# 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.

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<tr>
<th>Meeting Title</th>
<th>Governing Body Meeting</th>
<th>Date</th>
<th>Wednesday 16 August 2017</th>
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<tr>
<td>Chair</td>
<td>Dr Julian Povey</td>
<td>Time</td>
<td>1.00pm</td>
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<tr>
<td>Minute Taker</td>
<td>Sandra Stackhouse</td>
<td>Venue / Location</td>
<td>The Sovereign Suite, Shrewsbury Town Football Club, Oteley Road, Shrewsbury, SY2 6ST</td>
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**RESOLVE:** A private Governing Body meeting will precede this where it will be resolved that representatives of the press and other members of the public be excluded having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960).

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<td>GB-2017-08.156</td>
<td>Apologies</td>
<td>Julian Povey</td>
<td>1.00</td>
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<td></td>
<td>Ed Rysdale, Claire Skidmore, Jessica Sokolov, Finola Lynch</td>
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<td>GB-2017-08.157</td>
<td>Members' Declaration of Interests</td>
<td>Julian Povey</td>
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<td>GB-2017-08.158</td>
<td>Introductory Comments from the Chair</td>
<td>Julian Povey</td>
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<td>GB-2017-08.159</td>
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<td>Julian Povey</td>
<td>1.05</td>
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<tr>
<td>GB-2017-08.160</td>
<td>Matters Arising</td>
<td>Julian Povey</td>
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<td>GB-2017-08.161</td>
<td>Clinical and Financial Sustainability</td>
<td>Ilse Newsome</td>
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<td>Progress Report on Quality, Innovation, Productivity &amp; Prevention (QIPP) schemes</td>
<td>Michael Whitworth/ Nina White</td>
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<td>GB-2017-08.162</td>
<td>Musculoskeletal (MSK) update</td>
<td>Michael Whitworth/ Nina White</td>
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<tr>
<td>GB-2017-08.163</td>
<td>Shropshire Out of Hospital Care</td>
<td>Nicky Wilde</td>
<td>1.40</td>
<td>to follow</td>
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<tr>
<td>GB-2017-08.164</td>
<td>GP Five Year Forward View</td>
<td>Nicky Wilde</td>
<td>1.50</td>
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<td>GB-2017-08.165</td>
<td>Primary Care Needs Assessment</td>
<td>Nicky Wilde</td>
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<tr>
<td>GB-2017-08.166</td>
<td>CCG Annual Assurance Assessment – 2016/17</td>
<td>Simon Freeman</td>
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<td><strong>Corporate Performance Reports</strong></td>
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<td>GB-2017-08.167</td>
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<td>Ilse Newsome</td>
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<td>Corporate Performance Report</td>
<td>Julie Davies</td>
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<td>GB-2017-08.169</td>
<td>Contract Performance Report</td>
<td>Gail Fortes-Mayer</td>
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<td>GB-2017-08.170</td>
<td>Quality Report</td>
<td>Dawn Clarke</td>
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<td>GB-2017-08.171</td>
<td>Future Fit Draft Pre Consultation Business Case (PCBC)</td>
<td>Debbie Vogler</td>
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<td>GB-2017-08.172</td>
<td>A&amp;E Delivery Board</td>
<td>Julie Davies</td>
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<td>GB-2017-08.173</td>
<td>Governing Body Assurance Framework (GBAF)</td>
<td>Sam Tilley</td>
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<td>GB-2017-08.174</td>
<td>Finance &amp; Performance Committee</td>
<td>Keith Timmis</td>
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<td>William Hutton</td>
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<td>GB-2017-08.177</td>
<td>Quality Committee</td>
<td>Dawn Clarke</td>
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<td>GB-2017-08.178</td>
<td>Locality Boards</td>
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<td>• North Locality Board</td>
<td>Tim Lyttle</td>
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<td>• South Locality Board</td>
<td>Shailendra Allen</td>
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<td>• Shrewsbury &amp; Atcham Board</td>
<td>Deborah Shepherd</td>
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<td>GB-2017-08.179</td>
<td>Questions from Members of the Public</td>
<td>Julian Povey</td>
<td>4.40</td>
<td>verbal</td>
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<td>• At the discretion of the Chair questions from members of the public will be invited</td>
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<td>• If you would prefer to put this in writing, by 12.00 noon Tuesday 15 August to Dr Julian Povey, Clinical Chair, Shropshire CCG, Somerby Suite, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL or via email <a href="mailto:SHRCCG.CustomerCare@nhs.net">SHRCCG.CustomerCare@nhs.net</a></td>
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<tr>
<td>GB-2017-08.180</td>
<td>Any Other Business</td>
<td>Julian Povey</td>
<td>5.00</td>
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<td><strong>Date of Next Meeting</strong></td>
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<td>• 13 September 2017, time and venue to be confirmed</td>
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Dr Julian Povey (CCG Chair)
Dr Simon Freeman (Accountable Officer)
Mrs Claire Skidmore (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 Tim Lyttle (Chair – North Locality)
Dr Shailendra Allen (Chair – South Locality) - part meeting
Dr Julie Davies (Director of Performance & Delivery)
Mrs Sam Tilley (Director of Corporate Affairs)
Dr Steve James (Clinical Director – Primary Care)
Mrs Nicky Wilde (Director of Corporate Affairs)
Ms Dawn Clarke (Director of Nursing & Quality)
Mr Keith Timmis (Chair – South Locality) - part meeting
Mr William Hutton (Chair – South Locality) - part meeting
Mr Meredith Vivian (Clarity – Patient & Public Involvement)
Mrs Sarah Porter (Clarity – Transformation)
Mrs Tracy Eggby-Jones (Corporate Services Manager – Minute Taker)

Mr Graham Shepherd (Shropshire Patient Group – Observer)
Mrs Jane Randall-Smith (Healthwatch Shropshire – Observer)
Mrs Jane Chapman (NHS England Representative)
Mrs Jo Almond (Patient Voice) – Minute No. GB-2017-07.134
Miss Jessica Almond (Patient Voice) – Minute No. GB-2017-07.134
Mr Tony Menzies (Programme Manager Community Services) - Minute No. GB-2017-07.136
Mr Michael Whitworth (MSK Programme Director) – Minute Nos. GB-2017-07.139 & GB-2017-07.143
Mrs Debbie Vogler (Future Fit Programme Director) – Minute No. GB-2017-07.145

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

Minute No. GB-2017-07.129 - Apologies

2.1 Apologies were noted as follows:

- Mr Kevin Morris (General Practice Representative)
- Dr Deborah Shepherd (Chair – Shrewsbury & Atcham Locality)
- Mrs Gail Fortes-Mayer (Director of Contracting & Planning)
- Dr Geoff Davies (Clinical Director – Urgent Care & Finance)
- Professor Rod Thomson (Director of Public Health)
- Mrs Wendy Saviour (Director of Commissioning Operations - NHS England North Midlands)
- Mrs Vikki Taylor (Locality Director - NHS England North Midlands)
Minute No. GB-2017-07.130 - 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 Declarations of interest for new Members were included on the Governing Body Register of Interest, and published on the CCG’s website.

3.3 There were no other declarations of interest raised.

Minute No. GB-2017-07.131 - Introductory Comments from the Chair

4.1 Dr Povey began by reporting that the CCG had held its Annual General Meeting (AGM) earlier in the day, where the Annual Report and Annual Accounts were adopted.

4.2 Dr Povey drew Members’ attention to the item of Any Other Business relating to Shrewsbury & Telford Hospital NHS Trust (SATH) Proposed Transitional Model of Midwifery Led Services across Shropshire (GB-2017-07.155) and noted that this item would be taken immediately after agenda item GB-2017-07.137 (SATH Clinical Fragile Services).

4.3 Dr Povey reported that he would take questions from members of the public specifically on the Clinical & Financial Sustainability agenda items after that section had been presented. Questions relating to any other issues would be taken at the end of the agenda as scheduled.

Minute No. GB-2017-07.132 – Minutes of the Previous Meeting – 7 June 2017

5.1 The minutes of the Governing Body meeting held on 7 June 2017 were presented and 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 7 June 2017.

Minute No. GB-2017-07.133 – 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-2017-06.115 – Corporate Performance Report
  Dr Julie Davies advised that she had raised the concerns of Mr Shepherd regarding attendance at NHS 111 Governing meetings with the NHS 111 Regional Lead Commissioner and was given assurance of future attendance by the provider and regional team.

- Minute No. GB-2017-06.127 – Questions from Members of the Public
  Dr Julie Davies reported that she had spoken to Mr Steve Gregory, Director of Operations, at Shropshire Community Health NHS Trust (SCHT) with regards to GP cover at Ludlow Community Hospital from August and had been informed that no changes to the current arrangements were planned.

6.2 There were no other matters arising noted.

Minute No. GB-2017-07.134 – Patient Voice

7.1 Mr Vivian introduced Mrs Jo Almond and her daughter, Miss Jessica Almond, who were in attendance to share their experiences both in terms of being a service user and carer.

7.2 Jess began by talking about her disability and the health issues of people with disabilities. Jess read out a poem she had written about the challenges and opportunities she had faced. Jess reported that she lived independently with support from her parents and carers from the MacIntyre Charity. Jess also volunteered at several organisations and charities and had written two books, with a third one due to be released very soon, about her Nan who had suffered with dementia and had recently passed away.
7.3 Jo gave Members an overview of the challenges and positives she has faced as a carer for Jess over the 33 years and some of the stresses caused by the numerous assessments Jess had undergone. Jo read out a poem that she had written entitled ‘Guilt’ which reflected the emotional aspect of being a parent and carer of a child with learning disabilities.

7.4 Jo reported that Jess was the Vice Chair of the People’s Parliament in Worcestershire, who had written a white paper on the health of people with disabilities. The report showed that people with learning disabilities died younger than other citizens and that they also had a higher rate of unmet health needs, which contributed to their early death. It was reported that people with learning disabilities had a higher level of throat and stomach cancer and that their main cause of death was due to respiratory problems, with the second highest cause of death being coronary heart disease. It was also noted that people with learning disabilities were more likely to get diabetes and epilepsy, as well as be overweight and suffer mental health issues.

7.5 Jo welcomed the support of the MacIntyre Charity, both for her and Jess, which had allowed Jess to live independently and had also given her reassurance that Jess would be looked after in the future. Jo reported that the MacIntyre Charity had just received a grant to develop a 3 year dementia project as it was widely recognised that more people with learning disabilities were being diagnosed with dementia.

7.6 Jo highlighted the needs of carers who she noted also required the support of professions, both physically and emotionally, in order to be able to help individuals with learning disabilities.

7.7 Mr Vivian thanked Jo and Jess for their attendance, which he felt was very inspiring and showed how Jess had dealt with her disability in a positive and uplifting way. Mr Vivian also felt that Members could learn a lot from Jo and Jess’s life experiences and reflected that without support and encouragement people with learning disabilities lived shorter lives, but with the right support in place they would be able to grow and flourish. Mr Vivian recognised the enormous work of carers and the need to raise awareness of the support they required to undertake their work, particularly emotional support. It was noted that there were currently over 7m carers in the UK all of whom were putting enormous amounts of work in often without support for their own health and wellbeing and that their needs were also vitally important.

CLINICAL AND FINANCIAL SUSTAINABILITY


8.1 Mrs Skidmore presented a progress report on the current position in relation to the CCG’s QIPP (Quality, Innovation, Productivity and Prevention) programme for 2017/18.

8.2 Mrs Skidmore highlighted the following key points from the report:

- Early data suggested that the £17.71m QIPP target was achievable through the delivery of a combination of projects from the original CCG plan as well as new schemes introduced to make good the impact of any slippage or project closure.
- Key Project Management Office (PMO) staffing arrangements had been secured and QIPP reporting and meeting schedules were under revision to meet reporting requirements and enhance visibility of the programme.
- QIPP pipeline included work on both 2017/18 and 2018/19 schemes including identification of mitigating actions to offset delivery risks.

8.3 Mr Timmis reported that the Finance & Performance (F&P) Committee had reviewed the risks associated with each of the QIPP projects in order to seek further assurance on delivery. Mr Timmis also welcomed the QIPP pipeline work underway for 2018/19 which he felt would be invaluable.

8.4 Dr Povey referred to the review of expenditure in Complex Care and asked if there was any potential impact for individual patients. Dr Freeman reported that the CCG was currently looking at three key elements of Complex Care spend, these included undertaking a cleansing of all baseline cases to
ensure the CCG only paid for the cases that existed, liaising with the hospice to agree a block contract for end of life/palliative care and addressing the balance of joint funded care packages with the local authority. Dr Freeman emphasised that there would be no direct impact to individual patients or restrictions to statutorily funded health care as a result.

8.5 Dr Povey referred to Appendix 1 of the report and noted that the Non-Elective activity reduction and SATH QIPP programmes had a year-to-date figure of zero and questioned why this was the case. Mrs Skidmore explained that she did not have sufficient data at present in order to populate the table, however, it was an area of work ongoing into 2018/19 and formed part of the slippage she had referred to above.

RESOLVE: THE GOVERNING BODY NOTED the current position in relation to the QIPP schemes and SUPPORTED the Executive Team’s actions in managing delivery risks by identifying and delivering a mitigating action plan.

Minute No. GB-2017-07.136 – Community Services Review

9.1 Mr Tony Menzies, Programme Manager Community Services, was in attendance to present the Governing Body with an update on progress to date on the Community Services Review.

9.2 Mr Menzies highlighted the following key points from the report:

- The review was following a process which had been agreed with the Programme Board.
- A Clinical Reference Group (CRG) had been set up as a sub-group of the Programme Board. The CRG comprised 10 GPs and 3 clinical members from Shropshire Community Health NHS Trust (SCHT)
- The review was in the process of carrying out a clinical audit of the Diagnostics, Assessment and Direct Access to Rehabilitation and Treatment services (DAARTs), Minor Injuries Units (MIUs) and community hospital beds. The audit would also include GP minor injury services and CCG-funded private community beds.
- In accordance with General Condition 17.1 (Termination: No fault) of the contract, SCHT and Robert Jones & Agnes Hunt Orthopedic Hospital (RJAH) required 12 months’ notice of any change in contractual arrangements. Therefore, without prejudging the outcome of the review, and as a usual precautionary measure, notice had been formally served to SCHT for MIUs, DAARTs and community beds and to RJAH for community beds provided in Sheldon ward in Oswestry. If changes were deemed necessary, giving notice early would allow changes to the existing services or new services to be developed and implemented in a timely manner. However, if changes were deemed unnecessary the notice would be withdrawn and the services would continue without interruption.
- SCHT had been working since January to develop an accurate cost for the DAARTs, MIUs and community beds. The information provided to date was currently being analysed by the CCG’s financial team
- At the suggestion of patient and public representatives a table-top exercise to review the engagement work carried out by the Future Fit and Community Fit programmes had been completed.
- It was planned to complete the review by December 2017. The findings would be presented to the CCG’s Governing Body in January 2018.

9.3 Mrs Randall-Smith reported that Healthwatch Shropshire had shared their intelligence and information in relation to DAART, MIUs and community beds with the CCG, but felt that they had not received an update on progress. Dr Julie Davies advised that once all the evidence had been received and analysed and a case for change developed, then there would be a further period of engagement with patients and the public.

9.4 Dr Povey welcomed the clinical input on the CRG but asked what steps had been put in place to manage any potential conflicts of interest. Mr Menzies confirmed that that a Conflicts of Interest Register had been compiled for the CRG and Members were asked to raise any conflicts they had at the meeting. In relation to the clinical audit of DAART, MIU and inpatient community bed provision, Mr Menzies reported that this being carried out by an independent GP, Dr John Oates from Warwickshire.
Ms Clarke acknowledged that the notice given to SCHT and RJAH was a precautionary measure but was concerned that there could be a destabilisation of staff and asked how this was being communicated to staff to ensure their retention. Mr Menzies gave assurance that this had been identified as a risk and formed part of the communication plan and that extensive communications had taken place with staff.

**RESOLVE:** THE GOVERNING BODY RECEIVED AND NOTED the progress report on the Community Services Review and:

- APPROVED the process for completing the review
- NOTED the timescale for completing the review.
- NOTED that the usual formal notice had been given to Shropshire Community Health NHS Trust (SCHT) and Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) as a precautionary measure during a service review

**ACTION** Dr Julie Davies to present outcome of Community Services Review to Governing Body in January 2018.

Mr Menzies left the meeting at this point.

**Minute No. GB-2017-07.137 – Shrewsbury & Telford Hospital NHS Trust (SATH) Fragile Clinical Services**

10.1 Dr Julie Davies presented a briefing report which provided an update to the Governing Body on the latest position regarding the services declared as fragile by Shrewsbury & Telford Hospital NHS Trust (SATH) in March. It also provided assurance that all necessary actions continued to be taken to secure safe, good quality services for the patients of Shropshire as locally as the available provider capacity would allow.

10.2 Key points from the report were noted as follows:

- **Emergency Department (ED)** - The risk remained the same with the Emergency Departments at both sites, but the CCG was now working with SATH on its business continuity plans for ED alongside other key system stakeholders.

- **Ophthalmology** - The CCG was maintaining fortnightly oversight of ophthalmology, but was now working on a more strategic commissioning solution for paediatric ophthalmology due to the recent loss of a locum consultant. A report would be presented to the CCG’s Clinical Commissioning Committee (CCC) in August.

The new ophthalmology department had opened on schedule at Royal Shrewsbury Hospital (RSH) and it was hoped it would assist with the recruitment of a substantive workforce. It was expected that SATH would ask for a 3-6 month extension to the current temporary closure of the most challenged sub specialties to enable recruitment to take place.

- **Neurology** - A Task & Finish Group for Neurology had been set up with colleagues from Telford & Wrekin CCG to explore and make recommendations to the CCC for the long term sustainable commissioning of this service for the future. A report was due to the CCC in August.

- **Dermatology & Spinal Surgery** - The risks associated with dermatology and spinal services at SATH had reduced but would continue to be closely monitored by the Planned Care Working Group (PCWG) via its new agenda structure.

10.3 Dr Julie Davies reported that the quality and safety of all these services continued to be monitored in detail at the monthly Clinical Quality Review Meetings (CQRMs) and a monthly report continued to be provided to the Quality Surveillance Group (QSG), chaired by NHS England and attended by NHS Improvement, CQC and Healthwatch, to ensure they were kept informed of the on-going position regarding all of the fragile services.
Dr Julie Davies gave assurance that both Shropshire and Telford & Wrekin CCGs continued to work closely with their respective Healthwatch colleagues to monitor patient experience and any other concerns identified related to these fragile services.

Dr Julie Davies emphasised that Shropshire CCG would continue to take whatever commissioning action it needed to in order to secure the provision of safe, good quality services for the population of Shropshire.

**RESOLVE:** THE GOVERNING BODY RECEIVED AND NOTED the update on the latest position regarding the services declared as fragile by SATH in March.

THE GOVERNING BODY SUPPORTED the recommendations to:

- Maintain ongoing enhanced oversight of local A&E performance and the ongoing workforce situation at SATH.
- Ask the Clinical Commissioning Committee (CCC) to receive the draft Emergency Department Business Continuity plan in due course (date to be agreed with SATH) and provide assurance on it to the Governing Body.
- Maintain ongoing enhanced oversight of local ophthalmology service delivery, including the quality and patient experience impact of current arrangements and the ongoing workforce situation at SATH.
- Ask the CCC to receive the options for a solution to the strategic commissioning of paediatric ophthalmology across the county in August and make a recommendation to the Governing Body in September.
- Maintain ongoing enhanced oversight of local neurology service delivery, including the quality and patient experience impact of current arrangements.
- Ask the CCC to receive the options for a solution to the strategic commissioning of neurology across the county and potentially mid Wales in August and make a recommendation to the Governing Body in September.

THE GOVERNING BODY ENDORSED the change in the structure of the Planned Care Working Group to improve the oversight and management of at risk scheduled services at an earlier stage to help commissioners maintain access to good quality service for patients.

**ACTION**  
Dr Julie Davies to present assurance on SATH’s draft Emergency Department Business Continuity plan when available.

Dr Julie Davies to present recommendation from CCG’s Clinical Commissioning Committee (CCC) on the options for a solution to the strategic commissioning of paediatric ophthalmology across the county to the Governing Body in September.

Dr Julie Davies to present recommendation from CCG’s CCC on the options for a solution to the strategic commissioning of neurology across the county and potentially mid Wales to the Governing Body in September.

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**Agenda item GB-2017-07.155 – Shrewsbury & Telford Hospital NHS Trust (SATH) Proposed Transitional Model of Midwifery Led Services across Shropshire as taken at this point**

11.1 Dr Sokolov presented a briefing paper which the Governing Body was asked to consider on SATH’s Proposed Transitional Model of Midwifery Led Services across Shropshire.

11.2 Dr Sokolov reported that the Trust had proposed that in order to mitigate risks, provide safe care to mothers-to-be and support staff that inpatient and overnight provision be suspended in the three Midwife Led Units (MLUs) with the least birth activity (Ludlow, Bridgnorth and Oswestry) for a minimum period of 3 months from the beginning 1 July 2017. It was noted that during this period the maternity services available in the rural areas of Bridgnorth, Ludlow and Oswestry would include the following:

- Antenatal Services – Day attendees (9am – 5pm) at the MLU buildings, antenatal community (home) visiting, scanning and advice.
• **Intrapartum Care** – Home birth 24/7; using the on-call midwife service.

• **Postnatal Services** – Including day non-inpatient attendees (9am – 5pm) at the MLU buildings, postnatal community (home) visiting, and breast feeding support.

• **On-call Midwifery** – 24/7 on-call midwifery service to provide advice, support and/or home delivery.

11.3 Dr Sokolov stressed that the transitional model proposed by SATH was a response to address immediate risks to safety at the Trust and did not pre-empt the outcome of the MLU review which was due to be completed by October 2017. The MLU review would make recommendations for a medium to long-term plan for midwife-led maternity services and that the proposed timescale for the transitional model to be in place was between 3 and 6 months from July 2017, until the recommendations of the MLU review were implemented.

11.4 It was noted that as a service provider, SATH could make a unilateral decision to change a service on the grounds of safety without prior approval from the commissioning organisation. This had been confirmed by NHS England. However the CCG, as lead commissioner for maternity services had undertaken its own assurance activity to ensure proposals were in the best interests of patient safety. From the quality impact/risk assessment undertaken by Shropshire CCG it was considered that the transitional arrangements proposed by SATH were safe and appropriate.

11.5 Mr Timmis referred to the Workforce section (page 5) and noted that the Trust had rejected the use of agency midwives as a viable option to their workforce issues and asked if this was the same for doctors and nurses used by the Trust. Dr Sokolov felt she was unable to comment on the content of the SATH report as the CCG was not the author. Mr Shepherd confirmed that he had been in attendance at some of the meetings where the issue of using agency midwives had been discussed and it reported that it had been disregarded on the basis that expectant mothers wanted continuity of care which the Trust felt would not be provided through agency midwives.

11.6 Mrs Randall-Smith raised concern with regards to the terminology used for the model as ‘transitional’ suggested that the Trust was changing to another model, she felt it should be referred to as an ‘interim’ model as the outcome of the MLU review and future service provision was not yet known. Mrs Randall-Smith noted that the Trust had risk scored all the options, except the preferred option, and would be seeking assurance from the Trust in this regard, as well as service provision in rural community areas during this period of closure. Mrs Randall-Smith also had concerns in relation to communications to patients and public as it was felt to be confusing and advised that Healthwatch had offered to pre-read press releases before they were issued. Dr Sokolov acknowledged that there was anxiety by patients and the public and that the Trust needed to be as clear as possible with them to alleviate their concerns.

11.7 Dr Lynch asked how the CCG would get assurance that any issues raised following the temporary closure of the MLUs had been addressed by the Trust. Dr Sokolov reported that the Trust had regular meetings to receive and discuss patient feedback and that the CCG would have oversight of this through the SATH Maternity Clinical Quality Review Meeting (CQRM).

11.8 Dr Povey sought assurance that SATH were clear that the temporary closure of the MLUs were to address the immediate risks to safety and that the MLU review was a separate commissioner led review, where the outcome and recommendations would be received and developed by Shropshire and Telford & Wrekin CCGs, not the SATH. Dr Sokolov confirmed that the Trust was aware that any temporary change in maternity service provision would not pre-empt the outcome of the MLU review. Dr Sokolov highlighted that as part of the review a significant amount of engagement work was being undertaken which would inform the outcome.

11.9 Ms Clarke reiterated that the CCG had undertaken its own risk assessment to ensure that the proposals were in the best interests of patient safety and it had concluded that the short-term transitional arrangements proposed by SATH were safe and appropriate and that the Trust did not require prior approval from the CCG to change a service on the grounds of safety.

**RESOLVE:** THE GOVERNING BODY RECEIVED AND CONSIDERED the report from SATH on the proposed Transitional Model of Midwifery Led Services across Shropshire and SUPPORTED the Trust’s interim option based on the grounds of safety and risk assessment undertaken.
Minute No. GB-2017-07.138 – Complex Care – Choices Policy

12.1 Ms Clarke presented the Complex Care Choices Policy for approval by the Governing Body and reported that the purpose of the policy was to balance patient preference with safety and value for money and to provide transparency for those wishing to scrutinise the application of the CCG’s Policy for NHS Continuing Healthcare and NHS-funded Nursing Care.

12.2 The policy described the ways in which the CCG commissioned and provided care taking into consideration the individual’s preferences, while balancing the need for the CCG to commission care that was safe, effective and made best use of available resources. The policy would be used to inform practice and decision making where an individual wished to exercise choice in relation to where or how their care was arranged and delivered. It was noted that the policy included children and young people who were eligible for continuing care.

12.3 Ms Clarke reported that the National Framework for NHS Continuing Healthcare (2012) stated that ‘the package to be provided was that which the CCG assessed to be appropriate for the individual’s needs’ and that she was the designated lead for NHS Continuing Healthcare (CHC) within the CCG and responsible for reporting compliance with The National Framework.

12.4 Ms Clarke advised that by having a structured policy provided the CCG with the ability to audit the process, as well as make it transparent for the public.

12.5 Mr Hutton noted that the Governing Body had also approved the CHC Settings of Care policy in June and that the Audit Committee had received and commented on both policies at their recent meeting and felt that although they were clear in terms of their purpose, links between them needed to be made. Dr Freeman acknowledged that they were both CHC policies but noted that they stood alone in terms of their purpose.

RESOLVE: THE GOVERNING BODY APPROVED the NHS Continuing Healthcare Choice Policy for NHS Shropshire CCG.

ACTION Ms Clarke to ensure approved Complex Care Choices Policy is uploaded to CCG’s website.

Minute No. GB-2017-07.139 – Shropshire Out of Hospital Plan

12.1 Mr Michael Whitworth, Programme Director, was in attendance to give a presentation on the Shropshire Out of Hospital transformation work and progress to date.

12.2 Mr Whitworth reported that joint work between the CCG, Shropshire Council and SCHT on the phase 2 workstreams of the Out Of Hospital Transformation Plan were progressing well. In addition, external advisors had been commissioned to help better understand opportunities for change, based on national and international evidence based models of care, against the CCG’s baseline population health needs and secondary care utilisation.

12.3 Mr Whitworth referred to the health needs and utilisation of the population of Shropshire and noted that Shropshire residents had a long life expectancy with low rates of obesity and smoking, however, there were the expected demographic-related health issues associated with an aging population. It was noted that Shropshire was not a significant outlier, (with the exception of orthopaedics), with regards to utilisation, however the complex health needs of the CCG’s elderly population relied disproportionately on hospital care and reported that there were other models of care that offered an opportunity to positively impact on population health and demand management.

12.4 Mr Whitworth reported that evidence from international examples of transformational models of out of hospital care supported the delivery of STP (Sustainability & Transformation Plan) ambitions with regards to reduced hospital utilisation. However, system changes were required.

12.5 Mr Whitworth reported on the next steps as follows:

- Building on existing initiatives and reviews complete the collaborative design work for the model of out of hospital care for Shropshire
- Develop the business case for change
- Operate a demonstrator site programme to deliver new at scale out of hospital services (with early identification of priority pathways and localities for change)
12.6 A copy of the full presentation was available to view at http://www.shropshireccg.nhs.uk/governing-board-meetings-2017

12.7 Mr Shepherd asked how the Out of Hospital Plan related to the Neighbourhood work currently in progress. Mr Whitworth reported that the Neighbourhood work was a workstream of the Out of Hospital Plan, along with the prevention agenda, admission avoidance, all of which informed the STP.

12.8 Mr Vivian asked if the CCG was gathering any information from the demonstrator sites already underway around the country. Mr Whitworth confirmed that the CCG was gathering evidence from both the national and international demonstrator sites.

12.9 Dr Povey acknowledged that there was significant enthusiasm in Shropshire to implement the demonstrator site programme and asked if a timescale had been agreed. Dr Freeman reported this was likely to be implemented in 2018/19.

RESOLVE: THE GOVERNING BODY RECEIVED AND NOTED the progress on the Shropshire Out of Hospital transformation work.

Minute No. GB-2017-07.140 – NHS Constitution Indicators – Status Report

13.1 Dr Julie Davies presented a briefing paper which provided an overview of the NHS Constitution performance indicators that the CCG was held accountable for: including full year performance in 2016/17, initial Month 1 performance for 2017/18 and CCG actions in place to recover any performance that was not on track.

13.2 Key points from the report were noted as follows:

- The CCG was in recovery on 18wks Referral to Treatment (RTT) with both its main providers and that a recovery plan had been developed, which was on plan to deliver from October.
- The CCG was achieving the Diagnostics waiting times.
- The CCG was achieving the Cancer 62day RTT, but was off target on 31day subsequent treatment. Although the CCG had a strong track record of achieving this target historically commissioners were maintaining strong vigilance.
- The CCG was slightly off target on Breast symptoms and following a review of demand and capacity with SATH, to ensure there was sufficient for patient choice, it was established that more than 7% of patients locally were choosing to wait for personal reasons and not because of capacity issues. The issue would be discussed at the July Clinical Commissioning Committee (CCC) to see what further action could be taken to improve performance in this area.
- The CCG was working with all system providers to urgently finalise a recovery plan to deliver an improvement in A&E performance. In order to maintain ongoing oversight of A&E performance and ensure that the CCG was delivering on its obligations related to Frailty and Discharge to Assess it was recommended that the Governing Body receive the minutes from the System A&E Delivery Board meeting in future.

13.3 Mr Timmis noted his scepticism with regards to improvements in A&E performance given the significant work that had been undertaken over recent years with very little improvement. Dr Julie Davies felt that at a recent workshop, attended by all key stakeholders, including the local authority, additional assurance had been received that the Trust was doing everything it could to improve their internal systems and processes in order to optimise bed efficiency. Although Dr Julie Davies acknowledged that the Trust still needed to address its workforce issues.

13.4 Mr Hutton noted that there had been a deterioration in A&E performance in May and asked if it had been established what the root cause was, given that the trajectory had been achieved in the previous month. Dr Julie Davies reported that A&E was a multi-factorial performance measure and that any small variation could cause a significant impact in performance.

RESOLVE: THE GOVERNING BODY RECEIVED the report on the CCG’s performance against the NHS Constitution indications and NOTED that the current Referral to Treatment (RTT) performance recovery trajectory
THE GOVERNING BODY SUPPORTED the recommendation to receive the minutes from the System A&E Delivery Board meeting in order to maintain ongoing oversight of A&E performance and ensure that the CCG was delivering on its obligations related to Frailty and Discharge to Assess.

**ACTION** Dr Julie Davies to ensure minutes of the System A&E Delivery Board were presented to future Governing Body meetings for information and assurance.

**Questions from the Public**

14.1 Dr Povey opened the meeting to questions from members of the public at this point, specifically relating to the Clinical & Financial Sustainability agenda items. These were noted as follows:

- **Minute No. GB-2017-07.135 – Progress Report on Quality, Innovation, Productivity and Prevention (QIPP) Schemes**

  There were no questions raised.

- **Minute No. GB-2017-07.136 – Community Services Review**

  **Mr David Sandbach**

  Mr Sandbach assumed that as part of Community Services Review the CCG was gathering historical data and felt that the CCG needed to also look at what the population of Shropshire needed going forward and look at how these could be delivered through new technologies.

  Dr Julie Davies reported that the review was evaluating what current service provision there was and if appropriate a case for change would be developed, these would be based on the future requirements of the population.

- **Minute No. GB-2017-07.137 – Shrewsbury & Telford Hospital NHS Trust (SATH) Fragile Clinical Services**

  **Mrs Joyce Brand**

  Mrs Brand advised that she had not seen the level of frail elderly people in A&E that the report suggested and asked if they were precise figures.

  Dr Rysdale confirmed that elderly frail patients were the largest group of patients waiting in A&E for admission compared to other groups of patients.

  Dr Freeman reported that approximately 10% of admissions to SATH related to patients over the age of 85 and that they occupied 65% of the Trust's inpatient bed base. Dr Freeman advised that often their length of stay was higher than average due to their complex health needs.

  **Ms Gill George, Shropshire Defend Our NHS**

  Ms George noted that the report indicated that the CCG would be extending monitoring of respiratory, cardiology and stroke services and sought clarification what this would entail.

  Dr Julie Davies reported that respiratory services had fragility in the workforce and although access to the service was not currently an issue, the CCG had included it on the Risk Register in order to monitor the situation.

  With regards to cardiology services, Dr Julie Davies reported that the CCG was monitoring the timeliness of follow ups for patients to ensure they were conducted in a timely manner. Dr Davies advised she did not have any details to hand with regards to stroke services.

  Dr Julie Davies highlighted that although the CCG had increased its surveillance of these services she gave assurance that there were no issues currently relating to capacity and delivery.
Mr David Sandbach

Mr Sandbach felt that in order to address the fragile services issues at the Trust, the CCG should hold a private session for Members to discuss in detail future service provision.

- Minute No. GB-2017-07.155 – Shrewsbury & Telford Hospital NHS Trust (SATH) Proposed Transitional Model of Midwifery Led Services across Shropshire as taken at this point

Mrs Sylvia Jones, Clunbury Parish Council

Mrs Jones raised the following questions:

1. Mrs Jones sought a guarantee that expectant mothers in Shropshire could still opt for a home birth following the implementation of SATH’s transitional model and that midwives would be available.

Dr Povey confirmed that there was no change in the arrangements for expectant mothers who opted for a home birth.

2. Mrs Jones asked who was responsible for mothers who did not reach hospital and gave birth on route, either in a car or ambulance.

Dr Sokolov was not aware that there would be a clinical responsibility if a mother was not under the direct care of the NHS, but advised that she would clarify this with the Local Maternity System (LMS) Programme Board.

3. Mrs Jones asked if the proposed transitional model had any financial implications for the CCG’s budget.

Dr Povey reported that the CCG currently paid a tariff to the Trust per birth irrelevant where the birth took place and that there was no financial impact to the CCG.

Mr John Bickerton

Mr Bickerton felt that the residents of Oswestry were not being informed of the proposed changes to maternity services in Oswestry, he felt that the Councillors and MPs were saying one thing and the NHS saying another.

Dr Freeman stated that the CCG was not responsible for what Councillors and MPs reported, but emphasised the current position with regards to maternity services was as stated in the report from SATH and presented to the CCG’s Governing Body.

Councillor Madge Sheinton

Councillor Sheinton noted that it was regrettable that the MLUs had closed temporarily but felt that this was the safest option and that she could not continue to support the intermittent, and often short notice, closure of the units. Councillor Sheinton felt that as long as the MLU review, being conducted by the CCG, was open and transparent and provided options for future service provision then she supported the process.

Dr Sokolov agreed and felt that having the uncertainty created greater anxiety for expectant mothers. Dr Sokolov gave assurance that the MLU review process would face additional scrutiny from NHS England.

Mrs Joyce Brand

Mrs Brand noted that it had been reported that the closure of the Ludlow MLU had been due to staff shortages when in fact the midwives had been moved to support the Consultant Led Unit at Princes Royal Hospital (PRH).

Dr Sokolov explained that in order to provide a safe service to all expectant mothers there had been a need to withdraw some midwives from rural MLUs and redistribute them to the Consultant Led Unit. This was due to the need to provide an increased level of care to those patients at PRH who often had a higher risk of complications. Dr Sokolov reported that 85% of births took place at PRH and that any expectant mother deemed to have an increased risk of complications would automatically go to PRH and not a rural MLU.
Ms Gill George, Shropshire Defend Our NHS

Ms George asked if the CCG was aware that the paper presented to the SATH Board meeting on 29 June reported lower rates of sickness than the Trust's average and felt that this was at odds with what had been reported as the main reason for the closures of the MLUs.

Ms George also highlighted that the Trust had repeated its assertions that it did not have any difficulties in recruiting midwives, however, SATH's figures showed a running down of staffing levels in the obstetric unit and a significant cut in the planned level of input from both midwives and care staff over a two year period, despite the number of births at the obstetric unit rising.

Ms George advised that she was aware of midwives who had offered to work additional shifts but been turned down and that having longer commuting distance had made it difficult for midwives to take on additional shifts. Furthermore, Ms George reported some midwives were leaving their current post as they had been asked to take on a completely different role. With regards to agency midwives, Ms George advised that expectant mothers currently did not have one-to-one care from a midwife.

Ms George felt that there was a significant reduction to antenatal and post-natal care for mothers and greatly reduced access to maternity care for rural communities, as well as an increased difficulty in accessing a home birth.

Therefore, Ms George wished to ask the following questions:

1. Was the Governing Body confident about the decision it had taken?

   Dr Povey confirmed that the Governing Body was confident in its decision (i.e. to support the decision taken by SATH to temporarily close the three rural MLUs to inpatient births on the grounds of safety) and that having access to a safer services provided certainty to expectant mothers and that in order to do this the Trust needed to focus its resources on where the highest demand and proportion of births took place.

2. When did the CCG know of the decision by SATH to close the MLUs for a period of 3-6 months?

   Dr Sokolov reported that the CCG had become aware of the issues facing the MLUs over a period of time and that the MLU Programme Board had recognised the risks facing the service. The Trust had alerted the CCG to proposed changes to service provision in mid-June but had to undergo internal processes to develop the proposed model. Dr Sokolov confirmed that the CCG had sought assurance from NHS England that the Trust could go ahead and make a service change without prior approval from the CCG as it was based on safety grounds.

3. Will the CCG share the detail of its risk assessment, rather than the summary table contained in the report?

4. Will the CCG share the data it was using in the MLU review?

   Dr Povey confirmed that the data and risk assessment would be shared at an appropriate time during the review process.

Lady, Member of the Public

The lady asked what the CCG felt was an acceptable journey time for midwives attending a home birth and antenatal care, as she was concerned that there had been additional travelling time, particularly on the A49 due to roadworks, which had significantly increased the time to attend to patients.

Dr Povey felt that the question should be directed to SATH as the provider of the service.

Mrs Sylvia Pledger, Albrighton Patient Participation Group

Mrs Pledger felt that there needed to be a greater focus on the positives of having a designated Women’s & Children’s Unit in Telford and the excellent care of the unit and staff should be acknowledged, rather than focussing on the negatives of the temporary closure of the MLUs.
Dr Sokolov felt that the Trust and staff were under considerable pressure and that they wanted to ensure good outcomes for all their patients. Dr Sokolov encouraged Mrs Pledger to send her comments to the Trust.

Dr Povey recognised that there was potentially negative consequences for the Trust by all the media interest at present, which could compound the recruitment and retention of staff. Dr Povey reported that the Trust provided good quality safe services for the majority of its patients and worked hard to resolve any issues. Dr Povey added that healthcare provision inevitably had associated risks but the CCG and Trust were working hard to minimise these.

**Minute No. GB-2017-07.138 – Complex Care – Choices Policy**

**Councillor Madge Sheinton**

Councillor Sheinton referred to the timeliness of the Complex Care Team undertaking assessments of patients’ needs and whether there was sufficient staff to do this.

Ms Clarke confirmed that the NHS National Framework sets out clear timescales for Continuing Healthcare (CHC) assessments and that from the time a patient was referred for assessment and to the point a decision was made should be 28 days. However, Ms Clarke reported that this not only depended on the process but also the capacity of the Teams involved to make the decision, as it relied on access to Social Care staff.

**Minute No. GB-2017-07.139 – Shropshire Out of Hospital Plan**

There were no questions raised.

**Minute No. GB-2017-07.140 – NHS Constitution Indicators – Status Report**

There were no questions raised.

**ACTION**

Dr Sokolov to seek clarity from the Local Maternity System (LMS) Programme Board with regards to the questions raised by Mrs Sylvia Jones, particularly in relation to clinical responsibility for labouring mothers on route to hospital.

Dr Sokolov to ensure that the data and risk assessment relating to the MLU Review was made publicly available when appropriate in the review process.

Dr Shailendra Allen left the meeting at this point.

