part of the process termed 'de-prescribing'. The Medicines Optimisation Team (MOT) provided lists through the Care Homes Advanced Scheme (CHAS) so the information could be given to the care homes staff. Mr Mackey asked if when visiting care homes, if a Member of his team could be asked to accompany GPs on ward rounds and visits. Sessional staff were being recruited to enable expansion of the team to undertake this work.

Dr Thompson referred to the slides and pointed out that the increase marked in red were areas that the GPs had less influence over and asked if this was addressed through a similar forum to the practice nurses. Mr Mackey explained it was hoped work would be taken away from GPs and the plan was that the practice or group of practices was not going to provide any dressings. There would be one site, a large practice or a large nursing home, that would hold a large volume of dressings and the model would be looked at how that would work for three sites.

Dr Penney highlighted some issues regarding lack of knowledge of new names of prescription drugs, which had been reported nationally as an issue. Mr Mackey agreed this was a good point in that if GPs were used to prescribing a generic drug which then changed sometimes to a branded generic, which certainly happened in hospitals with changeover of doctors and nurses and rotations, they did not always recognise the brand and this was something Members should be aware of.

Action: Members were invited to contact Mr Mackey via email with any further queries they may have to: smackey@nhs.net

Mrs Stackhouse to circulate copies of the Prescribing update presentation for information for Members.

Minute No South.2017.35: Item 10 – Locality Assurance Framework (LAF)

The most recent copy of the Locality Assurance Framework (LAF) had been circulated electronically with hard copies also tabled with the meeting papers. Dr Wright advised the two issues regarding COMPASS and CAMHS, previously raised by the South Locality Board, should remain on the log for the time being. This would be reviewed following the new provider taking over the service.

Minute No South.2017.36: Item 11 – Any other business

11.1 Primary Care Mental Health Services

The discussion of this item was brought forward under Item 4: 'Matters Arising'.

11.2 Phlebotomy Service

Following the recent LMC meeting held about practices and phlebotomy, Dr Abbotts had requested this item to enquire as to present developments and if anyone was actioning this.

Dr Povey referred to the phlebotomy review carried out two years' ago, which had showed a very wide range of different ways phlebotomy was provided countywide dependent on the location. The CCG was aware this was a major challenge and was planning to look at it as part of the GP 5 Year Forward View and the £5.50 per patient and to perhaps add a one-off stabilisation payment to allow time to carry out this work. It was acknowledged it was a challenge and there was inequity in the way phlebotomy was currently provided. It was not an issue that was going to be solved quickly but would be looked as part of the CSR together with other reviews and the general change in the amount of work that would be coming from SaTH. The new Director of Primary Care, Ms Nicky Wilde would be focussing on this piece of work when she was in post.

11.3 Ophthalmology and Neurology Referrals in Shropshire

Dr Penney raised concerns that there were no ophthalmology or neurology referrals in Shropshire. A member of RAS had also contacted Bishop's Castle Surgery the day before to inform them that as a result of a previous survey undertaken they had been blacklisted for referrals. The practice had since been taken off the list after Dr Penney had discussed further with Mrs Trish Campbell but was concerned about the timing of the new service. Dr Povey informed members about potential new services and said he would ask Mrs Nina White, Head of Primary Care Strategy to contact Dr Penney.

Action: Dr Povey to request Mrs Nina White to contact Dr Penney.

11.4 Thank you to Out-going Chair and from Incoming Chair

On behalf of Locality Board Members, Dr Penney thanked Dr Wright for all the work he had carried out over the past three years and in particular for his quiet determination and drive.

Dr Allen also thanked Members for having faith in him as the new South Locality Chair. He said he would do his best and hoped he would work well with Members. An invitation was extended to Members to contact Dr Allen as he was very open for discussions and could email him whenever they felt the need on: sallen12@nhs.net

Action: Members were invited to contact Dr Allen to further discuss projects / issues at sallen12@nhs.net

There were no further items raised under any other business.

Minute No South.2017.37: Item 12 – Date and Time of Next Meeting

The next meeting has been scheduled to take place on **Wednesday 17 May 2017** at **Bridgnorth Medical Practice** at **4.30pm.**

Dates of Future Meetings:

Thursday 29 June	Mayfair Centre, Church Stretton
Wednesday 23 August	Bridgnorth Medical Practice
Thursday 5 October	Mayfair Centre, Church Stretton
Wednesday 15 November	Bridgnorth Medical Practice
Thursday 4 January 2018	Mayfair Centre, Church Stretton

PLT meetings:
Tuesday 9 May
Thursday 22 June
Wednesday 11 October

Signed: …… **Date:** ……..……
Dr Shailendra Allen, Locality Chair

South Locality Board Meeting – 30 March 2017

Action Table

Minute No.	Action Required	By Whom	By When
Minute No South.2017.29: Item 4 – Matters Arising 2.0 Declarations of Interests	Action: Members requested to return outstanding Declaration of Interest forms to Mrs Stackhouse: sandrastackhouse@nhs.net	All Members. Also all Practice Staff who have interests to declare.	As soon as possible
6.0 Community Mental Health Team (CMHT)	Dr Povey to ask Mr Kubilius to forward an urgent communication to all CCG practices confirming the new referral arrangements and service provision from SSSFT.	Dr Povey/ Mr Kubilius	As soon as possible
	Dr Povey to ask Mr Kubilius to urgently look into the concerns that had been highlighted with potential safety issues.	Dr Povey/ Mr Kubilius	As soon as possible
	Mr Kubilius to be invited to the next meeting to further discuss the changes in service. Mrs Stackhouse to include an item on Mental Health on the next meeting's agenda.	Mrs Stackhouse	Next meeting
	Dr Povey to ask Paul Cooper to look into Dr Bird's concerns regarding accessing the adult safeguarding team.	Dr Povey/ Mr Cooper	As soon as possible
	Dr Povey to request Mrs Jenny Stevenson, Membership Communications and Engagement Lead to produce a newsletter of service changes of both the CCG and Council on a single page and also to make available on the CCG's website an organisational structure and contact details.	Dr Povey/ Mrs Stevenson	As soon as possible
Minute No South.2017.34: Item 7 – Community Services Review	Action: Mrs Stackhouse to include an item the Community Services Review on the next meeting's agenda to discuss feedback.	Mrs Stackhouse	Next meeting
Minute No South.2017.34: Item 8 – Transformation Update	Members were invited to contact the SaTH Transformation Team if they required further information by emailing: transformation@sath.nhs.uk or by telephoning: 01743 261183.	ALL	On-going
	Mrs Stackhouse to circulate electronic copies of the Transformation update presentation for information for Members.	Mrs Stackhouse	As soon as possible

Minute No.	Action Required	By Whom	By When
Minute No South.2017.34: Item 9 – Prescribing Update	Members were invited to contact Mr Mackey via email with any further queries they may have to: smackey@nhs.net To circulate copies of the Prescribing Update presentation for information for Members.	ALL Mr Stackhouse	As soon as possible As soon as possible
Minute No South.2017.24: Item 11 – Any other business **11.3 Ophthalmology and Neurology Referrals** **11.4 Phlebotomy Service**	Dr Povey to request Mrs Nina White to contact Dr Penney. Members were invited to contact Dr Allen to further discuss projects / issues at sallen12@nhs.net	Dr Povey All Members	As soon as possible On-going

Shrewsbury & Atcham
Locality Board Meeting

held at 2.00pm on Thursday 16 March 2017

at The Severn Fields Health Village,
Sundorne Road, Shrewsbury SY1 4RQ

Shropshire
Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277595

Minutes

Name	Practice/Organisation	Signature
Dr J Pepper	Belvidere [Items 6-13]	Attended
Caroline Davis	Belvidere	*Apologies*
Dr M Fallon	Claremont Bank	Attended
Jane Read	Claremont Bank	Attended
Dr E Baines	Marden	Attended
Joy Baker	Marden	Attended
Dr A Cameron	Marysville	Attended
Izzy Culliss (Acting Chair)	Marysville	Attended
Dr S Watton	Mytton Oak	*Apologies*
Adrian Kirsop	Mytton Oak	Attended
Dr R Bland	Pontesbury	Attended
Heather Brown	Pontesbury	Attended
Dr H Callahan	Radbrook Green	Attended
Tony Marriott	Radbrook Green	*Apologies*
Dr Paul Rwezaura	Riverside	*Apologies*
Tracy Willocks (Vice Chair)	Riverside	*Apologies*
Dr D Martin	Severn Fields	*Apologies*
Steve Ellis	Severn Fields	Attended
Dr L Davis	South Hermitage	Attended
Caroline Brown	South Hermitage	Attended
Dr E Jutsum	The Beeches	Attended
Kim Richards	The Beeches	Attended
Jo Beason	Whitehall	Attended
Tim Bellett	Whitehall	*Apologies*
Dr K McCormack	Worthen	Attended
Cheryl Brierley	Worthen	*Apologies*
Dr D Shepherd	Locum GP and Educational Lead [Items 1-5]	Attended
Roland Brown	Severn Fields PPG	Attended
Jenny Birch	Belvidere PPG	Attended
Dr Simon Freeman	Accountable Officer [Items 1-7]	Attended
Dr Julian Povey	CCG Clinical Chair	Attended
Dr Jessica Sokolov	CCG Deputy Clinical Chair	Attended
Dr Steve James	Clinical Director – CCG	Attended
Anne Dray	Interim Director of Corporate Affairs	Attended
Dr Deborah Shepherd	GP Locum [Items 1-5]	Attended
June Telford	Interim Head of Primary Care	*Apologies*
Tony Menzies	Project Manager, Community Services Review [Item 8]	Attended
Sean Mackey	Interim Head of Medicines Management – Primary Care [Item 9]	Attended
Sandra Stackhouse	Committee Clerk/Personal Assistant – CCG (Minute Taker)	Attended

1. Welcome & Apologies

Mrs Izzy Culliss, Acting Chair, welcomed and thanked Members for attending. A special welcome was extended to Dr Freeman, Dr Sokolov and Dr Shepherd and a round of introductions was made.
Apologies were noted as above.

2. Members' Declaration of Interests

There were no declarations of interests received for items included on this meeting's agenda.

Members' attention was drawn to the new Conflicts of Interest policy and declaration of interests form, which was required to be completed by GP Partners, practice nurses and any employee who may have a conflict of interest with the CCG, including family members. Copies of this form had been tabled with extra copies for completion by practice staff. If there were no declarations to be made, Members were requested to still complete and asked to note 'nil' or 'none' on the return.

Mrs Culliss explained there had been a slow response with a number of declaration forms still outstanding. Members were requested to complete and sign as soon as possible, preferably handing in to Mrs Stackhouse at the meeting or forward by email to sandrastackhouse@nhs.net. If there were any further queries regarding conflicts of interest, Members were requested to contact: tracy.eggby-jones@nhs.net.

Action: Members requested to complete any outstanding Declaration of Interests forms and return to Mrs Stackhouse as soon as possible.

3. Minutes of Meeting held on 19 January 2017

The minutes of the previous meeting, held on 19 January 2017, were accepted as a true and accurate record and were signed by the Chair.

4. Matters Arising

Mrs Culliss referred to the actions from the previous meeting and it was agreed all had been completed or brought forward as items on this meeting's agenda. The following additional verbal updates were provided:

9. Prescribing Update – Members had been asked to consider the First Food advice and pathway. Mrs Culliss reported a further letter had been sent out to practices today.

   Members were reminded that Mr Mackey had asked for practices to contact him if they were interested in joining the Prescribing Incentive and POD schemes.

10. PPG Update and Feedback – Mrs Nina White was not in attendance but it had been confirmed she had discussed further with Mrs Jane Blay the lack of patient information from the Shropshire Skin Clinic as raised previously by Mrs Birch and had arranged for this concern to be logged on N2N concerns and would be raised at the next Clinical Quality Review Meeting (CQRM). Mrs Stackhouse reported she had been informed this issue had been raised with the Skin Clinic and it had been confirmed there was a policy that the clinic downloaded leaflets from the British Association of Dermatology for matters such as cryotherapy and other treatments. Following feedback raised at this meeting the Skin Clinic would be reviewing the policy through their governance group and the importance of informing patients if they experienced any complications to contact their GP or the clinic.

12.1 Any other business: Path Lab Test Results – Mr Ellis reported that Mrs Jenny Stevenson, Clinical Governance Co-ordinator, had forwarded an email to practice managers asking for the most appropriate telephone numbers to use for the pathways.

   There were no further matters arising.

5. Accountable Officer and Clinical Chair Update - Dr Simon Freeman, Accountable Officer gave brief updates on the following areas:

Finance – Since Dr Freeman had joined the CCG an interim executive team had been established and along with the Clinical Chair and Clinical Directors had worked really hard to prevent the financial position from further deteriorating and to achieve the year-end deficit of £26m. An agreed deficit total of £20m had been agreed for next year, which was a £6m improvement but when growth was added in, the CCG would be required to make savings of circa £18m out of a capitation of approximately £450m. The CCG would be looking to the localities to drive the agendas to address some of the more problematic issues within the CCG and was offering resources to practices at the beginning of 2017/18 to lead in addressing two areas in particular:

(1) Prescribing cost reductions – the CCG was looking at a scheme to provide £3 per patient for practices by paying last year's prescribing incentive scheme upfront which would require production of action plans to be submitted by end-April. (Further detail of this scheme was discussed under Item 9.)
(2) The CCG would also like practices to start looking at variations in emergency admissions.

It was reported there was a massive over-investment in surgical orthopaedics and when benchmarked with comparable CCGs, Shropshire's overspend was between £12m-£20m. To enable to reduce this for 2018/19, Dr Chris Tomlinson, would be leading the development of a pathway for elective orthopaedics and alternatives to surgery.

CCG Management Structure – Dr Freeman and Dr Povey had both been involved on the interview panels to recruit new members of the new executive team. An experienced Board Nurse had been appointed and the CCG was also seeking a new Director of Finance. Nicky Wilde, who was currently working for Telford and CCG, would be taking up the new role of Director of Primary Care in approximately three months' time.

Midwife Led Units (MLU) Review and the Community Review – Dr Sokolov offered some background on the MLU review explaining that Shropshire was an outlier for its number of MLUs and the acute trust had informed there had been a shortfall of approximately £1m in what the CCG was paying and what it was costing the Trust to run the service. In addition, there was also a problem with short-term closures of individual units because of staff shortages and in response to these issues and those that the public had raised a review of the MLUs would be conducted to see whether it was a sustainable model for future. There had also been a national maternity review in 2016 whereby there would be a maternity transformation programme.