**CORPORATE PERFORMANCE REPORTS**

**Minute No. GB-2017-07.141 – Financial Report**

15.1 Mrs Skidmore presented the CCG’s Financial report for the period ending 31 May 2017 (Month 2).

15.2 The following key points from the report were noted:

- Shropshire CCG continued to be in ‘Legal Directions’ and in formal financial recovery.
- The overall financial position to 31 May 2017 was currently forecasting an in year deficit of £19.4m which was in line with the agreed control total. This reflected the gap in the CCG’s current plan as a result of planned expenditure exceeding resource allocation.
- The cumulative financial position was forecasting £52.04m deficit which included brought forward £32.6m from previous years.
- Furthermore the position included allocation adjustment (£1.374m) regarding IR rule applications which had been noted as a national challenge to CCGs.
- The CCG entered 2017/18 with a number of known significant risks and had a QIPP target of £17.71m.
- Initial positions on NHS contracts were assessed on the Month 1 activity submission by providers and then a view had been applied to the robustness of the potential trajectory projection for the Month 2 position. In line with previous years this had been overlaid with early soft intelligence around delivery of services. It was noted that detailed contract activity would be provided as appendices for future reports.
- The CCG had achieved target on all four criteria within the Better Payment Policy for the month and work would continue with the Commissioning Support Unit (CSU) Team to further improve performance.
- The CCG was achieving the Cash target to date.

15.3 Mrs Skidmore reported that an assessment of the CCG’s financial risks had been undertaken and mitigating actions agreed.

15.4 Mr Timmis sought assurance that the terminology and figures used in the report were consistent with those within the QIPP report, as there was potential for confusion.

15.5 Dr Lynch referred to page 4 of the report where it stated that a 1% contingency reserve had been included as an element of delegated primary care resource and sought an explanation for this. Mrs Skidmore explained that under the business rules the CCG had to hold 1% of its budget in reserve in case of any unforeseen cost pressure. This reserve related to all expenditure in the CCG including the primary care resource.

**RESOLVE:** THE GOVERNING BODY RECEIVED AND NOTED the financial report for Month 2 and progress on key areas of financial reporting.

**Minute No. GB-2017-07.142 – Corporate Performance Report**

16.1 Dr Julie Davies presented a briefing paper which provided the Governing Body Members with an update on the CCG’s performance for the year 2017/18 against the Key Performance Indicators (KPIs) that the CCG was held accountable for with NHS England. 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 address areas of poor performance.

16.2 Dr Julie Davies noted that a number of the performance indicators had been reported on earlier in the meeting, see Minute No. GB-2017-07.140 – NHS Constitution Indicators, but provided Members with an update on other key performance as follows:

- **Ambulance response times** - As at April 2017, there were 480 handover delays for > 30 minutes and 63 for > 1 hour against zero tolerance. Performance for both indicators had improved for April compared to March. An action plan was now in place between SATH and West Midlands Ambulance Services (WMAS) to improve performance, which would be monitored via the A&E Delivery Board.

  It was noted that the new response time reporting (ARP) was currently being evaluated nationally and was due to report later in the month. Feedback on this would be included in future performance reports.

- **52 Week Waits** - The CCG had 11 over 52 week waiters with breaches at Wye Valley, Worcester and from Shropshire Community Health NHS Trust (SCHT). It was reported that all patients were scheduled for treatment in May and June. Dr Julies Davies highlighted that a couple of the patients had chosen to reschedule their appointment to July, but that there were no new 52 week waiters. Full contractual levers had been implemented against the poor performance and the CCG Performance Lead had requested a forward look of all >40wks waiters at all providers to try and prevent such breaches happening in the future.

  Dr Julie Davies advised that the CCG’s Referral Assessment Service (RAS) notifies patients of the waiting times for their secondary provider of choice so that they could make an informed choice of where to receive treatment.

16.3 Dr Julie Davies also referred to the annual health checks for people with learning disabilities and reported that the CCG was achieving 46.5% against the national average of 37.1%. Although this was higher than the national average, Dr Julie Davies felt there was still room for improvement and that a new health check pilot was underway to improve the process.

16.4 Mr Hutton was pleased to see that the CCG had now received performance data relating to NHS 111 and noted that 12% of the calls received had been referred to the ambulance service and asked if there had been any significant change in the conveyance rate for these calls. Dr Julie Davies advised that the CCG had requested this information and that they would be conducting a specific audit to test
the pathway and establish if there had been any change in the disposition of patients between Shropdoc and NHS 111.

16.5 Dr Lynch referred to page 2 (Ranking & Peer Groups) of the report and the NHS England IAF Dashboard noting that there was a number of new indicators and that the CCG had been ranked the lowest/poorest performing quartile under the “Better Care” category. Dr Julie Davies acknowledged the indicators included people with first episode of psychosis, crisis care and liaison mental health services transformation, management of long term conditions and patients waiting 18 weeks or less from referral to hospital treatment and that the CCG was focussing its efforts to address performance in these areas, although noted the CCG did not have any concerns with regards to the psychosis indicator due to the relatively low number of patients.

16.6 Dr Lynch also referred to page 14 (Primary Medical Care) and noted that the CCG was below the national average for extended access at weekends and evenings and asked what the exact figures were. Dr Julie Davies reported that the national average was 22.5% and the CCG was currently achieving 9.3%, improvements in this area were being picked up through the GP 5yr forward view workstream. Dr Freeman highlighted that the CCG was above the national average for GP access.

16.6 Mr Timmis noted that the Quality Premium Payments at year end position were contingent upon the CCG passing both the Finance and Quality Gateways and asked if the CCG needed to breakeven or achieve its control target in order to receive the payments. Mrs Skidmore confirmed that the CCG would need to achieve its control total.

**RESOLVE:** THE GOVERNING BODY RECEIVED the Corporate 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 to chair monthly Planned Care Working Group meetings with RJAH and SATH to oversee recovery of RTT.*

*Dr Julie Davies and Dr Freeman to continue to attend A&E Delivery Board to ensure system delivery of the A&E recovery trajectory.*

**Minute No. GB-2017-07.143 – Contract Performance Report 2016/17**

17.1 Mr Whitworth presented the Contract Performance report, which summarised the current contractual position at Month 1 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)

17.2 Key points from the report were noted as follows:

- Month 1 had an unusually low number of working days and nationally NHS England had asked CCGs to consider re-phasing their plans to reflect this.
- The June Strategic Contracting Board focussed on quality governance
- Monthly Teleconference call had been set up between SATH, the CCG, NHS England and NHS Improvement to progress significant performance issues
- Limited progress had been made on the collaborative QIPP schemes with SATH

17.3 Mr Whitworth highlighted that the report now included greater detail on SATH’s QIPP and Integrated Community Services (ICS) data.

17.4 Mr Whitworth reported that the contractual challenges and actions were outlined in section 2.2.2 of the report and noted that the majority of the challenge value in Month 1 related to Value Based Commissioning (VBC) prior approvals. Mr Whitworth advised that as these challenges were the first to be subjected to the VBC challenge validation process there was a high potential for the final figure to be materially different to the challenge figure.

17.5 Mr Whitworth reported that the VBC target was contained within the contract for RJAH and outside the contract for SATH.
17.6 Mr Whitworth noted that VBC activity for MSK was above plan, however the non-MSK activity was currently below plan. This had been picked up as part of the planning assumptions and forecasting.

17.7 Dr Povey referred to the Contractual Actions on page 6 of the report and noted that there was a contractual challenge of £547k for RJAH against a budget of £5.5m which he felt was high. Mr Whitworth clarified that the figure was the gross amount and related mainly to VBC MSK activity,

**RESOLVE:** THE GOVERNING BODY RECEIVED the Contract Performance Report for Month 1 and NOTED the current performance and actions being taken with each of the four main providers.

**Minute No. GB-2017-07.144 – Quality Report**

18.1 Ms Clarke presented a briefing paper which provided the Governing Body with a high level summary of the quality indicators and assurance. Ms Clarke reported that the CCG’s Quality Committee monitored the more detailed reports submitted by each provider through the Clinical Quality Review Meetings (CQRM).

18.2 Ms Clarke reported that a key function of the CCG was to ensure that the providers were providing safe and high quality services, and in order to be assured that the CCG had appropriate processes in place the CCG had commissioned the West Midlands Quality Review Service (WMQRS) to undertake a review of its existing internal quality, patient safety and experience function with the aim of improving the CCG’s arrangements for the management of quality, patient safety and patient experience. The review would be formative and build on the teams existing strengths.

18.3 Ms Clarke reported that the review day had taken place on 11 July 2017 and it was anticipated that the report would be with the CCG by 6 September 2017. A gap analysis would be completed on areas for improvement and any early actions would be undertaken as a result of the review and reported within future Quality Reports.

18.4 Ms Clarke highlighted that there appeared to be a delay in the CCG receiving completed Root Cause Analysis (RCAs) reports into serious incident investigation with several providers. The CCG would be reviewing its internal process for the management of serious incidents with the providers as part of the WMQRS review.

18.5 Ms Clarke noted that the workforce issues at SATH had been identified as a concern which was having an impact on the quality of service delivery in many areas within the Trust. This issue would be picked up and monitored through the CQRM.

18.6 Mr Timmis referred to the Shropdoc section (3.6.1) of the report and sought assurance that the CCG was monitoring the position with regards to those patients assessed as having chest pain following the NHS 111 assessment to ensure they were not coming to harm. Mr Timmis also noted that in section 3.8 (Care Homes) that the lack of a central register for the Care Homes Advance Scheme (CHAS) had been identified as a significant risk and asked how this would be addressed. Ms Clarke advised that she would pick these issues up and provide feedback at the next Governing Body meeting.

18.7 Dr Povey noted that Shropdoc was in the process of changing their model of care using Emergency Care Practitioners (ECPs) and asked if it had been discussed at the Shropdoc CQRM, particularly in relation to undertaking a Quality Impact Assessment (QIA). Ms Clarke confirmed that a meeting had taken place this week but she did not know the outcome, but would follow this up and feedback to Dr Povey.

**RESOLVE:** THE GOVERNING BODY RECEIVED the Quality Report for information and assurance regarding the steps being taken to improve and monitor the quality, safety and patient experience in commissioned services and NOTED the key points, concerns and risks contained within it.

**ACTION**

| Ms Clarke to include early actions from West Midlands Quality Review Service (WMQRS) review of CCG’s existing internal quality, patient safety and experience function in the August Quality Report and present full report to September Governing Body meeting.

Ms Clarke to follow up questions raised by Mr Timmis in relation to the NHS 111 assessments for patients with chest pain and lack of central register for the Care Homes |
Advance Scheme (CHAS) and associated risks and provide feedback to August Governing Body meeting.

Ms Clarke to provide feedback from the Shropdoc Clinical Quality Review Meeting (CQRM) in relation to undertaking a Quality Impact Assessment (QIA) following the implementation of the revised model of care by Shropdoc using Emergency Care Practitioners (ECPs).

STRATEGIC PLANNING REPORTS

Minute No. GB-2017-07.145 – Future Fit Programme Director’s Report

19.1 Mrs Debbie Vogler was in attendance to present the Future Fit Programme Director’s report, which provided Governing Body Members with an update of progress on Programme delivery since the last meeting and identified any key risks.

19.2 The following key points were noted:

- Work was nearing completion on the independent review. The supplementary Integrated Impact Assessment (IIA) clinical workshop and focus group work was complete and the Joint Committee arrangements were now finalised. Independent members of the Joint Committee had been appointed with the support of NHS England.

- The Programme timeline had been reviewed based around the availability of the independent review report, timing of the decision making meetings and the knowledge of the NHS England Assurance process requirements. Mrs Vogler drew Members’ attention to Appendix 1 which identified some key provisional dates along the critical path. It was noted that this may be subject to change dependent on the outcome of the independent review which was expected in mid July 2017 and presented to the Programme Board on 31 July and in public at the Joint Committee meeting in August. Public consultation could potentially commence at the end of September for 12 weeks.

19.3 Mrs Vogler reported that key heightened risks identified in the report were notably around resolving the source of capital, the more granular detail on the out of hospital solutions emerging from the neighbourhood work and the outcome of other reviews that were outside of Future Fit but may have interdependencies and links to the overall activity assumptions and affordability of the acute model and the wider Sustainability & Transformation Plan (STP). Discussions were ongoing between CCGs and the Acute Trust in order to resolve any outstanding issues prior to the NHS England Assurance process.

19.4 Mrs Volger highlighted that both Shropshire and Telford & Wrekin CCG Governing Bodies would receive the draft Pre Consultation Business Case (PCBC) at their August meetings, subject to the outcome of the independent review. Dr Povey confirmed that Shropshire CCG planned to move its Governing Body meeting from 9 August to 16 August in order to fit in with the proposed timeline.

RESOLVE: THE GOVERNING BODY RECEIVED AND NOTED the Future Fit Programme Director’s report.

GOVERNANCE

Minute No. GB-2017-07.146 – Healthwatch Report

20.1 Mrs Randall-Smith provided a verbal report on the activities of Healthwatch Shropshire during May and June 2017 following intelligence received.

20.2 Mrs Randall-Smith reported that at the recent Healthwatch England Annual Conference Mr George Rook had been awarded the ‘It All Starts with You’ award for the work he done on dementia in Shropshire. Mrs Randall-Smith advised that Healthwatch Shropshire had also been acknowledged as part of the award due to their engagement work.

20.3 In terms of intelligence, Mrs Randall-Smith reported that Healthwatch Shropshire had spent a significant proportion of their time reading and commenting on the Quality Accounts from local providers. As a result Mrs Randall-Smith highlighted that Healthwatch would be more rigorous going forward in engaging on the implementation of the priorities on quality with all providers.
20.4 The ‘Hot Topic’ for May and June focussed on Mental Health Services and Mrs Randall-Smith noted that they had not received a high level of responses and would, therefore, be repeating the exercise later in the year. This month’s ‘Hot Topic’ would be focussing on health and social care services linking to the ‘It All Starts with You’ award.

20.5 Mrs Randall-Smith reported that Healthwatch had received a number of comments relating to the lack of services for Adults with Attention deficit hyperactivity disorder (ADHD) and lack of therapy options for children and waiting times for Cognitive behavioural therapy (CBT).

20.6 Mrs Randall-Smith reported that feedback appeared to be around appointments, discharge arrangements, attitudes of staff and access to services, both positive and negative. Mrs Randall-Smith advised that this intelligence was feedback to the relevant providers.

20.7 Healthwatch Shropshire was involved in the Midwife Led Unit (MLU) and Community Services Reviews, as well as MSK, both in terms of receiving intelligence and communication and engagement.

20.8 An ‘Enter & View’ report had recently been published on a care home and a further report was due to be published in relation to a provider. The GP Enter & View programme was in the process of being implemented and practice visits were planned. Future Enter & View projects were planned for in-patient wards and out-patient clinics, as well as domiciliary care.

20.9 Mrs Randall-Smith noted that Healthwatch had funded a research project for Active Carers, which was a community group providing support to carers.

20.10 The Healthwatch Shropshire Annual Report 2016/17 had been published and was available to view via their website.

20.11 Finally, Mrs Randall-Smith drew attention to a survey that had recently been conducted by Shropshire Council on the future direction of Healthwatch Shropshire. The findings were due to be published shortly.

20.12 Dr Povey wished to congratulate Mr Rook on his award and advised that he would write formally to him on behalf of the Governing Body.

20.13 Mr Vivian referred to the increased rigorous monitoring of provider Quality Accounts going forward and asked whether there had been an issue in the past. Mrs Randall-Smith advised that in the past Healthwatch had received the draft Quality Accounts for comment, but had not received any further information and it was felt that Healthwatch should follow up the performance of local priorities.

20.14 Ms Clarke reported that she would also expect the CCG’s Quality Committee and CQRM to receive updates on progress against the local priorities and provide support where possible, as well as acknowledge positive findings.

20.15 Dr Julie Davies wished to record her thanks to Healthwatch Shropshire for their support in providing feedback on discharge from hospital, the intelligence received had been used to inform the Discharge to Assess project.

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

**ACTION** Dr Povey to formally write to Mr George Rook to congratulate him on his ‘All Starts With You’ Award presented to him by Healthwatch England for his work on dementia in Shropshire.

**FOR INFORMATION ONLY/EXCEPTION REPORTING**

**Minute Nos. GB-2017-07.147 to GB-2017-07.151**

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

- Finance & Performance Committee (29 March 2017)
- Primary Care Commissioning Committee (14 June 2017) and Terms of Reference
• Clinical Commissioning Committee (17 May 2017)
• Audit Committee (28 June 2017)
• Quality Committee (24 May 2017)

20.2 Dr Povey asked Members if there were any specific points they wished to raise in relation to the reports. These were noted as follows:

**Primary Care Commissioning Committee (14 June 2017)**

Mr Timmis presented the revised Terms of Reference (TOR) for the Primary Care Commissioning Committee (PCCC) for Governing Body approval

Mr Hutton referred to the latest Conflicts of Interest guidance from NHS England, which recommended that all the Lay Members should be members of the PCCC and, therefore, noted that the TOR would need to be updated to reflect this change.

**Audit Committee (28 June 2017)**

Mr Hutton reported that it had been noted at the Audit Committee meeting held on 28 June that there was an increased number of outstanding Internal Audit recommendations, the Committee would continue to monitor progress against these.

The Audit Committee had received two Internal Audit reports – one relating to Budget Setting (including QIPP) where ‘Moderate’ assurance was received, which was an improvement on the ‘Limited’ assurance previously received. Mr Hutton acknowledged the hard work of staff to improve the position. The second report related to Serious Incidents where ‘Limited’ assurance was received. Mr Hutton reported that the outstanding actions from the review would be picked up by Ms Clarke through the Quality Committee.

Mr Hutton reported that the Audit Committee had recommended that a refresh of the Governing Body Assurance Framework (GBAF) be undertaken via a Governing Body workshop, as well as a refresh of the CCG’s corporate objectives.

Mr Hutton noted that the Audit Committee had reviewed its TOR and advised that no changes were suggested. They would be reviewed again later in the year.

**RESOLVE:** THE GOVERNING BODY RECEIVED AND NOTED the reports from the Committees as noted above and APPROVED the revised Terms of Reference for the Primary Care Commissioning Committee, noting that a further amendment would need to be made to reflect the recommendation by NHS England for all Lay Members to be members of the PCCC.

**Minute No. GB-2017-07.152 – Governing Body Assurance Framework (GBAF)**

21.1 The Governing Body Assurance Framework (GBAF) was received. It was noted since the last Governing Body meeting both the Quality Committee and Finance & Performance Committees have met and reviewed the respective risks contained in the GBAF. The GBAF had also been reviewed by Executive Directors. As a result a number of updates had been made which for ease of reference were shown in the document in red. The updates showed progress in relation to a number of risk mitigations and whilst the assessment of risk ratings had not yet been downgraded, at this point clear positive movement in this regard was evident.

**RESOLVE:** THE GOVERNING BODY RECEIVED the Governing Body Assurance Framework (GBAF) and NOTED the review of the risks contained within the GBAF were highlighted in red text.

**Minute No. GB-2017-07.153 – Questions from Members of the Public**

22.1 Dr Povey opened the meeting to questions from members of the public relating to the agenda items discussed, excluding those items where the public had already had an opportunity to raise questions. These were recorded as follows:
• **Mr John Bickerton**

Mr Bickerton noted that subject to the outcome of the independent review, the public consultation on Future Fit would commence in September, however, there were no costings currently included in the options. Furthermore, he noted that West Midlands Ambulance Service (WMAS) were still not achieving their targets and felt that Future Fit would depend on the ambulance service meeting their agreed targets.

Dr Freeman acknowledged that there were still some unknowns associated with the Future Fit Programme and not having confirmation of the capital in advance was unusual. However, Dr Freeman reported that this was a national process and the Programme Board did not have control over it, but was working hard to address these issues. Dr Freeman advised that the affordability issue would be considered by both CCG Governing Bodies in August as part of the decision to proceed to public consultation.

With regards to WMAS, Dr Freeman reported that an impact analysis on the changed conveyance destination of trauma patients was currently being undertaken.

• **Mrs Sylvia Pledger, Albrighton Patient Participation Group**

Mrs Pledger referred to the patient voice and the presentation given by Jo and Jess Almond, which she felt highlighted the difficulties of being a carer and asked if there was a budget within the health service to provide care for carers in order to prevent them from becoming patients from stress related illnesses.

Dr Julie Davies reported that there was a small budget available for carers and the CCG was working with Local Authority colleagues to support carers with an assessment of their health in order to identify and address any issues and provide additional support where necessary.

• **Ms Gill George, Shropshire Defend Our NHS**

Ms George referred to the Primary Care Commissioning Committee minutes where it was reported there was an underspend in the primary care budget and a 1% reserve had been redirected to meet the CCG’s control total, although she noted that this was against NHS guidance as it should be ring-fenced for primary care. Ms George asked how much funding had been redirected to meet the CCG’s control total and who had made the decision.

Dr Freeman reported that the CCG’s primary care budget was approximately £41m, therefore, 1% reserve equated to £400k. The primary care underspend was approximately £200k which he noted was separate to the reserve. Dr Freeman reported that part of the underspend related to services that were commissioned from GPs that had not been undertaken in the expected quantities, part of it also related to temporary delays in getting primary care buildings up and running. Dr Freeman referred to the 1% reserve and reported that this was normally held by NHS England but this year CCGs had been advised to use the reserve to offset their control total, this applied to the whole CCG budget not just primary care.

Dr Povey confirmed that the core primary care funding was ring-fenced but the other elements of primary care funding were not ring-fenced.

• **Mr David Sandbach**

Mr Sandbach referred to the Governing Body minutes from June and reiterated his comment to include a third option as part of the Future Fit consultation and asked the Governing Body to reconsider its decision so that a model similar to that in Northumbria could be consulted upon.

Dr Freeman reported that there was no ability to include this in the current process and would mean having to start the entire Future Fit Programme again. Dr Freeman confirmed that the option for an emergency centre to be sited between Shrewsbury and Telford had been considered as part of the original long list but was not shortlisted.

• **Mrs Joyce Brand**

Mrs Brand asked when the Future Fit Programme had commenced and how much had been spent on the process to date.
Dr Povey advised that the Future Fit Programme had been developed following the Call to Action event held in October 2013 and it was difficult to be able to give a figure of the costing due to way in which it had been funded as it now linked to the STP.

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

**Minute No. GB-2017-07.154 – Any Other Business**

23.1 There were no items of any other business raised.

**NB:** Agenda item GB-2017-07.155 – Shrewsbury & Telford Hospital NHS Trust (SATH) Proposed Transitional Model of Midwifery Led Services across Shropshire was taken immediately after Minute No. GB-2017-07.137 – Shrewsbury & Telford Hospital NHS Trust (SATH) Fragile Clinical Services

**DATE OF NEXT MEETING**

The next scheduled meeting of the CCG Governing Body is:

- **CCG Governing Body Meeting (open to the public)**
  
  Wednesday 16 August 2017 - time and venue to be confirmed. Please note change from original date of 9 August 2017.

SIGNED …………………………………………………..  DATE …………………………………………...
### Shropshire Clinical Commissioning Group

**ACTIONS FROM THE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING – 12 JULY 2017**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Action Required</th>
<th>By Whom</th>
<th>By When</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB-2017-07.136 – Community Services Review</td>
<td>Dr Julie Davies to present outcome of Community Services Review to Governing Body in January 2018.</td>
<td>Dr Julie Davies</td>
<td>10 January 2018 Governing Body meeting</td>
<td></td>
</tr>
<tr>
<td>GB-2017-07.137 – SATH Fragile Clinical Services</td>
<td>Dr Julie Davies to present assurance on SATH’s draft Emergency Department Business Continuity plan when available.</td>
<td>Dr Julie Davies</td>
<td>Future Governing Body meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Julie Davies to present recommendation from CCG’s Clinical Commissioning Committee (CCC) on the options for a solution to the strategic commissioning of paediatric ophthalmology across the county to the Governing Body in September.</td>
<td>Dr Julie Davies</td>
<td>September Governing Body meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Julie Davies to present recommendation from CCG’s CCC on the options for a solution to the strategic commissioning of neurology across the county and potentially mid Wales to the Governing Body in September.</td>
<td>Dr Julie Davies</td>
<td>September Governing Body meeting</td>
<td></td>
</tr>
<tr>
<td>GB-2017-07.138 – Complex Care – Choices Policy</td>
<td>Ms Clarke to ensure approved Complex Care Choices Policy is uploaded to CCG’s website.</td>
<td>Ms Dawn Clarke</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>GB-2017-07.140 – NHS Constitutional Indicators – Status Report</td>
<td>Dr Julie Davies to ensure the minutes of the System A&amp;E Delivery Board were presented to future Governing Body meetings for information and assurance.</td>
<td>Dr Julie Davies</td>
<td>Future Governing Body meetings</td>
<td></td>
</tr>
<tr>
<td>GB-2017-07.144 – Quality Report</td>
<td>Ms Clarke to include early actions from West Midlands Quality Review Service (WMQRS) review of CCG’s existing internal quality, patient safety and experience function in the August Quality Report and present full report to September Governing Body meeting.</td>
<td>Ms Dawn Clarke</td>
<td>August Quality Report</td>
<td>10 September Governing Body meeting</td>
</tr>
<tr>
<td></td>
<td>Ms Clarke to follow up questions raised by Mr Timmis in relation to the NHS 111 assessments for patients with chest pain and lack of central register for the Care Homes Advance Scheme (CHAS) and associated risks and provide feedback to August Governing Body meeting.</td>
<td>Ms Dawn Clarke</td>
<td></td>
<td>Immediately</td>
</tr>
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<td></td>
<td>Ms Clarke to provide feedback from the Shropdoc Clinical Quality Review Meeting (CQRM) in relation to undertaking a Quality Impact Assessment (QIA) following the implementation of the revised model of care by Shropdoc using Emergency Care Practitioners (ECPs).</td>
<td>Ms Dawn Clarke</td>
<td></td>
<td>Provide feedback to August Governing Body meeting</td>
</tr>
<tr>
<td>GB-2017-07.146 – Healthwatch Report</td>
<td>Dr Povey to formally write to Mr George Rook to congratulate him on his ‘All Starts With You’ Award presented to him by Healthwatch England for his work on dementia in Shropshire.</td>
<td>Dr Julian Povey</td>
<td></td>
<td>Immediately</td>
</tr>
<tr>
<td>GB-2017-07.155 – Shrewsbury &amp; Telford Hospital NHS Trust (SATH) Proposed Transitional Model of Midwifery Led Services across Shropshire</td>
<td>Dr Sokolov to seek clarity from the Local Maternity System (LMS) Programme Board with regards to the questions raised by Mrs Sylvia Jones, particularly in relation to clinical responsibility for labouring mothers on route to hospital. Dr Sokolov to ensure that the data and risk assessment relating to the MLU Review was made publicly available when appropriate in the review process.</td>
<td>Dr Jessica Sokolov</td>
<td>Next Local Maternity System (LMS) Programme Board meeting</td>
<td>When appropriate as part of the MLU Review process</td>
</tr>
</tbody>
</table>
Subject: QIPP Update – M3 June 2017

Report Written by: Andrea Webster, Senior Programme Manager

Presented by: Ilse Newsome, Deputy Chief Finance Officer

Responsible Director: Claire Skidmore, Chief Finance Officer

For decision

For performance monitoring X

Other – please specify

Actions required by Members:

- To note the current position.
- To note the additional schemes identified to make good slippage in original plans and achieve £17.71m target for 17/18.

Key issues or points to note:

- Additional schemes have been successfully identified to support shortfall in 17/18 £17.71m target.
- Substantive Head of PMO appointed.
- Formalisation of governance and reporting mechanisms to embed QIPP within the organisation.
1. Introduction

The purpose of this report is to provide continued assurance to the Governing Body on the progress of the 17/18 QIPP Programme and the process being developed to support identification and delivery of 18/19 schemes.

2. PMO and Infrastructure

A conditional offer has been made to appoint a substantive Head of PMO with interim cover remaining in place to support the Programme until a start date is confirmed.

A substantive Project Support Coordinator role, Band 4 has recently been advertised to provide administrative support to the PMO.

The Programme structure is being developed to ensure the process for identification, delivery and monitoring of QIPP can be sustained and embedded within the organisation.

3. QIPP Programme for 2017/18

As at Month 3, the CCG has delivered £2.32m against a plan of £1.84m.

However, it was clear at Month 2 forecasting that the £17.71m target would not be met by the schemes in the CCG’s original plan leaving a shortfall of £3.4m. Hence a rapid piece of work was undertaken to identify schemes to make good the gap.

To support identification and delivery of QIPPs across the region, NHSE produced a Menu of Opportunities Guide and hosted launch events across the Midlands and East area. These events were well attended by CCG Executive Directors and staff and as a result potential opportunities were identified that would create new schemes for 17/18 and 18/19.

The Executive Directors, Commissioning and Scheme Leads also reviewed other areas of opportunity and as a result of both these efforts, the target has been recovered. This is illustrated in the table below.
The graphs below demonstrate both month on month plan versus savings and cumulative plan versus savings.

<table>
<thead>
<tr>
<th>Scheme Name</th>
<th>Total QIPP (+)</th>
<th>Year to Date</th>
<th>Annual 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td>Value Based Commissioning</td>
<td>2,000</td>
<td>498</td>
<td>185</td>
</tr>
<tr>
<td>MSK service redesign</td>
<td>3,000</td>
<td>300</td>
<td>597</td>
</tr>
<tr>
<td>Complex Care</td>
<td>4,000</td>
<td>300</td>
<td>886</td>
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<tr>
<td>Demand Management</td>
<td>1,000</td>
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<td>0</td>
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<tr>
<td>Prescribing</td>
<td>3,000</td>
<td>112</td>
<td>189</td>
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<tr>
<td>SATH Contractual</td>
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<td>0</td>
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<tr>
<td>Shrop Comm Contract</td>
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<td>402</td>
<td>366</td>
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<tr>
<td>RUH Contract</td>
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<tr>
<td>Other small schemes</td>
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<td>57</td>
<td>0</td>
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<tr>
<td></td>
<td>17,711</td>
<td>1,843</td>
<td>2,318</td>
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<tr>
<td>ADDITIONAL SCHEMES</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
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<tr>
<td>HISU</td>
<td>100</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Contract challenges</td>
<td>2,100</td>
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<td>0</td>
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<tr>
<td>SOOS improved redesign impact trajectory</td>
<td>194</td>
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<td>SOOS high impact MSK triage</td>
<td>200</td>
<td>0</td>
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<td>iBCF to fund L3 beds</td>
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<tr>
<td>Out of area repatriation of mental health service</td>
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<td>CHC backlog review</td>
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<td></td>
<td>3,154</td>
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<tr>
<td></td>
<td>20,865</td>
<td>1,843</td>
<td>2,318</td>
</tr>
</tbody>
</table>

Year to Date Annual 2017/18

The graphs below demonstrate both month on month plan versus savings and cumulative plan versus savings.
4. Conclusion

The QIPP target for 17/18 remains a challenge. However, additional schemes continue to be explored and proposals for 18/19 are currently being drawn together to enable early approvals and planning to be in place.
**Title of the report:** MSK Update

**Responsible Director:** Gail Fortes-Mayer, Director of Contracting & Planning

**Author of the report:** Sabrina Brown, MSK Project Manager & Michael Whitworth MSK Project Director

**Presenter:** Nina White, Head of Transformation

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

**Key issues or points to note:**

- **Project Update Overview** – A new project manager is now in post and the project plan has been reviewed and refreshed. Monthly programme board started in August and the membership includes a patient representative from each of the 3 localities.
- **VBC - Improvements** are progressing well.
- **Physiotherapy** – A standardised service specification is being developed with the 5 main local physiotherapy providers, and a directory of services is being developed to highlight gaps in current capacity.
- **SOOS - RAS to SOOS** administrative and clinical processes have been jointly mapped as part of the preliminary work required to deliver the NHSE high impact triage intervention for all orthopaedic referrals.
- **SOOS redesign / expansion** plans are to be presented to the August Clinical Commissioning Committee.

**Actions required by Governing Body Members:**

To receive and note the contents of this report.
Msk Update
Governing Body Meeting

16th August 2017
Project Update Overview

- Project Plan refresh complete and all work streams progressing
- Monthly Programme Board meetings are in place and the membership includes a patient representative from the 3 localities
- VBC improvements are ahead of plan. Work is on-going to reduce the administrative burden of the process and the development of outcomes monitoring

Physiotherapy

- Standardised service specification is currently being drafted following an engagement event with the 5 main local physiotherapy providers in July
- Directory of Service template circulated to all physiotherapy providers (4 of the 5 have completed and returned). The main focus of the template documents the services provided, activity, capacity, skill mix & staffing levels (to support the redesign work for physiotherapy services and capacity enhancement)
SOOS

- RAS to SOOS administrative and clinical processes have been jointly mapped as part of the preliminary work required to deliver the NHSE high impact triage intervention for all orthopaedic referrals. A workshop is scheduled for the 17 August 2017 to finalise plans for scaling the service up to meet the high impact intervention requirements.
- A review of the finance plans for the SOOS redesign / expansion is scheduled for the 11 August 2017, ahead of the August CCC meeting (the required recruitment process has been initiated ahead of final CCC approval to ensure timely implementation)
- Onward referrals from SOOS to secondary care from VBC procedures are being routed via RAS for prior approval coding – this is being progressed to come into operation in August

STP

- Joint economic analysis and longer term forecasting of orthopaedic and MSK activity with STP partners was agreed at the STP partnership board
Aim & Objectives:

Vision:
‘To commission a transformed MsK service that provides capacity to meet the needs of Shropshire patients in line with evidence based best practice’

Programme Aim:
• To commission a community based MsK service that provides appropriate access, efficiency and continuous improvement; whilst achieving proposed QIPP targets in conjunction with RightCare commissioning for value (CfV) and Shropshire’s Sustainability and Transformation Plan

Objectives:
• To develop a standardised service specification and redesign physiotherapy services across the County
• To redesign the SOOS service model and expand to the South of the County
• Agree and implement procurement model for MSK services (Prime Provider, Accountable Care organisation)
• Enhance the value based commissioning (VBC) policy
• Draft and implement a service specification for the Rheumatology Service
• Facilitate continuous development of primary care staff working within MsK
Msk Key Workstreams

1. Physiotherapy
   - Directory of Service
   - Standardised Physiotherapy Specification
   - Demand & Capacity Analysis
   - Redesign of Physiotherapy Services across the County

2. MSK
   - Expansion of SOOS services into the South of the County
   - Redesign of SOOS service model
   - Agree & implement procurement model of MSK services
   - Deep dive analysis of all MSK Activity
   - MSK Triage
   - Clinical pathway review & development
   - Enhancement of RAS Activity
   - Pain Management

3. VBC
   - Enhanced value based commissioning (VBC) policy (inclusive of complimentary therapies)
   - Review of other available national policies
   - Work up and implement pathfinder for spinal pathway
   - Formal introduction of an associated contractual prior approvals process
   - * BlueTech implementation / e-referrals

4. Rheumatology
   - Draft Service Specification
   - Obtain sign off and implementation with RJAH

5. Communications
   - Develop and implementation of communications strategy. To include: (Msk dedicated webpage, usage / circulation of available content, video's, patient information booklets etc

6. Education & Support
   - Education and Support with GP’s practices regarding referral criteria and prior approval
   - Education and support to improve MSK skills in primary care, including enhanced programme of care in the community (Osteoarthritis Keel University & Arthritis Research UK)

Drivers

- QIPP: Redesign of Physiotherapy (PR1718002_2)
- Reduce overall spend and explore alternatives to surgery that deliver better outcomes for patients

- QIPP: SOOS Redesign PR1718002_2
- SOOS Expansion PR1718002_3
- Revised Procurement Model for MSK Services in Shropshire (Prime provider, single provider or accountable care organisation)
- Elective High Impact Interventions NHSE
- NHS Right Care- commissioning for value
- Shropshire CfV Pack 2017
- (17/18 4.2 million – 18/19 10 million)
- Sustainability and Transformation Plan STP

- QIPP: Review to decommission non evidenced treatment and introduce criteria for non specialised procedures outside national benchmarking PR1718002_1

- Unmet BSR Standards

- Streamlined channels of communication to inform, engage and update internal and external stakeholders

- Development of skills and promoting cohesion within primary care across the county
Year Plan 17/18 – 18/19

2017 - 2018

• SOOS service model redesign and expansion to Shrewsbury & South
• Msk Triage NHSE – High Impact Intervention
• Standardised Physiotherapy Service Specification
• Redesign of physiotherapy services
• Deep Dive Analysis of all MSK activity
• Further development of Value based commissioning policy
• Communication strategy development and implementation
• New MSK service model preparatory works (e.g. public engagement, service specification sign off)
• Draft and implement Rheumatology Service specification
• Alignment with wider Sustainability & Transformation Plan

2018 - 2019

• Implementation of new MSK service model (prime provider)
• Continuation of communication strategy
• Further development of MSK services
• ICT /technology development
Title of the report: GP Forward View Progress Report

Responsible Director: Nicky Wilde, Director of Primary Care

Author of the report: Nicky Wilde, Director of Primary Care

Presenter: Nicky Wilde, Director of Primary Care

Purpose of the report:

In April 2016, the GP Forward View was published by NHS England. The document was produced in partnership with the Royal College of General Practitioners and Health Education England. The document details and acknowledges the current pressures facing General Practice and contains specific, practical and funded steps on investment, workforce, workload, infrastructure and care redesign. A copy of the GP Forward View can be found at https://www.england.nhs.uk/gp/gpfv/.

A phase 1 plan was submitted to NHSE in December 2016 and received a rating of Amber/Green. In February 2017 a more detailed phase 2 plan was submitted which also received a rating of Amber/Green.

The purpose of this report is to provide CCG Governing Body with assurance regarding the delivery of the GP Forward View in the CCG in Shropshire. The paper covers the key areas of work and presents the current position regarding financial allocations.

Key issues or points to note

- The key finding of the report is that the phase 2 submission document was submitted at a point in time and delivery dates will need refining against a more accurate and deliverable plan.
- Whilst the CCG is on schedule in many areas of the GPFV PMO plan, these delivery dates will start to slip over the coming months. With the newly appointed staff in the Primary Care Team this is recoverable; however a more clearly defined plan will be required during quarter 3.
- To support successful implementation communication and engagement with all stakeholders needs to be increased.
CCG Governing Board is asked to:

- Note the progress of implementation of the GPFV within the CCG
- Agree to a revised plan with more accurate delivery dates be agreed by Primary Care Committee (PCCC) during quarter 3
- Agree to future assurance to be provided to PCCC and reported to Governing Board through the minutes of PCCC or by exception.
General Practice Forward View – update to CCG Governing Body

August 2017

1.0 Introduction

1.1 In April 2016, the GP Forward View (GPFV) was published by NHS England. The document was produced in partnership with the Royal College of General Practitioners and Health Education England. The document details and acknowledges the current pressures facing General Practice and contains specific, practical and funded steps on investment, workforce, workload, infrastructure and care redesign. A copy of the GP Forward View can be found at https://www.england.nhs.uk/gp/gpfv/.

1.2 To support delivery of the GPFV in the CCG, a phase 1 plan was submitted to NHS England in December 2016 and received a rating of Amber/Green.

1.3 In February 2017 a more detailed phase 2 plan was submitted to NHS England, which included the delivery plans for both Shropshire and Telford and Wrekin. This submission also received a rating of Amber/Green.

1.4 The purpose of this report is to provide CCG Governing Body members with assurance regarding progress towards delivery of the GP Forward View in Shropshire.

1.4.1 The current position regarding financial allocations is also outlined in the paper.

1.4.2 This report also seeks clarification around the future assurance process for the monitoring of the delivery of the GPFV. It is recommended that this programme of work is formally reported to Primary Care Commissioning Committee (PCCC) and to Governing Board via the minutes of PCCC. Exception reports can be provided to Governing Board if required.

1.5 The assurance process to NHSE is by way of a monthly meeting with the GPFV programme Management Office (PMO). This feeds into the regional and national reporting process.

2.0 Key Programmes of Work

2.1 This section of the report provides a summary of work undertaken in each of these areas and outlines the next steps.

2.2 Access

2.2.1 The target set in the GPFV for access is that by the end of March 2019, all CCGs will be funded to ensure that their population have extended access to GP services 8am, 8pm, 7 days a week.

This 7 day service should be underpinned by patient engagement to determine the actual
need regarding 7 day working i.e. if a survey of the patient population confirms that 6
days a week is meeting their needs, then the 7th day could be covered by alternative
service i.e. walk-in at a central location or via an out of hours service specifically
commissioned to provide the 7th day.

NHS England will require evidence to support any CCG decision not to commission the
full 7 day service.

2.2.2 The approved delivery plan for access describes the following elements as being
important when commissioning improved access.

- Timings of appointments
- Capacity
- Ease of access
- Measurement
- Advertising and patient awareness
- Addressing inequalities
- Use of digital technologies

2.2.3 The plan also set out the need for the completion of the Primary Care Needs Assessment
to understand the current position and the next steps to be taken to deliver improved
access in line with the plan. The target date for completion of the Primary Care Needs
Assessment was initially February 2017. The CCG has now completed this piece of
work; however the completion date slipped to July 2017.

In addition to the areas highlighted in 2.2.2 above, the Primary Care Needs Assessment
also highlighted that the following areas were also important in delivering improved
access.

- Self-care
- Ability for patients to manage their own long term conditions
- Supporting Patient Participation Groups to enable a shared understanding of local
  practice population needs.
- Use of multi-disciplinary skilled workforce, to increase patient access, supported
  by excellent IT infrastructure and Estate.
- Increased resource into General Practice

2.2.4 The % delivery target laid out in the approved delivery plan for Shropshire stated that the
number of practices which will meet the definition of offering full extended access; that is
where patients have the option of accessing pre-bookable appointments outside of
standard working hours either through their practice or through their group.

The criteria of ‘Full extended access’ are:
Provision of pre-bookable appointments on Saturdays through the group or practice and
Provision of pre-bookable appointments on Sundays through the group or practice and
Provision of pre-bookable appointments on weekday mornings or evenings through the
group or practice

<table>
<thead>
<tr>
<th>Date</th>
<th>Target</th>
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<tr>
<td>November 2017</td>
<td>51% 22/43 practices</td>
</tr>
<tr>
<td>March 2018</td>
<td>67% 29/43 practices</td>
</tr>
<tr>
<td>November 2018</td>
<td>83% 36/43 practices</td>
</tr>
<tr>
<td>March 2019</td>
<td>100% 43/43 practices</td>
</tr>
</tbody>
</table>
2.2.5 Other targets relating specifically to the original access plan included engaging with those practices who do not currently deliver the Extended Hours Directed Enhanced Services and to engage with the public around access times. These activities will take place in quarter 3/4 of 2017/18.

2.2.6 There are 8 areas for access monitored by the GPFV PMO:

- Completed baselining and learning from pilots 31/08/2017
- Completed appetite and readiness assessments of practices 31/12/2017
- Public and Patient engagement completed, including a set of metrics produced to assess the impact of extended access on patients and the wider health system 31/03/2018
- Discussion paper on procurement options, based on the 7 core requirements, produced for discussion at governing bodies 31/03/2018
- Procurement model signed off by governing bodies 30/04/2018
- Services Procured 01/10/2018
- New service contracts started 31/03/2019
- 100% Access as per GPFV 31/03/2019

2.2.7 In order to deliver improved access and meet the targets outlined in the plan, further work around implementation is required.

2.3 10 High Impact Actions

2.3.1 The GPFV details innovation and best practice to enable the ‘Releasing Time for Patients’ programme. This programme of work is designed to free up to 10% of GPs’ time and have been named the 10 high impact changes. These were all reflected in the phase 2 plan which was submitted to NHS England.

- Active signposting
- New Consultation types
- Reduction in DNAs (did not attend)
- Developing the team
- Productive Workflows
- Personal Productivity
- Partnership working
- Social Prescribing
- Support Self Care
- Develop Quality Improvement Expertise

2.3.2 There are a number of support mechanisms available at national level to support both the CCG and GP Practices with delivery of the 10 high impact changes.

Releasing time for care. A £30 million programme to help practices release capacity and work together at scale, enable self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GP time and improving access to services. National resources and expertise will help groups of practices plan their own Time for Care programme. The CCG has not yet fully promoted this support to practices.
Building capability for improvement. Free training and coaching will be provided for clinicians and managers to grow confidence and skills in using improvement science and leading change. The CCG has not yet promoted this support to practices.

Training for reception and clerical staff. National investment of £45 million benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time. The programme is providing funding via CCGs towards training for receptionists to play a greater role in active signposting and for clerical staff to manage more incoming correspondence. Over the next five years, a typical 10,000 patient practice could receive around £7,500 towards training and backfill costs. The CCG received some of this funding

Practice manager development. A £6 million investment in practice manager development, alongside access for practice managers to the new national development programme. Working with practice manager leaders, the programme will support networking between managers at a local and national level, to share successful ways of managing workload and provide peer-to-peer encouragement and support. The CCG received some of this funding

Online consultation systems. A £45 million fund has been created to contribute towards the costs for practices to purchase online consultation systems, improving access and making best use of clinicians’ time. From April 2017 the programme will provide funding via CCGs towards the cost for practices to install an online consultation system, helping GPs spend more time doing what only they can do. This is work in progress across Shropshire CCG.

2.3.3 Each of the 1 high impact areas has their own individual work-plan that is monitored by the GPFV PMO. A brief outline of these areas is detailed below.

2.3.4 Active Signposting

The delivery plan identifies a requirement within the GP Forward View to ensure that patients are signposted to the most appropriate service to support their clinical need and to ensure that patients are seen in the right place first time. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional.

Active signposting has commenced in Shropshire with 40/43 practices so far accessing some level of training. Further staff training is scheduled from August 2017.

Joint work is ongoing between the CCG locality commissioning group managers and local authority colleagues to better understand how this work can link with related work elsewhere.

This programme of work is on schedule to deliver against the plan.

2.3.5 New types of Consultations

This set of innovations is about introducing new communication methods for some consultations, such using groups, skype, phone and email. Where clinically appropriate, these can improve continuity and convenience for the patient and reduce clinical time per contact.

The plan identifies that by September 2017 development plans will have progressed to enable delivery towards the end of this financial year.
2.3.6 Reduction in DNA’s

Patients, who routinely do not attend GP appointments, take up valuable GP capacity and can mean those who really need an appointment may not be able to get one.

The CCG has not as yet delivered against this area of development and will define this area more clearly in future reporting. The first task will be to identify the extent of DNAs in our GP practices.

2.3.7 Developing the Team - Workforce

This element is about developing the workforce which is probably one of the most important aspects within the 10 high impact changes. Broadening the workforce in order to reduce demand for GP time and connect the patient directly with the most appropriate professional.

The CCG has committed to develop a Primary Care Workforce plan which is aligned to the wider STP workforce plan and fit to deliver appropriate numbers of required staff to deliver the new model of care. There are a number of actions contained within the GPFV PMO return such as:

- Baseline workforce assessment completed
- Shropshire-wide General Practice workforce strategy produced
- GP workforce strategy integrated with wider STP workforce strategy
- Communication to GP teams of a shared understanding of the neighbourhood working model and the impact of this on new roles and the skill mix within General Practice
- Set of metrics developed and agreed to measure how new/enhanced roles have supported improved access and demand management
- Supporting general practice through introduction Clinical Pharmacists
- Pan-Shropshire approach to International Recruitment agreed
- Pan-Shropshire approach to the recruitment of Physician Associates agreed
- Pan-Shropshire approach to the recruitment of practice nurses agreed
- Pan-Shropshire approach to the recruitment of mental health workers agreed
- Pan-Shropshire approach to GP Career Plus agreed

The first formal meeting to discuss the Primary Care Workforce plan is scheduled for 14th August 2017. This is an area of work which is being led by NHS England.

2.3.8 Productive Workflows

As stated in the GP Forward View - workload has been identified as one of the biggest issues of concern to GPs and their staff. The work and processes undertaken in General Practice has increased year on year and therefore it is important that Practices look at the way in which they work to ensure all workflows are as productive as they can be. Some of the areas the CCG is looking at to support practices in addition to those already highlighted are around:-

Accessing funding to support care navigation
Improved document management/workflow
Accessing resilience funding
Sharing case studies of good practice

The CCG is relatively advanced in the planning around these areas and we need to ensure the most effective use of funding available.
2.3.9 Personal Productivity

Supporting staff to develop their personal resilience, as well as developing specific skills to allow them to work in the most efficient way possible is key to retraining the workforce. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed.

This is an area which has not been actively pursued and further support is required in this area.

2.3.10 Partnership working / New Model of Care

General Practice cannot work in isolation to become sustainable in the future – resources for Health and Social Care Services are scarce and therefore, where possible, organisations need to work together to make the most of the resource available. Health and Social Care are fully involved in the development of the New Model of Care and Locality working.

In Shropshire, there are 3 groups of Practices working in localities. All of these localities have a GP Chair, a Locality Manager and also a Locality Pharmacist working with them to support the design of the New Model of Care for the future. This new model will be aligned to the wider Out of Hospital work through the STP.

Whilst there are specific areas being monitored against this element of the plan, more definition is required around the Out of Hospital work and therefore the detail of the new model of care, before a more refined plan can be implemented.

This is an area which requires strategic direction to enable progress to be made in meeting this important objective.

2.3.11 Social Prescribing

Social Prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

Work is ongoing between the Local Authority and Locality leads to take this initiative forward. It is closely aligned to Active Signposting and Care Navigation.

There is currently a pilot ongoing in Shropshire and the learning will be shared and implemented across the CCG over the next 12-18 months.

2.3.12 Support Self-care

Supporting patients to self-care and be actively engaged in managing their conditions will be of increasing importance in the future. In term of planning around the GPFV this is an area that has not yet been discussed in any significant detail. This programme of work will be more clearly defined in quarter 3 of 2017/18.

2.3.13 Develop Quality Improvement Expertise

The task within this programme of work is to develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes. The team could be based in a CCG or federation. They should ideally include clinicians and managers, and have skills in leading change, using recognised improvement tools such as Lean, PDSA and SPC, and coaching GP practice teams.
This is another area where, to date, the CCG has not currently agreed a plan to take this area forward, although the new Primary Care Directorate is a significant step towards meeting with ambition. This support mechanism will be further developed in quarter 3 2017/18.

2.4 Estates and Technology Transformation

2.4.1 Shropshire CCG submitted 2 estates bids under the Estates and Transformation fund – one for Whitchurch and one for Shifnal. Both of these projects are progressing to timescales and are reported to Primary Care Committee.

There is also a wider programme of work around developing Primary Care Estate which is aligned to the STP Estates group. The Primary Care Estates work is reported to Primary Care Committee.

2.4.2 The CCG was also successful in securing funding for 2 IT projects:

Common Telephone System for all GP Practices (VOIP) - This project covers the implementation of a common telephone system across all Practices and will provide significant cost savings for Practices across the CCG, easier access for patients, better business continuity and scalability.

Wi-Fi - This project covers the provision of a Wi-Fi network for both patients and clinical staff across all GP Practices. For clinical purposes, clinical staff will be able to access the network attached to the N3 network; Patients (and clinical staff for non-clinical use) will be able to access a separate network not connected to the N3 line for use while in the Practice (i.e. in waiting rooms and/or meeting rooms). Certain types of traffic/data will be blocked and the network will be switched off during out of hours.

Both the IT projects are on target to deliver within the expected timescales and are aligned to the wider Primary Care and STP IT programme.

3.0 Engagement

3.1 There has been little engagement with patients and the public around the GP Forward View so far.

An engagement exercise was undertaken for the Primary Care Needs Assessment which will support the work going forward.

A specific piece of engagement work is required to support the new model of care and the 7 day access programmes of work.

A recommendation from this report is to develop a communication plan to engage with patients, stakeholders and GP Practices to increase awareness.

4.0 Finance

4.1 The GPFV states that by 2020/21 recurrent funding for GP Practices is to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a “turnaround” package of a further £500 million. Investments in staff, technology and premises are also planned.

4.2 The CCG needs to ensure that all available funding streams are identified and bids put forward to attract additional funding for our GP Practices.
4.3 The current reported position on funding for the CCG is detailed below.

Analysis of GPFV Income streams 2016/17 to 2019/20 as at August 17

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>Primary Care Transformation</td>
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<td>Online Consultations</td>
<td>78</td>
<td>105</td>
<td>53</td>
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<tr>
<td>Improved Access</td>
<td>751</td>
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<td>1,800</td>
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<td>GP Resilience Programme*</td>
<td>84</td>
<td>42</td>
<td>42</td>
<td>42</td>
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<tr>
<td>Total PCFV funds</td>
<td>110</td>
<td>1,381</td>
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<td>1,946</td>
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</tbody>
</table>

In addition to this, the CCG supported bids to NHSE against a Practice Manager Development Fund and was successful in securing some funding for Practice Manager development.

*It should be noted that the GP resilience funding is not automatically awarded to CCGs. There is a bidding process which has to be followed. The CCG is currently awaiting the outcome of 2017/18 bids.

5.0 Assurance process

5.1 The Assurance process for the GP Forward View follows both internal CCG assurance through the Primary Care Committee and external assurance through the GPFV PMO.

The most up to date draft reporting template for the PMO is provided at Appendix 1 for information. Although it is early days, the schedule remains mainly on track, however there is a lot more detailed work to be planned and undertaken to secure delivery.

5.2 To enable the CCG to support the GP Practices, a service specification has been designed and offered out to practices. This will enable the Primary Care Transformation funding identified in 4.3 above to be released to Practices. The CCG is currently awaiting feedback from practices on the specification offered.

6.0 Interdependencies

6.1 The delivery of the GPFV is dependent on a number of aligned programmes of work and also the capacity both within the CCG and GP Practices to deliver.

6.2 The Primary Care Directorate is a new Directorate within the CCG and team members are currently being appointed. There is an expectation that starting dates for 2 new team members will be October / November 2017. These team members will have responsibility for delivery of the GPFV within the CCG.

6.3 Many of the areas contained in the plan align to working with the Local Authority, specifically around areas of estates, social prescribing and care navigation. This relationship is working well, however delivery could be hindered if the coordination of
projects is not closely aligned.

6.4 The New Models of Care and locality working is also dependent on the Local Authority, the Community Trust and the Out of Hospital plans. There must be total alignment of the commissioning and delivery of the New Model of Care to ensure successful and timely delivery of projects.

6.5 The sole purpose of the GPFV is to implement innovative and evidenced ways of supporting General Practice to become more resilient and sustainable in the future.

To ensure this programme of work achieves this aspiration in Shropshire, the Primary Care Team needs to work closer with the practices and patients on understanding the advantages and risks involved and to work together to gain maximum impact. This programme of work should feel and look like a support programme and not a tick box exercise.

7.0 Key findings

7.1 The key finding of the report is that the phase 2 submission document was submitted at a point in time and delivery dates will need refining against a more accurate and deliverable plan.

7.2 Whilst the CCG is on schedule in many areas of the GPFV PMO plan, these delivery dates will start to slip over the coming months. With the newly appointed staff in the Primary Care Team this is recoverable; however a more clearly defined plan will be required during quarter 3.

7.3 To support successful implementation communication and engagement with all stakeholders needs to be increased.

8.0 Recommendations

8.1 CCG Governing Board is asked to:
   - Note the progress of implementation of the GPFV within the CCG
   - Agree to a revised plan with more accurate delivery dates be agreed by Primary Care Committee (PCCC) during quarter 3
   - Agree to future assurance to be provided to PCCC and reported to Governing Board through the minutes of PCCC or by exception.
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<tr>
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<th>Sub Project</th>
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<td>1</td>
<td>Models of Care</td>
<td>Shropshire</td>
<td>Neighbourhood working</td>
<td>Engagement activity with GPs around neighbourhood working completed</td>
<td>Nicky Wilde</td>
<td>30/09/2017</td>
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<td>Models of Care</td>
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<td>Neighbourhood working</td>
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<td>Models of Care</td>
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<td>Neighbourhood working</td>
<td>Learning from neighbourhood activity in Bishop’s Castle and Oswestry is rolled out</td>
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<td>Models of Care</td>
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<td>Plans agreed for how General Practice will formally link into the Neighbourhood Working model</td>
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<td>Completed baseline and learning from pilots</td>
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<td>Public and Patient engagement completed, including a set of metrics produced to assess the impact of extended access on patients and the wider health system</td>
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<td>11</td>
<td>Access</td>
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<td>Discussion paper on procurement options, based on the 7 core requirements, produced for discussion at governing bodies</td>
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<td>Shropshire</td>
<td>Workforce Strategy</td>
<td>Consistent approach to collating and analysing data on staff training and development agreed across the county</td>
<td>Jane Blay and Eluned Eagle</td>
<td>31/03/2018</td>
</tr>
<tr>
<td>23</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Workforce Strategy</td>
<td>Set of metrics developed and agreed to measure how new/enhanced roles have supported improved access and demand management</td>
<td>Jane Blay and Eluned Eagle</td>
<td>31/03/2018</td>
</tr>
<tr>
<td>24</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>Scoped interest of local acute and community provider partners in supporting general practice through provision of Clinical Pharmacists</td>
<td>Sean Mackay</td>
<td>31/03/2017</td>
</tr>
<tr>
<td>25</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>Scoped interest of general practices in having Clinical Pharmacists</td>
<td>Sean Mackay</td>
<td>31/03/2017</td>
</tr>
<tr>
<td>26</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>Developed options for Clinical Pharmacists in general practice</td>
<td>Sean Mackay</td>
<td>31/08/2107</td>
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<td>27</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>Bids submitted to recruit Clinical Pharmacists via national scheme</td>
<td>Sean Mackay</td>
<td>31/12/2017</td>
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<tr>
<td>28</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>Local Clinical Pharmacist recruitment schemes evaluated and next steps agreed</td>
<td>Sean Mackay</td>
<td>31/12/2018</td>
</tr>
<tr>
<td>29</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Clinical Pharmacists</td>
<td>S Clinical Pharmacists in Post</td>
<td>Sean Mackay</td>
<td>31/12/2018</td>
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<tr>
<td>30</td>
<td>Workforce</td>
<td>Shropshire and Telford</td>
<td>International recruitment</td>
<td>Pan-Shropshire approach to International Recruitment agreed</td>
<td>Jane Blay and Eluned Eagle</td>
<td>01/09/2017</td>
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<tr>
<td>31</td>
<td>Workforce</td>
<td>Shropshire and Telford</td>
<td>International recruitment</td>
<td>Pan shropshire bid submitted</td>
<td>Jane Blay and Eluned Eagle</td>
<td>30/11/2017</td>
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<td>32</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Physician Associates</td>
<td>Pan-Shropshire approach to the recruitment of Physician Associates agreed</td>
<td>Jane Blay and Eluned Eagle</td>
<td>tbc</td>
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<tr>
<td>33</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Nursing Framework</td>
<td>Pan-Shropshire approach to the recruitment of practice nurses agreed</td>
<td>Jane Blay and Eluned Eagle</td>
<td>tbc</td>
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<td>34</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Mental Health Assistants</td>
<td>Pan-Shropshire approach to the recruitment of mental health workers agreed</td>
<td>Jane Blay and Eluned Eagle</td>
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<tr>
<td>35</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>GP Career Plus</td>
<td>Pan-Shropshire approach to GP Career Plus agreed</td>
<td>Jane Blay and Eluned Eagle</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>36</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Practice Manager Development</td>
<td>Deadline for bid submissions from practices</td>
<td>Sara Edwards</td>
<td>24/05/2017</td>
</tr>
<tr>
<td>37</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Practice Manager Development</td>
<td>Successful practices informed</td>
<td>Sara Edwards</td>
<td>16/06/2017</td>
</tr>
<tr>
<td>38</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Practice Manager Development</td>
<td>Progress reports received from practices</td>
<td>Jane Blay</td>
<td>30/11/2017</td>
</tr>
<tr>
<td>39</td>
<td>Workforce</td>
<td>Shropshire</td>
<td>Practice Manager Development</td>
<td>3x Practice Managers trained</td>
<td>Jane Blay</td>
<td>31/03/2018</td>
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<tr>
<td>40</td>
<td>Workload, Resilience, 10 HIA</td>
<td>Shropshire</td>
<td>Active Signposting</td>
<td>Process agreed for the application for, and allocation of, the 2017/18 care navigation funding</td>
<td>Jenny Stevenson</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>41</td>
<td>Workload, Resilience, 10 HIA</td>
<td>Shropshire</td>
<td>Active Signposting</td>
<td>First wave of training commenced for reception staff on active signposting</td>
<td>Jenny Stevenson</td>
<td>31/08/2017</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Active Signposting</td>
<td>First wave of training completed for reception staff on active signposting (level 1 training)</td>
<td>Jenny Stevenson</td>
<td>30/06/2017</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Active Signposting</td>
<td>Level 2 training completed for reception staff on active signposting</td>
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<td>31/03/2018</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Active Signposting</td>
<td>Level 3 / 4 training completed for reception staff on active signposting</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>New types of consultations</td>
<td>Plan to introduce e-consultation and Skype consultation developed and implementation commenced</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>DNA</td>
<td>Plan to reduce the number of DNAs produced and implementation commenced</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Productive work flows</td>
<td>Identification of interest by Practices in training on improved document management/workflow</td>
<td>Jenny Stevenson</td>
<td>31/07/2017</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Productive work flows</td>
<td>Delivery of training to all Practices on improved document management/workflow</td>
<td>Jenny Stevenson</td>
<td>31/03/2018</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Personal productivity</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Social Prescribing</td>
<td>Social Prescribing Pilot referral process in place</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Supported self care</td>
<td>Plan to introduce self-care in practices developed and implemented</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Resilience Fund 16/17</td>
<td>Process to clarify and then monitor actions agreed under the 2016/17 Resilience Fund developed and agreed</td>
<td>June Telford</td>
<td>30/06/2017</td>
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<td>Resilience Fund 16/17</td>
<td>Case studies produced by practices</td>
<td>June Telford</td>
<td>31/07/2017</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Resilience Fund 17/18</td>
<td>Process outlined and agreed</td>
<td>NHS England</td>
<td>30/06/2017</td>
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<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Resilience Fund 17/18</td>
<td>Funding and outcomes agreed with practices</td>
<td>NHS England</td>
<td>31/07/2017</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Resilience Fund 17/18</td>
<td>System in place for monitoring impact of spend against agreed MoUs 2017/2018</td>
<td>Nicky Wilde</td>
<td>31/07/2018</td>
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<tr>
<td>Workload, Resilience, 10 HIA Shropshire</td>
<td>Resilience Fund 17/18</td>
<td>Case studies produced by practices</td>
<td>28/02/2018</td>
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<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>Outline Business Case (OBC) for new build of Shifnal premises submitted to PAU</td>
<td>Nicky W and Amanda A</td>
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<td>ETTF - Estates</td>
<td>OBC for new build of Shifnal premises submitted to PCCC</td>
<td>Nicky W and Amanda A</td>
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<tr>
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<td>Full Business Case (FBC) for new build of Shifnal premises completed</td>
<td>Nicky W and Amanda A</td>
<td>01/11/2017</td>
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<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>FBC for new build of Shifnal premises submitted to PAU</td>
<td>Nicky W and Amanda A</td>
<td>01/11/2017</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>FBC for new build of Shifnal premises submitted to PCCC</td>
<td>Nicky W and Amanda A</td>
<td>03/11/2017</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>FBC for new build of Shifnal premises submitted to SAAC</td>
<td>Nicky W and Amanda A</td>
<td>01/01/2018</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>OBC for new build of Whitchurch premises completed</td>
<td>Nicky W and Amanda A</td>
<td>01/12/2018</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>OBC for new build of Whitchurch premises submitted to PAU</td>
<td>Nicky W and Amanda A</td>
<td>01/12/2018</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>OBC for new build of Whitchurch premises submitted to PCCC</td>
<td>Nicky W and Amanda A</td>
<td>01/12/2018</td>
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<td>ETTF - Estates</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>FBC for new build of Whitchurch premises submitted to PCCC</td>
<td>Nicky W and Amanda A</td>
<td>01/03/2018</td>
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<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Estates</td>
<td>New build of Whitchurch premises commenced</td>
<td>Nicky W and Amanda A</td>
<td>tbc</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Digital / IT</td>
<td>Wifi / VoIP practice questionnaires analysed</td>
<td>Nigel Crew</td>
<td>01/08/2017</td>
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<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Digital / IT</td>
<td>Wifi / VoIP site surveys completed</td>
<td>Nigel Crew</td>
<td>01/10/2017</td>
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<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Digital / IT</td>
<td>Confirmation of practices contracting to proceed with wifi / VoIP</td>
<td>Nigel Crew</td>
<td>31/03/2018</td>
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<tr>
<td>ETTF &amp; Digital Shropshire</td>
<td>ETTF - Digital / IT</td>
<td>WiFi project implemented across all participating practices</td>
<td>Nigel Crew</td>
<td>31/03/2018</td>
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</table>
Purpose of the report:

In April 2015, Shropshire CCG took on full delegated authority from NHS England for certain specified primary care commissioning functions.

The primary care needs assessment has been carried out to ensure that the strategic aims identified in the CCG's initial Primary Care Strategy, published in January 2016, are the correct areas to be delivered, and to set out how the CCG will ensure the provision of sustainable and high quality general practice across the county.

The primary care needs assessment is written with reference to, and in alignment with, NHS England’s GP Forward View and the Sustainability and Transformation Plan (STP) for Shropshire, Telford and Wrekin. Other relevant local and national plans and priorities have also been referenced and used to inform the needs assessment.

Key issues or points to note:

Of specific note is the effect the CCG’s rural nature has on the provision of Primary Care services in Shropshire.

The CCG has invested in a Primary Care Directorate to support the future commissioning and development of Primary Care services and has a governance structure for decision making.

The key messages and recommendations are set out on page 5 of the report. In summary, the key recommendations are to:

- Develop locality profiles to inform the commissioning requirements for the local populations.
- Promote patient activation and disease prevention, wellness and healthy lifestyles.
- Support and develop more integrated working, support the development of new models of care and provide opportunity for shared workforce and resources.

- Continue to support Practices to develop their Patient Participation Groups to build on this Needs Assessment, and continue to undertake wider patient surveys to determine experiences and needs.

- Support delivery of the GP Forward View around a new model for Primary Care 8am – 8pm 7 days a week.

- Support delivery of the GP Forward View by commissioning high quality Primary Care at Scale, addressing inequalities by attracting a multidisciplinary skilled workforce, to increase patient access.

- Ensure there is planning and resource available to identify and manage those health conditions highlighted as a priority by public health and the increasing number of patients with complex health conditions.

- Develop long term infrastructure plans including workforce, technology and estate.

- Promote and develop a culture of continuous improvement and shared learning.

- Minimise unnecessary administrative pressures on practices.

- Ensure a robust reporting framework to Primary Care Commissioning Committee on delivery of the needs assessment.

- Develop a communications strategy for Primary Care.

The paper was taken to Primary Care Commissioning Committee (PCCC) on 2 August 2017. Comments from the Committee included:

- The need to link more to the patient input from the survey carried out through Healthwatch and patient groups (e.g. in the workforce section make more reference to the survey results around these issues).

- Reiteration of the level of challenge currently being faced by primary care around recruitment; vacancies; workload management (including a potential ‘right shift’ to secondary care due to the increasing workload in primary care); safety (the high numbers of patients being seen by general practice and is this number deemed ‘safe’); and capacity building / long term planning.

- The question of how the needs assessment fits in with the wider picture and the new models of care. This is the next stage for the Primary Care Directorate to take forward.

**Actions required by Governing Body Members:**

Governing Body Members are asked to:

- Acknowledge the content of the report.
- Agree to the Primary Care Directorate implementing the key actions identified in section 6 of the report.
- Agree to the recommendations and suggestions made by PCCC.
- Agree to the information within the report being used to inform the out of hospital new model of care.
<table>
<thead>
<tr>
<th></th>
<th>CCG Aims and Objectives (please provide details where applicable)</th>
<th>Yes/ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Objective 1 - Deliver a continually improving Healthcare and Patient Experience</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Through the implementation of the priorities identified within the needs assessment, the CCG will be better placed to address any current health inequalities, with the aim of improving equity, and maintaining and improving quality and patient experience.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Objective 2 - Develop a 'true membership' organisation (active engagement and clinically led organisation)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Addressing the priorities within the needs assessment as localities, led by the CCG’s locality commissioning group managers, should lead to increased engagement with the CCG’s member practices.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Objective 3 - Achieve Financial sustainability for future investment</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>The priorities within the needs assessment will be addressed in the context of our current financial position, and with a view to how high quality, equitable and sustainable primary care services can be delivered in the future, which will include best use of financial resources and targeting investment, in line with our STP.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Objective 4 - Visible leadership of the local health economy through behaviour and action</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Increased engagement with the localities, focusing on clinical priorities and new ways of working.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Objective 5 - Grow the leaders for tomorrow (Business Continuity)</td>
<td>Yes</td>
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<tr>
<td></td>
<td>This should partly be addressed through the workforce recommendations.</td>
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<tr>
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<th>Governance (please provide details where applicable)</th>
<th>Yes/ No</th>
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<tr>
<td>1</td>
<td>Does this report:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>- Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number)</td>
<td></td>
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<tr>
<td></td>
<td>- Have any legal implications?</td>
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<tr>
<td></td>
<td>- Promote effective governance practice</td>
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<tr>
<td></td>
<td><em>Provide a summary of the risks and any mitigating actions, any legal implications etc</em></td>
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<tr>
<td>2</td>
<td>Additional staffing or financial resource implications</td>
<td>No</td>
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<tr>
<td></td>
<td>To be determined</td>
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<td>3</td>
<td>Health inequalities</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Through the implementation of the priorities identified within the needs assessment, any current health inequalities should be highlighted and reduced.</td>
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<tr>
<td>4</td>
<td>Human Rights, equality and diversity requirements</td>
<td>No</td>
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<td></td>
<td>Requirements will be considered and addressed as appropriate.</td>
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<tr>
<td>5</td>
<td>Clinical engagement</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Improved clinical engagement through progressing the priorities at locality level.</td>
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<tr>
<td>6</td>
<td><strong>Patient and public engagement</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Patient and public engagement will be undertaken as appropriate as work plans progress. Patient participation groups will continue to be promoted.</td>
<td></td>
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## Contents

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<td><strong>Section 2: Context</strong></td>
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<td>2.1 Strategic context – national and local</td>
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<td>NHS England objectives</td>
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Executive Summary

Local context
In April 2015, Shropshire CCG took on full delegated authority from NHS England for certain specified primary care commissioning functions, in accordance with NHS England’s statutory powers under section 13Z of the National Health Service Act 2006 (as amended).

An initial Primary Care Strategy was published in January 2016 which set out 8 key strategic aims for the CCG. It was subsequently highlighted that a primary care needs assessment needed to be completed to ensure that the identified strategic aims were the correct areas to be delivered and to set out how the CCG will ensure the provision of sustainable and high quality general practice across the county. The publication of NHS England’s GP Forward View and the Sustainability and Transformation Plan (STP) for Shropshire, Telford and Wrekin in 2016 added to the need to assess the current position and future needs of primary care in Shropshire CCG. The primary care needs assessment is written with reference to, and in alignment with, these programmes of work. Other relevant local and national plans and priorities have also been referenced and used to inform this Needs Assessment. Details can be found in sections 1 and 2 of this report; of specific note is the effect the CCG’s rural nature has on the provision of Primary Care Services.

The CCG has invested in a Primary Care Directorate to support the future commissioning and development of Primary Care Services and has a Governance Structure for decision making.

Summary of current provision of primary care services
Shropshire CCG has 43 GP practices that are spread across three localities – North, South and Shrewsbury & Atcham. Alongside GPs coming together, or working together, as providers, the CCG has, with locality input, developed clusters of practices around which the CCG can commission non GP community services. These are outside the scope of the PCNA and are (will be) addressed within the CCG commissioning intentions.

The average practice list size is currently 7134, with individual practice populations ranging from 2,033 to 17,457 patients. Due to the rural nature of the county, 18 practices dispense medicines to their patients. Most practices operate a GMS contract, with one practice operating a PMS contract and two operating an APMS contract. There is one walk in centre (Primary Care urgent care centre), open 8am-8pm 7 days a week, located alongside the Emergency Department at the Royal Shrewsbury Hospital. The walk-in centre contract is part of a wider APMS contract which also has a registered list provided from a separate site, Whitehall Medical Practice in Shrewsbury. Out of Hours GP services are provided by Shropshire Doctors Cooperative Ltd. (Shropdoc).

A range of enhanced services are provided by GP practices. Some of these are nationally mandated and called Directed Enhanced Services and others, originally named local enhanced services, are commissioned locally and are now named locally commissioned services. Although all practices are signed up to deliver a range of enhanced services, the level of uptake is variable. The locally commissioned services are currently under review, and this review will seek to understand where there is variable uptake of enhanced Services and ensure equity of future provision.

The standard of general practice across Shropshire is seen to be high, with high Quality and Outcomes Framework (QOF) achievement, good Care Quality Commission (CQC) ratings, and high patient satisfaction scores. Details of these areas can be found in section 4 of this Needs Assessment.

There is a big focus on improved access to primary care within the GP Forward View. Additional funding is being invested via the GP Access Fund to ensure 100% of the patient population has access to pre-bookable and same day appointments to general practice services 8am – 8pm Monday to Friday. The national timescale for implementation of appropriate weekend provision is by April 2019. Patient satisfaction with access to their GP practice is good overall, however there are individual practices who achieve much lower satisfaction scores than the CCG average. All practices have enabled the Patient Online system to provide online access to patients for booking appointments, ordering repeat prescriptions and access to coded information in their medical record. The percentage of patients enabled to use these services are variable across our practices and there is a need to further promote this programme with practices and patients. Details around access can be found in section 3.1 of this report.

In an audit of GP practice premises undertaken in November 2015, most practices were interested in securing funding for premises developments and identified that they had issues with lack of space for current services and / or lack of space to expand their services. Projected population increases and many new housing developments being built and planned across the county have been identified as putting pressure on existing capacity. Premises developments need to consider future population growth and support new models of care and at scale working. This could mean basing some services around a ‘hub’ model, with one practice providing services for a wider local population, or a practice working closer with a wider multidisciplinary team. Accessibility and capacity for any new care model would therefore need to be considered in plans for premises developments. Further details around practice premises can be found in section 3.2 of this report.

There is scope for improved use of innovative technology across the health system. Some initiatives are currently being promoted and funded through the GP Forward View and Estates and Technology Transformation Fund (ETTF) such as the introduction of Wi-Fi in practices and better connectivity across phone and IT systems. This is an area which needs more thoughtful planning and development this year. Details can be found in section 3.3 of this report.

The resilience and sustainability of the overall primary care workforce and individual members of staff is under huge strain, with increasing demand and lack of recurrent resources. General Practice in Shropshire is facing the same issues as the rest of the country with pressures on GP and Practice Nurse recruitment and retention. Whilst the CCG has started to audit our Primary Care Workforce, further detailed analysis of the GP and wider primary care workforce is needed to identify need and address recruitment and retention issues. The CCG is working with NHS England and other CCGs to develop a plan across Shropshire and Staffordshire to take this work forward. Workforce also needs to be considered alongside the other workstreams of the GP Forward View (extended access, collaborative working, new models of care) and plans need to develop in parallel with the STP work that is looking at the workforce of the wider health and social care economy. Further information on plans is provided in section 3.4 of this report.

To help inform the development of this needs assessment, an engagement exercise was carried out with patient groups and GP practices (see section 5). The results of the patient questionnaire showed willingness amongst those surveyed to see a health professional other than a GP (for example seeing an Advanced Nurse Practitioner or discussing requirements with a Pharmacist where appropriate), however a low percentage of respondents said they would be willing to travel to another GP practice to access services. Both the patient and GP practice survey results showed support for the need to develop enhanced technology to facilitate more ways of accessing primary care services and advice, for example email and Skype.
It is vital that robust systems are in place, and available funding utilised, to support our current services and to ensure we develop services that are sustainable in the future. We also need to engage more with our patients about these areas of work, and involve them in the planning of primary care services.

**Key messages and recommendations**

The CCG should plan to commission high quality primary care at scale, addressing inequalities by attracting a multidisciplinary skilled workforce, to increase patient access, supported by excellent IT infrastructure and estate. This should be achieved through successful implementation of the programmes and initiatives within the GP Forward View workstreams, and in alignment with the plans set out in Shropshire, Telford and Wrekin’s Sustainability and Transformation Plan (STP). After consideration of the content of this document, the recommendations are to:

- Develop locality profiles to inform the commissioning requirements for the local populations. These profiles need to clearly set out the health needs for local populations, highlighting any variation across each patch. This will help identify whether the primary care services currently being provided are being delivered in the most appropriate way to meet local need and whether they are addressing identified clinical priorities; this will also help to inform locality, cluster and ‘at scale’ working, in line with new models of care; and will inform future primary care commissioning decisions.

- Promote patient activation and disease prevention, wellness and healthy lifestyles, by identifying resources to assist self-care and the ability for patients to manage their own conditions safely. This should involve increased access to information online and improving links across the local health and social care system, including the local authority work around resilient communities and healthy lives.

- Support and develop more integrated working, which will support the development of new models of care and provide opportunity for shared workforce and resources. This will subsequently support the aim of reducing workload on practices through improved understanding and navigation of the wider system, and improved patient outcomes and satisfaction.

- Continue to support Practices to develop their Patient Participation Groups to build on this Needs Assessment, and continue to undertake wider patient surveys to determine experiences and needs. This will enable a shared understanding of their local practice population needs and build relationships to ensure the sustainability of Primary Care for the future.

- Support delivery of the GP Forward View around a new model for Primary Care 8am – 8pm 7 days a week. Develop a formal plan to deliver this model, ensuring that equitable access is available and visible for both routine and urgent care in GP Practices.

- Support delivery of the GP Forward View by commissioning high quality Primary Care at Scale, addressing inequalities by attracting a multidisciplinary skilled workforce, to increase patient access. Identify the services required for the future model of care and the supporting technologies required. Supervision, peer review and audit processes to be clear to enable reduction of unwarranted variances.

- Ensure there is planning and resource available to identify and manage those health conditions highlighted as a priority by public health and the increasing number of patients with complex health conditions.

- Develop long term infrastructure plans including workforce, technology and estate.
• Promote and develop a culture of continuous improvement and shared learning. To introduce a formal mechanism for the sharing of CQC rated ‘outstanding’ practice.

• Minimise unnecessary administrative pressures on practices.

• Ensure a robust reporting framework to the Primary Care Commissioning Committee on delivery of this Needs Assessment.

• Develop a communications strategy for Primary Care.
Section 1

Vision and background

Future vision of primary care in Shropshire

The CCG acknowledges that general practice is the cornerstone of the NHS and as such requires support to make practices sustainable and resilient for the future. The CCG will oversee increased levels of investment in general practice, in line with additional funding being made available by NHS England and as set out in the GP Forward View. The CCG will also aim to ensure that further investment is made to support the continuation of high quality and sustainable primary care services through an expanded workforce, new models of care and improved infrastructure.

The CCG has invested in a dedicated Primary Care Directorate to support the commissioning and development of Primary Care Services. Shropshire CCG has 43 GP practices, spread across three localities – North, South and Shrewsbury & Atcham. Each locality is primarily supported by a locality chair (GP), a locality commissioning manager and a locality pharmacist. Whilst the three identified localities are for wider CCG commissioning purposes, practices may choose to use a similar geography to deliver primary care at scale and thereby strengthen their resilience by working closer with other key partners.

The CCG will work with the three localities to fully understand the clinical needs and future infrastructure requirements for their individual populations and commission new models of care that meet these needs - working at scale and supported by integrated multidisciplinary teams.

GP Practices will be supported to form collaborations and alliances to deliver primary care at scale, explore new workforce models and ways of working that align with the neighbourhood model set out in the local Sustainability and Transformation Plan (STP).

Background

It was announced in April 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning. CCGs were asked to submit expressions of interest to NHS England, setting out their preference for how they would like to exercise this expanded primary medical care commissioning function from a choice of three models:

1. **Greater involvement** – an invitation to CCGs to work more closely with their local NHS England teams in decisions about primary care services
2. **Joint commissioning** – enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee
3. **Delegated commissioning** – an opportunity for CCGs to take on full responsibility for the commissioning of general practice services

Shropshire CCG subsequently applied for full delegated authority, in accordance with NHS England’s statutory powers under section 13Z of the National Health Service Act 2006 (as amended)\(^2\) and was approved for full delegated commissioning functions for the management and commissioning of most GP contracts with effect from 1 April 2015. This has meant the transfer of appropriate budgets from NHS England to the CCG, and the transfer of responsibility for decision making. NHS England provides dedicated support.

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The total CCG budget for primary care (including commissioning) for 2017/18 is £105.1 million. This includes areas such as prescribing, enhanced services, commissioning schemes and the out of hours service.

In terms of the Governance arrangements for the delegated arrangement and to address potential conflict of interest in decision making, a Primary Care Commissioning Committee (PCCC) was established as the corporate decision-making body for the management of the delegated functions and to exercise delegated powers. The PCCC enables members to make collective decisions on the review, planning and procurement of primary care services in the Shropshire CCG area. The functions of the Committee are undertaken in the context of a desire to promote commissioning of primary care services to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

To inform the work of this committee there is a Primary Care Working Group to facilitate effective working between CCG teams and other key stakeholders. Both the PCCC and the working group ensure robust oversight of the commissioning of Primary Care medical contracts and service provision. Formal terms of reference are agreed and in place for both the PCCC and the working group. These are reviewed annually to ensure compliance with any new guidance. PCCC meetings are held in public and are chaired by a lay member. Minutes of the PCCC are presented to the CCG Governing Body.