Future Fit – Dr Povey reported that both Shropshire CCG and Telford & Wrekin CCG had supported reforming a joint committee of a different membership that would prevent a tied vote. This would consist of six members from each CCG, with three independent Members, two of which would be clinical and one managerial. Telford & Wrekin Council and Telford and Wrekin CCG had requested an independent review of the process of Future Fit and once this had been carried out the joint committee would meet again to make a decision about the preferred site for the Emergency Centre and the planned care site.

Community Fit - It was acknowledged that the Community Fit and the neighbourhood work in the STP had not been fully explained and from the outset it had been wrongly implied there would be a big left shift of work moving to general practice. The CCG and the Council had commissioned Optimity, specialist advisors, to look at the neighbourhood work and would be carrying out a place based needs system looking at what the different areas of Shropshire require. It was hoped the outcome of this work would show that work coming out of the hospital would not be impacting as much on GPs but would show the work could be carried out in a different way that could build community resilience and develop the services in the community. Before the pre-consultation business case was approved it needed to be demonstrated how the Community Fit element of the work would be funded. Other areas being reviewed were: general community services including rural MIUs and the DAARTs service in Shrewsbury, Bridgnorth and Oswestry to look at different and more efficient ways of working.

Board Structure – Four Members who were leaving the CCG Governing Body Board. Both Drs Otter and Stanford were retiring and the two Locality Chairs, Kevin Morris and Dr Stuart Wright had reached the end of their tenure. Dr Tim Lyttle, Bridgewater Surgery, Whitchurch had been elected as North Locality Chair and would be starting in that role in July. Dr Shailendra Allen, Broseley Medical Practice had nominated himself for the role of South Locality Chair and an election was due to take place at the next South Locality Board meeting.

Two Locality Board Members from the north had nominated themselves for the election for the CCG Governing Body Board role, were: Kevin Morris, Practice Partner at Cambrian, and Sue Evans, Practice Manager at Plas Ffynnon. Mrs Anne Dray, Interim Director of Corporate Affairs would be writing out to Members inviting them to elect the Board representative. Both Dr Steve James and Dr Povey had extended their tenures on the Board by one year and two years respectively to avoid having the majority of members up for re-election at any one time.

The roles of the Locality Chairs had been changed and would be much more involved in the Clinical Commissioning Committee and driving plans in the CCG and in the localities. They would be working with Locality Managers, locality pharmacists and a locality team to put in place some CCG work and working with practices around new models of care as well.

6. Locality Chair Update

Election of Locality Chair

Mrs Culliss advised two nominations had been received for the role of Locality Chair; one from Dr Deborah Shepherd, locum GP and one from Mr Steve Ellis, Practice Manager at Severn Fields. Members were asked if they had any questions they wished to ask Dr Shepherd and Mr Ellis before they were asked to step out of the meeting room and Members made decided their vote. No further questions were raised.

At this point Dr Shepherd and Mr Ellis stepped out of the meeting room whilst the election took place.

Dr Callahan sought clarification that the post for a commitment of four sessions. Dr Povey confirmed that ideally it would be for four sessions but it would be possible to look at the role covering two sessions, which

would include attendance at the CCG Board, Locality and the CCC meetings but that would leave limited time to engage with the practices. It would therefore be more beneficial if a candidate working two sessions worked alongside a second who could cover the locality work with the Locality Managers.

It was explained that Dr Shepherd and Mr Ellis were available for four sessions and two sessions per week respectively. It was added that Dr Shepherd and Mr Ellis had discussed sharing the role but Dr Shepherd had expressed her wish to work the four sessions and would be stepping down from being the Educational Lead if she was elected as Locality Chair. It was suggested that if the Member offering two sessions per week was elected if would perhaps be preferable to have a clinician to work alongside the Chair to carry out some of the engagement work also.

After briefly running through the rules of the election process, Members were asked if there were any further questions or issues they wished to raise, following which Members present were individually requested to name their practice's preferred candidate. When added to the two proxy votes already received, out of the 12 votes cast, Dr Shepherd received 7 votes and Mr Ellis received 5 votes. Belvidere Medical Practice was not in attendance for this item.

Following the election, Dr Shepherd and Mr Ellis re-joined the meeting.

Members congratulated Dr Shepherd on being elected as Locality Chair. Dr Shepherd expressed her gratitude to those Practice Members who had voted for her looked forward to taking over as Locality Chair from 1st April.

7. Local Digital Roadmap and IT Update

7.1 Local Digital Roadmap (LDR) - Using PowerPoint presentation slides, Dr Steve James, Clinical Director of Information and Enhanced Technologies, gave an update on the LDR and work which had been carried out over the last 18 months, commencing with the national objectives set in 2015 which were: to be paper-free at the point-of-care by 2020; to have digitally-enabled self-care; real-time analytics at the point of care; and whole system intelligence to support population health management and effective commissioning, clinical surveillance and research.

It was explained the LDR process started 3-4 years' ago with a local health economy group, which met every three months to share ideas and a group was developed initially called the Digital Strategy Group, since renamed the Digital Enabling Group. This group had input from Future Fit and had oversight and feedback from the STP. An initial workshop was held in June 2016 where all the parties came together to share ideas and to edit the initial document.

Dr Freeman referred to the point: 'LDR supportive of STP organisational and service transformation' and commented that the work coming from the hospital was as yet undefined in the STP and previous reference to the left shift of work had been unfortunate and misleading. It was considered the STP should be addressing how to avoid future patients attending hospital for conditions that could be better managed in the community if the infrastructure was there for them to do it. It was the extent to which the local digital roadmap could enable some of those schemes to work in a more productive way. Dr James agreed and explained that when the LDR was first produced and refreshed in October 2016 it should have been getting more direction from the STP as to what it wanted from the LDR and the team had tried to align the document to the present STP.

The main providers had been asked to do a digital maturity assessment, primary care came out very favourably as it was already paper-free but Shropshire was below the national average in Technology, Medicines Management and Optimisation and Standards. As a result of the data collation and discussion a vision was developed which was in the first reiteration of the LDR and that was by 2020 to have:-

- An integrated care record across our economy (with a suggestion starting with end of life by March 2018)
- Patients as co-authors of their record. Contributing and interacting with their record, approving access, booking appointments, repeat prescriptions, etc.
- Data Sharing agreements in place right across the system to enable the vision of a paperless NHS at the point of care.
- Universal capabilities significantly delivered by March 2018 – (ten measures and it is the belief the CCG will be performance-managed – certainly NHSE was looking for these to be delivered largely by March 2018)
- Tele Health at scale 2016-2020.
- Collaboration locally and regionally – standards, infrastructure, procurements, large projects like big data population health analytics.

Dr Freeman pointed out that one of the big challenges was that the technology did not deliver anything, it required people to do things. Dr James pointed out that the last signed data sharing agreement was with A&E and the Urgent Care Centre which was not really used. A conversation ensued which discussed data sharing agreements and accessing records. It was pointed out that part of issue was that the output of clinical records was not standardised and it would be difficult to find a solution that would encompass the different formats

used. Dr James advised data collaboration had come out as one of the priorities from the clinical and professional workshop.