Developing the primary care needs assessment

A draft Primary Care Strategy was published in January 2016 and identified 8 key strategic aims: However, it was understood that the information to support these priorities was incomplete and therefore it was highlighted that a primary care needs assessment needed to be completed to further inform the detail of these strategic aims.

1. **The benefits of scale** – Practices should, wherever possible, be large enough to provide the full range of services.
2. **Workforce** – Develop opportunities for more collaboration between practices and different staffing models.
3. **Collaboration between practices in ‘GP Networks’** – Support practices to manage workload, sharing good practice, functions, support staff and services.
4. **Integrated care** – Primary and community health and care services should work in a more closely integrated way, supported by hospital specialists.
5. **Information Technology** – Enable different methods of communication and facilitate the development of new models of care and the provision of a more integrated service.
6. **Premises** – Ensure appropriate premises to deliver services.
7. **Supporting change** – To support organisational development, clinical leadership and the professional development of frontline staff.
8. **Commissioning** – Use the levers and flexibilities available to them to facilitate innovation, improvement and integrations.

**Process followed and timescales**

The process for carrying out this primary care needs assessment started in Autumn 2016. It was very important to the CCG that the views of patients and local GPs were sought as well as collating information from other sources to support the work. A patient questionnaire was developed and the CCG’s lead for engagement and involvement liaised with the Shropshire Patients’ Group who facilitated completion of the patient survey in December 2016. 452 responses were received. An online practice manager and GP survey
was developed and carried out in February 2017. 60 responses were received. The results of these questionnaires are included in section 5 of this document.

During a recent reorganisation of the CCG Structure, it was agreed that a new Primary Care Directorate should be established and team members were recruited from May 2017. This process is ongoing and all staff members are expected to be in place by September 2017. It is important that Primary Care works across all Directorates to ensure consistency.

One of the initial priorities for the team has been to identify the current ongoing issues in Primary Care and to finalise the primary care needs assessment, based on the information held, which is the most recent available at the time of writing. It should be noted that the information in this report reflects a point in time and the needs assessment should be reviewed every two years.

Readers should note that where Primary Care is referred to in this document, it refers to GP service provision rather than the traditional interpretation of Primary Care which also includes Dentists, Opticians and Community Pharmacy. There is a separate Pharmaceutical Needs Assessment process.

**Expected outcomes of the Needs Assessment**

The expected outcome of the Needs Assessment is to have a document which contains up to date relevant information, on which the CCG can base future decisions to further improve and support Primary Care in Shropshire.

The Primary Care Needs Assessment also cross references with other important documents, such as the CCG’s draft Strategic Estates Plan, Sustainability and Transformation Plan (STP), NHS England’s GP Forward View and the wider Five Year Forward View.
Section 2 - Context

2.1 Strategic Context - National and Local

The CCG recognises the importance of understanding national priorities and ensuring that these are translated to meet our local needs. As this document may be read in isolation to other national and local documents, this section concentrates on enabling an understanding of the current national and local documentation that have informed the Primary Care Needs Assessment.

National Context

The NHS Five Year Forward View\(^3\) was published by NHS England in October 2014 and set out why improvements were needed on the triple aim of better health, better care, and better value. Following the Five Year Forward View, specific national improvement blueprints were developed with key partners for urgent and emergency care, cancer, mental health, primary care, and maternity services. 2017 sees NHS England’s work focus shift decisively to supporting delivery and implementation of those key priorities.

The key national headlines in terms of context for this include:

- A growing population with more complex needs
- Increasing prevalence of long term conditions, which is often under-recorded
- Increasing demands on General Practice services
- Growing challenges in relation to patient experience of accessing services
- Accelerating growth in General Practice workforce
- Better distribution of workforce to address issues of inequity

The General Practice Forward View\(^4\) was published by NHS England in April 2016. The GP Forward View recognises the growing pressures on, and underinvestment in, general practice and nationally commits to an extra £2.4 billion a year to support general practice services by 2020/21. It aims to improve patient care, access, and to invest in new ways of providing primary care.

As part of the GP Forward View, NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups (CCGs). It includes help for vulnerable practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme aimed at speeding up the transformation of services.

NHS England objectives

The objectives set out in the ‘Government’s mandate to NHS England for 2017-18’\(^5\) are as follows:

- Through better commissioning, improve local and national health outcomes, and reduce health inequalities
- To help create the safest, highest quality health and care service
- To balance the NHS budget and improve efficiency and productivity
- To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.
- To maintain and improve performance against core standards
- To improve out-of-hospital care
- To support research, innovation and growth

\(^3\) [https://www.england.nhs.uk/five-year-forward-view/](https://www.england.nhs.uk/five-year-forward-view/)
\(^4\) [https://www.england.nhs.uk/gp/gpfv/](https://www.england.nhs.uk/gp/gpfv/)
Regional priorities (NHS England)

In addition to the NHS England objectives listed above, the regional NHS England team are currently finalising their priorities for GP practices for 2017/18. These are expected to be to:

- Improve access to high quality primary care services
- Improve health outcomes for patients and NHS workforce with clear focus on prevention
- Reduce unwarranted variation
- Maximise the use of technology to improve access and self-management with action plans for keeping people well
- Ensure Primary Care Estate is aligned to meet the needs of the future planned housing growth and to support new models of care

Local context

- Shropshire CCG covers a large geographical population of around 306,7556
- There are 43 GP practices in total
- 40 practices hold a GMS (General Medical Services) contract, 1 practice holds a PMS (Personal Medical Services) contract, and 2 practices are operating an Alternative Provider Medical Services (APMS) contract
- 18 practices dispense medicines to their patients

Several papers and strategies have been produced by and in collaboration with the CCG, identifying the main areas for concentration over the next few years:

- **Shropshire Health and Wellbeing Strategy 2016-2021**7 - The priorities set out in the Health and Wellbeing Strategy are prevention and sustainability - health promotion and resilience; promoting independence at home; promoting easy to access and joined up care.
- **NHS Future Fit**8 – NHS Future Fit is the programme across Shropshire, Telford and Wrekin where local patients, doctors, nurses and other health professionals are all working together to improve care at local hospitals. The programme recognises that the success of the reorganisation of acute hospital services has interdependencies with having a robust and supportive community model of care. Specifically, there is an expectation within the Future Fit planning assumptions that there will be a reduction in the demand on acute services by more patients having their care needs met and managed in community settings. This element of the NHS Future Fit programme of work is being progressed through the STP neighbourhood work stream. There is a need to align workforce planning in all areas of health and social care as the future skillset will look different to those historically developed.
- **Sustainability and Transformation Plan (STP)**9 – Local organisations such as the NHS and social services have been asked to work together to produce plans (STPs) for their areas for the next five years. Shropshire and Telford and Wrekin’s STP focuses on the need to address the wider determinants that result in poor health and wellbeing in our communities; to reduce unwarranted variations in care to ensure that everyone has the best outcome and experience of health and care possible; and to create a sustainable health and care system that helps our communities to thrive and prosper.
- **A local GP Forward View implementation plan** is in place for Shropshire, Telford and Wrekin. This sets out the aims and milestones to be achieved by the CCG, and is overseen by a Programme Management Office (PMO) working on behalf of NHS England. The work streams within the GP Forward View implementation plan inform the main sections of this needs assessment.

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6 GP registered population at 1st April 2017
8 [http://nhsfuturefit.org/](http://nhsfuturefit.org/)
9 [http://www.shropshireccg.nhs.uk/strategies](http://www.shropshireccg.nhs.uk/strategies)
Joint Strategic Needs Assessment - The Joint Strategic Needs Assessment (JSNA) is a process by which the local authority, CCG, NHS, voluntary and community sector and other partners agree health and wellbeing needs based on clear evidence. The partners undertake joint intelligence and analysis to produce information which is then used to agree overarching priorities for action. The four key issues affecting the health of the population in Shropshire are: an ageing population; health inequalities; lifestyle risk factors to health; long-term conditions and non-communicable disease. Some of the detail from the JSNA has informed the ‘Population Need’ section of this document. A summary JSNA document was published in 2012 but more up to date information sits behind topic specific issues and is available from the Public Health Team at Shropshire Council.

Shropshire CCG Strategic Estates Plan – In June 2015, the Department of Health published a Local Estates Strategic Framework and confirmed the need for strategic estates planning. An Interim Draft Strategic Estates Plan, focusing on general practice, was produced in January 2016 and is currently being updated.

Mental Health Strategy - Nationally mental health services are undergoing significant transformational change, mandated under the Five Year Forward View for Mental Health. Locally, Shropshire CCG and Shropshire Council are working together to translate this national transformation into a local mental health strategy. Current work programmes identified for 2017/18 are: Urgent and Crisis care for people experiencing mental distress; a review of Improving Access to Psychological Therapies (IAPT), including GP Counsellors in primary care; ensuring people with Long Term Conditions, initially those with diabetes and respiratory conditions, have access to psychological therapies.

Primary Care Strategy – A draft strategy was produced in January 2016, setting out the key strategic aims listed above. Moving forward, this needs assessment will directly inform an implementation plan.

Priorities and direction of travel
The various strategic documents and pieces of work listed above identify the priorities and direction of travel for primary care as:

- Prevention, wellness and healthy lifestyle promotion
- Self-care and patient activation, especially for patients with complex needs
- New models of care – Primary Care at scale delivering integrated out of hospital care with local communities
- Extended access to primary care services, outside of core hours
- Holistic equitable access to services (physical and mental health)
- Reducing unwarranted variation to deliver high quality patient care
- Developing and attracting a highly skilled and motivated multi-disciplinary workforce
- Improved technology and sharing of information
- Outcomes Based Commissioning making the most efficient use of resources
- Sustainable General Practice including Primary Care Estate

This primary care needs assessment is structured to cover the following areas that reflect those within the GP Forward View and STP - the current position, where we need to be and how we plan to get there:

- Access
- Infrastructure (premises and IT)
- Workforce
- Workload and resilience
- New models of care
- Quality

https://www.shropshire.gov.uk/joint-strategic-needs-assessment/
2.2 Population Need

Shropshire Health Profile

Public Health England published Shropshire’s latest Health Profile data in July 2017\textsuperscript{11}. The profile shows that the health of people in Shropshire is generally better than the England average. Life expectancy for both men and women is higher than the England average. The JSNA provides more detail around Shropshire’s population and health needs.

- The GP registered population of Shropshire is about 306,755\textsuperscript{12} spread over an area of 1,235 square miles.
- Shropshire is the largest land locked county in England with a population of mainly white British ethnicity (approximately 98%) and a high proportion of people aged over 50 years old.
- Overall the health of the population in Shropshire is good. Both male and female life expectancy is significantly higher than national figures. Inequalities exist however.
- Life expectancy is 4.2 years lower for men and 3.3 years lower for women in the most deprived areas of Shropshire than in the least deprived areas.
- Areas of deprivation exist in pockets across the areas of the CCG with a high concentration in North Shrewsbury.
- Over 80% of the population is identified to be in ‘good’ health with 18% having a long-term health condition.

The JSNA identifies the key issues facing Shropshire as being:

- Ageing population
- Health inequalities
- Lifestyle risk factors to health
- Long term conditions and non-communicable disease
- Access to services, with the population spread over a large geographical area and most of the population living in rural areas

Shropshire demographic projections for 2031

Shropshire Council’s \textit{Information, Insight and Intelligence} web pages\textsuperscript{13} include long term population projections, which show what Shropshire’s population will be if the recent trends continue. The projections can be used in many areas of demographic research, including life expectancy projections.

- The population of Shropshire is projected to increase by 16.9% in the 25-year period from 2006 to 2031 (from 289,300 in 2006 to 338,000 in 2031).
- Oswestry district is projected to experience the highest level of growth out of all the Shropshire districts, increasing by 33.9% from 39,700 in 2006 to 53,200 in 2031, with the North of Shropshire projected to experience the second highest level of growth at 23%.
- Both Bridgnorth and Shrewsbury & Atcham districts are projected to see the lowest levels of growth in population, of around 8.3%.
- The age structure in Shropshire is projected to be quite different in 2031 than it was in 2006. The age groups set to see the greatest change are age groups below 45, the greatest decline projected to be in the 30-44-year-old population group.
- Both age groups 65-84 years and 85 years and over will see projected increases in all the Shropshire districts.

\textsuperscript{11} \url{https://fingertips.phe.org.uk/profile/health-profiles}
\textsuperscript{12} GP registered population at 1\textsuperscript{st} April 2017
\textsuperscript{13} \url{https://new.shropshire.gov.uk/information-intelligence-and-insight/#}
Rurality

Shropshire is classed as a ‘largely rural’ county, with 57% of the population living in rural areas\textsuperscript{14}. Figure 1 below shows the urban and rural classification of Shropshire and illustrates the spread of the population.

\textsuperscript{14} 2011 census data - https://new.shropshire.gov.uk/media/5320/shropshire-council-key-facts-and-figures-2016-17.pdf
another and share good practice. Lack of mobile phone coverage and broadband in some areas will have an impact on the IT solutions being developed across the county, for both patients and practices, and must be factored into implementation plans.

Populations in our more rural areas are older than those in the more urban areas and therefore have different health needs. When looking at clinical priorities, health need should be assessed at a very local level, such as the Shropshire Council place plan areas and STP neighbourhoods, and not just collectively across our three localities.

Transport is an issue in rural areas – not only for patients accessing services but also for clinicians when undertaking home visits and needing to navigate the minor roads. Transport issues and rural access must be considered when planning future models of care and looking at working at scale; different solutions will be needed for different areas, especially those of a more rural nature.

We should also act to further explore the funding for rural practices. Whilst the Carr-Hill formula for calculating the global sum (see section 2.3) does include an element for rural health, it is possible that pockets of deprivation in our more rural areas are missed through the way public health data is put together nationally. Further work is needed around potential funding issues around general funding and how additional services such as dispensing impact on both the CCG and rural practices.

Clinical priorities
From the documents referred to earlier in this paper, the following have been identified as clinical priorities for the CCG:

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Recommendation
Looking at the profile and health needs of our local population, it is vital that the planning of primary care services takes these areas into consideration at both a Shropshire wide level and in smaller population clusters. Data currently exists at individual practice level and at CCG level. Shropshire Council produces area profiles by ward and parish and has also produced 18 Place Plans15 across Shropshire, which identify the infrastructure and investment needs within each community. The Place Plans are aimed at ensuring that Shropshire Council and their partners understand the local priorities within each community and that resources can therefore be targeted appropriately.

The CCG’s primary care team, working closely with NHS England’s primary care team, local business intelligence and the local authority’s public health team, should work more closely with individual practices and localities moving forward to ensure local clinical priorities are being addressed. Data on local health needs should be collated into a profile for each locality and sub-cluster and analysed to identify where further work is needed to address any unwarranted variation. These profiles should clearly set out the health needs for local

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15 https://www.shropshire.gov.uk/place-plans/
populations, highlighting any variation across each patch, and should inform the commissioning requirements for the local population. This will help identify whether the primary care services currently being provided are being delivered in the most appropriate way to meet local need; will help to inform locality, cluster and ‘at scale’ working, in line with new models of care; and will help to inform future primary care commissioning decisions.

2.3 Primary Care service provision

When the CCG received delegated commissioning status in April 2015, there were 44 GP Practices in the CCG with an average list size of 6880 patients per practice. As at June 2017, there are 43 GP practices with an average list size of 7,134 patients per practice (nationally the average practice list size as at May 2017 was 7,820\(^{16}\)). Individual practice populations range from 2,033 to 17,457 patients.

As outlined earlier in this document, the future of General Practice in England is in the political and policy spotlight. There is an encouragement to ensure the sustainability of Primary Care by ‘scaling up’ GP practices into larger organisations or networks capable of delivering a wider range of coordinated services in the community 8am – 8pm, 7 days a week. The Five Year Forward View also provides a clear indication that larger primary care organisations are the national direction of travel. The benefits for patients are highlighted to be facilitating improved access, ‘at scale’ working through clusters or localities which shows benefits through economies of scale, shared back office functions and enabling new ways of working. This in turn will improve practice resilience and sustainability and therefore secure patient services for the future.

Contracts in Primary Care

The General Medical Services (GMS) contract is the most commonly used contract for general practice and was introduced in 2003. As at June 2017, the CCG has 40 practices working to this contract. NHS Employers leads negotiations with the General Practitioners Committee (GPC) - which is part of the British Medical Association (BMA) - on changes to the GMS contract. The GMS contract covers three main areas:

- **The Global Sum** – covering the costs of running a general practice, including some essential GP services. The GMS global sum formula (the Carr-Hill formula) distributes the core funding to general practices for essential and some additional services. Payments are made according to the needs of a practice’s patients and the cost of providing primary care services. The formula considers issues such as age and deprivation. This formula is being debated nationally and is subject to change.

- **The Quality and Outcomes Framework (QOF)** – is a voluntary annual reward and incentive programme for all GP surgeries in England. It aims to resource and reward good practice. All practices in Shropshire currently participate in the QOF.

- **Enhanced Services (ES)** – covering additional services that practices can choose to provide. Enhanced services can be commissioned nationally (Directed Enhanced Services – DES) or locally (Local Enhanced Services – LES) to meet the healthcare needs of the population. These local enhanced services are now called locally commissioned services.

The Personal Medical Services (PMS) contract is a locally negotiated contract between the commissioner and GP practice and these agreements can offer local flexibility compared to the nationally negotiated GMS contract. The PMS contract offers the three main elements of the GMS contract as listed above. In 2016, the CCG had 9 GP practices working under these contracts, however following a PMS review led by NHS England, 8 of the PMS contract holders transferred back to GMS contracts to bring levels of funding in line across all practices. There is now only 1 practice in Shropshire CCG working to a PMS contract.

\(^{16}\) [http://www.content.digital.nhs.uk/catalogue/PUB23978](http://www.content.digital.nhs.uk/catalogue/PUB23978)
Alternative Provider Medical Services (APMS) is another contracting route available for CCGs to commission primary medical services. The APMS contract offers the three main items of the GMS contract. As at June 2017, the CCG has two Practices working to this contract; one is a temporary contract providing services to a registered patient list and one is a practice commissioned as a GP-led health centre and provides walk in GP services as well as services to a GP registered list. This service also supports the streaming of patients through to the Emergency Department at the local Hospital. The CCG is currently in the planning stages to provide the patients who are registered at the temporary GP Practice more permanent access to services.

Types of services offered in primary care
As set out above, there is a ‘global sum’ paid to practices that includes some essential GP services. In addition to this, practices are incentivised to sign up to the Quality and Outcomes Framework (QOF) and enhanced services that are commissioned both locally and nationally. Participation in these areas across Shropshire GP practices is outlined below.

Enhanced Services

<table>
<thead>
<tr>
<th>Type of enhanced service</th>
<th>Enhanced service</th>
<th>Number of practices signed up to provide service (2016/17) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG currently commissions several Local Enhanced Services (LES):</td>
<td>Provision of Services to Manage Minor Injuries</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Diagnosis and Treatment of Deep Vein Thrombosis</td>
<td>41 (initial), 25 (full)</td>
</tr>
<tr>
<td></td>
<td>Anti-Coagulation Monitoring</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Phlebotomy Services</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>High Risk Drug Monitoring (formerly Near Patient Testing)</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Vasectomy</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Osteoarthritis</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Care Homes Advanced Scheme (CHAS)</td>
<td>26</td>
</tr>
<tr>
<td>From 1st April 2017, there are four Directed Enhanced Services (DES) which are commissioned directly by NHS England:</td>
<td>Extended Hours</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Learning Disabilities Health Check Scheme Minor Surgery</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Out of Area Registrations</td>
<td>42 (remaining practice provides this as part of APMS contract)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>The following Public Health Directed Enhanced Services (DES) are commissioned by NHS England:</td>
<td>Hep B (new born babies)</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>HPV completing dose</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>MMR aged 16 and over</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Meningococcal ACWY</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Meningococcal completing dose</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Pertussis in pregnant women</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Rotavirus (routine childhood)</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Shingles (routine aged 70)</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Shingles (catch up aged 78)</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Men B Vaccination</td>
<td>43</td>
</tr>
</tbody>
</table>
As can be seen, the range of enhanced services provided by GP practices is variable. The locally commissioned services are currently under review, and this review will seek to understand where there is variable uptake of enhanced services and ensure equity of future provision.

**Quality and Outcomes Framework (QOF)**

The Quality and Outcomes Framework (QOF) is an annual reward and incentive scheme for GP practices. There are 19 clinical areas within the clinical domain of QOF, plus an additional six within the public health domain.

The average overall QOF points achievement for Shropshire CCG for 2015/16\(^\text{17}\) was 97.47% (compared to a national average of 95.33%). This information can be used to support changes required to improve the key clinical priorities identified earlier in this needs assessment.

**Recommendations**

Although provision of GP services, and the health of Shropshire’s population, is good overall, the CCG should seek to identify and address local variances.

The CCG has no control over the content of the GP contract or directed enhanced services (DES), which are set and offered nationally through NHS England. Locally commissioned services (local enhanced services) can however be locally designed and are a way to incentivise practices to offer additional services that are identified as a local need, or way to offer alternative service provision.

At the time of writing, the locally commissioned services offered by the CCG are currently under review to ensure that they are offered equitably and provide quality and value for money. A review is also underway of work undertaken in primary care that is not currently funded as part of the contracts. These reviews should be completed and measures put in place by April 2018.

The NHS health checks, commissioned by public health at Shropshire Council, are delivered through a contract with Shropdoc on behalf of all the GP practices. Although all practices are signed up to this, it has been highlighted that delivery is variable. It is recommended that the CCG works with public health in their efforts to improve uptake and delivery of NHS health checks going forward, which form an important part of the prevention programme.

\(^{17}\) 2016/17 QOF achievement data will be published in Autumn 2017
Section 3 – Current state and addressing the gaps

3.1 Access to primary care services

Primary Care is the first point of entry for most patients in diagnosing and treating health problems. GPs and other staff play a crucial role in treating minor medical conditions, managing patients’ long-term conditions in the community and referring them for hospital treatment or social care, as appropriate.

Good access to a GP is important to patients. Poor access can cause stress and frustration at a time when they may already be worried, and may prolong discomfort or pain. Prompt diagnosis and treatment are important in achieving the best health outcomes for those patients whose conditions will not get better on their own. Good access to general practice also reduces pressure on other parts of the NHS, particularly hospital Accident and Emergency departments which, in turn, helps the health system to make the best use of its resources. Practices need to be provided with adequate resources to meet the needs of the population and requirements of the local health system.

Ensuring good access to general practice is a priority for the CCG. The Government has committed to recruiting 5,000 extra doctors across the country to work in general practice, to enable an 8am to 8pm service, 7 days per week, by 2020. For the NHS England Midlands and East Region, the target number of new GPs is approximately 1,500, of which 450-500 would be for the West Midlands area (the figure for Shropshire is not yet known). The CCG needs to ensure that plans are in place to deliver this aspirational improved access target. The main aspects to ensure improved access to General Practice can be summarised into the following groups:

- **Distribution of GP practices** - The GP Practices in Shropshire are distributed across the geography of the county. The rural nature of the county means that access to health services is an issue and when looking at future potential for at scale working, there will need to be different models for different localities.

- **Availability of appointments** – For urgent care, the CCG has a GP Walk-in Centre which is open to all patients 8am – 8pm 7 days a week, 365 days a year and a GP out of hours service. Access to routine appointments is looked at later in this section.

- **Continuity of Care** – Patients need to build a connection with their healthcare professional to create a relationship of trust. It is not always possible for patients to see the same GP all the time, however the CCG needs to ensure the processes are in place for this trust relationship to remain in place, even if the patient’s “usual” GP is not available. This, as a minimum, is the sharing of patient records, as appropriate, and with the patient’s permission.

**Current levels of GP access in Shropshire**

Through the core contracts, GP practices are contracted to provide primary care services within the core hours of 8am – 6.30pm, Monday to Friday (excluding bank holidays). However, there are several other services in place for patients to access primary care services.

**NHS 111**

NHS 111 is available across the whole of England and is the free number to call when patients have an urgent healthcare need but it’s not a 999 emergency. The service was designed to direct patients to the right local service, first time, and is available 24 hours a day, 365 days a year.
When Patients call 111 they are assessed by fully trained advisers who are supported by experienced nurses and paramedics. Patients are asked questions to assess symptoms and get the healthcare advice needed or they are directed to the most appropriate local service. If the NHS 111 team think patients need an ambulance, they will send one immediately. 111 call handlers can transfer calls directly to the Shropdoc service.

**Shropdoc**

Outside of core hours (between the hours of 6.30pm and 8am during the week and from 6.30pm on a Friday until 8am the following Monday, and on bank holidays), cover for urgent primary care need (need that is not life threatening, but which the patient feels cannot safely wait until their GP practice is next open) is provided by Shropshire Doctors Co-operative Ltd (Shropdoc), a GP-led organisation. The Shropdoc service answers calls for patients when their own surgery is closed to ensure that their needs are safely met until their surgery is next open.

In the next two years the CCG plans to go out to procurement for the Out of Hours contract in a joint venture with Telford and Wrekin CCG.

**GP Walk-In Services**

Shropshire has a GP walk-in centre (primary care urgent care centre) which is available for all patients to access and is delivered as part of an APMS contract. It is currently sited alongside the Emergency Department at the Royal Shrewsbury Hospital. The current services are open 8am – 8pm, 7 days a week, 365 days a year. The service is currently provided by Malling Health. The contract for this service is due to be reviewed prior to the end of the current contract term in April 2019.

**Extended Hours Directed Enhanced Service (DES)**

The aim of the extended hours enhanced service is for practices to provide routine appointments to their registered population at times outside of core contracted hours to allow patients to attend the practice at a time when it is more convenient for them.

Practices can operate either solely or as a group and appointments can be offered with GPs and nurses. There is an option to provide telephone consultations and use other methods of communication. The level of extended opening that must be provided under this agreement is based on the contractor’s list size and is calculated at 30 minutes per 1,000 registered patients.

27 of the 43 GP practices in Shropshire CCG signed up to the extended hours DES in 2016/17. Between these practices 393 appointments were offered each week outside of core contracted hours (i.e. before 8am, after 6.30pm, or at the weekend).

**GP Access Fund**

Shropshire CCG is currently part of a pilot site for the GP Access Fund (previously Prime Minister’s Challenge Fund), the background to which is outlined below.

STW Provider Services Ltd was established as a GP Federation across Shropshire and Telford & Wrekin in 2013, offering opportunity for member GP practices to deliver healthcare services collaboratively.

The STW Federation, together with Shropdoc and GP First (the federation covering Stafford and the surrounding area), was successful in securing £4.2million from the Prime Minister’s Challenge Fund (a national fund set up to help improve access to General Practice). The funds are being used for a wide range of pilot developments – including working towards seven day a week access to GPs. A total of 17 Shropshire practices, 10 in the Shrewsbury and Atcham locality and 7 in the South locality, are currently participating in offering
Extended access via this scheme. The contract for delivering this scheme is in place between NHS England and Shropdoc, who then sub-contract a number of the participating practices to act as ‘hubs’ who between them staff the appointments and provide use of their premises. The patients of the participating practices are then able to access appointments outside of core hours but not necessarily at their registered practice.

Extended access via the GP Access Fund is about access for a patient population rather than an individual practice list. This has become a pilot for the 7 days working initiative detailed in the GP Forward View.

**Delivery of extended access pilot**

Data for March 2017 showed the following levels of appointment provision and uptake for that month:

<table>
<thead>
<tr>
<th></th>
<th>Shrewsbury (10 practices)</th>
<th>South (7 practices)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total appointments available</td>
<td>192</td>
<td>315</td>
</tr>
<tr>
<td>Total appointments booked</td>
<td>177</td>
<td>295</td>
</tr>
<tr>
<td>GP appointments booked</td>
<td>177</td>
<td>275</td>
</tr>
<tr>
<td>Nurse appointments booked</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Appointments remaining</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td><strong>Uptake of appointments</strong></td>
<td><strong>92%</strong></td>
<td><strong>94%</strong></td>
</tr>
<tr>
<td>DNAs</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td><strong>DNA rate</strong></td>
<td><strong>6%</strong></td>
<td><strong>5%</strong></td>
</tr>
</tbody>
</table>

In Shrewsbury, 32-40 appointments were offered Monday - Friday during March 2017, with 16 appointments offered on a Saturday (not every week). In the South, 40-56 appointments were offered Monday – Friday during March 2017, with 32-48 appointments offered on a Saturday.

The table on the following page shows which practices are currently part of the GP Access Fund pilot and which practices were signed up to the extended hours enhanced service for 2016/17.

This information shows that currently only one practice in the south locality offers appointments on a Saturday. Three practices in the Shrewsbury and Atcham locality offer some access to appointments on a Saturday. Two practices in the north locality, both in Oswestry, offer appointments on a Saturday.

A good proportion of practices in the south locality (80%) and in the Shrewsbury and Atcham locality (69%) are signed up to the extended hours enhanced service, with only 33% signed up in the north locality.

No practices in the north locality are currently part of the GP Access Fund pilot. The initial contract for the GP Access Fund pilot ended in March 2017 but was extended for a further 18 months. The aim during this time is for the pilot to be extended to cover more of the CCG’s population, recognising the current inequity.

The CCG will look in more detail at the reasons for the variances and commission services to ensure equity of access. From April 2018, there will be additional funding available for extended access via the GP Forward View to work towards the 100% population coverage target by April 2019.
<table>
<thead>
<tr>
<th>Practice Code</th>
<th>Locality</th>
<th>Practice Name</th>
<th>Extended hours ES</th>
<th>GP Access Fund pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>M82021</td>
<td>South</td>
<td>Albrighton Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82601</td>
<td>South</td>
<td>Alveley Medical Practice</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>M82033</td>
<td>South</td>
<td>Bishops Castle Medical Practice</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>M82004</td>
<td>South</td>
<td>Bridgnorth Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82051</td>
<td>South</td>
<td>Broseley Medical Practice</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>M82024</td>
<td>South</td>
<td>Brown Clee Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82008</td>
<td>South</td>
<td>Church Stretton Medical Practice</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>M82041</td>
<td>South</td>
<td>Cleobury Mortimer Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82046</td>
<td>South</td>
<td>Craven Arms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82620</td>
<td>South</td>
<td>The Meadows Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82019</td>
<td>South</td>
<td>Much Wenlock and Cressage</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82031</td>
<td>South</td>
<td>Highley Medical Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82043</td>
<td>South</td>
<td>Portcullis Surgery</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82038</td>
<td>South</td>
<td>Shifnal and Priorslee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82014</td>
<td>South</td>
<td>Station Drive Surgery</td>
<td>Yes (incl. alternate Sat)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>12 /15 practices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82018</td>
<td>Shrewsbury</td>
<td>The Beeches Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82048</td>
<td>Shrewsbury</td>
<td>Belvidere Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82034</td>
<td>Shrewsbury</td>
<td>Claremont Bank Surgery</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82047</td>
<td>Shrewsbury</td>
<td>Marden Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82040</td>
<td>Shrewsbury</td>
<td>Marysville Medical Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82002</td>
<td>Shrewsbury</td>
<td>Mytton Oak Medical Practice</td>
<td>Yes (sat once a month)</td>
<td>Yes</td>
</tr>
<tr>
<td>M82030</td>
<td>Shrewsbury</td>
<td>Pontesbury Medical Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82016</td>
<td>Shrewsbury</td>
<td>Radbrook Green Surgery</td>
<td>Yes - incl. Sat</td>
<td></td>
</tr>
<tr>
<td>M82006</td>
<td>Shrewsbury</td>
<td>Riverside Medical Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82032</td>
<td>Shrewsbury</td>
<td>Severn Fields Medical Practice</td>
<td>Yes - incl. Sat</td>
<td></td>
</tr>
<tr>
<td>Y02495</td>
<td>Shrewsbury</td>
<td>Whitehall Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82060</td>
<td>Shrewsbury</td>
<td>South Hermitage Surgery</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M82604</td>
<td>Shrewsbury</td>
<td>Worthen Medical Practice</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>9 /13 practices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82045</td>
<td>North</td>
<td>Bridgewater Medical Practice</td>
<td></td>
<td></td>
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<tr>
<td>M82026</td>
<td>North</td>
<td>Cambrian Medical Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82022</td>
<td>North</td>
<td>The Caxton Surgery</td>
<td>Yes - Sat</td>
<td></td>
</tr>
<tr>
<td>M82017</td>
<td>North</td>
<td>Clive Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y05569</td>
<td>North</td>
<td>Claypit Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82044</td>
<td>North</td>
<td>Dodington Surgery</td>
<td></td>
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<tr>
<td>M82010</td>
<td>North</td>
<td>Drayton Medical Practice</td>
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</tr>
<tr>
<td>M82025</td>
<td>North</td>
<td>Ellesmere Medical Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82058</td>
<td>North</td>
<td>Hodnet Medical Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82020</td>
<td>North</td>
<td>Knockin Medical Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82005</td>
<td>North</td>
<td>Plas Ffynnon Medical Centre</td>
<td>Yes - Sat</td>
<td></td>
</tr>
<tr>
<td>M82023</td>
<td>North</td>
<td>Prescott Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M82011</td>
<td>North</td>
<td>Shawbury Medical Practice</td>
<td></td>
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</tr>
<tr>
<td>M82035</td>
<td>North</td>
<td>Wem and Priorslee Medical Practice</td>
<td></td>
<td></td>
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<tr>
<td>M82013</td>
<td>North</td>
<td>Westbury Medical Centre</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>5 /15 practices</strong></td>
<td></td>
<td></td>
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GP Patient Survey – patient satisfaction with access
The GP Patient Survey is an England-wide survey, providing practice-level data about patients’ experiences of their GP practice. The latest results from the GP Patient Survey were published in July 2017. In Shropshire CCG, 9,668 questionnaires were sent out, and 4,946 were returned completed. This represents a response rate of 51%. In terms of questions with specific reference to access, results were as follows:

- 81% of patients rated their overall experience of making an appointment as “Good” or “Very Good”, compared to a national average of 73%. Practice results ranged from 52% to 98%.
- 94% of Shropshire respondents found their appointment convenient.
- Of the people who could not get a convenient appointment at their GP practice, 19% of patients either used another NHS service or did not see anyone at all, 4% went to A&E, and 4% decided to see a pharmacist. These figures are like national averages.
- 81% of Shropshire patients found it easy to get through to their practice by phone, compared to a national average of 68%. The lowest scoring practice in Shropshire achieved a score of 32%.
- 88% of patients could get an appointment when they wanted one compared to the national average of 84%. Practice scores ranged from 73% to 99%.
- 100% of practices have enabled patient access to online appointment booking and online repeat prescription requests – however 51% of patients that responded were unaware of these services.
- 78% of respondents were satisfied with their practice opening hours. This compares to a national average of 76%. Individual practice results ranged from 50% satisfaction to 96%.

Recommendations
The GP Forward View puts a big focus on improved access to GP services and the CCG needs to plan for this innovation. Additional funding is being provided to enable CCGs to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services. There must be 100% coverage from April 2019, with all patients being able to access pre-bookable and same day appointments to general practice services 8am-8pm Monday to Friday, with appropriate weekend provision. Appointments can be provided on a hub basis with practices working at scale.

There should be a considered approach to implementing extended access through the GP Access Fund, with service models that address identified levels of demand. Lessons should be learned from the pilot, data from which should help inform what has worked well in terms of promoting the scheme to patients and utilisation of appointments. Where groups of practices are interested in delivering additional capacity, this ‘at scale’ working should be encouraged. Service models for the more rural areas of the county will not necessarily work in the same way as those in Shrewsbury and the market towns, but access should be equitable.

When commissioning additional access to general practice services, the CCG must at the same time consider those services to which the practice may need access (for example whether it will be possible to send off blood tests over the weekend).

The latest GP Patient Survey (GPPS) results18 for the CCG showed that 78% of respondents were satisfied with their practice opening hours. This compares to a national average of 76%. Individual practice results ranged from 50% satisfaction to 96%.

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It will be important to use this survey feedback, along with other mechanisms of patient feedback and engagement, to determine local need for extended access to GP services.

The CCG should work with practices to maintain the overall high levels of patient satisfaction with practice opening hours. Those areas where levels of satisfaction are lower than the CCG average should be identified and addressed as part of locality plans. The CCG will need to work with localities and with patient groups to develop its plans to improve access in line with patient need and within the requirements of the GP Forward View.

3.2 Primary Care Estate

A draft CCG Strategic Estates Plan was published in January 2016. The plan was produced by NHS Property Services in conjunction with Shropshire CCG and the local Trust sites, covering the wider NHS estate within Shropshire but focusing on the GP estate. This plan supported primary care bids for the NHS England Estates and Technology Transformation Fund (ETTF), a multi-million-pound investment (revenue and capital funding) in general practice facilities and technology across England (between 2015/16 and 2019/20). The plan was updated in June 2016 but remains a draft document that is currently under review and is due to report to Primary Care Commissioning Committee in August 2017.

At the time of the plan being produced, there were 44 GP practices with 14 branch surgeries. As at June 2017 there are 43 GP practices (Mount Pleasant Medical Practice and Haughmond View Medical Practice merged in April 2016) with 13 branch surgeries (the Knighton site of The Meadows Surgery closed in December 2016), so a total of 56 sites.

Primary Care Estates Audit

GP practices were asked to complete a premises audit questionnaire in November 2015, with a view to the information informing a CCG-wide primary care estates strategy.

51 practice sites (some main and some branch) responded to the audit. The results were as follows:

- Tenure - 65% freehold and 24% leasehold. Six of unknown tenure.
- Condition - most properties were judged to be in excellent, good or satisfactory condition (14%, 47% and 18% respectively); most (98%) were under 100 years old, although 24% were of unknown age. There were two listed buildings.
- ETTF - 63% of practices were interested in securing funding for major developments through the Estate and Technology Transformation Fund.
- List expansion (workforce) - 47% advised that expanding their workforce would not enable them to increase patient list numbers.
- List expansion (premises) - 47% considered that expanding their premises would enable them to increase their patient list.
- Premises expansion - 53% stated that they would like to expand their premises (two said they would only if it was financially viable).
- Residential / nursing home provision - most practices (65%) were unaware of plans to increase residential or nursing home provision in the area.
- ICT provision - 20% were happy with their computer-based technology and 51% were happy with their telephony system with most having equipment that had been replaced / upgraded within the past year. Some of the challenges were poor / slow internet connection (20%), out-of-date software or hardware (6%) and lack of space for equipment. Two commented that they would like to increase their ICT technology to facilitate video-calling, e.g. Skype.
• One of the most challenging problems for practices was lack of space for current services and / or lack of space to expand their services.

The survey identified 25 GP-led development opportunities.

6 Facet Surveys* were undertaken in January 2016 to support ETTF bids and to establish if current premises could support future needs under the Five Year Forward View. (*The 6 Facet Survey forms the ‘core’ estates information required by HBN 00-08 (NHS Estatecode)19. Historically this has always been regarded as the ‘minimum data set’ of information necessary on which to base intelligent decisions about the future of an estate.)

**Draft Strategic Estates Plan**

The draft Strategic Estates Plan, developed in 2016, identifies the estates challenges across the CCG. Between 2006 and 2026, Shropshire Council is proposing 27,500 new homes and Shropshire Council’s Core Strategy sets out this housing requirement. Over the next 5-10 years this will have a huge impact on patient numbers at many our GP practices.

The plan sets out investment opportunities across the CCG which consider potential new ways of working (for example delivery of services through ‘hub’ sites). This plan is currently being reviewed and updated – the review will ensure that it is in line with the STP delivery plan.

It is important for the CCG to continue to work with local planners to ensure that there is sufficient Primary Care capacity to meet the increase in patient population across the geography of the CCG.

**Estates and Technology Transformation Fund (ETTF)**

NHS England’s Estates and Technology Transformation Fund (ETTF) is a multi-million-pound investment (revenue and capital funding) in general practice facilities and technology across England (between 2015/16 and 2019/20). It is part of the General Practice Forward View commitment for more modernised buildings and better use of technology to help improve general practice services for patients.

The CCG co-ordinated the submission of the Estates and Technology Transformation Fund (ETTF) bids from GP practices in January 2016. Because of the bids, there are two schemes underway for new premises – one for the three practices in Whitchurch to come together in a single premise and one for Shifnal.

**Recommendations**

The CCG’s strategic estates plan is currently under review but will set out recommendations for the general practice estate, including opportunities for investment and how future premises developments should align with the STP, new models of care, and facilitate at scale working. A final strategic estates plan will be developed by Autumn 2017 and will link directly to the health needs of Shropshire and the clinical priorities as set out in earlier in the document.

In addition to the developments underway as ETTF schemes, there are several other estates issues which the CCG is considering, all of which are contained within the updated estates plan.

An improvement grant process is currently being put in place at the CCG. Practices will be encouraged to have plans ready to submit as and when funding becomes available – the CCG will then assess and prioritise the plans to enable developments to take place. At the time of writing this needs assessment, there is no allocated funding available for practices to access.

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3.3 Primary Care Information Technology

The CCG recognises the national requirement to improve IT infrastructure and the sharing of data. As highlighted, technology has a major role to play in addressing some of the issues associated with the rural nature of Shropshire, both in terms of patient access to services and in terms of better connecting our GP practices.

The CCG’s IT strategy is built around the local digital roadmap, which is laid out across the STP footprint of Shropshire, Telford and Wrekin.

42 of the 43 GP practices in Shropshire CCG currently use the EMIS Web Primary Care Clinical System for recording patient information, with the remaining practice using Vision. Any referrals for care into the acute or community setting are generated at a practice level and sent via the Referral Assessment Service (RAS) using the e-Referral System. Further work is needed to ensure that all referrals both urgent and planned follow agreed pathways and criteria.

Local Digital Roadmap
The local digital roadmap aims to create a digitally enabled health and social care economy across Shropshire. A few key actions have been identified:

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions (the summary care record)
- Patients can access their GP record
- GPs can refer electronically to secondary care
- GPs receive timely electronic discharge summaries from secondary care
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice

Estates and Technology Transformation Fund (ETTF)
Following a successful ETTF bid, Shropshire CCG will be rolling out the following IT based solutions for practices:

- Wi-Fi in all practices
- Voice over Internet Protocol (VOIP) telephone system in all practices

Wi-Fi and VOIP have been offered to all practices and implementation is currently in progress. Implementation will be completed by the end of 2017/18 – most of practices are expected to take up this offer.

These improvements will also lay the foundations for further digital improvements in Primary Care.

Patient Online
Patient Online is designed to support GP practices to offer and promote online services to patients: appointment booking, ordering of repeat prescriptions and access to coded information in records. Since April 2016, all GP practices in Shropshire can offer their patients access to these online services.

The BMA and NHS England have made a joint commitment to encourage practices to register a minimum of 20% of their patients for at least one online service by 31 March 2018. Practices are also required to support patients to use apps to access Patient Online services. Finally, practices should continue to provide patients who request it, with online access to clinical correspondence.
As at December 2016 (which was the latest published data available at the time of writing), the percentage of patients enabled for online access to appointments and ordering of repeat prescriptions ranged from 0.9% to 42.9% across the CCG (average practice achievement of 14%). For patient access to coded information in records, one practice had achieved 13%; the remaining practice achievement was between 0% and 5% (average 1%). Further work is needed to support practices in this area.

**Recommendations**

The CCG’s IT Forum, which covers Shropshire, Telford and Wrekin, is the group that oversees the support and development of IT within the GP practices. Funding through the Estates and Technology Transformation Fund (ETTF) via the GP Forward View is supporting the implementation of technology as outlined above, as well as funding streams specifically for online consultations.

Shropshire CCG will be working with our practices to develop a range of new models of consultation. This will include:

- Improvements to walk in and pre-bookable appointments both in and out of core hours
- Developing the use of multidisciplinary workforce
- Telephone appointments
- Group sessions
- Awareness raising of how to access GP appointments
- Implement telehealth at scale to drive health benefit
- Introduction of a range of Public Health prevention initiatives in Primary Care
- Supporting practices to embrace technological advanced to support care

As part of plans to work more collaboratively, the CCG is supporting groups of practices to explore shared IT platforms for tasks such as document management.

Programmes such as Patient Online should reduce practice workload by putting more ownership and responsibility on the patient, and reducing incoming calls to the practice. The CCG should continue to promote practice uptake and promote the availability of these services to patients, with the support of a regional NHS England ‘digital champion’.

Progressing primary care IT remains the remit of the CCG’s IT Forum and local digital roadmap. There is a clinical champion in place, supported by a part-time IT Manager. Progress will be reported to the Primary Care Working Group and Primary Care Commissioning Committee as appropriate, as well as being a key part of the STP. Consideration should be given to the current arrangements for the technical support provided by the Commissioning Support Unit for Primary Care IT.

### 3.4 Workforce

There are approximately 190 WTE GPs working across Shropshire CCG (including locums, registrars and retainers) according to NHS Digital workforce data (experimental statistics, March 2017\(^{20}\)). This equates to 0.6 GPs per 1000 head of population. Nationally, the number of FTE GPs equates to 0.59 per 1000 head of population (based on total registered patients\(^{21}\) and experimental workforce statistics\(^{22}\)). A key pledge within the GP Forward View is to deliver 5000 more full-time equivalent GPs and 5000 other primary care


\(^{21}\) [http://www.content.digital.nhs.uk/catalogue/PUB23978](http://www.content.digital.nhs.uk/catalogue/PUB23978)

professionals across the country by 2020. For the NHS England Midlands and East Region, the target number of new GPs is approximately 1,500; of which 450-500 would be for the West Midlands area (the figure for Shropshire is not yet known). Further work is required on data for other healthcare professionals currently working in Primary Care.

The CCG will continue to support the delivery of high quality Primary Care at scale and attracting and investing in a multidisciplinary skilled workforce. To support the development of a long-term workforce strategy, we intend to undertake an analysis of primary care workforce predictions for the next five years, working closely with our local GP practices, Health Education England, NHE England and the Community Education Provider Network (CEPN). This work will be aligned to the STP work programme for workforce development and other ongoing work-programmes as identified earlier in the paper.

Local GP workforce survey
A survey of all GP practices in the CCGs in our local area was carried out in October 2016 to determine the current structure of the workforce across the patch. This data was compared with other sources of data – such as NHS Digital (previously the Health and Social Care Information Centre - HSCIC) which is collected from GP practices via the Primary Care Web Tool – to determine the number of staff across all Practices as well as some key ratios for benchmarking against the suggested national averages.

20 (45%) of Shropshire CCG GP practices responded to the local workforce survey. 42 practices (95%) participated in the March 2017 NHS Digital Workforce data collection (this data collection is now mandatory and is to be carried out on a quarterly basis via the Primary Care Web Tool or the new Health Education England tool that is being rolled out).

This information will be used to develop a workforce plan to deliver a sustainable general practice workforce that will form the foundation of the future models of collaborative care.

- At the time of the survey, 4 of the Shropshire GP practices who participated had GP vacancies (3 partner, 2 salaried – presumably one vacancy was for either of these options)
- One practice had a Practice Nurse vacancy
- 16 GPs were thinking about retiring over the next 5 years
- 4 Nurses were thinking about retiring over the next 5 years
- The main reasons (across the whole survey so not just Shropshire CCG) for retiring were reaching the age of retirement; a few cited work life balance and workload pressures.
- To establish whether there was an appetite in primary care for new primary care roles, practices were asked to rank which of the existing and emerging new practice roles they would consider recruiting to in the next five years – see table on page 28.

The final conclusions from the report were that regarding the number of people looking to reduce and retire early there are several factors in play; the impact of both the seniority payments and the recent changes to the NHS pension, and where people are looking to reduce their hours or take early retirement, which will influence the morale and work life balance and pressure of those who remain.

Coupled with the local and national challenges in recruiting GPs and Practice Nurses, this issue is further compounded. There is a need to retain the current workforce and to improve work life balance and workload pressures should be a top priority.
Several GP practices across Shropshire already offer medical students and GP registrar placements. These placements are supported by local universities. This offers opportunities to develop additional skills and competencies as well as developing the skills and knowledge of other members of the team. This assists in breaking down historical professional boundaries and promotes primary care as a career destination. The rural nature of some of our practices could be a negative to offering placements and we need to be able to demonstrate the positive aspects of working in a rural area.

The CCG is working with the local GPs and CEPN to actively engage and promote the benefits and opportunities for GP practices to become training practices for student nurses and develop mentoring skills for practice nurses linked to local universities.

The CCG provided match funding to support the implementation of a Practice Nurse Facilitator post for a 12-month period in collaboration with Health Education West Midlands. Two nurse facilitators were appointed for one session each per week across Shropshire and Telford & Wrekin CCGs. The posts are funded by Health Education West Midlands via the local CEPN and the two CCGs, who are working in partnership to support the implementation of the Health Education England General Practice Nursing Career Framework. Their role is to assist in the development of pre-and post-registered nursing workforce in general practice. They support nurses new to general practice and those undertaking the Fundamentals of General Practice Nursing programme. In addition, their role is to provide support to mentors who are mentoring student nurses, set up Practice Nurse Network Groups where wanted, gather information about training needs and help provide a voice for local nurses in General Practice. There is a growing number of nurse placements in Shropshire practices.

The CCG has also recognised that further support is needed for Practice Nurses and it is recommended that this be included as part of a Primary Care Workforce Strategy.

The CCG has historically supported GP education, mentoring, clinical leadership development and protected learning events and these continue to develop in a positive direction. To further support practices with challenges, NHS England also offers the services of a General Practice Support Team.
Funding has been made available from NHS England for practice manager development training, and funding is available for reception and administrative staff to undertake enhanced roles in active signposting and correspondence management.

Some of the GP practices are using monies available from the 2016/17 GP resilience fund (part of the GP Forward View GP development programme) to pay for joint training to support collaborative working.

Further discussions are also required around the skill sets available within each practice and how these skills can be better shared between practices as part of the joint working.

**Recommendations**

One of the desired outcomes from the original CCG Strategy was to have an empowered, diverse and self-sustained workforce, which is an outcome the CCG still aspires to. There is an increasing population with a nationally decreasing workforce and there is a risk of a reduction in the quality of care provided and therefore patient safety due to an exhausted workforce.

Shropshire needs to promote the benefits of their geography and services to be an attractive place to work. Through creating varied innovative opportunities to diversify a clinical portfolio career, covering a wide spectrum including research, leadership, training and an alternative clinical focus, we can then retain the current workforce and attract future workforce.

Through the STP, work will be carried out to expand multi-disciplinary team working and to look at more collaborative and innovative ways of utilising the collective workforce. This is backed up by the workforce elements of the GP Forward View, which are being led by NHS England’s regional primary care team and include the following initiatives. Consideration needs to be given to the impact the new ways of working will have on other sectors:

- **Clinical pharmacists** in general practice – this is a national scheme and the CCG is supporting bids from GP practices.
- **International recruitment** – there will be a pan-Shropshire approach to this.
- **Recruitment of Physician Associates** - there will be a pan-Shropshire approach to this. A Physicians Associate ambassador has been appointed regionally to promote this role and some individual practices are exploring this option.
- **Recruitment of practice nurses** - there will be a pan-Shropshire approach to this.
- **Recruitment of mental health workers** - there will be a pan-Shropshire approach to this. Locally, CMHT link workers will be based around clusters of practices, which supports a more collaborative approach.

Whilst the CCG has a whole time equivalent GP workforce ratio that is similar to the national average, there is a need to fully identify the overarching clinical workforce ratio to assess overall need. An audit is being carried out to further analyse the position locally and ensure the workforce data currently held is completely accurate (and gives a complete picture). This will then be kept up to date and accurate moving forward using a Health Education England (HEE) workforce tool. This information will inform a workforce strategy.

The CCG needs to encourage the use of new workforce models with locality groups as they work more collaboratively together and as new care models emerge. Many practices have extended their multi-disciplinary team to include Advanced Nurse Practitioners and are exploring the role of clinical pharmacists and physician’s associates.
3.5 Workload and GP resilience

The GP Forward View recognises the increasing workload and pressure on general practice and seeks to reduce unnecessary administrative burden on GPs. Locally, the CCG also acknowledges the concerns increasingly raised by GPs about unnecessary work shifting from secondary care. It is also recognised that the increasing ageing population in Shropshire brings with it additional workload in terms of caring for patients in nursing and residential homes and in our more rural areas. In more general terms, patient demand and expectations continue to rise.

30% of respondents to the survey of GPs and Practice Managers carried out as part of this needs assessment (see section 5) considered their practice to be ‘vulnerable’.

Care Navigators

A £45m fund has been created as part of the GP Forward View’s GP development programme, for care navigation training – to be used by practices to train reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence, to help free up GP time, and is available over the next four years.

Shropshire’s practices are adopting a group / locality based approach to care navigator training. Care navigators will supplement the successfully implemented practice based Community and Care Coordinators scheme. The CCG is also exploring how this links up with care navigation in the local authority, and work being undertaken around social prescribing.

Correspondence management

Shropshire practices are at different stages with correspondence management, ranging from administrative staff who already read many of the GPs’ letters through to practices where the GPs read and taken action all the letters coming into the practice personally. Practices have been accessing training to look at, improve or implement systems within their practices for improved workflow of correspondence, and will also be looking to share best practice.

10 High Impact Actions

Shropshire CCG will be supporting the implementation of the GP Forward View 10 high impact actions to release time for care. As set out below, a number of these actions will be supported by wider STP work streams.

1. Active signposting – This will be further developed in conjunction with STP partners, particularly linking in with established Social Care and Voluntary Sector signposting schemes and will be linked to the development of the community directory, Shropshire Choices.
2. New consultation types – This will be linked to the implementation of our Local Digital Road Map and our Estates and Technology Transformation Fund bids.
3. Reduce Did Not Attends (DNAs) – review options for improving appointment systems and working with patient groups to develop awareness and reduce the impact of DNAs.
4. Develop the team – utilise national investment and opportunities of working at scale and collaboration to support training of clerical and reception staff. Develop the care navigator role with allocated funding.
5. Productive workflows – Share good practice both locally and nationally to develop innovative ways of working. Develop greater links to STP developments.
6. **Partnership Working** – ensure this flows through all transformation activities and that links between Primary Care and the STP are strengthened. Develop the locality infrastructure and the support this offers.

7. **Social Prescribing** – Build on the pilot scheme in the north of the county and link to both the existing CCG Community and Care Coordinators and Social Care Let’s Talk Local schemes.

8. **Support Self Care** – This is a theme that runs through the STP, but requires greater alignment with Primary Care. Strengthen links with Shropshire Council’s Public Health Prevention programme (‘Healthy Lives’) and Social Care ‘Resilient Communities’ work.

9. **Personal Productivity** - Develop support mechanisms and training and development opportunities for staff in collaboration with our partners.

10. **Develop QI expertise** - development of a transformation and quality support offer.

**Clinical Pharmacists in General Practice**

As mentioned in the workforce section, there is a national programme underway to recruit clinical pharmacists in general practice. The GP Forward View committed to over £100m of investment to support an extra 1,500 clinical pharmacists to work in general practice by 2020/21.

GP practices were invited to apply for funding to help recruit, train and develop more clinical pharmacists. Providers participating in the programme will receive funding for three years to recruit and establish clinical pharmacists in their general practices for the long term.

Having clinical pharmacists in GP practices means GPs can focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. This helps GPs manage the demands on their time.

There are already practices within Shropshire who employ a clinical pharmacist, and groups of practices are interested in putting in a bid for this funding. The CCG’s medicines optimisation team are supporting practices who are interested in bidding for funding.

**Prescription Ordering Direct (POD)**

The CCG is in the process of rolling out Prescription Ordering Direct (POD), a scheme that seeks to reduce medicines waste and reduce workload on general practice by reducing incoming calls for repeat prescriptions and the associated administrative work. Ideally, any clinical pharmacists employed by practices or groups of practices would work with and alongside the POD.

**Recommendations**

Working more collaboratively as groups of practices is key to addressing the pressures of workload and the impact that has on both individual and collective resilience. Practices are starting to form alliances (Darwin Health in Shrewsbury, some practices within the north and south localities have become members of OHP, and more local collaborations such as the south-east group of practices have formed). This is at early stages and GP resilience monies through the GP Forward View have supported the setting up of these groups.

Through collaborative working, better communication, and the sharing of some back-office functions and processes, such as HR and shared document management systems, practices will become more resilient. In turn, this is the first step towards the development of new care models and new ways of working. These new models should ultimately integrate the wider health and social care system, with new workforce models based around a patient population.

Through the STP, the CCG and partners should ensure that primary care is linked up with the wider community work being led by the local authorities. Shropshire Council’s ‘Healthy Lives’ and ‘Resilient Communities’ work has a focus on prevention and patient self-care, as well as developing social prescribing where patients can be
supported to access resources within the community where it is a social intervention that is required rather than a medical one. Promoting care navigation, through the training of GP practice reception and administrative staff to have a more enhanced role in actively signposting patients to these services, and expanding the role of the Community and Care Coordinators, should also reduce the number of unnecessary appointments made with a GP. The use of local directories and the Shropshire Choices website will underpin this work. There is a huge amount of working going on across the county, and the CCG has a key role in ensuring collaborative working.

How to manage demand on the whole health and social care system is a key workstream within the STP. Keeping patients out of hospital and reducing admissions and referrals into secondary care is a priority for the CCG and will be included within locality plans for the GP practices. Frailty and MSK are key areas of clinical focus and GP engagement in these projects is essential, alongside other partners such as Shropshire Council, Shropshire Community Health NHS Trust and the acute providers.

3.6 New Models of Care

The Department of Health’s Five Year Forward View outlines new models of care. Four prototype care models were defined which encouraged organisations to work together to deliver patient care. In addition, the BMA’s vision of ensuring a responsive, safe and sustainable General Practice included increased collaboration between GP Practices.

The new models of care outlined in the Five Year Forward View outline integrated out of hospital care with local communities. The CCG supports this approach. Whilst considering the delivery of new service models, the CCG should work with practices to not only encourage them to work collaboratively, but also on a wider scale with hospital and community colleagues.

As mentioned above, several Shropshire GP Practices are moving towards this model of operating at scale with groups of ‘Alliance’ organisations emerging with the objectives of working in a more collaborative way.

STP Neighbourhood Model

The STP’s plan for neighbourhood working will be used as the basis for providing health and care services for people who need professional help, but not hospital treatment. The aim is that GPs, social care, community nurses, therapists and mental health workers increasingly work together to provide a consistent range of services at a local level. These Neighbourhood Care Teams would be the first port of call for patients with diabetes, and other long-term conditions patients who might otherwise have to go to hospital but who don’t need emergency services; and patients who have recently been discharged from hospital. They would be the link between clinical and community care.

The Neighbourhood offer is founded on a placed based approach to meeting local need, placing primary and community care at the centre and using a multidisciplinary and asset based approach to delivering care and support. GPs engagement is essential and further work in needed to understand their involvement in terms of delivery. This approach needs to acknowledge current pressures and capacity issues and wrap additional levels of support around practices. This in turn looks to address the anomaly of a simple “left shift” from secondary to primary care given primary care pressures and looks to develop alternative options, where appropriate, such as social prescribing. Central to the Neighbourhood model is the focus on prevention and building community resilience as key strands of demand management. Shropshire’s neighbourhood model also looks to consider rurality and poor transport links in some areas of the county and to build this into
solutions by ensuring communities and individuals can be self-reliant and self-caring where appropriate. The CCG needs to further define the new model of care and engage with the General Practice population to enable delivery.

**Primary Care Services - Key Messages**

- Contract arrangements are complex and whilst much of this is outside the CCGs control, the CCG should minimise additional administrative pressures on practices.
- Reviews currently being undertaken around the locally commissioned services and work being carried out that is not contracted or funded should be completed, with the aim of providing equity for patients and resourcing practices for the work being undertaken outside of the core contract.
- Health checks should be promoted and GP Practices supported to deliver this important prevention intervention.
- We need to continue to ensure that Primary Care is supported to deliver care to complex patients and to address the clinical priorities.
- Support for practices to provide primary care at scale and deliver new models of care, 8am – 8pm 7 days a week is required.
- Equitable access needs to be available and visible for both routine and urgent care in GP Practices.
- Continued support for Practices with premises and IT development and workforce is key for future success.
- Improved methods of communication and engagement are needed to share strategic, plans and best practice to ensure high quality coordinated care.
- The CCG need to continue to undertake patient surveys to determine experiences and needs.
- Ensure primary care is fully involved and engaged in the new models of care as they start to emerge, and that groups and alliances of practices are fully linked in with the STP neighbourhood work.
- Ensure primary care is fully sighted on, and linked in with, the local authority work around resilient communities and healthy lives. Work around care navigation should facilitate this aim of linking up all the different resources and work taking place across the local health and social care system.
Section 4 – Quality

General practice in Shropshire is seen to be of high quality, with high QOF achievement, good ratings from Care Quality Commission (CQC) inspections and high patient satisfaction scores. However further work is needed to ensure this high-quality care can be continued.

QOF achievement and Primary Care Web Tool

The Quality and Outcomes Framework (QOF) is an annual reward and incentive scheme for GP practices. There are 19 clinical areas within the clinical domain of QOF, plus an additional six within the public health domain. The average overall QOF points achievement for Shropshire CCG for 2015/16 was 97.47% (compared to a national average of 95.33%).

Through QOF the CCG can look at disease prevalence (percentage of eligible patients on QOF disease registers) for individual practices and the CCG. There will be different factors causing variance in prevalence, not least the demographics of a patient population. By understanding local need and identifying any unwarranted variances, the CCG should ensure that appropriate services are in place and being delivered in the right way to meet need.

The Primary Care Web Tool allows CCGs and NHS England to identify outlying practices across several quality outcome measures and indicators. The tool provides a CCG overview to highlight significant variation across its practices. A total of 6 or more points that are more than 2 Standard Errors of Mean (SEM) outside the mean value is considered to represent significant variation warranting further investigation. Shropshire CCG has no practices with more than 3 points which are 2 SEM outside the mean value.

The data held within the Primary Care Web Tool is used to populate a primary care quality dashboard, which will be used to inform practice support visits carried out by the CCG.

Care Quality Commission (CQC) ratings

The Care Quality Commission (CQC) is the independent supervisory body of health and adult social care in England. They ensure that services provided are safe, effective, compassionate, high-quality and encourage care services to improve.

The CQC has visited all the GP practices in Shropshire. One practice was rated as ‘requires improvement’ and the CCG is satisfied that actions have been implemented to address all the concerns and issues raised. Of the remaining practices, six have been rated as ‘outstanding’ and the rest as ‘good’.

CCG Quality Measures

Primary care quality dashboard

A primary care quality dashboard has been developed by the Commissioning Support Unit’s business intelligence team, which is populated by information from the Primary Care Web Tool and other sources such as the Friends and Family Test data, complaints data, and information recorded via Datix (an incident reporting system). The data is at CCG level but provides an overview and highlights trends. Individual practice data packs are also produced and shared with practices. This information is used to inform practice visits and discussions around quality, patient safety and patient experience. This dashboard needs to be reviewed and formally reported to Primary Care Commissioning Committee both at CCG and practice levels. Activity currently underway includes infection prevention and control, safeguarding (adult and children), supporting people with learning disabilities, working with public health to improve screening and immunisations.
Practice support visits

Practice support visits have been taking place on an annual basis, however the format and content of these visits is currently under review and will be information from these visits will inform the dashboard discussed above.

Recommendations

The CCG is working to bring together all the various data held, to make it as meaningful as possible to both practices and the primary care team. Locality profiles and locality plans are being developed by the primary care team, which will help to demonstrate local priorities and areas of focus. The CCG will continue to link in with NHS England and the CQC to address any areas of concern and a primary care lead within the CCG’s quality directorate has been identified to facilitate this.

A mechanism for promoting and sharing good practice should be put in place, including a formal mechanism for sharing CQC rated ‘outstanding’ practice. A formal method of providing assurance to Primary Care Committee is required.
Section 5 - Patient, Professional & Public Engagement

Patient Survey

To inform this Primary Care Needs Assessment, the CCG commissioned a patient engagement exercise with patient groups from practices in Shropshire, ensuring that the patient voice was heard.

Patients were encouraged to fill out a short survey, either paper based or online, and the results were collated and analysed on a weekly basis to ensure a representative section of the patient population.

Patient Group Survey Results

The patient survey was carried out in December 2016. Over 450 patients responded to the survey with patients from a cross section of all GP Practices represented. Most respondents (nearly 63%) were female and nearly half (47.55%) were aged 65 and over.

- 13% visit a GP less than once a year but over 22% visit their GP more than 3 times a month.
- Nearly 95% of patients are happy to see a GP and almost 75% are happy to see a Practice Nurse. As far as seeing other types of healthcare professionals is concerned, there seems to be a growing acceptance from patients, with 65% saying they would be happy to see an Advanced Nurse Practitioner (ANP), 48% indicating they would be happy to discuss their requirements with a Pharmacist and 37% would be happy to see a Physiotherapist, where appropriate.
- The majority (nearly 67%) of patients who were asked what types of information would help them to self-manage minor illnesses better, stated that online information as well as printed leaflets on common conditions would be more useful. However, just over 58% of patients would not visit their GP Practice and would try to self-manage a mild condition. It is important that the CCG makes this information available to patients.
- Whilst the majority (82%) of patients indicated that they prefer to book their appointments by telephoning their surgery, a large number (46%) would also book online, whilst a growing number (22%) would be happy to book their appointments using a mobile phone App.

![Survey Results Chart]

3) (*) How would you prefer to make appointments at your medical practice? (Please tick all that apply)

- By telephone
- Online
- Using an app on your mobile phone
- In person at the surgery

- Whilst almost 99% of patients still prefer to see their GP face to face, there are growing numbers who appear to want to communicate through other media such as telephone (over 65%), visually over the internet (13%), email (25%) and text (over 16%). This supports the need to ensure that our GP Practices have an ability and infrastructure to deliver these new ways of working.
74% of patients said that they would not be happy to travel to another practice for their appointments. This reflects the rurality of Shropshire and the distance between practices in the more rural areas, and supports the need to explore different options for models to deliver extended access.

**Professional Viewpoint – GP and Practice Managers Survey**

As well as gaining the views of patients and the public, the CCG also sought the views of local GPs and Practice Managers. An online survey was carried out in February 2017 and 60 responses were received.

**Survey results - key challenges faced in Primary Care**

The results of the survey highlighted some consistent responses, with the following being the most frequently raised challenges facing local General Practice:

- Managing patient expectations and lack of time to spend with individual patients
- Deficiencies in communication regarding the many policy changes cascaded from the Department of Health and NHS England
- Lack of funds for the development of Primary Care
- Managing additional work being moved from Secondary Care into Primary Care especially for the more complex care patients
- Liaison with secondary care and community services
- Recruitment and retention is becoming more challenging
- Too much bureaucracy and reporting in the system
- Reduction in revenue streams
- Increasing patient numbers with complex needs

The Survey also covered areas such as methods of contact with patients, flexibility of services in the area and use of technology for improving patient access:

- Several GPs and Managers indicated they were willing to use Face to Face or Telephone to have a consultation with their patients, however 33% of respondents said they would be happy to use face to face electronic methods (such as SKYPE or WebGP or eConsult type services) and others indicated the use of SMS/Text (55%) and email (43%).
62% of the GPs indicated they would be happy for patients to travel to other locations for enhanced Primary Care services and 96% indicated they would be happy for their patients to be seen elsewhere for other Outreach and urgent appropriate services.

With direct reference to patient access, all Practices offered a range of same day urgent care appointments as well as pre-bookable appointments, however the delivery is not consistent across Practices.

Where patients can book same day urgent care appointments, most surgeries (65%) triage requests for these urgent appointments. 32% were using GPs to triage.

81% of surgeries indicated that they did not offer walk in appointments as it was difficult to manage the unplanned demand.

Most surgeries (80%) still offer Face to Face advice for minor illness. However, there is an indication of a willingness to move to offering advice online (75%). Almost half of respondents indicated that they already use the Voluntary/Charitable Sector to help signpost patients to appropriate services.

GPs have indicated that they would be happy to strengthen their workforce with other professionals including Pharmacists, Social Workers, Voluntary Sector, Physiotherapists, Advanced MSK Practitioners and a range of more specialist nurses.

It was universally indicated that all Practices that responded would be open to working with other practices in various ways, with the majority suggesting sharing of clinical staff and management functions.
Patient, Professional & Public Engagement – Key Messages

- The overriding similarities between the patient and professional survey results have been identified as the need to improve the use of technology and access to information to manage patient care.
- Patients indicated that they are happy to consult with a variety of Healthcare Professionals at their practices. This included Pharmacists, Physiotherapists and Physician’s Associates. There is also a willingness from Practices to explore diversification of the workforce.
- Most patients surveyed found no problem getting an appointment with their GP Practice.
- GPs are feeling the effect of care closer to home and the additional workload being received from secondary care. This, together with increasing numbers of patients with complex conditions, increasing reporting and a reduction in revenue, is causing unwarranted pressures on Practices.
- Practices said that they are keen to work with their colleagues to manage the threats to Primary Care and to provide a sustainable service to their patients.
- 30% of Practices stated that their Practice Organisation is in a vulnerable condition.
**Section 6 - Summary of Priorities**

The purpose of this document was to understand the need in Primary Care from a Patient, Commissioning and Provider perspective.

Taking into consideration the key messages from each section of this assessment, the priorities for 2017/18 should be to:

- Develop locality profiles to inform the commissioning requirements for the local populations. These profiles need to clearly set out the health needs for local populations, highlighting any variation across each patch. This will help identify whether the primary care services currently being provided are being delivered in the most appropriate way to meet local need and whether they are addressing identified clinical priorities; this will also help to inform locality, cluster and ‘at scale’ working, in line with new models of care; and will inform future primary care commissioning decisions.

- Promote patient activation and disease prevention, wellness and healthy lifestyles, by identifying resources to assist self-care and the ability for patients to manage their own conditions safely. This should involve increased access to information online and improving links across the local health and social care system, including the local authority work around resilient communities and healthy lives.

- Support and develop more integrated working, which will support the development of new models of care and provide opportunity for shared workforce and resources. This will subsequently support the aim of reducing workload on practices through improved understanding and navigation of the wider system, and improved patient outcomes and satisfaction.

- Continue to support Practices to develop their Patient Participation Groups to build on this Needs Assessment, and continue to undertake wider patient surveys to determine experiences and needs. This will enable a shared understanding of their local practice population needs and build relationships to ensure the sustainability of Primary Care for the future.

- Support delivery of the GP Forward View around a new model for Primary Care 8am – 8pm 7 days a week. Develop a formal plan to deliver this model, ensuring that equitable access is available and visible for both routine and urgent care in GP Practices.

- Support delivery of the GP Forward View by commissioning high quality Primary Care at Scale, addressing inequalities by attracting a multidisciplinary skilled workforce, to increase patient access. Identify the services required for the future model of care and the supporting technologies required. Supervision, peer review and audit processes to be clear to enable reduction of unwarranted variances.

- Ensure there is planning and resource available to identify and manage those health conditions highlighted as a priority by public health and the increasing number of patients with complex health conditions.

- Develop long term infrastructure plans including workforce, technology and estate.

- Promote and develop a culture of continuous improvement and shared learning. To introduce a formal mechanism for the sharing of CQC rated ‘outstanding’ practice.
• Minimise unnecessary administrative pressures on practices. Ensure a robust reporting framework to the Primary Care Commissioning Committee on delivery of this Needs Assessment.

• Develop a communications strategy for Primary Care.
Subject: CCG Annual Assessment Results 2016/17

Report Written by: Claire Skidmore; Chief Finance Officer

Presented by: Simon Freeman; Accountable Officer

Responsible Director: Simon Freeman; Accountable Officer

For decision

For performance monitoring

Other – please specify

Members are asked to read the attached letter from NHSE; to reflect on its contents and note that the Executive team are focused on delivering improved ratings for 2017/18.

Key issues or points to note:

- The CCG has been rated **inadequate** for 2016/17 though NHSE note the positive progress made in-year towards financial recovery and improved organisational resilience.
- The CCG remains under special measures and will transfer to a new 'reframed' regime in 2017/18.
- The letter highlights a number of areas of good practice as well as challenges and suggests areas for improvement or development. These will be addressed in-year and each will have relevant executive input and oversight of their delivery.
Introduction

1.1. The CCG Improvement and Assessment Framework for 2016/17 contains indicators that align key objectives and priorities with the NHS Five Year Forward View. CCGs are rated based on their performance against these indicators and can achieve an overall rating of either inadequate; requires improvement; good or outstanding\(^1\).

1.2. For 2016/17, Shropshire CCG received an **inadequate** rating and remains in special measures. NHSE have however noted the positive progress made specifically in relation to financial turnaround and organisational resilience. In her letter, Wendy Saviour, Director of Commissioning Operations NHSE Midlands and East also notes her expectation that the CCG will come out of special measures in-year.

2. **Key Areas of Strength/Good Practice**

2.1. NHSE noted four areas of good practice for 2016/17:

- consistent delivery of IAPT recovery and waiting times;
- strong cancer waiting time performance;
- effective response to the in-year capacity and capability review;
- achievement of all six clinical priority areas.

3. **Key Areas of Challenge**

3.1. Four key areas of challenge were also highlighted:

- referral to treatment and four hour wait performance remain some of the worst in the country;
- the CCG has one of the lowest rates of digital interaction between primary and secondary care;
- financial balance and QIPP delivery is a significant challenge;
- the CCG became subject to legal directions at the beginning of the year because of concerns about leadership and governance.

4. **Key Areas for Improvement and Development Needs**

4.1. Areas noted for improvement or development will be monitored closely by me and the rest of the Executive team to ensure that the CCG continues to recover with a view to improving its rating for 2017/18.

4.2. Areas of responsibility are allocated as follows:

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\(^1\) Further information on the scoring methodology is contained in the NHSE letter appended to this report.
### Improvement

<table>
<thead>
<tr>
<th>Description</th>
<th>Director Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address financial situation within Shropshire STP; strengthen the CCG’s underlying position during 2017/18</td>
<td>Claire Skidmore</td>
</tr>
<tr>
<td>Make full use of Right Care tools and Menu of Opportunities to support the significant QIPP requirement</td>
<td>Julie Davies; Gail Fortes-Mayer; Dawn Clarke; Nicky Wilde; Claire Skidmore</td>
</tr>
<tr>
<td>Address low rates of E-Referral utilisation</td>
<td>Gail Fortes-Mayer; Julie Davies</td>
</tr>
<tr>
<td>Ensure that the level of 52 week waiters in 2016/17 is not repeated in 2017/18</td>
<td>Julie Davies</td>
</tr>
</tbody>
</table>

### Development

<table>
<thead>
<tr>
<th>Description</th>
<th>Director Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversee delivery of recovery actions to ensure delivery of RTT and 4 hour targets</td>
<td>Julie Davies</td>
</tr>
<tr>
<td>Prioritise delivery of the planned reduction of elective orthopaedics in 2018/19</td>
<td>Gail Fortes-Mayer</td>
</tr>
<tr>
<td>Continue to further stabilise the organisation focusing on building resilience, capability and capacity</td>
<td>Simon Freeman; Sam Tilley</td>
</tr>
<tr>
<td>Support development of system wide leadership to enable delivery of STP and Future Fit priorities.</td>
<td>Simon Freeman</td>
</tr>
</tbody>
</table>

### 5. Conclusion

5.1. The Executive team and I have a lot of work to do over the coming months in order to build on work already done to introduce stability, leadership and stronger governance to Shropshire CCG. We are working hard to demonstrate that we are ready to be lifted from special measures and will continue to focus energies on actions to improve both financial and quality ratings. We aim to deliver an improved rating for 2017/18.

Appendix 1: NHSE letter to Simon Freeman 13th July 2017
Dear Simon

2016/17 CCG annual assessments

The CCG annual assessment for 2016/17 provides each CCG with a headline assessment against the indicators in the CCG improvement and assessment framework (CCG IAF). The CCG IAF aligns key objectives and priorities as part of our aim to deliver the Five Year Forward View. The headline assessment has been confirmed by NHS England’s Commissioning Committee.

This letter provides confirmation of the annual assessment, as well as a summary of any areas of strength and where improvement is needed from our year-end review (Annex A).

Detail of the methodology used to reach the overall assessment for 2016/17 can be found at Annex B. The categorisation of the headline rating is either outstanding, good, requires improvement or inadequate.

The final draft headline rating for 2016/17 for Shropshire CCG is Inadequate.

All CCGs assessed as inadequate at year-end will be placed in a reframed special measures regime. Special measures will embrace support to help CCGs improve and will no longer be closely linked to the use of legal directions, although the two will not be mutually exclusive.

The Directions currently in place for the CCG will remain in conjunction with special measures.

Overall, the results for the NHS in England in 2016/17 represent an improvement from 2015/16, which is a significant achievement for commissioners and is representative of - much hard work during what has been a difficult year.
The 2016/17 annual assessments will be published on the CCG Improvement and Assessment page of the NHS England website on 19 July 2017. At the same time they will be published on the MyNHS section of the NHS Choices website. The dashboard with the data has already been made available through NHS England regional teams, and will be reissued with year-end ratings on 19 July 2017. CCGs will also receive confirmation of their assessment in three clinical priority areas (cancer, mental health and dementia), at the same time. Assessments for diabetes, learning disabilities and maternity are expected to follow later in the year.

Thank you for your CCG’s contribution to delivering the Five Year Forward View, and your focus on making improvements for local people. I look forward to working with you and your colleagues during 2017/18, including following up on the annual assessment.

I would ask that you please treat your headline rating in confidence until NHS England has published the annual assessment report on its website on 19 July. This rating remains draft until formal release. Please let me know if there is anything in this letter that you would like to follow up on.

Yours sincerely

Wendy Saviour
Director of Commissioning Operations
NHS England, Midlands and East
Annex A – 2016/17 summary Shropshire CCG

Key Areas of Strength / Areas of Good Practice
- The CCG have consistently maintained delivery of the IAPT recovery and waiting times.
- The CCG have worked effectively throughout the year to achieve strong cancer waiting time performance.
- The CCG have responded effectively to the Capacity and Capability review commissioned in year.
- The CCG achieved all six clinical priority areas based on local assessment.

Key Areas of Challenge
- Referral to Treatment performance and 4 hour wait performance in Shropshire remains one of the worst in the country. Only 85.3% of patients attending SaTH were treated within 4 hours of arrival in 2016/17.
- Shropshire CCG have one of the lowest rates of digital interaction between primary and secondary care. You must work with GP practices and providers to address this to improve this position.
- Achieving financial balance and QIPP delivery has been a significant challenge however the CCG overcame significant in year challenges to deliver its control total for 2016/17.
- Leadership and governance concerns led to the CCG becoming subject to Legal Directions at the beginning of the year.

Key Areas for Improvement
- NHSE has increasing confidence that the organisation is capable of delivering the 2017/18 QIPP in full. The overall financial situation must be addressed within the Shropshire STP, and efforts must be made to strengthen the underlying position during 2017/18.
- The CCG should make full use of the NHS Rightcare tools along with the Menu of Opportunities (MOO) in order to support the significant QIPP requirement of the CCG.
- Shropshire CCG has a low rate of E-Referral utilisation. This will need to be addressed in year.
- The CCG had 56 patients who waited over 52 weeks for treatment. You will need to work with providers to ensure that the level of 52 week waiters observed in 2016/17, are not repeated during 2017/18.

Development Needs and Agreed Actions
- Oversee the delivery of recovery actions to achieve the Referral to treatment and 4 hour targets.
- Prioritise delivery of the planned £10m reduction in elective orthopaedics for 2018/19.
• Continue implementation of the agreed actions to further stabilise the organisation and build resilience, capability and capacity.
• Support the development of system wide leadership to enable delivery of STP and Future Fit priorities.

Summary
Overall we note the positive progress you have made, particularly in the latter part of the year in relation to your efforts to deliver financial turnaround and the progress you have made to improve organisational resilience.

Given the above and progress made in implementing the key recommendations of the Capacity and Capability review, we would expect the CCG to come out of special measures in year and move towards the removal of legal directions.

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Annex B – Assessment Methodology

NHS England’s annual performance assessment of CCGs 2016/17

1. The CCG IAF comprises 60 indicators selected to track and assess variation across 29 policy areas covering performance, delivery, outcomes, finance and leadership. This year, assessments have been derived using an algorithmic approach informed by statistical best practice; NHS England’s executives have applied operational judgement to determine the thresholds that place CGCs into one of four performance categories overall.

Step 1: indicator selection

2. A number of the indicators were included in the 2016/17 IAF on the basis that they were of high policy importance, but with a recognition that further development of data flows and indicator methodologies may be required during the year. However, by the end of the year, there were data limitations for four of the indicators, so these have been excluded. These four indicators are set out below:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of deaths which take place in hospital</td>
<td>End of life choice indicator – placeholder only for 2016/17, new indicators introduced for 2017/18</td>
</tr>
<tr>
<td>Ambulance waits</td>
<td>Data not available for pilot sites</td>
</tr>
<tr>
<td>Outcomes in areas with identified scope for improvement</td>
<td>Data available for 65 wave 1 CCGs only</td>
</tr>
<tr>
<td>Expenditure in areas with identified scope for improvement</td>
<td>Data available for 65 wave 1 CCGs only</td>
</tr>
</tbody>
</table>
Step 2: indicator banding

3. For each of the 209 CCGs, the remaining 56 indicator values are calculated. For each indicator, the distance from a set point is calculated. This set point is either a national standard, where one exists for the indicator (for example in the NHS Constitution); or, where there is no standard, typically the CCG’s value is compared to the national average value.