Mrs Baker asked what the patients felt about the data sharing agreement with information being shared with parties they did not know. Mrs Birch referred to a discussion at the SPG meeting the previous day when it had been raised that the information regarding Ophthalmology referrals had been passed to an outside organisation in Berkshire. Mrs Birch was advised the ophthalmic work had been outsourced to *The Practice*, whose head office was located in Berkshire. Mrs Birch highlighted that patients had not been happy their personal data had been shared with an outside organisation and it was very variable how patients wished their data to be shared.

Dr Freeman explained when carrying out complex risk stratification where patients' data are merged from different sources, the patient could opt out of different levels according to whether the data is to be shared for clinical purposes or for risk stratification but this would require explaining to patients.

The STP guidance published in February 2016 stated that, in developing STP content and ensuring delivery of transformation, local health and care systems should harness the opportunities that digital technology offers. The best plans would be coherent across all elements, including 'digital'. STPs were expected to have a 'golden thread' of digital technology running through the ambitions and plans for transformation and sustainability. The development of a LDR was a clear opportunity for local communities to articulate how they would harness technology to accelerate change.

There was a new Programme Director for the STP, Phil Evans and it was hoped to agree delegated authority of the DEG in order to continue with this work. Champions were sought to lead on this work and there was a national suggestion there should be CCIO (Chief Clinical Information Officers) in each organisation. Next steps included agreement around delivery and funding for individual projects. Dr James confirmed the GP system of choice still operated at a practice level.

Mrs Birch raised that the Nuffield Hospital did not appear in the list of organisations and pointed out there was a problem in transferring care from one organisation to another. Dr James said this could certainly be looked into but the clinicians tended to work in the local system.

Dr Pepper further raised there was currently an issue with patients who have been seen privately and then wished to continue their care in the NHS and not infrequently there is a point of which problems come up being seen in the right clinic by the right person after the initial consultation. Dr James acknowledged this issue and the CCG would bear this in mind.

Dr McCormack referred to a scheme operating in the South East called 'The Patient Knows Best', which was a solution for patients owning their own records. Dr James said this was certainly one model that could be used for a more extensive electronic health record and would solve a lot of the issues around data sharing as it is owned by the patient who gives access to it. However, general feedback from patients was that they would not wish to own the whole record but to have access to it and knowledge of who else had access.

Action: Dr James to note feedback following discussion and take back to the DEG.

7.2 Web based consultations – Members were reminded about the funding that was available in April for web based consultations and there were two basic alternatives: (1) 'Ask My GP' and (2) the EMIS-based system 'Web GP' or 'E-Consult'. Both systems were similar and based on triaging people using algorithms away from the surgery. A summary highlighting the differences between the two systems was tabled.

A letter would be forwarded to practices, which would also include the presentations from the IT Forum and links to web-based demos. Practices would be asked for expressions of interest. A number of views were put forward questioning whether these systems would save time. Dr James explained he was not advocating this was a solution but it was a national initiative that was available for practices and encouraged Members to consider and there was some evidence that it might reduce GP workload. There were some practices across the county who had already expressed an interest and were waiting for the service to be rolled out.

Mrs Birch suggested it would be useful if the system could be restricted to simple questions. Dr James agreed that it would be helpful to take this to the PPG groups for further discussion and feedback. It would certainly appeal to the younger generations and more IT-friendly users. Ms Beason commented that when the system was considered previously there had been concern that some patients would learn the appropriate answers that was required to access a consultation.

Action: Practices were asked to consider take-up of the web based consultations systems and respond to the communication that was to be circulated.

7.3 Data Sharing Agreements

A communication would be forwarded to practices to consider signing up to three data sharing agreements:

1) The POD for repeat prescriptions - access would be required to EMIS for the patients' prescriptions but just that area and so the data sharing agreement would be sharing for that specific purpose.

2) The MOT's pharmacists and technicians already have agreements with practices when accessing patients they see on behalf of the practices but request a data sharing agreement for them to be able to do that remotely as well as in the practice to enable medication reviews. This would also add to potentially more work for the POD moving forward and would require access to most of the record but would be for pharmacists and pharmacy technicians only.

3) Primary care data for risk stratification tool, which would be pseudonymised but the practice viewing it would see the patient identifiers. Previously there had been an extract available through Graphnet but was not used and the CCG was requesting to be able to extract primary care information to go into a risk stratification tool.

Action: Mrs Stackhouse to circulate Dr James' PowerPoint slides for information for Members.

8. Community Services Review

Mr Tony Menzies, Interim Project Manager, attended to give a brief overview for Members about the Shropshire Community Services Review (CSR) outlining the background and strategic context. The declared primary goal of Shropshire CCG is to improve the long term health of the population. This needed to be achieved in the context of Shropshire's ageing population, rurality, associated access issues and a recurrent overspend of £20m per year.

It was explained that the local health economy would focus its efforts to develop place-based care, increased community care and greater integration/working with partners. The scope of the review would cover the following areas county-wide: community beds; Diagnostic, Assessment & Access to Rehabilitation (DAART) Centres; and Minor Injury Units (MIUs). It would be a clinically led review by two GP board members, Dr Jessica Sokolov and Dr Finola Lynch and the governance would be via a programme board that would be chaired by joint clinical leads and would include representatives from SCHT, SaTH, the local authority, the CCG and patients and carers groups. The remit of this group was to put forward recommendations and any commissioning decisions would be made by Shropshire CCG Governing Body.

A sub group of the Programme Board would be a Clinical Reference Group, which would score potential options and identify a preferred option; and ensure clinical leadership supporting the clinical redesign of services across organisations to meet the needs of the local population. Members of this group would comprise clinical leads, two GPs from each locality, and SCHT and SaTH clinicians. The process was explained and a detailed delivery plan, including an engagement and communication plan, was currently being developed.

It was anticipated the timelines for the completion of this work were: MIUs expected during the summer; DAARTs early autumn and the beds work approx. late autumn/winter. This would depend on a number of factors including how quickly information was received from SCHT who were working closely with the CCG. An email from Drs Sokolov and Lynch had been circulated to practices seeking support from the localities requesting two GP volunteers from each locality to become involved. The Clinical Reference Group was due to meet on 30th March.

Dr Fallon enquired as to cost of these reviews and Mr Menzies replied that the Team was still developing the budget and communication costs. Dr Povey explained the costs were included in the CCG's programme work so it was difficult to work out the exact cost but as an example the review carried out by Optimity would cost in the region of £20K but the review of the Future Fit process would be higher.

When asked by Mr Brown if the email had been forwarded to any patient representatives, Mr Menzies confirmed the CCG was working with them. The first stage would involve just the clinicians but the patient representatives would be invited for the second stage when choosing the options. Patient representatives were also included on the Programme Board.

Dr Sokolov made a further point that the CCG was not to institute a system of delivering care without refreshing services. The demographics were expected to change and systems needed to be constantly reviewed and although reviews such as the Optimity Review was external and an additional cost, this was normal CCG work. Although there was a feeling there appeared to be a lot of reviews being carried out it was necessary work. The CCG needed to ensure that it was getting value for money from the services it was commissioning and if there were issues that were creating pressure within the system and potentially jeopardising the care of patients, it was the CCG's responsibility to change the system.

Dr Fallon pointed out there appeared to be a huge increase in the CCG's deficit position from 18 months' ago and a large amount of money was unaccounted for. Dr Povey reassured Members the CCG's overspend of

£26m had been spent on patient care and had not been misused. Mrs Dray said a communication would be forwarded confirming the running costs.