4. Indicator values are converted to standardised scores (‘z-scores’), which allows us to assess each CCG’s deviation from expected values on a common basis. CCGs with outlying values (good and bad) can then be identified in a consistent way. This method is widely accepted as best practice in the derivation of assessment ratings, and is adopted elsewhere in NHS England and by the CQC, among others.\(^1\)

5. Each indicator value for each CCG is assigned to a band, typically three bands of 0 (worst), 2 (best) or 1 (in between).\(^2\)

Step 3: weighting

6. Application of weightings allows the relatively greater importance of certain components (i.e. indicators) of the IAF to be recognised and for them to be given greater prominence in the rating calculation.

7. Weightings have been determined by NHS England, in consultation with operational and finance leads from across the organisation, and signal the significance we place on good leadership and financial management to the commissioner system:

- Performance and outcomes measures: 50%;
- Quality of leadership: 25%; and,
- Finance management: 25% (the assessment of financial plan is zero weighted to ensure focus on financial outturn)

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\(^1\) Spiegelhalter et al. (2012) *Statistical Methods for healthcare regulation: rating, screening and surveillance*

\(^2\) For a small number of indicators, more than 3 score levels are available, for example, the leadership indicator has four bands of assessment.

*High quality care for all, now and for future generations*
8. These weightings are applied to the individual indicator bandings for each CCG to derive an overall weighted average score (out of 2).

**Figure 1: Worked example**
Anytown CCG has:
- Quality of leadership rating of “red” (equivalent to a banded score of 0)
- Finance management rating of “amber” (equivalent to banded score of 1)
- Finance plan is zero weighted.
- For the remaining 53 indicators, 9 are banded as 0 (outlying, worst), 12 are banded as 2 (outlying, best) and 32 are banded as 1 (in between).
- The total of the banded scores for these indicators is therefore (9x0) + (12x2) + (32x1) = 56
- The weighted average score is calculated as:
  \[25\% \times 0 + [25\% \times 1] + [50\% \times (56/53)] = 0.78\]

9. Each CCG’s weighted score out of 2 is plotted in ascending order to show the relative distribution across CCGs. Scoring thresholds can then be set in order to assign CCGs to one of the four overall assessment categories.

10. If a CCG is performing relatively well overall, their weighted score would be expected to be greater than 1. If every indicator value for every CCG were within a mid-range of values, not significantly different from its set reference point, each indicator for that CCG would be scored as 1, resulting in an average (mean) weighted score of 1. This therefore represents an intuitive point around which to draw the line between ‘good’ and ‘requires improvement’.

11. In examining the 2016/17 scoring distribution, there was a natural break at 1.45, and a perceptible change in the slope of the scores above this point. This therefore had face validity as a threshold and was selected as the break point between ‘good’ and ‘outstanding’.

12. NHS England’s executives have then applied operational judgement to determine the thresholds that place CCGs into the ‘inadequate’. A CCG is rated as ‘inadequate’ if it has been rated red in both quality of leadership and financial management.
13. This model is also shown visually below:

**Deriving the 2016/17 CCG IAF assessment ratings**

**Step 1:** Indicators selected
- 80 Indicators in the IAF
- of which, 55 included in the end-year rating calculation
- 5 indicators excluded due to data quality or risk of data completeness
  - % of deaths in hospital
  - Ambulance waiting times
  - 2x HighCare indicators
  - Financial plan

**Step 2:** Indicators banded
- Indicator values derived for each CCG
- Measure of deviation calculated ("z-score") for each CCG value
- Outlying CCGs assigned to bands with scores of 0 (worst), 2 (best), and 1 (the rest)

**Step 3:** Weights applied, average score calculated
- Indicator weightings:
  - Quality of leadership: 25%
  - Finance in-year: 25%
  - The rest combined: 50%
- Worked example for Anytown CCG above
  - Average score calculated for CCG as sum of:
    - [Leadership] 25% * 0
    - [Finance] 25% * (1/1)
    - [The rest] 50% * (56/53)
  - 0.78 (out of a possible 2)

**Step 4:** Scores plotted and rating thresholds set
- The distribution of average scores (out of 2) is plotted for all 209 CCGs. The threshold between requires Improvement and good is set at 1, and the outer bounds for the outstanding and inadequate categories are set by eye-balling the distribution to identify any natural breaks. NHS England executives have applied judgement to determine appropriate thresholds between categories.

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KEY POINTS FINANCE POSITION AT 30th JUNE 2017 (MONTH 3):

Summary Position

- Shropshire CCG continues to be in “Directions” and in formal financial recovery.
- The overall financial position to 30th June 2017 is currently forecasting an in year deficit of £19.4m which is in line with the agreed control total. This reflects the gap in the CCG’s current plan as a result of planned expenditure exceeding resource allocation.
- The cumulative financial position is forecasting £52.0m deficit which includes brought forward £32.6m from previous years.
- The CCG entered 2017/18 with a number of known significant risks and has a QIPP target of £17.71m.

Income and Expenditure Headlines

- Initial positions on contracts are assessed on the month 2 activity submission by providers and then a view has been applied to the robustness of the potential trajectory projection for month 3. In line with previous years this has been overlaid with early soft intelligence around delivery of services.
- To date there are some areas of variance reported in the finance position and there are a small number of forecast variances at year end. There is nothing material of note at this point in the year.

Statement of Financial Position (‘balance sheet’) Headlines

- The CCG has achieved its target on all four criteria within the Better Payment Policy for this month and work will continue to maintain performance.
- The CCG is achieving its cash target to date; each month so far has ended with cash levels less than 1.25% of the monthly draw down. This is a national requirement for all CCGs.
- The finance team are working to cleanse the SOFP, in particular focusing on debtors and creditors.
RECOMMENDATION TO THE COMMITTEE

The Committee are asked to:

- **Note** the content of this report
- **Note** the progress on key areas of Financial Reporting

CONTEXT AND IMPLICATIONS

<table>
<thead>
<tr>
<th>Financial implications</th>
<th>As noted in the report</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR/Personnel implications</td>
<td>None to note</td>
</tr>
<tr>
<td>Promoting equality and equity – implications</td>
<td>None to note</td>
</tr>
<tr>
<td>Considerations for Quality &amp; Safety</td>
<td>None to note</td>
</tr>
<tr>
<td>What patient and public involvement has there been in this issue, or what impact could it have on patient/public experience?</td>
<td>None to note</td>
</tr>
<tr>
<td>Any Conflicts of Interest to be declared</td>
<td>None to note</td>
</tr>
</tbody>
</table>
1. Recommendations

The Committee are asked to:
- Note the content of this report
- Note the progress on key areas of Financial Reporting

2. Introduction

The purpose of this report is to articulate the finance position of the CCG noting any risks that may be related to finance.

NHS Shropshire CCG continues to be in “Directions” and in formal financial recovery and is in close dialogue with NHE England colleagues in this respect.

The overall financial position to 30\textsuperscript{th} June 2017 is a forecast in year deficit of £19.4m which is in line with the agreed control total. This reflects the gap in the CCG’s current plan as a result of planned expenditure exceeding resource allocation.

The cumulative financial position is £52.0m deficit which includes a brought forward deficit of £32.6m from previous years.

3. Overall Financial Position

The table below gives the summary level financial position to 30\textsuperscript{th} June 2017. This position has been reported to NHS England and is consistent with the position held within the Integrated Single Financial Environment (ISFE), the ledger system.

A full breakdown of CCG expenditure is included at Appendix 1.
4. Contract Position

The following summary of contract positions is given to month 3 and using the month 2 activity data, being the most recent information available at the time of writing.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>2017/18 Annual Budget £000</th>
<th>2017/18 Budget Year to Date - month 3 £000</th>
<th>2017/18 Actual Year to Date - month 3 £000</th>
<th>2017/18 Variance Year to Date - month 3 £000</th>
<th>2017/18 Outturn Expenditure £000</th>
<th>2017/18 Outturn Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shrewsbury and Telford Hospitals NHS Trust</td>
<td>133,595</td>
<td>33,304</td>
<td>33,275</td>
<td>(29)</td>
<td>134,627</td>
<td>1,032</td>
</tr>
<tr>
<td>Robert Jones and Agnes Hunt FT</td>
<td>33,350</td>
<td>8,314</td>
<td>8,314</td>
<td>0</td>
<td>32,920</td>
<td>(430)</td>
</tr>
<tr>
<td>West Midlands Ambulance Service Contract</td>
<td>11,206</td>
<td>2,802</td>
<td>2,920</td>
<td>118</td>
<td>11,676</td>
<td>470</td>
</tr>
<tr>
<td>Other Acute Contracts</td>
<td>19,567</td>
<td>5,773</td>
<td>5,755</td>
<td>(18)</td>
<td>19,507</td>
<td>(60)</td>
</tr>
<tr>
<td>Acute NCA’s</td>
<td>4,250</td>
<td>1,062</td>
<td>1,034</td>
<td>(28)</td>
<td>4,250</td>
<td>0</td>
</tr>
<tr>
<td>Acute Special Placements</td>
<td>51</td>
<td>13</td>
<td>4</td>
<td>(9)</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>Winter Resilience</td>
<td>473</td>
<td>118</td>
<td>136</td>
<td>18</td>
<td>473</td>
<td>0</td>
</tr>
<tr>
<td>Future Fit</td>
<td>339</td>
<td>85</td>
<td>89</td>
<td>4</td>
<td>339</td>
<td>0</td>
</tr>
<tr>
<td>Acute Services - Other</td>
<td>504</td>
<td>126</td>
<td>102</td>
<td>(24)</td>
<td>504</td>
<td>0</td>
</tr>
<tr>
<td>Acute Services Team</td>
<td>39</td>
<td>10</td>
<td>5</td>
<td>(5)</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Programme Pay Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Services Total</td>
<td>203,374</td>
<td>51,607</td>
<td>51,634</td>
<td>27</td>
<td>204,386</td>
<td>1,012</td>
</tr>
</tbody>
</table>

**Note 1:** The Shrewsbury and Telford Hospitals NHS Trust position includes both Contract and Non Contract values. (Activity and Finance Tables reported elsewhere reflect the contract position only).

**Shrewsbury and Telford Hospitals Trust – YTD £29k under: FO £1.032m overspend**

At the month 3 position, Shrewsbury and Telford Hospitals contract is reporting a year to date marginal underspend and a forecast overspend of £1.032m at the year end.

Last month, the identified slippage on the QIPP Programme was profiled into the forecast of £2.4m over and this has been mitigated in part in month 3 by the introduction of new schemes during June, hence resulting in a net forecast overspend of £1.032m.

The table below gives a summary of spend at SaTH at POD level. Contract QIPP of £1.6m has been lodged in full against the plan for Non PbR variable and would explain part of the significant variance on that line. Further, the CCG is currently in discussion with SATH as the Trust have chosen to use a different profile of activity in their plan to what was signed off in the contract. This has the effect of creating potentially spurious variances on a number of rows. The CCG will strongly pursue the agreement of one phasing for the year in order to ensure a shared view of the in-year position.

Critical Care is currently showing an under-spending position both in year and as a forecast; as this area is volatile it will be monitored closely during the coming months.

The final row on the table below, “QIPP profile refresh” indicates the CCG’s forecasting assumption for QIPP Delivery in year. There is no ‘plan’ figure for this as an element of QIPP attributed to SATH was not agreed up front in the contract.
### Shropshire CCG Governing Body meeting: 16 August 2017

**Agenda item: GB-2017-08.167**

Shropshire CCG Position at Month 03 - Finance (Per Month 3 SATH Monitoring adjusted)

<table>
<thead>
<tr>
<th>POD</th>
<th>Ytd Cost Plan £</th>
<th>Ytd Cost Actual £</th>
<th>Adjustments</th>
<th>Ytd Cost Variance £</th>
<th>Cost Variance as % of Total Cost Variance</th>
<th>2017-18 Cost Plan £</th>
<th>2017-18 Cost FOT £</th>
<th>FOT Cost Variance £</th>
<th>FOT percentage Variance above Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(01) Day Case</td>
<td>3,007,900</td>
<td>3,667,653</td>
<td></td>
<td>0.753</td>
<td>1.7%</td>
<td>10,582,263</td>
<td>10,825,834</td>
<td>243,570</td>
<td>1.7%</td>
</tr>
<tr>
<td>(02) Elective</td>
<td>1,641,497</td>
<td>1,639,831</td>
<td></td>
<td>(38)</td>
<td>-0.0%</td>
<td>3,395,542</td>
<td>6,457,894</td>
<td>2,452,352</td>
<td>(224,619)</td>
</tr>
<tr>
<td>(03) Emergency</td>
<td>12,780,072</td>
<td>13,196,685</td>
<td></td>
<td>682,517</td>
<td>5.0%</td>
<td>25,636,550</td>
<td>25,677,893</td>
<td>4,341,343</td>
<td>1.7%</td>
</tr>
<tr>
<td>(04) Non-Elective Other</td>
<td>1,998,078</td>
<td>1,838,818</td>
<td></td>
<td>(159,260)</td>
<td>(9.9%)</td>
<td>8,198,721</td>
<td>7,390,967</td>
<td>767,754</td>
<td>(9.5%)</td>
</tr>
<tr>
<td>(05) Regular Admissions</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td>0.0%</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>(06) Critical Care</td>
<td>366,399</td>
<td>449,886</td>
<td></td>
<td>(316,487)</td>
<td>(41.3%)</td>
<td>4,150,854</td>
<td>1,845,698</td>
<td>2,305,156</td>
<td>(41.3%)</td>
</tr>
<tr>
<td>(07) Outpatient Treats</td>
<td>2,386,789</td>
<td>2,852,782</td>
<td></td>
<td>465,993</td>
<td>3.0%</td>
<td>9,352,773</td>
<td>9,692,256</td>
<td>379,483</td>
<td>3.0%</td>
</tr>
<tr>
<td>(08) Outpatient Follow Up</td>
<td>1,751,450</td>
<td>1,778,842</td>
<td></td>
<td>27,392</td>
<td>1.6%</td>
<td>7,028,058</td>
<td>7,167,282</td>
<td>139,224</td>
<td>1.6%</td>
</tr>
<tr>
<td>(09) Outpatient Procedures</td>
<td>2,369,491</td>
<td>1,867,248</td>
<td></td>
<td>(108,312)</td>
<td>(6.5%)</td>
<td>5,208,389</td>
<td>6,576,264</td>
<td>1,367,875</td>
<td>(6.5%)</td>
</tr>
<tr>
<td>(10) Accident and Emergency</td>
<td>923,967</td>
<td>1,968,647</td>
<td></td>
<td>105,680</td>
<td>5.4%</td>
<td>2,236,095</td>
<td>2,807,626</td>
<td>571,531</td>
<td>5.4%</td>
</tr>
<tr>
<td>(11) Non-PBM Variable</td>
<td>3,997,061</td>
<td>4,701,622</td>
<td></td>
<td>704,561</td>
<td>18.4%</td>
<td>11,922,829</td>
<td>12,177,000</td>
<td>2,254,171</td>
<td>18.4%</td>
</tr>
<tr>
<td>(12) Non-PBM Block</td>
<td>261,805</td>
<td>421,825</td>
<td></td>
<td>0.00</td>
<td>0.0%</td>
<td>1,047,219</td>
<td>1,087,720</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>(13) CQUIN</td>
<td>456,148</td>
<td>456,148</td>
<td></td>
<td>0.00</td>
<td>0.0%</td>
<td>1,855,762</td>
<td>1,855,762</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32,654,314</td>
<td>33,921,038</td>
<td></td>
<td>0.00</td>
<td>0.0%</td>
<td>133,290,254</td>
<td>133,750,032</td>
<td>4,459,788</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Please note (as stated at the summary table above) that the value reported in this table relates to the baseline contract for SaTH only and that other elements of healthcare expenditure (including prisoner healthcare) are included within the summary and Appendix 1.

Robert Jones and Agnes Hunt NHS Foundation Trust – YTD breakeven: FO £0.43m underspend

For Month 3, Robert Jones and Agnes Hunt NHS Foundation Trust contract is reporting a year to date breakeven and forecasting an underspend of £0.43m.

In a similar way to the SaTH position reported above, the movement from last month is as result of the introduction of non-contracted QIPP schemes which have mitigated the slippage previously reported.

In the POD analysis below, it can be seen that there is currently an under-spending position reported in Day Cases and an overspend reported in elective in patients. The underlying reasons for this are currently being discussed with the provider to understand if this trend is anticipated to change during the year.
As with the SATH position, the final item in this table, “QIPP Profile Refresh” reflects an assumed level of QIPP delivery by year end. This was not in the contract up front and therefore does not appear in the Plan figure.

### Other Acute Contracts

For Month 3, Other Acute contracts are reporting a year to date under-spend of £18k and forecasting an under-spend of £60k.

The West Midlands Ambulance contract is however demonstrating considerable over-performance to month 3 and the reasons for this are being investigated. In order to reflect the potential impact of this trend continuing, the forecast has been uplifted to £470k accordingly.

Further to this, a potential omission has been made from the patient transport service contract in respect of priority journeys for high dependency patients; this is currently forecast to be a £288k pressure at the year end. The reasons for this and potential mitigations are currently being explored.

### 5. Financial Performance – Other

#### Complex Care – YTD £21 over: FO £0.391m under

As reported at the month 2 position, the Complex Care budget included the full value of £4m relating to the planned QIPP schemes for the year and as a result of this was recording a commensurate under-spend of around £3.8m. At the month 3 position, the budget has now been reduced to incorporate the planned savings; the result of this is to reflect a more appropriate resource level for the service.

The introduction of two new QIPP schemes relating to MH placements and backlog reviews has resulted in a forecast under-spend of some £391k.
Prescribing – YTD £366k under: FO breakeven
Following receipt of the first month detailed reporting from the BSA, the prescribing expenditure has come in at levels that match the budget profile and is consistent with measures that are being put in place to secure efficiencies. A prudent approach has been taken to the forecast and this remains at a breakeven position until more detailed information becomes available.

Reserves
A summary of all reserves budgets are provided in the table below. The main movement from last month’s Commissioning Reserve (including: collaborative risk share (£1m), 0.5% headroom transfer from 1% reserve, MLU service review (£0.9m), winter resilience (£1.5m). – total £4.6m) are the application of the Complex Care QIPP reported above (£4m) and a number of smaller allocation receipts which will be factored into the position in future months.

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Annual Budget £000</th>
<th>2017/18 Budget Year to Date - month 3 £000</th>
<th>2017/18 Actual Year to Date - month 3 £000</th>
<th>2017/18 Variance Year to Date - month 3 £000</th>
<th>2017/18 Outturn Expenditure £000</th>
<th>2017/18 Outturn Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioning Reserve</td>
<td>9,341</td>
<td>612</td>
<td>367</td>
<td>(245)</td>
<td>7,732</td>
<td>(1,609)</td>
</tr>
<tr>
<td>1% Non Recurrent Reserve</td>
<td>1,922</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,922</td>
<td>0</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>1,922</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,922</td>
<td>0</td>
</tr>
<tr>
<td>Reserves Total</td>
<td>13,185</td>
<td>612</td>
<td>367</td>
<td>(245)</td>
<td>11,576</td>
<td>(1,609)</td>
</tr>
</tbody>
</table>

Running Costs YTD £0.298m overspend: FO Breakeven
The Running Cost element of the CCG allocation is showing a year to date overspend of £0.298m with forecast breakeven. The main area of overspend is due to expenditure relating to a number of senior interim appointments which has continued in the first three months of 2017-18 pending the commencement of recently appointed substantive Executives. The Executive Team are all now in post and it is anticipated that this position will improve month on month accordingly.

The requirement of the Better Payment standard is that 95% of invoices should be paid within 30 days of receipt by an organisation.
CCG performance against the target was achieved for this month for NHS and Non-NHS payments. The CCG Finance Team will continue to work closely with staff to ensure invoices are paid within 30 days of receipt by an organisation.

Cash
The CCG is required to estimate its cash requirement prior to the start of each month and drawdown cash funding. In line with guidance, the CCG must ensure cash levels remain below 1.25% of the monthly draw down.

The actual level of cash held in the bank at the end of June was £30k. This is within the levels required by NHS England and demonstrates a successful management of cash balances.

The CCG will continue to work to manage and monitor Cash Flow and overall Cash position.

Statement of Financial Position (SOFP)
The SOFP to 30th June 2017 is included at Appendix 2. The finance team are currently reviewing balances in the SOFP with a view to maintaining a 'clean' report.

Aged Debtors and Aged Creditors
The majority of the value in these reporting lines relates to ongoing dialogue with the Local Authority and the residual to the negotiations around the settlement of S117 recharging. The CCG is now in receipt of credit notes for the council invoices and the impact of this will be shown in the next monthly report.

The CCG Finance team are working with Budget Managers within Continuing Healthcare to manage invoice workflow and ensure appropriate action is taken to clear invoices.

8. QIPP Programme 2017-18

The QIPP Programme has been referenced throughout this report and additional detail is included in the PMO QIPP report elsewhere on the agenda.
9. Underlying Financial Position/ Risks Mitigations

Underlying Financial Position

As at Month 3, the CCG has reported an underlying forecast position of £14.67m deficit.

Risks/ Mitigations

The finance team produce a detailed analysis of potential financial risks and map mitigations to these risks in order to ensure that financial control can be maintained.

The CCG has not assumed any benefit from the 0.5% reserve within the risks and mitigations.

The CCG has successfully reduced the balance of unmitigated risk to zero at the month 3 reporting cycle as detailed in the table below:

<table>
<thead>
<tr>
<th>Risks</th>
<th>Potential Risk Value Mth02</th>
<th>Potential Risk Value £m</th>
<th>Proportion of Total %</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute SLAs</td>
<td>2.44</td>
<td>2.00</td>
<td>39.87%</td>
<td>Acute contract activity pressure</td>
</tr>
<tr>
<td>Community SLAs</td>
<td>0.60</td>
<td>0.30</td>
<td>5.98%</td>
<td>Potential shortfall on delivery of contract line savings</td>
</tr>
<tr>
<td>Mental Health SLAs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Continuing Care SLAs</td>
<td>0.30</td>
<td>0.24</td>
<td>4.71%</td>
<td>Potential impact of CHS reviews</td>
</tr>
<tr>
<td>QIPP Under-Delivery</td>
<td>7.58</td>
<td>1.39</td>
<td>27.65%</td>
<td>Potential under delivery on total programme (refreshed in line with QIPP trajectory review)</td>
</tr>
<tr>
<td>Performance Issues</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>0.29</td>
<td>0.29</td>
<td>5.83%</td>
<td>Potential Category M impact above plan</td>
</tr>
<tr>
<td>Running Costs</td>
<td>0.38</td>
<td>0.38</td>
<td>7.48%</td>
<td>Transition on appointment to approved structure</td>
</tr>
<tr>
<td>Other Risks</td>
<td>1.16</td>
<td>0.42</td>
<td>8.40%</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL RISKS**: 12.74

<table>
<thead>
<tr>
<th>Mitigations</th>
<th>Expected Mitigation Value Mth02</th>
<th>Expected Mitigation Value £m</th>
<th>Proportion of Total %</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncommitted Funds (Excl 1% Headroom)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency Held</td>
<td>2.35</td>
<td>2.19</td>
<td>43.62%</td>
<td>Potential contingency release</td>
</tr>
<tr>
<td>Contract Reserves</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Investments Uncommitted</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Uncommitted Funds Sub-Total</td>
<td>2.35</td>
<td>2.19</td>
<td>43.62%</td>
<td></td>
</tr>
<tr>
<td>Actions to Implement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further QIPP Extensions</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Non-Recurrent Measures</td>
<td>1.75</td>
<td>2.23</td>
<td>45.43%</td>
<td>Risk Reserve release and potential planned expenditure restrictions</td>
</tr>
<tr>
<td>Delay/ Reduce Investment Plans</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Other Mitigations</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Mitigations relying on potential funding</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Actions to Implement Sub-Total</td>
<td>1.75</td>
<td>2.23</td>
<td>46.53%</td>
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</tbody>
</table>

**TOTAL MITIGATION**: 4.10

NET RISK / HEADROOM: (8.65) | 0.00

BEST CASE IMPACT: 2.35 | 2.19

WORST CASE IMPACT: (10.65) | (2.83)

Forecast Outturn Under/Expenditure: (19.40) | (19.40)

RISK ADJUSTED CONTROL TOTAL: (28.05) | (19.40)

---

Commentary

Potential contingency release

Potential under delivery on total programme (refreshed in line with QIPP trajectory review)

Potential Category M impact above plan

Transition on appointment to approved structure

Acute contract activity pressure

Potential shortfall on delivery of contract line savings

Potential under delivery on total programme (refreshed in line with QIPP trajectory review)

All risks occur and further actions all unsuccessful, uncommitted funds mitigate only.

No risks materialise and funds remain uncommitted.

This should match the surplus reported on the ledger.
2017/18 Financial Summary Position as at Month 3

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2017/18</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget Year to</td>
<td>Actual Year to</td>
<td>Variance Year to</td>
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<tr>
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<td>Date - month 3</td>
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<td>Co-Commissioning Allocation</td>
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<td>Shrewsbury and Telford Hospitals NHS Trust</td>
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<td>Future Fit</td>
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<td>Strategy &amp; Service Redesign</td>
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<td>452,459</td>
<td>111,143</td>
<td>111,144</td>
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<tr>
<td>Total</td>
<td>52,025</td>
<td>12,401</td>
<td>12,402</td>
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<tr>
<td>Deficit Brought Forward</td>
<td>(32,624)</td>
<td>(8,156)</td>
<td>(8,156)</td>
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<tr>
<td>In Year Deficit</td>
<td>19,401</td>
<td>4,245</td>
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Originator of Report: Claire Skidmore
Author of Report: Ilse Newsome
### Statement of Financial Position as at 30th June 2017

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<tr>
<th></th>
<th>APR-17</th>
<th>MAY-17</th>
<th>JUN-17</th>
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<td><strong>PPE</strong></td>
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<td>375,571</td>
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<td><strong>Accumulated Depreciation</strong></td>
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<tr>
<td><strong>Other Receivables Non-Current</strong></td>
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<td>(390)</td>
<td>(390)</td>
</tr>
<tr>
<td><strong>Total Other Non-Current Assets</strong></td>
<td>(390)</td>
<td>(390)</td>
<td>(390)</td>
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<td><strong>Non-Current Assets</strong></td>
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<td>83,576</td>
<td>101,093</td>
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<td>349,409</td>
<td>29,602</td>
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<td><strong>Accounts Receivable</strong></td>
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<td>6,796,675</td>
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<td><strong>TOTAL ASSETS</strong></td>
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<td>7,229,661</td>
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<td>24,431,683</td>
<td>23,288,791</td>
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<td><strong>Current Liabilities</strong></td>
<td>19,213,407</td>
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<tr>
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<td>(17,475,297)</td>
<td>(18,018,072)</td>
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<td><strong>Total Taxpayers Equity</strong></td>
<td>(11,458,344)</td>
<td>(17,475,297)</td>
<td>(18,018,072)</td>
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<tr>
<td><strong>TOTAL EQUITY + LIABILITIES</strong></td>
<td>8,028,339</td>
<td>7,229,661</td>
<td>5,543,995</td>
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**Agenda item:** GB-2017-08.168  
**Shropshire CCG Governing Body meeting:** 16 August 2017

<table>
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<tr>
<th>Title of the report:</th>
<th>Governing Body SCCG Performance Report 2017/18</th>
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<tbody>
<tr>
<td>Responsible Director:</td>
<td>Julie Davies, Director of Performance &amp; Delivery</td>
</tr>
<tr>
<td>Author of the report:</td>
<td>Julie Davies, Director of Performance &amp; Delivery</td>
</tr>
<tr>
<td>Presenter:</td>
<td>Julie Davies, Director of Performance &amp; Delivery</td>
</tr>
</tbody>
</table>

**Purpose of the report:**
To update the governing body on the CCGs performance to date in 2017/18 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 early 2017/18.

They key standards that were not met for SCCG are :-

**Cancer 2wk breast symptoms**  
**IAPT access target**  
**A&E 4hr target**  
**Ambulance handovers >30mins and >1hr**  
**>52 wk waiters**  
**RTT**

2wk breast symptoms remains cause for concern (as this target was failed in 16/17) which the majority of breaches in Month 2 at an out of county provider. The CCG has been managing this through the lead commissioner but with little sign of improvement the issue was escalated through NHSI at the July PCWG and now the CCG has a NHSI lead contact to work with directly to have oversight of the local plans for recovery.

**IAPT access** – the reduction in performance in Q1 has been investigated with SSSFT and is due to some issues with a new single point of access for this service. The provider has assured the CCG that the issues have now all been resolved but that performance will not recover until August. SSSFT remain confident of achieving the target from Q2 onwards.
A&E performance remains challenged and showed a small improvement in June compared to May but remains behind the recovery trajectory. The additional actions identified last month are being progressed by both the CCGs and Local Authorities. Ongoing workforce issues within the Trust continue to make any improvement fragile and the position reported at the July SAED showed a worsening position. SaTH has a number of actions linked to improved internal efficiency including reconfiguring the bed base to ensure the split between planned care and unscheduled care is in line with ongoing demand and available staffing. These are all work in progress for the Trust and will be reported monthly to the system SAEDB with key performance metrics focused on the key improvement action areas for the first time in August. The system has appointed an Urgent Care Director following interviews at the end of July.

The system has continued the improvement in the >1hr responses times at the start of the financial year but has not yet been able to eliminate them. An action plan is now in place between SaTH and WMAS to improve this and is being monitored via the A&E Delivery Group. WMAS is attending the group on the 9th August to discuss progress and any outstanding issues. In addition to the local work, as ambulance handover is a challenge across the region, the regional commissioner (Sandwell & West Birmingham CCG) is coordinating an urgent 8wk project on this across the West Midlands to identify urgent actions for improvement by late autumn. The new response time reporting (ARP) is now being rolled out nationally following the publication of the successful evaluation report.

The CCG has 9 over 52 wk waiters with breaches at Wye Valley, Worcester and from ShropComm. All patients are scheduled for treatment in June and July as some patients DNA’d their appointments scheduled in June. The CCG is aiming for zero >52 wk waits from August, but this is subject to our out of county providers eliminating their breaches. Full contractual levers have been implemented against this poor performance with all providers and the CCG performance lead now receives a forward look of all >40wks waiters at all providers to try and prevent such breaches happening in the future.

For RTT both local providers remain on track with their respective improvement trajectories. As a result the CCG will recover its performance best case in September and worst case October based on its local provider projected performance.

<table>
<thead>
<tr>
<th>Actions required by Governing Body Members:</th>
</tr>
</thead>
<tbody>
<tr>
<td>J.Davies to continue chairing monthly planned care working group meetings with RJAH and SaTH to oversee recovery of RTT.</td>
</tr>
<tr>
<td>J.Davies / S.Freeman continue to attend A&amp;E Delivery Board to ensure system delivery of the A&amp;E recovery trajectory.</td>
</tr>
<tr>
<td>J.Davies to chair the A&amp;E Delivery Group on an interim basis until the System Urgent Care Director comes into post.</td>
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Does this report and its recommendations have implications and impact with regard to the following:

<table>
<thead>
<tr>
<th>A: CCG Aims and Objectives</th>
<th>Yes/ No</th>
</tr>
</thead>
</table>
| 1 | Objective 1 Deliver continually improving Healthcare and Patient Experience  
   *Achievement of the performance metrics will improve outcomes and patient experience* | Yes |
| 2 | Objective 2 Develop a ‘true membership’ organization (active engagement and clinically led organization) | No |
| 3 | Objective 3 Achieve Financial sustainability for future investment | No |
| 4 | Objective 4 Visible leadership of the local health economy through behavior and action | No |
| 5 | Objective 5 Grow the leaders for tomorrow (Business Continuity) | No |

<table>
<thead>
<tr>
<th>B: Governance</th>
<th>Yes/ No</th>
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</thead>
</table>
| 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 | Yes  
   *Risk no. 73/16 NHS Constitution* |
| 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**  
   *The action taken by the CCG to deliver all its constitutional targets will address any health inequalities currently present in the areas the performance targets are not being met* | Yes |
| 4 | **Human Rights, equality and diversity requirements** | N/A |
| 5 | **Clinical engagement** | N/A |
| 6 | **Patient and public engagement** | N/A |
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 2017/18. They are part of the CCG’s Improvement and Assessment Framework (IAF) for 2017/18 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 May 2017 and June 2017 where data is available.

3. The CCG Improvement and Assessment Framework indicators are taken from the June 2017 NHSE IAF dashboard.

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 2016/17, trajectories have been set as part of the Sustainability & Transformational Fund (STF), in the 2017/18 planning round. For Robert Jones and Agnes Hunt Hospital and Shrewsbury and Telford Hospital Trust, these included;

   - A&E 4 Hour Wait
   - 18 Weeks RTT Incompletes
   - Cancer 62 day Waits
RANKING AND PEER GROUPS

7. In the latest 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, these include the following:
   o “People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral”
     This largely due to small numbers: performance now better than at March 16
   o “Patients who received all 3 NICE standards for Diabetes”
     The data is for 15/16 and is likely to be improved for 16/17. The national range is very compressed with Shropshire being only 35 points below the national average.
   o “Digital Interactions between Primary and Secondary Care”
     The CCG rating is reduced due to the way SaTH operates indirect appointment booking –
     This is being addressed with the provider currently and progress reported via the PCWG
   o “Crisis care and liaison mental health services transformation”
     The CCG is working with the provider to improve this measure and this is a priority area for the CCG in 17/18
   o “Outcome and expenditures in areas identified with scope for improvement”
     The CCG has utilised the Right care Packs to identify areas where improvement may be realised e.g MSK services
   o “Patients waiting 18 weeks or less from referral to hospital treatment”
     Improvement trajectories are in place at SaTH who remain positive about achieving the standard in September 2017

8. Shropshire ranked in the best performing quartile in 15 indicators
   o Injuries from Falls
   o Support for people with Long Term Conditions
   o Level of Inequality for admissions for Ambulatory Care conditions and Urgent Care conditions
   o Quality of Life for Carers
   o Quality of Primary Care
   o Quality of Adult Social Care
   o Emergency Admission rate for Urgent care Conditions
   o MH Out of Area Placements
   o Annual Health Checks for people with Learning Difficulties
   o Primary Care Workforce
   o Patient Experience of GP services
   o Delivery of an integrated urgent care system
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<th>Outcome/Target</th>
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<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
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<tbody>
<tr>
<td>Cancer Diagnosed at Early Stage - % of cancers diagnosed at Stage 1 &amp; 2</td>
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<tr>
<td>Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer</td>
<td>2016/17</td>
<td>83.8%</td>
<td>85%</td>
<td>89.2%</td>
<td>89.2%</td>
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<tr>
<td>Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service</td>
<td>2016/17</td>
<td>93.8%</td>
<td>90%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status</td>
<td>2016/17</td>
<td>89.8%</td>
<td>No National Standard</td>
<td>86.1%</td>
<td>87.8%</td>
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<tr>
<td>Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for suspected cancer</td>
<td>2016/17</td>
<td>93.7%</td>
<td>93%</td>
<td>94.2%</td>
<td>93.5%</td>
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<tr>
<td>Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms</td>
<td>2016/17</td>
<td>92.4%</td>
<td>93%</td>
<td>92.1%</td>
<td>91.8%</td>
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<tr>
<td>Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis</td>
<td>2016/17</td>
<td>98.7%</td>
<td>96%</td>
<td>98.5%</td>
<td>98.0%</td>
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</tr>
<tr>
<td>Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery</td>
<td>2016/17</td>
<td>97.1%</td>
<td>94%</td>
<td>90.9%</td>
<td>100.0%</td>
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<tr>
<td>Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is anti cancer drug regimen</td>
<td>2016/17</td>
<td>99.9%</td>
<td>98%</td>
<td>100.0%</td>
<td>100.0%</td>
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</tr>
<tr>
<td>Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course</td>
<td>2016/17</td>
<td>98.6%</td>
<td>94%</td>
<td>100.0%</td>
<td>98.1%</td>
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<tr>
<td>One-year survival for all cancer</td>
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<td>70.9%</td>
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<tr>
<td>(England 70.4%)</td>
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<tr>
<td>Cancer patient experience of responses, which were positive to the question &quot;Overall, how would you rate your care?&quot;</td>
<td>2015</td>
<td>8.7 (England)</td>
<td></td>
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<td>8.7 (CCG)</td>
</tr>
</tbody>
</table>

Shropshire CCG – KEY PERFORMANCE INDICATORS
CANCER

9. As at May 2017, 1 cancer indicator did not achieve the standard in the month:
   - 2 week wait - Breast, 92.1% against 93% standard

10. For the Cancer 2 week wait (Breast) in May 2017 at CCG level, there were 8 breaches - 3 breaches were due to patient choice and 5 were at Worcester. The CCG is pursuing performance issues at Worcester with the lead commissioner. It has also been escalated to NHSI via the monthly PCWG as there has been little sign of improvement over recent months at Worcester.

11. SaTH achieved all cancer targets in May. 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. At the July PCWG the Trust predicted a temporary dip in performance in June but recovery from Month 4. The reasons behind this will be discussed in detail at the August PCWG.

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 was 2 104 day cancer breaches reported for May 2017. Both of these patients were subject to medical delay as a result of requirements for other medical input prior to cancer treatment. All long wait cancer patients should be reviewed through CQRM to ensure processes are not likely to cause harm and that any systemic reasons for delay should be investigated, understood and remedied. This feedback is still not being received by commissioners as per the new reporting requirements and has been escalated to the SaTH Director of Nursing. The CCG has created a log of all >104 day breach patients to ensure we get the appropriate feedback on all relevant cases.
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest Baseline Position</th>
<th>Outturn Position</th>
<th>Standard Outturn-Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG/SSSFT)</td>
<td>2016/17</td>
<td>16.1%</td>
<td>15%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.1%</td>
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<td></td>
<td></td>
<td>3.7%</td>
</tr>
<tr>
<td>IAPT Recovery Rate (CCG/SSSFT)</td>
<td>2016/17</td>
<td>54.6%</td>
<td>50%</td>
<td>59.2%</td>
<td>57.8%</td>
<td>50.9%</td>
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<td></td>
<td></td>
<td></td>
<td>58.2%</td>
</tr>
<tr>
<td>New target 2016 (SSSFT) with relevant conditions to access talking therapies in 6 weeks</td>
<td>2016/17</td>
<td>75%</td>
<td>95.6%</td>
<td>98.7%</td>
<td>98.3%</td>
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<td></td>
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<td>97.5%</td>
</tr>
<tr>
<td>New target 2016 (SSSFT) with relevant conditions to access talking therapies in 18 weeks</td>
<td>2016/17</td>
<td>95%</td>
<td>96%</td>
<td>99%</td>
<td>99.4%</td>
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<td></td>
<td></td>
<td></td>
<td>97.9%</td>
</tr>
<tr>
<td>60% of people experiencing first episode of psychosis to access treatment within 2 weeks</td>
<td>2016/17</td>
<td>68%</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>50.0%</td>
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<td></td>
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<td>33.0%</td>
</tr>
<tr>
<td>Children &amp; Young People's Mental Health Services Transformation</td>
<td>5 Questions: 2 fully Compliant 2 Partially Compliant 1 Not Compliant</td>
<td>5 Questions: Fully Compliant</td>
<td>Q4 2016/17 85%</td>
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<tr>
<td>Crisis Care &amp; Liaison mental health services transformation</td>
<td>15 Questions: 15 fully Compliant 3 Partially Compliant 6 Not Compliant</td>
<td>Questions Fully Compliant</td>
<td>Q4 2016/17 50%</td>
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</tr>
<tr>
<td>Out of Area placements for acute mental health inpatient care - transformation</td>
<td>3 Questions: 9 fully Compliant 6 Not Compliant</td>
<td>Questions Fully Compliant</td>
<td>Q4 2016/17 100%</td>
<td></td>
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<tr>
<td>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</td>
<td>2016/17</td>
<td>98.8%</td>
<td>95%</td>
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</tbody>
</table>
MENTAL HEALTH – IMPROVED ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

14. Performance for IAPT is as follows:

- Roll Out standard 15%. Performance for June is reported locally as 1.1%, a deterioration over the previous month, with a year to date position of 3.7%. This has been investigated with SSSFT and the recent issues with performance have been due to some teething problems with a new single point of access for this service. The provider has assured the CCG that the issues have now all been resolved but that performance will not recover until August. They remain confident of achieving the target from Q2 onwards.