Action: Practices to consider the request for two GP volunteers to assist with the CSR.

Mrs Stackhouse to circulate Mr Menzies' PowerPoint slides for information for Members.

Dr Povey/Mrs Dray to forward a note to Members confirming running costs per head.

9. Prescribing Update

Mr Sean Mackey, Interim Head of Medicines Management – Primary Care attended to give an update on the Medicines Optimisation Scheme covering the following:

Cost Effective Prescribing Framework A communication would be sent out to practices in the next two weeks but the incentive was going to be different this year and a summary was given as follows:

- £273K upfront payment under SLA with 50% available from April and a further 50% in May based on successful submission of an action plan on how practices are going to reduce expenditure over the next 12 months.
- Confirmed Individual Practice Prescribing budgets, the process of which is going to be approved at the Formulary Committee on Monday.
- A further payment of up to £2 per patient if the CCG underspends the Prescribing budget overall and individual practices underspend their budgets.
- Monthly monitoring of prescribing data and QIPP indicators.
- Locality lead pharmacist supervision, underneath the pharmacists will be technicians who will be around to do the switch work and audit work in order to save money to support you.
- Additional to the £273K there is potential £600K investment (only paid out if sufficient underspend) for the whole PQOS.

Prescription Ordering Direct (POD) scheme: The CCG was looking to recruit three practices in the first quarter, seven in the second, fourteen in the third. By the end of the year it was hoped to have approx 21 practices operating through the POD:

- Call centre approach to managing patient requests for repeat medications.
- Managed repeats not allowed through community pharmacy.
- Based upon the Coventry CCG model as highlighted in the HSJ.
- Reduction of 8-12% prescription volume in Coventry based upon 30 practices.
- Telford CCG started same in November 2016.
- Conservative estimate of £1m savings for the first year of POD in Shropshire.

If practices wished to express an interest in the first tranche of the above scheme, they were asked to contact Mr Mackey on: smackey@nhs.net During a short question and answer discussion the following points were made and confirmed:

Mr Mackey confirmed the scheme did require electronic prescription services and remote access. The call centre was going to be based at WFH. A meeting had been arranged with the dispensing practices from the south locality to discuss how they could be involved and also in pilots around the Electronic Prescription Service (EPS) also.

Dr Fallon referred to the mention of controlled drugs not being dispensed via the EPS. Mr Mackey confirmed there would be some exceptions in drugs such as Warfarin that would not be encouraged through this scheme but those practices that expressed interest, if decided to go ahead, the detail would be discussed of how that would work and SLA arrangements and what that included.

If the community pharmacists provided Medication Administration Record (MAR) sheets to a care home, that could still go ahead but they could not order on behalf of the home. Part of the process of setting up the POD would be to communicate with all the community pharmacists in the area to say they no longer could do managed repeat prescriptions; these needed to come direct through the practice or through the POD. There would be two nursing home pilots who would be asked to come direct through MOT. A technician and clinical pharmacist would be available 9am-5pm Monday to Friday so the training would be on the medication and not clinical queries at this stage. The Scriptswitch would not be functioning at the POD. The funding was recurrent so if a practice employed a member of staff as a pharmacist the money could be used to make up the shortfall. Regarding the actual allocation of budgets to practices, Mr Mackey was hoping to discuss with as many practices as possible.

Care Homes medicines Optimisation service:

- Service to cover the 130 Care Homes.
- Training.

- Clinical patient reviews.
- Link to POD.
- Wastage reductions.
- See patient within 48 hours of admission to/discharge from Care home, which is led by Ceri Wright? Our technician.
- Savings of £675K.

Prescribing policies:

- Common medicines for minor ailments: Paracetamol; Hayfever preps for >18 years, etc. A list of products that the CCG would prefer not for GPs to prescribe anymore will be circulated to practices.
- Oral Nutritional supplements – Care Homes refer to Dietician; MUST scores and "Think food" for 1 month. From 1st May if a care home ask the GP for a sip feed and they have done the MUST scores and the "Think food" for 1 month – you can refer them to the Medicines Optimisation Team dietician – Liz and her other dieticians she is bring in and they will determine whether it is appropriate that patient has a sip feed.
- Review of Area Prescribing Committee and Board agreement on managing non-adherence to recommendations.
- Scriptswitch.
- Hospital drug pathway reviews.
- Bluteq.
- Hospice contract review.

Possibilities:

- Wound product DN basis. A pilot – ultimately we are going to move wound care away from you having to prescribe. With stoma items as well but with wound care initially. District Nurses are going to have stock at their bases and they are going to supply from that stock. What we have seen locally and nationally is that we can save approx 20% in wastage in the cost of the products but also it means the workload in practices is reduced. DNs love it because they are not hanging on waiting for prescriptions to be generated from a practice as well.
- New Stoma contract.

The Medicines Optimisation Team (MOT) would do their best to support practices the best way they could. Dr McCormack suggested, if there was a potential £400k savings to be made on sip feeds, was it worth having a dedicated person to work on this area. Mr Mackey agreed and advised that funding had been secured to employ Ms Bainbridge for a further year and also to recruit another dietician who would be able to take all those referrals from care homes for sip feeds, however they were not prescribers. As from 1st May if a care home asks for a sip feed that has not followed the process through Ms Bainbridge then this would be referred back to the dietician. If a GP starts a patient themselves then they must ensure a 'must score' has been done to ensure it is appropriate, and if so, they have done one month of the Think Food options then to consider prescribing a sip feed. Ms Bainbridge was also working with the hospital on this process also.

Dr Pepper pointed out that GPs had been asking for the district nurses to carry the dressings stocks for a number of years and the Medicines Optimisation Team was to be congratulated for progressing this work. Mr Mackey advised that it would be initially be one base with a view to eventually moving to all nine bases. There was not a lead pharmacist as yet for the locality but Mr Mackey explained now that a Director of Primary Care had been appointed plans could be made to go out to advert and Members would be informed as soon as possible a pharmacist was in place. If practices would like to join the scheme or have any further queries they were requested to contact Mr Mackey by email to: smackey@nhs.net

Action: Members requested to contact Mr Mackey if practices would like to join the scheme or have any further queries/concerns to: smackey@nhs.net

Mrs Stackhouse to circulate Mr Mackey's PowerPoint slides for information for Members.

10. PPG Update & Feedback

Mrs Birch, patient representative reported a Shropshire Patients' Group (SPG) meeting had been held the day before at which patients discussed a long list of areas of work patients were involved in. Mr Brown referred back also to the previous meeting, which Dr Simon Freeman had attended, which had been considered beneficial for both the SPG and Dr Freeman as it was thought it was his first contact with patients, listening to their stories as well as what was happening within the group.

Mrs Birch reported she was pleased that the Fracture Liaison Service was now included on local agendas. This was a service, which the National Osteoporosis Service (NOS) have been advocating for some time and was also supported by NICE, the Orthopaedic Society, and the National Osteoporosis Society. Mrs Birch gave a brief outline of the service which is offered for anyone who goes into hospital with a fracture are assessed to see whether they have osteoporosis and if they do or are at risk to have osteoporosis then treatment is started and the best services are those which follow up the patients to make sure they are taking the medication, taking

it correctly and then reassessed. NOS had estimated that it would save just under £4m and would reduce hip fractures by half. Mrs Birch advised that Will Carr, Service Development Project Manager of NOS would be very happy to answer any queries, email: w.carr@nos.org.uk

Dr Povey commented that there had been a lot of work around this already and through the GP contract one of the areas was osteoporosis which encouraged screening people. The council was responsible for falls prevention and the CCG had appointed a project worker Samina Arshad for frailty, fractures, falls who was doing some scoping work of the current system. A frailty pathway was also included in the neighbourhood work.

11. Key Messages for CCG Board & Locality Assurance Framework

The Locality Assurance Framework (LAF) spread sheet, used to log and track queries and issues of concern from the localities, had been updated and distributed to Members. Members confirmed there were no further issues to be noted.

12. Any other business

12.1 Locality Managers

Ms Brown enquired about the appointment of the Locality Managers following the interviews that had been recently held. Ms Brown had taken part in the interview panel and was disappointed the chosen applicants had not been appointed so far. Dr Povey explained there had been a query regarding the process and was hopeful the applications would be re-shortlisted very soon. As to the timeframe Ms Brown was advised to contact June Telford, Head of Primary Care who would be able to advise of the interview dates.

12.2 DMARDs

Dr Pepper raised the initiation of DMARDs and referred to a letter sent approximately May 2016 explaining that the CCG was looking to commission a service whereby secondary care initiated DMARDs and would then transfer patients once they had stabilised. This had not happened so far with Belvidere patients and it was understood some practices were able to refer to Oswestry and others were not.

Dr Povey explained the business case had been sent back to RJAH for the costings to be reviewed. The scheme was what RJAH had designed and they would initiate, stabilise and transfer patients back. There was a question about what did stabilisation mean and around the costing of the service, which if it was going to require extra funding a QIPP would need to be developed to pay for the DMARDs. This work was on-going.

Dr Pepper queried the timescale because Belvidere had been at the point of returning the letters because it was considered there was a patient safety and resource issue. Dr Povey confirmed the scheme was originally approved in March and RJAH had been actively working with the CCG to develop this work. It was agreed this information was useful and was suggested that an update on such areas would be helpful to practices.

12.3 Shared Formulary

Dr McCormack highlighted the acute trust appeared to be taking unilateral decisions in initiating patients on very expensive medications and discharging them on those drugs. Two examples of drugs were quoted, including bisphosphonate sodium clodronate, which it was said there was limited evidence in helping with prevention of secondary breast cancer and had not been approved by NICE.

Mr Mackey explained that in other areas, such as Manchester, Leeds, there were collaborative working arrangements where the consultant would approach the Drugs and Therapeutic Committee (D&T) to say they would like to prescribe sodium clodronate to patients. If approved at D&T this would then go to the Area Prescribing Committee (APC) to approve and would then remain as a red drug in secondary care. The current process in Shropshire was different in that the consultant would write to the GP who decides whether they prescribed it or not or the request is dealt with via an Individual Funding Request (IFR). It was considered it would be a much better process to follow a functioning APC and traffic light formulary where there was a shared formulary and it was hoped to move to that model by early summer.

12.4 GP Workforce Development Workshop

As a reminder and for information, June Telford, Interim Head of Primary, had requested to table a copy of an invitation letter received from the Community Education Provider Network to attend a GP Workforce Development Workshop that had been forwarded to Practice Managers already. This event was to be held on 6 April at Shrewsbury Town Football Ground commencing at 12.30pm with light lunch provided.

Action: Members were asked to consider attending the GP Workforce Development Workshop on 6 April as detailed in the information circulated.

13. Date and Time of Next Meeting

Locality Boards had been requested to meet monthly from the beginning of the financial year, which was to include pre-scheduled formal meetings, PLT sessions and the joint extraordinary localities board meeting. It was agreed the next formal meeting would be held on: **Thursday 18 May 2017** at the **Severn Fields Health Village, Sundorne Road, Shrewsbury, SY1 4RQ** commencing at **2.00pm.**

Future Meeting Dates

All Thursday afternoons, 2.00pm start at Severn Fields Health Village, Sundorne Road, Shrewsbury

Thursday 8 June
Thursday 20 July
Thursday 21 September
Wednesday 27 September
Thursday 19 October
Thursday 16 November
Thursday 18 January 2018
*Dates in blue indicate PLT sessions

Signed: ..... **Date:** .....

Shrewsbury & Atcham Locality Board Meeting – 16 March 2017

Action Table

Minute No.	Action Required	By Whom	By When
2. Declarations of Interests	Members requested to complete any outstanding Declaration of Interests forms and return to Mrs Stackhouse as soon as possible.	ALL	As soon as possible
7.1 Local Digital Roadmap and **7.2 Web based consultations**	To note feedback following discussion and take back to the DEG. To consider take-up of the web based consultations systems and respond to the communication that was to be circulated.	Dr James ALL	26 April DEG mtg As soon as possible
8. Community Services Review	Members to consider the request for two GP volunteers to assist with the CSR. To circulate Mr Menzies' PowerPoint slides for information for Members. To forward a note to Members confirming running costs per head.	ALL Mrs Stackhouse Mrs Dray	As soon as possible As soon as possible As soon as possible
9. Prescribing Update	Members were requested to contact Mr Mackey if practices would like to join the scheme or have any further queries/concerns to: smackey@nhs.net To circulate Mr Mackey's PowerPoint slides for information for Members.	ALL Mrs Stackhouse	On-going As soon as possible
12.4 GP Workforce Development Workshop	Members were asked to consider attending the GP Workforce Development Workshop on 6 April as detailed in the information circulated.	ALL	6 April

NHS
Shropshire
Clinical Commissioning Group

Agenda item: GB-2017-06.126
Shropshire CCG Governing Body meeting: 7 June 2017

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 GBAF risks

Key issues or points to note:

The GBAF was previously presented at the Governing Body meeting on 10 May 2017.

Since that meeting the Quality Committee has met and reviewed its items on the GBAF. As a result, updates have been made to item 2 – Quality and Safety. The risk score associated with this item has been increased in relation to a number of issues currently being addressed across the system. Mitigating actions have been updated and further detail has been presented to the Board via the Quality Report.

Actions required by Governing Body Members:

Review the risks contained within the GBAF, with particular note of the amendments and increa risk score associated with risk 2 – Quality and Safety

Does this report and its recommendations have implications and impact with regard to the following:		
A: CCG Aims and Objectives (please provide details where applicable)		**Yes/ No**
1	Objective 1 - Deliver a continually improving Healthcare and Patient Experience *please provide details relating to objective 1*	
2	Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation) *please provide details relating to objective 2*	
3	Objective 3 - Achieve Financial sustainability for future investment This report provides assurance to the Governing Body that the risks to delivery of the CCG's strategic aims and operational targets are being managed	Yes
4	Objective 4 - Visible leadership of the local health economy through behaviour and action *please provide details relating to objective 4*	
5	Objective 5 - Grow the leaders for tomorrow (Business Continuity) *please provide details relating to objective 5*	
B: Governance (please provide details where applicable)		**Yes/ No**
1	Does this report: • Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number) • Have any legal implications? • Promote effective governance practice This report provides assurance to the Committee and the Governing Body that the risks included in the GBAF are being managed	Yes
2	Additional staffing or financial resource implications *If yes, please provide details of additional resources required*	
3	Health inequalities *If yes, please provide details of the effect upon health inequalities*	
4	Human Rights, equality and diversity requirements *If yes, please provide details of the effect upon these requirements*	
5	Clinical engagement *If yes, please provide details of the clinical engagement*	
6	Patient and public engagement *If yes, please provide details of the patient and public engagement*	