- The Recovery rate fell to 50.9% in June and is still above target at the end of Q1

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 7 days against 95% standard. The final year position was 98.8%
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest</th>
<th>Baseline</th>
<th>Position</th>
<th>Outturn/Standard</th>
<th>Standard/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliance on specialist inpatient care for people with a learning disability and/or autism (per million pop)</td>
<td>Monitoring commenced in 2016/17</td>
<td>Trajectory</td>
<td>1.19%</td>
<td></td>
<td>Q4 2016/17</td>
</tr>
<tr>
<td>Proportion of people with a learning disability on the GP register receiving an annual health check</td>
<td>2015/16</td>
<td>37.1% (England)</td>
<td></td>
<td></td>
<td>46.5% (2015/16: CCG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest</th>
<th>Baseline</th>
<th>Position</th>
<th>Outturn/Standard</th>
<th>Standard/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality and still births per 1,000 population</td>
<td>2015</td>
<td>6.42</td>
<td></td>
<td></td>
<td>(2015: CCG)</td>
</tr>
<tr>
<td>Women's experience of maternity services</td>
<td>2015</td>
<td>82.1</td>
<td></td>
<td></td>
<td>(2015: CCG)</td>
</tr>
<tr>
<td>Choices in Maternity Services</td>
<td>Monitoring commenced in 2016/17</td>
<td></td>
<td></td>
<td></td>
<td>67.3% (2015 CCG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest</th>
<th>Baseline</th>
<th>Position</th>
<th>Outturn/Standard</th>
<th>Standard/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain a minimum of two thirds diagnosis rates for people with dementia</td>
<td>2016/17</td>
<td>67.8%</td>
<td>67%</td>
<td>69.4%</td>
<td>69.8%</td>
</tr>
<tr>
<td>The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months</td>
<td>2015/16</td>
<td></td>
<td></td>
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<td>80%</td>
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<td></td>
<td>(2015/16: CCG)</td>
</tr>
</tbody>
</table>
LEARNING DISABILITIES (LD)

17. There are two indicators relating to LD:
   - At Q4, 2016/17, the rate for reliance on specialist inpatient care for people with a learning disability and/or autism was reported as 222 per 1m population. In absolute terms this is 68 patients.

18. Nationally people with mild LD are being identified in mental health services as part of the Transforming Care reporting criteria. Funding has been secured from NHSE for refurbishment of premises at Church Parade which will allow improvements to be achieved on this measure. This investment will proceed once arrangements over the leasehold are clarified with the Local Authority.

MATERNITY

19. The maternity indicator position is reported annually. There are three indicators in the dashboard, with data now populated. These have not yet been updated from 2015 data and show the CCG in the middle range of the national distribution.

DEMENTIA

20. Dementia diagnosis continues to perform above the national standard.
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>April-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td>Achievement of milestones in the delivery of an integrated urgent care service</td>
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</tr>
<tr>
<td>Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
<td>Q3 2016/17</td>
<td>904 (England)</td>
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<tr>
<td>A&amp;E Waiting Time - % of people who spend 4 hours or less in A&amp;E (SaTH)</td>
<td>2016/17</td>
<td>80.9%</td>
<td>95%</td>
<td>84.5%</td>
<td>77.5%</td>
<td>79.6%</td>
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<td>80.5%</td>
</tr>
<tr>
<td>Trolley Waits in A&amp;E - Number of patients who have waited over 12 hours in A&amp;E from decision to admit to admission (SaTH)</td>
<td>2016/17</td>
<td>17</td>
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<td>0</td>
</tr>
<tr>
<td>Ambulance Handover time - Number of handover delays of &gt;30 minutes (RSH + PRH)</td>
<td>2016/17</td>
<td>7125</td>
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<td>1703</td>
</tr>
<tr>
<td>Ambulance Handover time - Number of handover delays of &gt;1 hour (RSH + PRH)</td>
<td>2016/17</td>
<td>1600</td>
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<td>189</td>
</tr>
</tbody>
</table>
21. For June 2017, the SaTH A&E 4 Hour Wait target has not been achieved and is reported as 79.6% (an improvement from the previous month) against an 82.2% STF trajectory. This is un-validated data.

24. Performance in June was below the planned STF trajectory at SaTH. Actual attendances at A&E are below the expected numbers in the STF trajectory but breaches since the start of May are higher than planned. SCCG A&E attendances are below plan at Month 3. Performance on Delayed Transfers of Care (DTOC) in SaTH continues to be ahead of the target at 2.7% for May which is ahead of the target of 3.5%.

25. The additional actions agreed last month re Frailty for the front door and one for improved discharge at the back door are progressing and on track to deliver improvement from September. The Local Authorities are continuing to work to improve the visibility of complex discharge needs earlier in the patients spell in hospital to reduce delays when they are medically fit for discharge. Ongoing workforce issues within the Trust continue to make any improvement fragile and the position reported at the July SAED showed a worsening position. In addition SaTH have a number of actions linked to improved internal efficiency including reconfiguring the bed base to ensure the split between planned care and unscheduled care is in line with ongoing demand and available staffing. These are all work in progress for the Trust and will be reported monthly to the system SAEDB with key performance metrics focused on the key improvement action areas for the first time in August.

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

27. As at June 2017, WMAS reported there were 567 handover delays for > 30 minutes including 96 for > 1 hour at SaTH. This represented a small improvement in > 30mins but a significant improvement on the >1hr delays on the May data. An action plan is now in place between SaTH and WMAS to improve this and this is being monitored via the A&E Delivery Group. WMAS is attending the group on the 9th August to discuss progress and any outstanding issues.

28. The CCG is investing £90k of winter monies into SaTH in support of addressing the handover delays problem at RSH. It is too early to assess the impact of this investment but it will be monitored closely by the CCG to determine the effectiveness of the investment.
| Indicator Description | Latest Baseline | Latest Position | Latest Outturn/Standard | Standard Target | April-17 | May-17 | June-17 | July-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | YTD |
|-----------------------|----------------|----------------|-------------------------|----------------|---------|-------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| Ambulance Clinical Quality - Red Performance within 8 mins (WMAS) | WMAS New metric | 75% | 69.7% | 66.5% | 67.6% | 67.9% | | | | | | | | | | 67.9% |
| | SCCG New metric | | 48.9% | 47.0% | 48.8% | | | | | | | | | | | 48.2% |
| Category 1 (mm:ss): 75th Percentile | WMAS New metric | 00:08:36 | 00:08:56 | 00:08:50 | | | | | | | | | | | | |
| | SCCG New metric | 00:12:36 | 00:12:50 | 00:14:04 | | | | | | | | | | | | |
| Category 1 (mm:ss): 90th Percentile | WMAS New metric | 00:11:22 | 00:11:45 | 00:11:48 | | | | | | | | | | | | |
| | SCCG New metric | 00:17:44 | 00:18:31 | 00:18:34 | | | | | | | | | | | | |
| Category 2 (mm:ss): 90th Percentile | WMAS New metric | 00:16:43 | 00:18:39 | 00:18:10 | | | | | | | | | | | | |
| | SCCG New metric | 00:25:16 | 00:29:40 | 00:28:18 | | | | | | | | | | | | |
| Category 3 (mm:ss): 90th Percentile | WMAS New metric | 00:28:59 | 00:39:53 | 00:38:02 | | | | | | | | | | | | |
| | SCCG New metric | 00:36:29 | 00:45:17 | 00:41:27 | | | | | | | | | | | | |
| Category 4T (hh:mm:ss) : 90th Percentile | WMAS New metric | 01:00:32 | 01:20:12 | 01:18:45 | | | | | | | | | | | | |
| | SCCG New metric | 00:41:07 | 01:08:07 | 01:04:21 | | | | | | | | | | | | |
| Crew Clear delays of >30 minutes (RSH + PRH) | 2016/17 4462 | | | | | | | | | | | | | | | 288 |
| Crew Clear delays of >1 hour (RSH + PRH) | 2016/17 970 | | | | | | | | | | | | | | | 36 |
| Delayed Transfers of care attributable to the NHS (LA) | 2016/17 6342 | | | | | | | | | | | | | | | 6253 (Rolling Year) |
| DTCR Rate (SaTH) | | | | | | | | | | | | | | | | 2.7% |
| DTCR Rate (RJAH) | | | | | | | | | | | | | | | | 2.7% |
| Population use of hospital beds following emergency admission | Q3 2016/17 501.9 (England) | | | | | | | | | | | | | | | 4.8% |

Page | 11
URGENT & EMERGENCY CARE – AMBULANCE RESPONSE TIMES, CREW CLEAR AND DELAYED TRANSFERS OF CARE

29. The ARP pilot has now been completed. An independent evaluation report has been provided and has recommended the roll out of the approach nationally. This provides an opportunity to re-focus on the call response time performance.

28. The crew clear zero tolerance was exceeded for each month during 2016/17, with > 30 minutes showing an average of 372 each month, and >1 hour showing an average of 81 per month. April 2017/18 is showing 288 and 36 respectively which is an improvement but there is more work to be done to further improve this. Ambulance handover is a challenge across the region and the regional commissioner (Sandwell & West Birmingham CCG) is coordinating an urgent 8wk project on this across the West Midlands to identify urgent actions for improvement by late autumn.

29. DTOC – In May 2017, the number of delay ed days increased slightly from the April figure to 2.7% of occupied bed days. This is still ahead of the agreed trajectory at SaTH. The position at RJAH has improved slightly in April to 4.3% from the previous month. 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. A similar improvement was seen in SCHT with the May value being 8.8% compared to 9.4% in April. Both Trusts have DTOC improvement plans which are being monitored through their respective contract meetings to ensure achievement of the 3.5% target by September 2017.

30. The CCG has agreed improvement trajectories with Shropshire LA as required by NHSE to reduce the number of delayed days due to NHS and Social Care reasons. This will be reported from September.
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest (Q3 2016/17)</th>
<th>Baseline</th>
<th>Outturn/Standard</th>
<th>Standard/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inequality in emergency admissions for urgent care sensitive conditions</td>
<td>1,758</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with the quality of consultation at a GP practice</td>
<td>458</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with the overall care received at the surgery</td>
<td>90.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with accessing primary care</td>
<td>81.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended access to GP services on a weekend and evening</td>
<td>22.5% (England)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care workforce: Number of GPs and Practice Nurses (full-time equivalent) per 1,000 weighted patients by CCG</td>
<td>1.04 (England)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Elective Access

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest (Q3 2016/17)</th>
<th>Baseline</th>
<th>Outturn/Standard</th>
<th>Standard/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT - incompletes (CCG)</td>
<td>90.6%</td>
<td>92%</td>
<td>88.6%</td>
<td>89.4%</td>
</tr>
<tr>
<td>RTT - incompletes (SaTH)</td>
<td>88.5%</td>
<td>92%</td>
<td>91.2%</td>
<td>91.4%</td>
</tr>
<tr>
<td>RTT - incompletes (RJAH)</td>
<td>89.4%</td>
<td>92%</td>
<td>90.0%</td>
<td>91.3%</td>
</tr>
<tr>
<td>No. of 52 Week Waiters (CCG)</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Test Waiting Time &lt; 6 weeks (CCG)</td>
<td>1.8%</td>
<td></td>
<td></td>
<td>0.8%</td>
</tr>
<tr>
<td>Diagnostic Test Waiting Time &lt; 6 weeks (SaTH)</td>
<td>1.7%</td>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Diagnostic Test Waiting Time &lt; 6 weeks (RJAH)</td>
<td>0.2%</td>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>CANCELLED OPERATIONS - No. OF PATIENTS RE-ADMITTED WITHIN 28 DAYS (SaTH)</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CANCELLED OPERATIONS - No. OF PATIENTS RE-ADMITTED WITHIN 28 DAYS (RJAH)</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PRIMARY MEDICAL CARE

31. Access to and satisfaction with Primary care services continues to be rated highly by Shropshire patients and compares well with the overall England position.

32. Extended access at weekends and evenings is an area where improvement is indicated for the CCG as it is below the national average and therefore is a section within the GP 5yr forward view work stream.

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

33. The CCG achieved performance of 89.4% in May, a small improvement on the April position. This was made up of 88.5% achievement at SaTH, 92.4% at RJAH and 88.1% at all other providers. This indicates that all providers continue to struggle to achieve the target.

34. SaTH has a target of achieving the 92% standard from September 2017. Recovery trajectories are in place in the failing specialties in SaTH with target recovery dates set. SaTH remains confident of achieving these and continues to rate their overall level of confidence at 80% in achieving the Trust target. The CCG continues to work toward a more sustainable long term approach to commissioning of Neurology services for the longer term, via a task and finish group with colleagues in T&W and Powys.

35. RJAH achieved 91.4% in May and is confident of achieving the 92% target from October 2017.

36. In May there were 9 52 week waiters reported for the CCG. These patients consisted of a small number at Wye Valley and Worcester Acute Trusts and the ongoing number of ENT patients previously identified at Shropshire Community Trust. These patients had treatment dates booked for June and July so will continue to be reported as breaches until they are treated. The CCG is aiming for zero >52 wk waits from August, but this is subject to our out of county providers eliminating their breaches. Full contractual levers have been implemented against this poor performance with all providers and the CCG performance lead now receives a forward look of all >40wks waiters at all providers to try and prevent such breaches happening in the future.

37. Performance against the 99% standard for waiting time for a Diagnostic Test was achieved by the CCG in May with a level of 99.5%
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest</th>
<th>Baseline</th>
<th>Position</th>
<th>Outturn/Standard</th>
<th>Standard</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>People eligible for standard NHS Continuuing Healthcare per 50,000 population. Consistent application across the country is the measurement</td>
<td>2016/17 Q3</td>
<td>45.0</td>
<td>(England)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Latest</th>
<th>Baseline</th>
<th>Position</th>
<th>Outturn/Standard</th>
<th>Standard</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare acquired infection (HCAI) measure (MRSA)</td>
<td>2016/17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Healthcare acquired infection (HCAI) measure (Clostridium difficile infection)</td>
<td>2016/17</td>
<td>58</td>
<td>73</td>
<td>3</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>E. coli bacteraemia</td>
<td>2016/17</td>
<td>205</td>
<td>21</td>
<td>17</td>
<td>18</td>
<td>56</td>
</tr>
</tbody>
</table>
38. Performance for CHC at CCG level for Q3 1617 is at 42.7% against a national figure of 45%. This national data has been recently published as part of MyNHS dashboard.

HEALTH ACQUIRED INFECTION MRSA AND CDIFF

39. For 2016/17 there have been no incidences of MRSA reported at CCG level in Q1 2017/18.

40. C Difficile – for Q1 only 11 incidences were reported which is ahead of schedule.

41. E Coli infections were slightly above target in June and for Q1 as a whole. The annual target for the CCG is 205. The anonymised data of these cases will be analysed and shared with the Local Health Economy E coli BSI Reduction Group and the Local Health Economy IPC Group to identify opportunities and potential interventions to reduce the risk of E. coli BSI in the CCGs population and achieve the ambition to reduce all E coli BSI reported at CCG level by 10% or greater by March 2018.

NHS 111

42. The CCG is now receiving data direct from the regional commissioning lead for NHS 111. There were 2890 calls triaged by NHS 111 registered to Shropshire in May 2017. Of these 25.8% (694) were triaged by CA. Of the triaged calls 41% were referred to OOH service and 12.9% to the ambulance service. As this has only recently been made available further analysis of this is underway within the CCG, the outcome of which will be included in future reports.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Data Position</th>
<th>Percentage of QP</th>
<th>Latest position - achieving?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving antibiotic prescribing in primary care</td>
<td>Mar-17</td>
<td>10%</td>
<td>Both Parts</td>
</tr>
<tr>
<td>Cancer</td>
<td>2015</td>
<td>20%</td>
<td>No</td>
</tr>
<tr>
<td>E-Referrals</td>
<td>Q4 2016/17</td>
<td>20%</td>
<td>Yes</td>
</tr>
<tr>
<td>GP Patient Survey</td>
<td>Jul-17</td>
<td>20%</td>
<td>No</td>
</tr>
<tr>
<td>Local Measure 1: % of IAPT patients receiving a course of treatment</td>
<td>Q4 2016/17</td>
<td>10%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Measure 2: Emergency admissions for chronic ambulatory care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sensitive conditions for people of all ages per 100,000 total population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Measure 3: % of Diabetes patients receiving the 8 care processes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Data Position</th>
<th>Percentage of QP</th>
<th>Latest position - achieving?</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Incomplete</td>
<td></td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>A&amp;E Waits</td>
<td>Q4</td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>Max 2 month (62 day) wait from urgent GP referral to first definitive</td>
<td>Q4 2016/17</td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>treatment for cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
QUALITY PREMIUM PAYMENTS

43. 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 later in the year as per the national reporting timescales.

44. 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 aiming to deliver 95% in Q4 2017/18, and for RTT 93.7% by the end of March 2018 and the 92% target from September 2017

For RTT incompletes, RJAH is to deliver 92% from October 2017

RECOMMENDATIONS

44. The Governing Body is asked to NOTE the contents of the report and the CCG actions contained within to recover performance in those areas which are currently below target.
<table>
<thead>
<tr>
<th>Title of the report:</th>
<th>Major Contract Performance Reports - Month 2 (May 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Director:</td>
<td>Gail Fortes-Mayer, Director of Contracting &amp; Planning</td>
</tr>
<tr>
<td>Author of the report:</td>
<td>Charles Millar, Head of Contracting, Planning &amp; Performance Meryl Flaherty, Head of Contracting CSU</td>
</tr>
<tr>
<td>Presenter:</td>
<td>Gail Fortes-Mayer, Director of Contracting &amp; Planning</td>
</tr>
</tbody>
</table>

**Purpose of the report:**

This report summarises the current contractual position at Month 2 for the CCG’s four main contracts and highlights key contractual issues for review by the Governing Body.

**Key issues or points to note:**

- Over-performance in SaTH in Daycases and Emergencies is being examined in more detail in the CCG;
- QIPP reporting is being reviewed;
- VBC is ahead of target at M2;
- Activity at Q3 for SSSFT is being reviewed to determine if an AQN should be raised;
- AQN being raised through lead commissioner over WMAS activity;

Consideration being given to issuing Information Breach Notice to SSSFT over failure to submit a national return.

**Actions required by Governing Body Members:**

To note the current performance and actions.
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.

2. **Contracts Overview**

2.1 **Shrewsbury and Telford Hospital NHS Trust**

2.1.1 **Activity**

The variance on most lines has increased since Month 1 and overall the activity is 0.3% over plan. Contract phasing was reviewed at the Activity and Finance contract meeting on the 20th April with the Trust and a small alteration will be made to the phasing to reflect the April working days issue. The areas of over performance are similar to the 16/17 year being in Daycases and Emergencies.

<table>
<thead>
<tr>
<th>Activity</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Cases</td>
<td>3841</td>
<td>4062</td>
<td>221</td>
<td>5.7%</td>
</tr>
<tr>
<td>Elective</td>
<td>465</td>
<td>365</td>
<td>(100)</td>
<td>-21.4%</td>
</tr>
<tr>
<td>Emergency</td>
<td>4322</td>
<td>4406</td>
<td>84</td>
<td>2.0%</td>
</tr>
<tr>
<td>Non Elective</td>
<td>681</td>
<td>582</td>
<td>(99)</td>
<td>-14.6%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>467</td>
<td>299</td>
<td>(168)</td>
<td>-36.0%</td>
</tr>
<tr>
<td>First Outpatients</td>
<td>9173</td>
<td>9618</td>
<td>445</td>
<td>4.9%</td>
</tr>
<tr>
<td>Follow Up Outpatients</td>
<td>14280</td>
<td>14378</td>
<td>98</td>
<td>0.7%</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>8289</td>
<td>7798</td>
<td>(491)</td>
<td>-5.9%</td>
</tr>
<tr>
<td>A&amp;E Attendances</td>
<td>9636</td>
<td>9796</td>
<td>160</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

2.1.1.2 **Referrals**

SATH referrals continue to be on a slight downward trajectory. SaTH being unable to accept new referrals into a number of fragile services will also be impacting on the downward trajectory.
2.1.2 Finance

For Month 2, Shrewsbury and Telford Hospitals contract is reporting a year to date breakeven position. No QIPP savings are planned to be achieved by Month 2.

2.1.3 Contractual Actions

2.1.3.1 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 M1 challenge position is as follows:

<table>
<thead>
<tr>
<th></th>
<th>M1*</th>
<th>M2*</th>
<th>M3</th>
<th>M4</th>
<th>M5</th>
<th>M6</th>
<th>M7</th>
<th>M8</th>
<th>M9</th>
<th>M10</th>
<th>M11</th>
<th>M12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full challenge value</td>
<td>£99k</td>
<td>127k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£226k</td>
</tr>
<tr>
<td>Validated value</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The majority of the challenge value in M2 relates to VBC prior approvals. As these challenges will be first subject to the VBC challenge validation process there is a high potential for the final figure to be materially different to the challenge figure.

2.1.3.2 Activity Query Notices (AQN)

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

2.1.3.3 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.

Recovery plans are in place for all the specialties not achieving the 92% target with expected achievement dates. The recovery plans and trajectories are monitored at the Planned Care Working Group.

A monthly teleconference between the CCG, SaTH, NHSE & NHSI is now in place to cover the major performance issues.

It should be noted that financial sanctions cannot be applied under the contract as part of the national STF (Sustainability and Transformation Fund) process.

2.1.3.4 Contractual Prior Approvals - Value based Commissioning (VBC)

Contractual prior approvals have been in place for the treatments contained in the VBC Policy since October 2016. Contractually, the commissioner is not required to pay for activity carried out without an appropriate prior approval. VBC activity at SaTH is just ahead of target at M2 year to date.
The CCG is in discussion with the Trust to implement Blueteq, an electronic approval system, to minimise any additional administrative burden associated with the prior approvals process.

2.1.3.5 Key actions summary from Monthly Contract Meetings

- **Blueteq** - Discussion took place around benefits of implementing Blueteq for the CCG.
- **Ophthalmology Action Plan** - Task and Finish Group now meets fortnightly. SaTH had been requested to provide an update on the Plan to the next meeting.
- **Neurology** – A task and finish group is now in place to with the Trust

2.1.3.6 – Strategic Contracting Issues (SaTH)

A strategic contracting board was held on 6th June 2017 between Shropshire CCG, Telford & Wrekin CCG and SaTH. The following matters of escalation issues were discussed.

- 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 range of actions were assigned to the Clinical Quality Review Meeting (CQRM). The aim is to de-escalate these matters at the August Contract Board.
2.2 Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH)

2.2.1 Activity

May year to date activity is slightly above plan. The largest variance in activity is in First Outpatients. It is encouraging to note that Follow-Up Outpatients are relatively close to plan at this stage.

<table>
<thead>
<tr>
<th>Point of Delivery</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Cases</td>
<td>474</td>
<td>415</td>
<td>(59)</td>
<td>-12.5%</td>
</tr>
<tr>
<td>Elective</td>
<td>352</td>
<td>357</td>
<td>5</td>
<td>1.4%</td>
</tr>
<tr>
<td>Non Elective</td>
<td>38</td>
<td>29</td>
<td>(9)</td>
<td>-23.5%</td>
</tr>
<tr>
<td>Regular Admissions</td>
<td>53</td>
<td>62</td>
<td>9</td>
<td>16.9%</td>
</tr>
<tr>
<td>First Outpatients</td>
<td>3223</td>
<td>3800</td>
<td>577</td>
<td>17.9%</td>
</tr>
<tr>
<td>Follow Up Outpatients</td>
<td>8969</td>
<td>9155</td>
<td>186</td>
<td>2.1%</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>476</td>
<td>506</td>
<td>30</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

2.2.1.2 Referrals

Since June 2016, referrals to RJAH have generally been falling but with a higher than expected level in March. The trend is monitored at the monthly contract meetings and at the Planned Care Working Group.

2.2.2 Finance

For Month 2, Robert Jones and Agnes Hunt NHS Foundation Trust contract is reporting a year to date underspend of £0.042m. QIPP activity and reporting is being reviewed and refined with the Trust and will be updated for next month’s report.

2.2.3 Contractual Actions

2.2.3.1 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 CCG will pay only on reconciliation of Service Level Agreement Manager, data (SLAM) with Patient Level Data.
The M1 challenge position is as follows:

<table>
<thead>
<tr>
<th></th>
<th>M1*</th>
<th>M2*</th>
<th>M3</th>
<th>M4</th>
<th>M5</th>
<th>M6</th>
<th>M7</th>
<th>M8</th>
<th>M9</th>
<th>M10</th>
<th>M11</th>
<th>M12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full challenge value</td>
<td>£547k</td>
<td>£758k</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td>£1305k</td>
<td></td>
</tr>
<tr>
<td>Validated value</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The majority of the challenge value in M2 relates to VBC prior approvals. As these challenges will be first subject to the VBC challenge validation process there is a high potential for the final figure to be materially different to the challenge figure.

### 2.2.3.2 Activity Query Notices (AQN)

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

### 2.2.3.3 Contract Performance Notices

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

### 2.2.3.4 Value based Commissioning (VBC)

Contractual prior approvals have been in place for the treatments contained in the VBC Policy since October 2016. Contractually the commissioner is not required to pay for activity carried out without an appropriate prior approval. Cumulatively at M2, RJAH VBC activity is ahead of target.

![RJAH Actual VBC Activity](chart.png)

**RJAH Actual VBC Activity**

- **Actual VBC activity**
- **2017/18 Contract Baseline VBC Activity**

### 2.2.2.5 – Key actions summary from Contract Meetings

- **Blueteq** – Discussions are underway around Blueteq.
- **Neurology** - RJAH advised that the Royal Stoke NHS Trust has served notice on the provision of consultant neurology sessions. The CCG is exploring options for alternate service providers.
- **Children in Outpatient Clinics** - RJAH to supply a formal progress report on the CQC actions concerning children in adult outpatient services.
2.3 Non Acute providers

2.3.1 Shropshire Community Health Trust

The M2 financial position is a £40k underspend. Currently, repairs to the flooring are taking place at Bridgnorth Community Hospital. This has resulted in a reduction of 13 beds on a temporary basis. Work started on 5th June, and is expected to last up to 6 weeks. A similar plan is in place for Bishop’s Castle, with work commencing when Bridgnorth is complete.

<table>
<thead>
<tr>
<th>Area</th>
<th>Activity Plan</th>
<th>Activity Actual</th>
<th>% Variance (Activity)</th>
<th>Value Variance (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBR</td>
<td>5,609</td>
<td>5,651</td>
<td>0.08%</td>
<td>(£39,888)</td>
</tr>
<tr>
<td>Non PbR</td>
<td>86,021</td>
<td>94,261</td>
<td>9.6%</td>
<td>£857</td>
</tr>
<tr>
<td>Total</td>
<td>91,630</td>
<td>99,912</td>
<td>9%</td>
<td>(£39,031)</td>
</tr>
<tr>
<td>MIU Clinics</td>
<td>130</td>
<td></td>
<td></td>
<td>£429</td>
</tr>
</tbody>
</table>

- 58.3% Inpatient under-activity against plan (-28) = -£30,339
- 26.2% under-activity against plan in Outpatients (-369) = -£39,004
- 12% under-activity against plan in Radiology (-202) = -£1,638
- 9.7% over-activity against plan in MIU (331) = £21,541
- 30.7% over-activity against plan for Welsh patients in MIU (55) = £9,551

Some of the reductions in activity are due to reductions in capacity as a result of workforce issues

2.3.1.2 RTT 52 week Waiters

There were 3 Shrops patients that breached over 52 week waits in Audiology / ENT. This was due to an interface issue with SaTH which has been resolved.

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 were open at the end of May
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** – Meetings are taking place between the CCG, SaTH and SCHT to ensure there is clarity in contractual arrangements between the providers where pathways are inter-linked.

- **SCHT** has been requested to provide a formal list of services it considers vulnerable due to 3rd party workforce constraints.

2.4 **South Staffordshire and Shropshire Healthcare Trust**

**Activity**

The contract is currently 12.6% under the activity target with a £15,603 underspend once the financial adjustments are applied. The financial adjustment is the application of the 5% cap and collar and the upper and lower tolerances

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity plan</th>
<th>Activity Actual</th>
<th>% Variance Activity</th>
<th>YTD Finance Variance</th>
<th>YTD Financial adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>215,405</td>
<td>188,294</td>
<td>-12.6%</td>
<td>(£519,674)</td>
<td>(£15,603)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>215,405</strong></td>
<td><strong>188,294</strong></td>
<td><strong>-12.6%</strong></td>
<td><strong>(£519,674)</strong></td>
<td><strong>(£15,603)</strong></td>
</tr>
<tr>
<td>PICU</td>
<td>100</td>
<td>123</td>
<td>23%</td>
<td>£2,230</td>
<td></td>
</tr>
<tr>
<td>PICU Nurse Specialing *</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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%. The significant activity variance has been raised with the Trust. They anticipate the variance to have reduced by M3. If this is not the case, contract activity management action will be put in place.

2.4.1.1 **Contractual Actions**

An Information Request has been issued concerning the access criteria to Norbury Unit (PICU) as there are concerns that this has been defined as a ‘male only’ unit but Commissioners have not been formally notified.

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

SSSFT did not submit Month 12 16/17 IAPT data to HSCIC as required nationally. As a result, Commissioners are considering whether an Information breach notice will be issued and if a financial penalty will be applied.

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.
- **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 Providers

<table>
<thead>
<tr>
<th>Out of County Acute Contracts</th>
<th>Annual Plan (£)</th>
<th>YTD Plan (£)</th>
<th>YTD Actual (£)</th>
<th>Variance vs. Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of County Acute Providers</td>
<td>£19,567,000</td>
<td>£5,773,000</td>
<td>£5,755,000</td>
<td>(£18,000)</td>
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<tr>
<td>West Midland Ambulance Service</td>
<td>£11,206,000</td>
<td>£2,802,000</td>
<td>£2,920,000</td>
<td>£118,000</td>
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The M2 challenge position is as follows:

<table>
<thead>
<tr>
<th></th>
<th>M1*</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
<th>M5</th>
<th>M6</th>
<th>M7</th>
<th>M8</th>
<th>M9</th>
<th>M10</th>
<th>M11</th>
<th>M12</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Full challenge value</td>
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<td></td>
<td></td>
<td></td>
<td>£335k</td>
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<td>Validated value</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The majority of the challenge value in M2 relates to VBC prior approvals. As these challenges will be first subject to the VBC challenge validation process there is a high potential for the final figure to be materially different to the challenge figure.

2.5.1 Contractual Actions

An activity query notice is being raised through the lead commissioner in respect of over-performance on the WMAS contract.

3. Recommendations

The committee is asked to note the current performance and actions.
Title of the report: Shropshire CCG Nursing, Quality and Patient Experience Assurance and Improvement Exception Report

<table>
<thead>
<tr>
<th>Responsible Director:</th>
<th>Dawn Clarke- Director of Nursing, Quality &amp; Patient Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of the report:</td>
<td>Nursing, Quality, Patient Safety and Experience Directorate – Senior Team Shropshire CCG</td>
</tr>
<tr>
<td>Presenter:</td>
<td>Dawn Clarke- Director of Nursing, Quality and Patient Experience</td>
</tr>
</tbody>
</table>

**Purpose of the report**

The CCG commissions services from a number of providers and the quality and safety of these services is assured through the monitoring of quality schedules and site visits.

Each provider contract has a clinical quality review meeting (CQRM) that meets on a regular basis and reviews a range of quality indicators that are included within the quality schedules. These indicators include patient safety issues, complaints, serious and untoward incidents, infection prevention and control and other indicators of quality improvement and service quality.

This report provides a high level summary of those quality indicators and is submitted to the CCG Governing Body for assurance purposes. The CCG Quality Committee monitors the more detailed reports submitted following each provider CQRM.

**Key issues or points to note:**

The CCG has received the draft report of the West Midlands Quality Review Service (WMQRS) review to check the factual accuracy. The CCG has been asked to provide comments back by to WMQRS 17th August 2017.

The CCG will review its internal process for the management of serious incidents as part of the WMQRS review and the Serious Incident Internal audit. An action plan has been developed and will be presented to the Quality Committee in August 2017.

Workforce issues impacting on the quality of service delivery in many areas within the Shrewsbury and Telford Hospitals NHS Trust has been identified as a concern. Although responsive when concerns are raised, no sustainable solutions have been found to address the longstanding capacity and workforce issues experienced by the Trust. Furthermore the position appears to have deteriorated in a number of areas. An NHS England risk review is to take place on the 10th August 2017 to establish whether the risks identified require action over and above the normal escalation process between the Trust and its commissioners.

**Actions required by Governing Body Members:**

To note the key points/concerns/risk raised.

To receive this report for information and assurance regarding the steps being taken to improve and monitor the quality, safety and patient experience in commissioned services.
<table>
<thead>
<tr>
<th>Governance</th>
<th>Yes/ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Does this report:</td>
<td></td>
</tr>
<tr>
<td>• Provide Shropshire CCG with assurance against any risk in the BAF? (provide risk number)</td>
<td>Yes</td>
</tr>
<tr>
<td>• Have any legal implications?</td>
<td>N/A</td>
</tr>
<tr>
<td>• Promote effective governance practice</td>
<td>Yes</td>
</tr>
<tr>
<td>A summary of the risks and any mitigating actions provided in the report.</td>
<td></td>
</tr>
<tr>
<td>2  Additional staffing or financial resource implications</td>
<td>Yes</td>
</tr>
<tr>
<td>Safe staffing levels submitted by each provider.</td>
<td></td>
</tr>
<tr>
<td>3  Health inequalities</td>
<td>No</td>
</tr>
<tr>
<td>None Identified at the time of the writing the report.</td>
<td></td>
</tr>
<tr>
<td>4  Human Rights, equality and diversity requirements</td>
<td>No</td>
</tr>
<tr>
<td>None identified at the time of writing the report.</td>
<td></td>
</tr>
<tr>
<td>5  Clinical engagement</td>
<td>Yes</td>
</tr>
<tr>
<td>Demonstrated as part of the Quality Assurance Process (QAP) and across provider and commissioner teams.</td>
<td></td>
</tr>
<tr>
<td>6  Patient and public engagement</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient engagement and experience is sought as part of triangulating assurance regarding commissioned providers.</td>
<td></td>
</tr>
</tbody>
</table>
1.0 Introduction

1.1 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.

1.2. The quality schedules and monitoring allow for early identification of failing services and specialties. The mechanisms for early identification is via the contractual mechanism in the first instance and then on to the CCG Quality Committee and the CCG Governing Body.

1.3 The purpose of this report is to provide the Governing Body 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 the nationally contracted processes entered into by commissioners and service providers. These arrangements are outlined in detail in the NHS standard contracts 2017/19. 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 report.

2.0 CCG Quality Patient Safety and Experience function review

2.1 The CCG has received the draft report from the West Midlands Quality Review Service (WMQRS) to check the factual accuracy. The CCG have been asked to provide comment back to the WMQRS by 17th August 2017. The final report is due by 6th September 2017.

2.2. The CCG will review its internal process for the management of serious incidents as part of the WMQRS review and the Serious Incident Internal audit. An action plan has been developed and will be presented to the Quality Committee in August 2017.

3.0 Provider Overview

3.1 Shrewsbury and Telford Hospital NHS Trust (SaTH)

3.1.1 Workforce issues impacting on the quality of service delivery in many areas within the Shrewsbury and Telford Hospitals NHS Trust has been identified as a concern. Although responsive when concerns are raised, no sustainable solutions have been found to address the longstanding capacity and workforce issues experienced by the Trust. Furthermore the position appears to have deteriorated in a number of areas. An NHS England risk review is to take place on the 10th August 2017 to establish whether the risks identified require action over and above the normal escalation process between the Trust and its commissioners.

3.1.1.1 Outcomes:
- Unsustainable services – ophthalmology, neurology moving to other providers
- Patients having to travel out of county for care
- Risk of impact on patient safety
3.1.1.2 Emergency Departments: Non- Delivery of NHS Constitutional Targets – A&E 4 hours Standards Urgent Care

Following concerns raised, SaTH has confirmed the steps taken to manage patients in ED awaiting transfer. These include:

- Introducing a formalised handover process to further mitigate risk
- A&E juniors have been reminded of the importance of a clear handover to the Medical Registrar to include the timelines and urgency of review
- Nurses continue to do observations and escalate any concerns to the clinical team
- Audit commenced of all 4hr plus waits 'care rounding'

3.1.2 Neurology

3.1.2.1 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.

3.1.2.2 At the July 17 CQRM the Trust reported to commissioners they have a very high number of patients waiting beyond planned or within the agreed standard. As at 23rd June 2017, 369 patients were waiting. A further meeting is scheduled for 9th August 2017 to progress a sustainable system wide solution for Neurology services.

3.1.3 Ophthalmology

3.1.3.1 Workforce issues continue. The plan for 3 sub-specialty areas to remain closed to new referrals with other provider’s remains in place. 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.

3.1.3.2

- Serious incident reported in June 2017 relating to booking and scheduling.
- Estates work completed on the newly refurbished Ophthalmology department at RSH end of June 2017.
- As at July 2017 the service remains closed. Waiting lists are currently at 414 patients, an improvement from the 1200 patients initially waiting

3.1.4 Maternity services

3.1.4.1 The Governing Body has previously received information and briefing papers regarding the actions taken to secure assurance of maternity services at SaTH NHS Trust.

3.1.4.2 There are 3 reviews of maternity safety currently underway:

- Internal review of maternity safety commissioned by the Trust's Quality & Safety Committee (Completed).
- The NHSI review of specific cases as requested by the Secretary of State
- Royal College of Obstetricians and Royal College of Midwifery service review (planned)
3.1.4.3 The Trust has undertaken a review of maternity workforce and has put in place a temporary suspension of inpatient midwifery led units (MLU) at 3 locations from July 2017.

3.1.4.4 The Trust is working with Shropshire CCG on a commissioned review of the Midwife Led Units across the County and is a work stream of the newly established Local Maternity System Programme Board. The relevant recommendations of ‘Better Births’ are included in the terms of reference. The CCG is also in the process of securing the expertise of an external expert midwife to support the review.

3.1.5 Review of the Stroke Service

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

3.1.5.2 At the July 2017 CQRM Commissioners received the full implementation action plan and an NHS England review of stroke services is planned for 24th August 2017.

3.1.6 Review of Theatres

3.1.6.1 The West Midlands Quality Review Service carried out a review of theatre services on 15th and 16th March 2017.

3.1.6.2 The Trusts CEO responded to the WMQRS with assurances relating to the immediate risks. CCGs have received the full action plan that addresses all identified areas of concern by Sept 17.

3.1.7 Infection Prevention and Control

3.1.7.1 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).

<table>
<thead>
<tr>
<th></th>
<th>Shrewsbury and Telford Hospital (Data to end June 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Month</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>CDI</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: PHE HCAI web surveillance system

3.1.7.2 MRSA Bacteraemia

3.1.7.3 No cases of MRSA bacteremia were reported in June 2017.

3.1.7.4 Clostridium difficile

3.1.7.5 Two cases of CDI were attributed to SaTH in June 2017.

3.1.8 The Care Quality Commission (CQC)

3.1.8.1 The Care Quality Commission (CQC) report on SaTH NHS Trust is expected to be published in September 2017 but this is yet to be confirmed. The SaTH CQRM and SCCG Quality Committee (sub-committee) of the Governing Board will monitor implementation of the actions arising.
3.2 The Robert Jones and Agnes Hunt Hospital (RJAH)

3.2.1 Infection Prevention and Control

3.2.2.1 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).

<table>
<thead>
<tr>
<th></th>
<th>This Month</th>
<th>In-month Target</th>
<th>This Month 16/17</th>
<th>YTD</th>
<th>YTD Target</th>
<th>YTD 16/17</th>
<th>% Under/Over Target</th>
<th>Annual Target</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>On target</td>
<td>0</td>
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</tr>
<tr>
<td>CDI</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>-50%</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: PHE HCAI web surveillance system

3.2.2.2 Clostridium difficile

3.2.2.3 One case of CDI was reported in June. Analysis of route cause is being undertaken

3.3 Shropshire’s Community Healthcare Trust (SCHT)

3.3.1 Infection Prevention and Control

3.3.1.1 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).

<table>
<thead>
<tr>
<th></th>
<th>This Month</th>
<th>In-month Target</th>
<th>This Month 16/17</th>
<th>YTD</th>
<th>YTD Target</th>
<th>YTD 16/17</th>
<th>% Under/Over Target</th>
<th>Annual Target</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>-100%</td>
<td>2</td>
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</tbody>
</table>

Source: PHE HCAI web surveillance system

3.4 Marie Stopes International (MSI)

3.4.1 The CCG was notified that, following an incident elsewhere, a full review of the surgical process for Termination of Pregnancies (TOPs) at Telford was being undertaken.

3.4.2 On the 26th July 2017, MSI’s Medical Director, Lead Anesthetist, Associate Director of Quality and Director of Contracts completed an internal review of the Telford Surgical site to ensure it is safe and fit for purpose. The

3.4.3 As a result of this review concerns were raised around limitations in surgical service delivery caused by the layout of the premises. The review team felt we were unable to optimise client flow to create the safe and satisfactory client experience they would want.
3.4.4 As a result of the above review it is MSI’s intention, for the time being, to continue to direct surgical clients to other MSI locations (with Birmingham being the most local location) based on client choice in order that they can focus on further detailing around the Telford location and possibly consider alternative options of service delivery.