Governing Body Assurance Framework Version 17.2
updates since Governing Body 10 May 2017 shown in red
Appendix I

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)**										
68/16	AN **Previous risk CCG 62/16 Revised April 16**	Key Principle 3	**1 Finance** There is a risk that the CCG fails to achieve its planned control total for 17/18 specifically: QIPP delivery Contract performance and delivery	NHSE Meetings with P.Watson every 4 weeks Development of a plan for 17/18 Comprehensive QIPP Programme in place PMO in place and review of QIPP process and focus on delivery in F&P Committee *Constitution, Standing Orders,* Prime Financial Policies *and Scheme of Reservation and Delegation* AO and CFO to sign all expenditure, Freeze on all discretionary expenditure Monthly sign off of budget reports by budget holders and GB Contract reports to F+P Committee and Governing Body of contracts activity and finance -ytd and fot Business Case challenge/due diligence on schemes and ROI Directors and Budget Holders have signed off budgets for 17/18 (March 2017) Deep DIve at Finance and Performance Committee of 17/18 budgets Monthly QIPP Group meeting and regular reporting to Finance and Performance Committee and Executive Team (wef 1.4.17) Finance and Perfomance Committee of QIPP Programme (April 2017) Review of Disinvestment Process	**Lead Committee - Finance and Performance Committee** Regular reporting of Finance, Contracting and Performance position to Finance and Performance Committee and Governing Body Signed Contracts/Budgets for 17/18 Effective Contract challenge process operating - Acute Completion of internal audit recommendations from 2015/16 and 16/17 and outstanding audit actions reviewed at Audit Committee. Additional capacity sourced in Finance and Commissioning Action Trackers for Contract Management Meetings with Providers QIPP Group meets monthly with regular reports to Finance and Performance Committee in Governing Body Finance Reports. Assurance gained through improving internal audit reports.	**Gaps in controls:** PMO in early establishment phase **Gaps in Assurances:**	Extreme Likelihood 5 x Impact 5 = 25	PMO process continued embedding. Out to advert for substantive positions. (DH) 1.6.17 Permanent Finance Staff roles are out to advert (DH) 1.6.17 Continue to improve the levels of CCG assurance through internal and external audit reports. (DH) 31.7.17	Extreme Likelihood 5 x Impact 5 = 25	Deborah Hayman	3.5.17
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 Health Watch CQC QSG Joint Commissioning Serious Incident Panel in place Planned review of Quality, Patient Safety and Experience Structure, systems & process and assurance	**Lead Committee - Quality Committee** CQRM meetings with providers which feed into the Quality Committee. Minutes of QC meeting and Chairs report presented monthly to Governing body Joint Commissioning Serious Incident Panel reports to Quality Committee Planned review of Quality, Patient Safety and Experience Structure, systems & process and assurance	**Gaps in Controls:** Reporting to the Quality Committee requires a review on level of detail provided to provide correct level of assurance to the governing body Limited assurance on CCG Quality, Patient Safety and Experience Structure, systems & process and assurance	Possible x Major = High 16	a review on level of detail provided to Quality Committee to provide correct level of assurance to the governing body to be undertaken. Exception reporting and escalation in terms of level of assurance to Governing Body currently being reviewed by Quality Committee and will include invitation to Shropshire Healthwatch to attend future Quality Committee meetings. (LI) 31.3.17 BB reviewing the requirements of the Quality Committee with the Chair April 17. Also subject to confirmation with the execuitve team and AO to undertake a comprehensive root and branch review of the quality, patient safety and experience team, systems, processes, roles, responsibiliities and accountability to ensure fit for purpose as currently in the NHS IAF Dashboard lowest performing quartile under the better care category. For update at Governing body private board May 17. Also ensure correct fit with contracting, delivery and performance. WMQRS Commissioned to undertake the review. Planning meeting 13/6/17. Review day 4/7/17. GP Governing Body member and Contracting and Delivery teams (CCG) involved in the review along with the chair of the Quality Committee. T&W CCG involved in SI review process Healthwatch involvement confirmed as a) seat on NHSE Quality Surveillance Group b) seat at Governing Body Public Meeting c) monthly one to ones with Director of Nursing and Quality'	Possible x Moderate = High 12	Barbara Beal	19.4.17

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
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	A+E Delivery Board in place Planned Care Working Group for Cancer and Referral to Treatment Times (RTT) in place	**Lead Committee - Finance and Performance Committee** A&E Rapid Improvement Plan agreed with NHS England and progress reported monthly Contract and quality monitoring data Provider Contract meetings (including RAP monitoring) CQRM meetings Reporting to Finance and Performance Committee and to Governing Body	**Gaps in controls:** A&E Delivery Board's effectiveness of managing A&E Rapid Improvement plan. Lack of UCWG to oversee detailed delivery of individual improvement projects. **Gaps in Assurances:**	Likely x Major = Extreme 16	A&E Delivery Board has agreed to appoint a Director of Urgent Care (interviews 8.5.17) and Project manager capacity to support delivery across the system - (System AO's) . The Director will embed a PMO approach into A+E recovery and ensure detailed delivery of individual improvement projects. Contract performance notice has been issued for RTT requesting a comprehensive action plan to be submitted to the CCG by 12 May	Possible x Moderate = High 9	Julie Davies	3.5.17
74/16	AS 20/09/16 NEW	Key principle 1, 3 and 4	**4. Transformation** **T**here 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.	Strategic Transformation Plan (STP) Board and workstreams developed across acute (Future Fit) and *2 neighbourhood working areas* SRO leads and support staff identified for workstream delivery Future Fit Programme Board - Board includes all providers. *Transformation Dashboard in place* *STP update standard item on CCC agenda*	**Lead Committee - Clinical Commissioning Committee** Standing reporting item on Governing body agenda on development of STP Plan. Submitted first draft of STP to NHS England 30/06/16 - feedback received for further refinement for September 2016. Revised draft submitted 31.1.17	**Gaps in Controls:** The CCG recovery plan remains to be fully developed although strong progress is being made with NHS England CCG is not represented in the governance structure of the STP and this needs addressing STP plan does not reflect Shropshire financial position and this is being worked on Shropshire Neighbourhoods plan needs significant revision if it is to meet Shropshire needs **Gaps in Assurances:** Reporting of implementation of STP to Governing Body yet to be determined	Almost certain x Major - Extreme 20	STP governance structure to be discussed at June Partnership Board (SF) 30.6.17 STP to reflect Shropshire position.SNF to present to June Partnership Board (SF) 30.6.17 Review of Neighbourhoods commissioned and complete - revised governance to be in place by end of May 2017.(SF) 31.5.17 Transformation dashboard to be developed (TBC) STP to be put as standard item on CCC agenda (complete May 17)	Possible x Major = High 12	Simon Freeman	3.5.17
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 Comms and Engagement plans for significant pieces of work in a standard format CCG shared team supplemented with CSU support Staff newsletter GP newsletter Patient Advisory Group (PAG) in place (advisory committee replacing PPECC) 3 Locality Committees and Chairs are Governing Body (GB) Members enabling a clear *communications conduit between the membership and GB* Appointment of Governing Body GP with a lead for communications and engagement with the membership	**Lead Committee - Clinical Commissioning** 360 Stakeholder survey feedback Equality Delivery System2 reporting Feedback from Shropshire Healthwatch via formal reporting and feedback into Governing body via Healthwatch observer.	**Gaps in controls:** Improve communications to staff and member practices Communication and Engagement arrangements for all QIPP schemes **Gaps in Assurances**:	Likely x Major = Extreme 16	Review and implement Communications and Engagement Plan (ST) 30.6.17. Communication and Engagement arrangements for all major 2017/18 QIPP schemes to be in place using standard template to include Communications and engagement, EQIA,EIA and PIA . QIPP plans to include CCG staffing implications(QIPP Leads). 31.3.17. Comms and engagement plans in place for a number of QIPP schemes @ 30.4.17 and process of review by PAG instigated.	Possible x Major = High 9	Sam Tilley	3.5.17
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* *Clear and structured OD plan for the organisation* Executive team prioritising key workstreams. Sickness absence information to Executive Team *Statutory and Mandatory Training targets achieved* Staff newsletter *OD Plan in place*	**Lead Committee - All** Staff feedback via staff OD group Line management 1:1 with staff Training reports reviewed by Directors *Organisational Culture* Staff Survey results Staff briefings AO meeting with small groups of staff on a regular basis following feedback from staff identified identified the need for informal executive drop in sessions Reviewed sickness/absence and implementing planned interventions with support from human resources	**Gaps in controls:** Prioritised Restructure Plan to allow staff resources to be targeted Clear and structured OD plan for the organisation Statutory and Mandatory Training targets not achieved **Gaps in assurances:** Key workforce KPIs not reported to Board Key workforce KPIS not accurately recorded and stored centrally Staff survey not recently undertaken	Likely x Major = Extreme 16	Restructure Plan to be developed to firstly stabilise the organisation and then develop a permanent structure (DH) 30.4.17 OD Plan to be revised to meet the needs of the new permanent structure and role of the organisation.(ST and Organisational Development Delivery Group) Undertake OD diagnostic review and plan interventions across all levels of the organisation 30.5.17 New Statutory and Mandatory Training System to be implemented (ST) 31.5.17 Staff survey needs to be completed and actions taken forward for areas of deficit (ST) Autumn 2017 Staff absence information and statutory and mandatory training achievement needs to be reported to Governing Body and monitored by line managers and Executive team on a regular basis (AD). First quarterly report to ET Feb 17. OD Group re-established	Possible x Major = High 9	Sam Tilley	3.5.17

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
77/16	AS 20/09/16 NEW	Key principle 1,2,3 and 5	**7. of Provider Workforce** There is a risk that providers ability to deliver services and remain financially viable is not sustainable.	Primary care: Prime Ministers Challenge Fund project work on creating a sustainable workforce locally. *Primary Care 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 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** Primary Care: Individual GP practice visits Reporting to PCC and Governing Body. PCWG reporting into PCC *GPFV workforce section assured by NHSE* *Primary Care workforce survey completed* Secondary Care: 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	**Gaps in controls:** Up to date Primary Care Strategy Full analysis of Acute Trusts position and options for business continuity long term workforce planning via Future Fit and STP workforce workstream Gap in Primary Care leadership at governing body Gaps in assurances: GPFV Workforce section assured by NHSE Primary Care workforce survey results into PCC Formal sight of the provider Business Continuity plan and risk assessment LWAB reporting into Quality Committee Reporting of Primary Care development and performance requiring development as per internal audit report	Like x catastrophic = Extreme 20	Primary Care Strategy development now incorporating GPFV priorities and will incorporate outcomes from: a)Primary Care Needs Assessment and b)Primary Care workforce survey . There will be an update on the workforce survey undertaken by the new Locality Managers by 31 August. Primary Care Working Group overseeing implementation Plan. Final Strategy due 31.8.17 (JT) New Executive Structure to address gap in Primary Care leadership approved at Governing Body December 2016. Substantive Director of Primary Care commencing end May 2017 Review to be undertaken of assurance process including LWAB to underpin STP (BB) Internal audit recommendations to be delivered (JT)	Possible x Major = High 12	Barbara Beal	3.5.17
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'	Financial performance challenges Addressed above. Leadership challenges Substantive AO in place, *Interim Directors in place* Clinical Chair in place *Governing Body has full complement of GP representatives* Key principles in place to support delivery of CCG objectives *Organisational development plan across all levels in the organisation* Patient Advisory Group in place	**Lead Committee - Governing Body** Financial performance challenges - addressed above. Monitoring delivery of key objectives Organisational culture Staff survey results Staff Briefings / Newsletters GP Newsletters Membership Locality meetings 360 degree stakeholder survey	**Gaps in controls:** Clear organisational development plan across all levels in the organisation **Gaps in assurances:** programme of proactive engagement with public and membership	Like x catastrophic = Extreme 20	Undertake OD diagnostic review and plan interventions across all levels of the organisation (ST) (31.5.17) Staff survey in planning phase April 2017. undertake 360 degree survey. Survey closed 28.3.17. Final report due to Public Governing Body July 2017(ST) 3 Locality Managers recruited May 2017 Development of proactive engagement timetable with public via face to face, digital and traditional media (MJ/KH) April 2017. Plans developed for some QIPP schemes. Further roll out on hold during Purdah.	Possible x Major = High 9	Sam Tilley	3.5.17
71/16	Accountable Officer	Key principle 1,2,3,4 and 5	**9. Directions** There is a risk that the CCG will fail to achieve revocation of NHS England Directions within an agreed time frame.		**Lead Committee - Governing Body** Refer to assurances in risk CCG 68/16 Agreed actions completed as evidenced by action notes Up to date Constitution and Committee TOR and regular meetings and recordings of discussions and decisions Periodic reporting to Governing Body on Capacity and Capability Plan progress.	**Gaps in controls:** Absence of a robust organisational development plan to improve organisational culture and delivery **Gaps in Assurances:** Review of governance arrangements/statutory groups undertaken and constitution amended however further revisions to take place.	Likely x major = High 16	2016-17 control total achieved. Undertake OD diagnostic review and plan interventions across all levels of the organisation (ST) PWC Capability and Capacity Plan complete Constitution reviewed March 2017 and Committee Terms of Reference reviews in progress. Further review of constitution, Governing Body Committees and scheme of delegation/reservation taking place (AD) 31.5.17.	Possible x Major = High 9	Simon Freeman	3.5.17
78/16	GB 8.2.17	Key Principles 1, 3	**10. 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	STP Programme Board in place *Neighbourhood Plans in Place* Approved Better Care Fund Plan	**Lead Committee - Clinical Commissioning Committee** Sustainability and Transformation Plan approved by NHS England Health and Wellbeing Board	**Gaps in controls:** Neighbourhood Plans in place **Gaps in Assurances**: STP approval by NHSE	Almost certain x Major - Extreme 20	Review of Neighbourhoods complete	Possible x Major = High 9	Simon Freeman	3.5.17

Note Items in the Key Controls and Source of Assurance columns which are underlined and in italics relate to items which should be in place to achieve control or assurance but are either missing or are not as robust as needed. They will be resolved when the actions included in the action column are complete.
Items in red are amendments from the version presented to the April 2017 Governing Body and which have been amended as a result of discussions at Governing Body Committees or lead officer updates

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