3.4.5 Telford and Shrewsbury early medical units are open as usual for early medical services.

3.4.6 MSI are keen to work in partnership with the CCG’s to provide a high quality service that is acceptable to the commissioners, MSUK and women themselves and as such MSI are undertaking further detailed work that will be shared with the CCG when complete.

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

3.5.1 No quality concerns have been escalated to the CCG Board Assurance Framework.

3.6 Shropdoc (Out of Hours provide for Shropshire, Telford & Wrekin)

3.6.1 The Shropdoc challenges are reported separately with assurance to patients on the continuity of their care. There is no immediate change to the service.

3.7 Community Optometry

3.7.1 There are approximately 40 individual providers of community optometry services across Shropshire and T&W, each of whom is being issued with an NHS contract (shorter form).

3.7.2 The quality team has requested clarification from the CCG contracts team, in terms of the contract monitoring process as there is currently no clear understanding of how quality standards/indicators can be effectively monitored. Discussions with the optometry advisor for both CCGs identified that small amount of performance information submitted by providers through the invoicing process could be monitored quarterly and the process for this is to be agreed.

3.8 Care Homes and Domiciliary Care providers.

3.8.1 During several quality and patient safety visits to care home providers it is evident that there is a lack of clarity around the Care Homes Advance Scheme (CHAS). There is no central register held by the CCG as this is perceived as a contract between GPs and care home providers. There is a lack of awareness amongst care home providers around their responsibilities and also on the numbers of their residents who are subject to a CHAS. During the investigation of an incident at one care home, the provider informed us that they understood that the presence of a CHAS caused confusion around whether an individual should be transferred for secondary care. All these concerns and issues have been shared with the medicines management team who oversee the scheme and quality monitoring.

3.8.2 The care homes provider spreadsheet has been updated for July 2017. The CQC liaison meeting held jointly with Shropshire and Telford and Wrekin CCGs and Local Authorities was held on 22nd June. A further meeting is scheduled for 9th August 2017.
3.8.3 As a result of Infection, Prevention and Control 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. These include Bradney House, Cloverfields, Edgeley House, Elmhurst, Maesbrook and Meadowbrook.

3.8.4 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.

4.0 **Recommendation**

4.1 The Governing Body is asked to receive the report for assurance purposes. The CCG Quality Committee will monitor the detailed reports submitted following each provider CQRM.
### System A&E Delivery (SAED) Group Meeting

**Room K2, William Farr House**

**Date of Meeting:** Tuesday, 27 June 2017  
**Time of Meeting:** 2.00pm - 4.00 pm

### Attendees:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Institution</th>
</tr>
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<tbody>
<tr>
<td>Simon Freeman (Chair)</td>
<td>Accountable Officer, Shropshire CCG</td>
</tr>
<tr>
<td>Michael Whitworth</td>
<td>Interim Director of Planning and Contracting, Shropshire CCG</td>
</tr>
<tr>
<td>Fran Beck</td>
<td>Executive Lead for Commissioning, Telford &amp; Wrekin CCG</td>
</tr>
<tr>
<td>Jane Chapman</td>
<td>NHSE</td>
</tr>
<tr>
<td>Victoria Deakins</td>
<td>Powys Teaching Health Board</td>
</tr>
<tr>
<td>Nicholas Beth</td>
<td>NHSI</td>
</tr>
<tr>
<td>Graham Shepherd</td>
<td>Shropshire Patient Group</td>
</tr>
<tr>
<td>Jan Ditheridge</td>
<td>Chief Executive, Shropshire Community Health NHS Trust</td>
</tr>
<tr>
<td>Andy Begley</td>
<td>Director of Adult Social Care, Shropshire Council</td>
</tr>
<tr>
<td>Tanya Miles</td>
<td>Head of Adult Social Care, Shropshire Council</td>
</tr>
<tr>
<td>Sarah Dillon</td>
<td>Assistant Director of Social Care, Telford &amp; Wrekin Council</td>
</tr>
<tr>
<td>Debbie Kadum</td>
<td>COO, SaTH</td>
</tr>
<tr>
<td>David Evans</td>
<td>Chief Officer, Telford and Wrekin CCG</td>
</tr>
<tr>
<td>Kate Ballinger</td>
<td>Healthwatch, Telford and Wrekin</td>
</tr>
<tr>
<td>Carol McInnes</td>
<td>Assistant Chief Operating Officer (Unscheduled Care), SaTH</td>
</tr>
<tr>
<td>Pippa Wall</td>
<td>WMAS</td>
</tr>
<tr>
<td>Steve Gregory</td>
<td>Director of Nursing, Shropshire Community Health NHS Trust</td>
</tr>
<tr>
<td>David Coull</td>
<td>Chief Executive, Shropshire Partners in Care</td>
</tr>
<tr>
<td>Claire Turner</td>
<td>Notes</td>
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1. **Apologies**

Simon Freeman welcomed everyone to the meeting and asked members of the Board to introduce themselves.

Apologies for absence were received from Debbie Kadum (CCO, SaTH), Julie Davies (Director of Performance and Delivery, Shropshire CCG), Simon Wright (CEO, SaTH), Jo Leahy (Chair, T&W CCG), Jane Randall-Smith (Healthwatch) and Ian Winstanley (CEO, Shropdoc).

Jan Ditheridge commented that Shropdoc had not attended the last few meetings and out of hours was an important component of emergency care.

**Action:** Simon Freeman to pick up meeting attendance with Shropdoc.

2. **Minutes of Previous Meeting/Matters Arising**

The Minutes of the previous meeting held on the 30 May 2017 were agreed as an accurate record.
SaTH Internal Operational Plan - Carol McInnes confirmed that this was the most comprehensive and visible plan that she had seen and had been based on a considerable amount of data. The document tabled had been condensed into a few slides for ease of reference. The purpose of the Operational Plan was to highlight the issues that the Trust was currently facing, primarily around performance and also workforce, which were the two key elements of the Plan. She had picked up issues relating to Unscheduled Care, as this sat under her portfolio. It was noted there was a 16% level of improvement required in order to deliver the target for 4 hour A&E targets for the year. The Trust was consistently failing to achieve the 95% target and in March the performance was noted as 44%. Some of the issues related to getting patients out of A&E into one of the assessment areas because of bed blocking. In summary around 60% of all admitted patients could be traced back to ward unavailability, which was classed as a bad discharge. Also workforce problems had an impact on lack of discharges as not enough doctors were available to go on the ward rounds. It was noted that when the Trust did recruit staff, they could not retain them. The Trust have identified key projects to take this forward and there were detailed plans to back this work up.

One of the key projects related to reconfiguration of bed base. Carol McInnes confirmed the shift in reconfiguration of beds would be in the region of 22, approximately one ward. Simon Freeman stated that the problem was not related to the number of beds, as more beds could always be provided, but these additional beds would become blocked again. The problem related to discharge and if this was sorted, additional beds would not be necessary.

Other areas of work that the Trust were reviewing related to weekend working and implementation of the Red to Green/safer initiative. There was also a project on transferring patients into community provision to reduce the bed base in the acute sector. It was noted that there was a cohort of patients just below the MFFD list that did not need to be in a hospital bed, but there were reasons why a discharge was not possible, ie a care package to start etc.

Jan Ditheridge confirmed if the Trust could increase from 18-20% clinical discharges to over 50% that this would significantly improve bed capacity.

Simon Freeman commented that there were empty beds in the community almost on a daily basis, so why would the acute Trust create more beds, when available beds were already there to be utilised. Carol McInnes stated that these beds were often designated for Pathway 2 beds. Beds were empty, not because they did not meet the criteria, but because the Trust could not discharge the patients.

Simon Freeman commented that the SAED Board needed to make decisions, it could not carry on having lengthy discussions with no action being taken. It was helpful to see an element of the Trust plan. It was commented that the Commissioners clearly needed to work alongside the Trust to sort the issues out, but he could not see a viable reason to open another 70 beds, in a health economy that was over bedded in terms of discharge in the first place.

3. Current Performance Dashboard

Due to the fact that the current performance dashboard had not been circulated with the
papers, it was agreed that Michael Whitworth would e-mail the dashboard to members after the meeting. It was noted that current performance remains challenging and the dashboard only confirmed this. The new dashboard was work in progress as NHSI had requested the data on one page. Pippa Wall confirmed there was a dashboard which WMAS circulated to a number of A&E Delivery Boards and that this data could be standardised and incorporated into this performance dashboard, to enable consistency.

It was agreed that Pippa Wall send this directly to Fran Beck in the first instance.

**Actions:**  
Michael Whitworth to circulate Performance Dashboard to members.  
Pippa Wall to circulate WMAS dashboard to Fran Beck for inclusion in the monthly performance dashboard.

### 4. Feedback from Escalation Meeting

Simon Freeman fed back from the Regional Escalation meeting held on Monday, 19 June 2017, where NHSI and NHSE had noted that the health economy was not working together in trying to resolve the issues.

There was concern that the presentation provided at the Regional Escalation meeting had not been agreed by all, nor had a pre-meet taken place. Resolving both these issues going forward would help present a more coherent health economy response.

### 5. Project Status Reports

There were five high impact areas that the SAED Board needed to review. Simon Freeman requested that these be discussed briefly, which could then link into the demand and capacity refresh update and the SaTH internal Operational Plan.

It was noted that the out of hospital work was going well, but the impact on overall performance was still not feeding through.

**Primary Care Streaming in A&E Project Status Report** - Noted RSH was 85% compliant with the national model whereby streaming needed to be done at the front door by the Trust, minor illnesses directed to a GP and minor injuries to nurses. The national model required the service to be staffed by a prescribed number of staff, including two GPs and a nurse. Simon Freeman asked what NHSI's position was regarding implementing primary care streaming in A&E. Nicholas Beth confirmed there were two parts to this, capital and revenue and there was a framework to secure funding. David Evans confirmed that all the guidance regarding primary care streaming confirmed that this was supposed to be cost neutral across the system. This programme needed to be up and running by September and after considerable discussion it was agreed that an options paper should be brought back to the next meeting.

Simon Freeman commented that this was a delivery group that needed to take appropriate actions and it needed to be clear what actions were needed in each case. The SAED Board needed to agree what actions needed to be taken for the next meeting and what decisions the group had to take. Simon Freeman suggested that the SAED needed to be clear on what the national scheme was, what the impact would be, and
what the options were. David Evans stated that NHSI needed to confirm that the capital was dependent on following the national model.

**Action:** Carol McInnes to bring an options paper back to the next SAED Board meeting.

**Reducing Non-admitted Breaches Project Status Report** - Carol McInnes confirmed that in the last four weeks there had been continued senior clinical oversight of breach performance. When it was busy in A&E the focus went to those admitted patients that were really sick. Non-admitted patients were seen and treated, but not necessarily in the times set out in the targets. The substantive tracker role had been put in place in April and operationally this had proved valuable at handover/peak times when the department was busy. The second piece of work related to lean methodology and was linked in with the Virginia Mason work. The work planned for the next four weeks was for a VMI lead to visit to provide a steer for the Kaizan event in PRH to ensure effective streaming processes were in place. Improvements would hopefully be seen from day one. Colin Ovington, previously Acting Director of Nursing, had been earmarked to be the dedicated Director to support the two emergency departments. A general discussion resulted from the performance summary graphs. David Evans stated that looking at the graphs, there was a downward trend, meaning that performance was actually getting worse.

Jan Ditheridge stated that if non-admitted minors performance could get up to 100% this would help with the non-admitted majors performance. There were actions for SaTH to deal with internally, but the COO group also needed to look at options regarding this. This was the first time that the COOs had produced this data analysis, so it was noted these status reports were only a starting point. The project status reports were just for information to keep the SAED Board informed of work progressing.

Simon Freeman was concerned that plan actions needed to be linked to percentage improvements, that way the SAED could determine whether these actions had worked, or not, or whether they were not the right actions in the first place, or whether there were new issues which needed resolving.

**Discharge to Assess Project Status Report** - Agreed to pick this up next month.

**Ambulance Handovers Project Status Report** - Carol McInnes gave a brief outline of the project status confirming that three key themes had been identified, data management, process issues and behavioural issues and she provided examples of these. Noted the number of patients arriving in ED and being handed over within 15 minutes of arrival was 41.45% in May. The Ambulance Service arrival times charts were also discussed at length.

David Evans commented that he thought that activity levels in terms of ambulances was the same at the moment, with no increase, so was there a disposition? If ambulances were going up there must be a disposition and if this was the case the CCGs would need to look at this as there was no additional funding available. Pippa Wall confirmed she was happy to review the data as this was the first time she had seen the chart.
It was noted that Clinical Leads at SaTH confirmed that RSH was busy in the day, which the graphs confirmed and the number of ambulances attending PRH increased at night. The data also highlighted that there was an additional ambulance every hour.

Fran Beck confirmed a data analysis sub-group was being set up to ensure all organisations were working with the same data, thus enabling 'one version of the truth'. This group would include John Cliffe from the Trust, the CSU and COO Managers.

David Evans stated that rather than putting all the effort into getting the data correct, surely more work needed to be done on getting the ambulance waiting times at the front door down.

**Internal Flow Project Status Report** - Noted that a weekend audit had been undertaken and analysis of this was underway and appropriate actions could then be implemented. Training sessions had been put on for all clinical staff and all ward areas were receiving a daily report. The number one problem in A&E resulted in the inability to discharge patients for whatever reason and a lot of work had already been done on this, but the Trust needed to establish why this was still not happening.

Kate Ballinger asked who was quality checking the discharges at the Trust as poor discharges obviously lead to re-admissions, but at the moment, this was not impacting on the Trust, as the discharges were not happening.

Steve Gregory confirmed that if there was a zero admission rate the Trust was not taking enough risks, which may be one of the issues for the lack of discharges.

Carol McInnes confirmed that there were action plans behind this work. She stated that she had several ward managers who were on long term sick, junior workforce managers currently on sick leave, and staff were under enormous stain and pressure and she could not afford to lose anyone else.

Simon Freeman had agreed to Chair the COO meeting going forward so some of these issues would be addressed by the time the next SAED Board took place in July. Again Simon Freeman asked for clarification on: where we were currently, what were the issues, were these the blockers in the system, and what actions we were going to take to resolve?

Graham Shepherd asked what were the top three internal delays in the Trust? Could these be resolved immediately? Carol McInnes confirmed there was a detailed plan behind this and she would pick this up outside the meeting with Graham.

**Action:** Carol McInnes to liaise with Graham Shepherd to discuss the top three internal delays.

6. **Recovery Trajectory - The Way Forward**

Noted this would be discussed at the COOs meeting next week.
## Action:
Simon Freeman to discuss at COOs on Wednesday, 5 July 2017.

### 7. Workforce

Carol McInnes confirmed that to date, the ED department were currently understaffed. Out of the current 5.00 WTE Consultants, only 4.00 WTE covered the on-call rota and two out of the five Consultants did not work across both sites. Recruitment issues at speciality doctor level had a further impact. At PRH there were 5.00 WTE substantive posts, with no vacancies, but at RSH there were 5.00 WTE substantive posts, with 4.00 WTE vacancies, but another 1.00 WTE post would become vacant in July. This led to a reliance on locum middle grade doctors covering overnight at PRH and some nights at RSH.

Consultants were consistently working above and beyond to close gaps. Actions to date were noted, including a continued rolling plan of national and international recruitment.

Colin Ovington, had been made a dedicated Director to provide support to both EDs, and would be commencing his role next week.

Simon Freeman asked whether NHSI were clearly sighted on medical staffing issues. It was noted that following last month’s SAED Board meeting, Nicholas Beth confirmed he had gone to UHNM and asked why they had pulled support for joint recruitment. The management of UHNM confirmed that they had not and asked for examples, so he was waiting for a response from Simon Wright or Ed Borman so he could progress this.

Jan Ditheridge asked whether there was merit in using the EMPs out in the rural community. This needed further discussion and may solve some of the issues. At RSH there were 3.5 WTE EMPs, but these were seeing a relatively small number of patients. The Community Trust had offered their support before, but this may need exploring again. This was becoming a Business Continuity issue now. The COOs were the right people to take this work forward. Was there anything else that needed to be considered, ie closing some of the community beds and putting the workforce into the acute setting? The providers needed to work together as a whole health economy.

Kate Ballinger asked if an interim report could be provided at the next SAED Board meeting. Simon Freeman agreed.

**Action:** COOs to provide an interim report on workforce to the next SAED meeting.

Andy Begley asked why the Trust were experiencing problems retaining medical staff and Simon Freeman commented that medical staff did not want to work a 1 in 4 rota.

### 8. Admissions/Frailty

Agreed due to time constraints, that this would be deferred to the next meeting. Fran Beck stated that this was really important and the SAED Board were not giving it justice.
<table>
<thead>
<tr>
<th>Agenda item: GB-2017-08.172</th>
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It was agreed that it would be one of the first items on next month’s Board agenda.

**Action:** Admissions/Frailty to be included at the beginning of next month’s agenda.

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<tr>
<th>9. SAED Terms of Reference</th>
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Agreed that members needed time to review these, so any comments or amendments were requested for the next meeting.

David Coull was conscious that he had not attended many of the meetings so would welcome the membership being reviewed as was not sure which meetings required the presence of a social care representative.

**Action:** Comments/amendments on the circulated ToR to be brought back to next month’s meeting.

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<th>10. Winter Monies</th>
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Last year Shropshire CCG had not been able to allocate winter monies to the Trust. Michael Whitworth had produced a slide deck to progress this work. The MRET and readmissions deductions were linked to the National tariff payment system. Guidance was now outside the national tariff, so it was not statutory, but good practice. Commissioners were encouraged to look at investment across all funding sources and engage with system resilience partners, which in this case was the SAED Board. In terms of funding (Shropshire CCG only), there was £1.9m for winter/resilience funding and £4.3m (current post QIPP figure) for MRET and re-admissions. Some commitments had already been earmarked against the winter monies, ie High Intensity Service Users, Paramedic Response Unit (now decommissioned, but legacy costs associated with this), HALO and Community Care Co-ordinators. Current planning assumptions was that there was currently £1.5m uncommitted monies.

In terms of MRET and re-admissions money most of this went into ICS (Shropcom and the Local Authority). Previously there had been issues about how effective this had been, but it was now noted to be the way forward. As a Commissioner the CCG would be saying the money was being spent on the right things, but as a partner, if the money was seen to be spent better elsewhere, a process would be required to prioritise and look at alternatives. Were these schemes focussed on keeping people out of hospital and the answer was yes. These schemes had been recurrently funded to date, but should have been funded non-recurrently.

Shropshire CCG had approximately £1.5m uncommitted money and the process of how this money was allocated needed to be discussed, ie do the SAED Board want to get bids in, or do the SAED Board want to work collectively. How did people feel about this? Proposals needed to come back to the SAED for approval.

After considerable discussion it was agreed that Michael Whitworth and Fran Beck agree a process for moving forward. The aim would be to start spending the money in September.
<table>
<thead>
<tr>
<th>Action: Michael Whitworth and Fran Beck to agree a process for allocating funds.</th>
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<tr>
<td>At this point Jan Ditheridge, Graham Shepherd, Nicholas Beth and Andy Begley left the meeting.</td>
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</table>

11. **Winter Plan**

David Evans confirmed the Winter Plan was in the very early stages, so it was agreed to bring a draft back to the next meeting. The two CCGs were responsible for producing the Winter Plan jointly. The SAED Board needed to be assured that the health economy was going to cope this winter. A first cut to be brought back to the next meeting.

**Action:** Julie Davies and Fran Beck to produce a first cut for next month’s Meeting.

12. **Any Other Business**

Noted all papers needed to be ready for circulating with the next agenda. Only by exception should papers be tabled.

**Action:** All Board papers to be circulated with the agenda in future.

13. **Date and Time of Next Meeting:**

Tuesday, 25 July 2017 at 2.00 pm in SPIC Meeting Room, Denby House, Telford
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 12 July 2017.

Since that meeting the GBAF has been reviewed by Executive Directors. As a result a number of updates have been made which for ease have been noted on the document in red. These updates show progress in relation to a number of risk mitigations and whilst the assessment of risk ratings have not yet been downgraded, at this point clear positive movement in this regard continues to be evident.

Actions required by Governing Body Members:
Review the risks contained within the GBAF, with particular note of the amendments noted in red
Does this report and its recommendations have implications and impact with regard to the following:

<table>
<thead>
<tr>
<th>A: CCG Aims and Objectives (please provide details where applicable)</th>
<th>Yes/ No</th>
</tr>
</thead>
</table>
| **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* |  |

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<tr>
<th>B: Governance (please provide details where applicable)</th>
<th>Yes/ No</th>
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</table>
| **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* |  |
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)

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<thead>
<tr>
<th>Key Principle</th>
<th>Previous risk</th>
<th>New</th>
<th>Action</th>
<th>Lead Name</th>
<th>Timescale</th>
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<tr>
<td>Principle 1</td>
<td>Finance</td>
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<td>Principle 2</td>
<td>QIP</td>
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Governing Body Assurance Framework Version 17.3

updates for Governing Body August 2017 shown in red

Risk ID

<table>
<thead>
<tr>
<th>No.</th>
<th>Description of risk</th>
<th>Action</th>
<th>Lead Name</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>1</td>
<td>Finance</td>
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<td>2</td>
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<td>QIP</td>
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<td>5</td>
<td>QIP</td>
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Key Controls

- Summary of existing controls/systems in place to manage the risk
- 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

- Likelihood: High 9, Medium 8, Low 7
- Impact: High 9, Medium 8, Low 7
- Likelihood x Impact = 81 = High

Action / Lead Name / Timescale

- Reporting to the Quality Committee requires a review on level of detail provided to provide correct level of assurance to the governing body to be undertaken.

- 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 through actions set out below.

- A review of the requirements of the Quality Committee carried out with the Chair April 17. Confirmed by the executive team and AO. Public Governing Body and QC to undertake a comprehensive root and branch review of the quality, patient safety and experience function, systems, processes, roles, responsibilities and accountability to ensure fit for purpose as currently in the NHS IAF Dashboard lowest quartile under the better care category. Update to Governing Body private board May 17 completed. Also ensure correct fit with contracting, delivery and performance. Review commenced June/July 17 monthly reporting on progress and on receipt of report and action plan implementation through the DON.

- The Healthwatch involvement confirmed as a) seat on NHSE Quality Assurance Group at Governing Body Public Meeting) monthly or once with Director of Nursing and Quality.

- August 2017: Healthwatch confirmed as member of Quality Committee. Away day with Nursing and Quality Team 25 August 2017 to finalise structure. Significant Incident audit report and action plan to Quality Committee in August.
<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Opened by when</th>
<th>Map to key principle</th>
<th>Summary title of risk and fuller description of risk</th>
<th>Key Controls</th>
<th>Source of Assurance</th>
<th>Gaps in Controls/Assurances</th>
<th>Assessment of risk level - Low / Medium / High / Extreme Risk / Movement of risk rating</th>
<th>Action / Lead Name / Timescale</th>
<th>Risk mitigation / Assessment of risk level - Low / Medium / High / Extreme Risk</th>
<th>Risk Owner</th>
<th>Amend Review name and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/10</td>
<td>AS 2016 NEW</td>
<td>Principle 1 and 2</td>
<td>5. NHS Constitution</td>
<td>Lead Committee - Finance and Performance Committee</td>
<td>A&amp;E Delivery Board in place</td>
<td>A&amp;E Rapid Improvement Plan agreed with NHS England and Project Manager capacity to support delivery across the system - (System AO)</td>
<td>A&amp;E Delivery Board’s effectiveness of managing the System A&amp;E Recovery plan.</td>
<td>Likely X Major = Extreme Risk</td>
<td>A&amp;E Delivery Board has appointed a Director of Urgent Care (start date can be confirmed) and Project Manager capacity to support delivery across the system - (System AO)</td>
<td>Julie Davies</td>
<td>8.8.17</td>
</tr>
<tr>
<td>7/10</td>
<td>AS 2016 NEW</td>
<td>Principle 1 and 2</td>
<td>Planned Care Working Group for Cancer and Referral to Treatment Times (RITT) in place</td>
<td>Lead Committee - Commissioning Committee</td>
<td>Strategic Transformation Plan (STP) Board and workstreams developed across acute, community and primary care to ensure sustainability</td>
<td>RITT in place</td>
<td>Referral to Treatment Times (RTT) in place</td>
<td>Likely X Major = Extreme Risk</td>
<td>The CCG Recovery Plan is progressing through the final stages of the NHS assurance process and is expected to be de-escalated by the Autumn</td>
<td>Sam Tilley</td>
<td>5.7.17</td>
</tr>
<tr>
<td>7/10</td>
<td>AS 2016 NEW</td>
<td>Principle 1 and 2</td>
<td>6. Communication and Engagement</td>
<td>Lead Committee - Clinical Commissioning Committee</td>
<td>Communications and Engagement Plan and Strategy</td>
<td>30 Stakeholder survey feedback</td>
<td>Communication and Engagement arrangements for all QIPP schemes</td>
<td>Likely X Major = Extreme Risk</td>
<td>Communication and Engagement post now recouped. Ten further communications will be recruited to ensure the CCG has enough capacity to cover the communication and engagement requirements associated with the key workstreams and local communications and general: business. Work is ongoing to review and implement the Communications and Engagement Plan</td>
<td>Sam Tilley</td>
<td>5.7.17</td>
</tr>
<tr>
<td>7/10</td>
<td>AS 2016 NEW</td>
<td>Principle 5</td>
<td>8. CCG Workforce Resilience and trust</td>
<td>Lead Committee - All</td>
<td>Clear and structured OD plan for the organisation</td>
<td>Key workforce KPIs not reported to Board</td>
<td>Key workforce KPIs not accurately recorded and recorded centrally</td>
<td>Likely X Major = Extreme Risk</td>
<td>Organisational structure in the final stages of being complete. Executive posts filled and wider recruitment commencing</td>
<td>Sam Tilley</td>
<td>6.8.17</td>
</tr>
<tr>
<td>Risk ID</td>
<td>Opened On / Closed On</td>
<td>Map to Key Principle</td>
<td>Summary title and fuller description of risk</td>
<td>Key Controls</td>
<td>Source of Assurance</td>
<td>Gaps in Controls/Assurances</td>
<td>Action / Lead Name / Timescale</td>
<td>Risk mitigation assessment of risk level - Low / Medium / High / Extreme</td>
<td>Revised Review / next review date</td>
<td></td>
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</tbody>
</table>
| 171/0 | All 2016/16 NEW       | 1. 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. | **Lead Committee - Quality Committee, Primary Care Committee**  
Primary Care Strategy  
Primary Care Workforce Group (PCWG) led by NHS with a remit to look at sustainable Primary Care Workforce for the future. | **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 framework  
Cap in Primary Care leadership at governing body  
GAP in primary care workforce survey results to be delivered | Primary Care Strategy development now incorporating GPITV principles and will incorporate outcomes from:  
a) Primary Care Needs Assessment agreed by the Primary Care Commissioning Committee and being presented to CCG Board in August 2017  
b) Primary Care workforce survey. Through the national survey, this information is collated vis-à-vis GP practice audit. A GP workforce audit is underway and will be completed during quarter 2. Audits for other Primary Care Workforces will follow in line with the GPITV MMC programme. Gold is defined as Primary Care Workforce is now included in the STP work programme and will be reported to Primary Care Commissioning Committee  
New Executive Structure to address gap in Primary Care leadership approved at Governing Body December 2016. Subsidiary Directorate of Primary Care commenced at the end of May 2017  
Internal audit recommendations to be delivered (LT) Complete and reported to Primary Care Committee  | **Possible** | 9.5.17 |
| 171/0 | Accounts & Finance  
Officer / Chair | 2. 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  
Stakeholder AD in place, Board in place, Chair in place  
Governance Body has full complement of GP Chairs and Interim Directors in place  
Patient Advisory Group in place  | **Lead Committee - Governing Body**  
Financial performance challenges - addressed above. | **Lead Committee - Governing Body**  
Financial performance challenges - addressed above. | **Gaps in controls:**  
Clear organisational development plan across all levels in the organisation  
Monitoring delivery of key objectives  
Key principles in place to support delivery of CCG objectives  
Organisational development plan across all levels of the organisation  
Staff training and support  
Leadership challenges  
Stakeholder AD in place, Board in place, Chair in place  
Governance Body has full complement of GP Chairs and Interim Directors in place  
Patient Advisory Group in place | **Up to date** | Senior Tally | 9.5.17 |
| 171/0 | Accounts & Finance  
Officer / Chair | 3. Directions | There is a risk that the CCG will fail to achieve organisational and CCG objectives due to lack of resources and capability. | **Lead Committee - Governing Body**  
Organisational Capability Plan progress.  
Communication and Engagement arrangements for all major projects  | **Gaps in controls:**  
Communication and Engagement arrangements for all major 2017/18 projects to be in place using standard template. To include communications and engagement, ESAS and PPA. QIPP plans to include CCG staffing implications/QIPP Leads. 31.3.17. Comm and Engagement plans in place for a number of QIPP schemes to include process of review by PAG represented. Lay member for Public and Patient Engagement supporting GP development options currently being considered | **Possible** | Senior Freeman | 9.5.17 |
| 171/0 | Accounts & Finance  
Officer / Chair | 4. 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 Plan in place  
Approved Better Care Fund Plan | **Gaps in controls:**  
review of governance arrangements/institutional groups undertaken and constitution amended however further revisions to take place | STP programme report presented to Governing Body | **Possible** | Simon Freeman | 9.5.17 |
### Risk Matrix

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>Likelihood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rare</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
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<tr>
<td></td>
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<td>4</td>
<td>8</td>
<td>12</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Likely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Almost certain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Consequence

- **5 Catastrophic**: 5 - 10 - 15 - 20 - 25
- **4 Major**: 4 - 8 - 12 - 15 - 20
- **3 Moderate**: 3 - 6 - 9 - 12 - 15
- **2 Minor**: 2 - 4 - 6 - 8 - 10
- **1 Negligible**: 1 - 2 - 3 - 4 - 5

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

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5</td>
<td>Low risk</td>
</tr>
<tr>
<td>6 - 10</td>
<td>Moderate risk</td>
</tr>
<tr>
<td>11 - 15</td>
<td>High risk</td>
</tr>
<tr>
<td>16 - 25</td>
<td>Extreme risk</td>
</tr>
</tbody>
</table>
Shropshire Clinical Commissioning Group

MINUTES OF THE
FINANCE & PERFORMANCE COMMITTEE
HELD IN ROOM B, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL
ON WEDNESDAY 31ST MAY 2017 AT 12.30PM

Present
Mr Keith Timmis (Chair) Lay Member
Mrs Deborah Hayman Interim Chief Finance Officer
Mrs Claire Skidmore Chief Finance Officer
Mr William Hutton Lay Member and Audit Chair
Mr Michael Whitworth Interim Director of Contracting & Planning
Dr Julie Davies Director of Performance & Delivery
Dr Geoff Davies Clinical Director

In Attendance
Mr Mike Taylor PMO Lead (12.50pm – 1.25pm)
Mrs Faye Harrison Personal Assistant/Minute Taker

Apologies
Dr Jessica Sokolov Deputy Clinical Chair

FPC-2017-05.043 - Apologies

1.1 Apologies were received from Dr Jessica Sokolov.

1.2 Mr Timmis welcomed new Chief Finance Officer Claire Skidmore to the meeting and thanked Deborah Hayman for all her hard work and dedication in her time as interim CFO.

FPC-2017-05.044 - Members’ Declaration of Interests

2.1 There were no declarations of interest.

FPC-2017-05.045 - Minutes of Previous Meeting held on 26th April 2017

3.1 The minutes from the previous meeting were agreed as being a true and accurate record.

FPC-2017-05.046 - Matters Arising/Action Tracker

4.1 The Action Tracker was discussed and updated as appropriate. Please see attached. Some further updates are detailed below.

4.2 Dr Davies/Mrs Hayman to discuss the A&E Delivery Board at Executive Team with regard to where the committee reports – Dr Julie Davies updated that there is no formal authority to report to anywhere in particular as regulators attended meeting. It was agreed to include updates in the Performance Report at this meeting going forward.
4.3 Dr Julie Davies updated that Quality has been added back onto the agenda at the WMAS Meeting. All issues should be raised as N2N concerns which can be brought to the Quality Committee for documentation. Dr Geoff Davies suggested further discussion through the Locality Managers/Locality Boards would be beneficial.

**FPC-2017-05.047 - Workplan**

5.1 It was agreed to remove the Complex Care Deep Dive from the Workplan for May; this can be brought back to a future meeting when it is appropriate. Keith Timmis and Claire Skidmore to meet for further discussion.

**Action:** Mr Timmis/Mrs Skidmore to meet to discuss Workplan and Complex Care Deep Dive

5.2 Following on from the QIPP Deep Dive at last month’s meeting it was agreed an update would be brought to a future meeting. This requires addition to the Workplan.

**Action:** Mrs Harrison to add QIPP Update to Workplan

**FPC- 2017-05.048 – QIPP Update**

6.1 Mr Mike Taylor, PMO Lead joined the meeting to update members on QIPP progress.

6.2 Mr Taylor reported that the PMO Team vacancies are ready to go out to advert and he is awaiting response from HR.

6.3 Mr Timmis enquired around the conclusion in the paper and whether the programme was achievable given some of the problems e.g. with the contracts. Mr Taylor drew members’ attention to the table in the report around QIPP performance. There is work ongoing around the Menu of Options (MOO) and also a number of new schemes which are being looked at to close the contract gap. Although Mr Taylor felt it would be challenging to reach the £17.7m target he commented that the CCG is in a much better place than this time last year.

6.4 Mrs Hayman highlighted that there are other things which can be done such as a review of reserves. Meryl Flaherty from the CSU is looking into the IR issue and there is some funding which can be released for that. There will be some difficult decisions around what to invest in which will include the winter pressures money. Every spending decision needs to be clearly articulated as there is risk involved.

6.5 Mr Timmis wanted everyone to be clear that it was the responsibility of this committee to report any issues they are not satisfied about to the Governing Body.

6.6 Dr Julie Davies commented that there is a positive opportunity around the ‘invest to save’ schemes such as Frailty, Admissions Avoidance and Primary Care to deliver a saving.

6.7 Mrs Hayman felt that it would be important to focus on the detail to make the necessary savings but also to monitor the mitigating risks reporting up to NHS England.

6.8 Mr Whitworth commented that there is a clear challenge ahead but he felt optimistic. Currently there is no Urgent Care Transformation Scheme but there is possibility of
6.17 Mr Timmis moved on to discuss the 2018/19 schemes and raised the issue of the CHC hotel costs. He was concerned that if they are relying on this for a QIPP saving national pressures such as the minimum wage would not help the situation. Mr Whitworth reported that they are working closely with the Local Authority to approach the scheme in a market management way. The ultimate aim is to have a single integrated system. They are getting involved with SPIC around Domiciliary Care; the Community Trust are also involved.
6.18 Mr Whitworth reported that there was a graph which was shared at the A&E Delivery Board which he will circulate to members as he felt it would be useful. Issues will be picked up at the Discharge to Assess Task and Finish Group.

Action: Mr Whitworth to circulate graph which was presented to A&E Delivery Board to members for information

6.19 Mrs Hayman reported that the economies of scale information will be required when interlinking with the Council. Travel issues will also need to be taken into consideration.

6.20 Mr Hutton enquired about the limitation to delivery QIPP and whether it was more of a capacity and resource issue. Dr Julie Davies reported that issues can be dealt with in the short term however capacity will be looked at.

6.21 Mrs Hayman reported that some parts of QIPP are around the Primary Care/GP prevention agenda and how this is better resourced and managed.

6.22 Mr Taylor further reported that one of the schemes was the STP Out of Hospital scheme and there are 4 sub-schemes looking at the transformation and areas of investment.

MONTHLY MONITORING FOR FINANCE AND PERFORMANCE

FPC-2017-05.049 – Finance Report

7.1 Mrs Hayman highlighted the most important part of the report which is that we delivered what we said we would do. Unqualified accounts have been submitted and a much improved Audit findings report has been received. Mr Timmis emphasised that although the accounts are unqualified the regularity opinion and value for money conclusion were both qualified and highlighted that too much money was being spent, FutureFit was not being delivered and we are not working effectively with partners.

7.2 Mrs Hayman added that all of the appendices had now been added to the document along with the standardised wording regarding the 1% reserve.

7.3 Mr Whitworth shared positive feedback received at the recent Escalation Meeting regarding the progress that has been made over the past 12 months and delivering what was required.

7.4 Mr Hutton made an enquiry regarding the Local Authority debtors payments detailed on page 15 of the report and Mrs Hayman reported that:
3. Prescribing Drug Misuse Recharge Jan 15 – March 16 – Agreed
4. Falls Clinics funded by Public Health – Arbitration
5. Provision of 2016/2017 Falls Clinics - Arbitration
6. Prescribing Drug Misuse Recharge April 14 – March 15 – Agreed
All items on the creditors list on page 16 have been cleared.
FPC-2017-05.050 – Contracting Report

8.1 Mr Whitworth highlighted that this year there is a £1.6m QIPP and robust activity assumption. He felt that there was less risk loaded into the current position and monitoring referrals closely would be a key indicator.

8.2 Mr Whitworth drew members attention to the table on page 9 of the paper around SSSSFT activity and a £1.6m underspend with a financial adjustment which takes it down to £108,000. Further discussion was held around this point and the recent CQC visit.

| Action: | Mr Whitworth and Mrs Skidmore to meet to discuss integrating the finance and contracting reports to ensure there is no level of duplication. |

8.3 Discussion was held around the Community Nurses at ShropDoc. It was reported that Telford have served notice which has resulted in ShropDoc serving notice to the CCG. We don’t have a contract with them for the Nurses it is commissioned through the Community Trust and they sub-contracted it to ShropDoc. This is not a 24 hour service.

FPC-2017-05.051 – Performance Report

9.1 Dr Julie Davies updated members that slow progress is being made at the A&E Delivery Board. She reported that SaTH overachieved their trajectory in April which will fall back in May. This was predominantly due to a reduction in demand and that the Delayed Transfers of Care were down to 2.2% however there continue to be workforce challenges. Further discussion was held around the significant challenges within the hospital.

9.2 Dr Julie Davies reported that as part of the Ambulance contract mediation the HALOs were removed however Clinical Commissioning Committee supported the proposal of Corridor Nurses and the £90,000 to fund this.

9.3 Dr Julie Davies further reported that the first phase around complex discharges is complete and the second phase and audit is underway. The big issue around pathway 3 bed funding is being looked at jointly with the Council to implement discharge to assess.

9.4 The trajectory list which was submitted to NHSI was 87.5% which included coding and counting although the minimum amount is 90% by September. The weekly Chief Operating Officers’ meeting has been tasked with finding alternatives to get this to target. SaTH need to be held to account for their internal flow and internal processes. Discharge to Assess should be where it needs to be by the Autumn. Focus now needs to be on reducing demand, admittance avoidance and frailty and care homes.

9.5 Mr Timmis enquired about SaTH agreeing to their original trajectory and not achieving this and whether this is likely to occur again. Dr Julie Davies reported that monthly escalation meetings are currently taking place to address the issues. She highlighted her main concern around the Ambulance Conveyance and they are currently looking at the Worcester model; this will be taken to Executive Team on Monday and to the A&E Delivery Board in June.
9.6 Mr Timmis asked for an update on the MIU and Dr Julie Davies reported that the data is not incorporated currently although work is on going with NHSI to get this included as required.

9.7 It was reported that Telford & Wrekin have served notice on the Walk in Centre at PRH.

9.8 SaTH have met with the Ambulance Service and drafted an Ambulance Handover Improvement Plan which will be taken to the COO meeting later today.

9.9 Dr Julie Davies reported on 18 weeks and that because of the performance notice SaTH were obliged to provide a detailed improvement plan, trajectories by specialty and overarching Trust position. Plans were submitted which were not up to standard and a revised plan is due by 1 June.

9.10 Dr Julie Davies wanted to bring the over 52 week waits to the attention of the committee as all these have now been cleared at RJAH however there are a few out of county and some within the Community Trust’s Audiology Service; 9 in total who were scheduled in for March, April and May although they have had a couple who did not attend which will roll forward.

9.11 Mr Hutton highlighted a problem with the graph in the report as it was not consistent with the one below. Dr Julie Davies agreed to ensure this was altered.

**Action:** Dr Julie Davies to ensure the A&E graph on page 8 is altered to be consistent with one below.

9.12 Discussion was held around the category demand graphs. Mr Hutton suggested that the model doesn’t fit for rural counties.

9.13 Waiting list targets were discussed and Mrs Hayman emphasised that these need to be more specific and not focus on activity.

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**FPC-2017-05.052 – Governing Body Assurance Framework**

10.1 Mr Timmis highlighted that generally the GBAF looks at quality issues but that in terms of achieving constitutional standards and targets did members feel the wording was ‘severe’ enough? He commented that the lack of management needed highlighting as a risk. Discussion was held around the scoring of the risks and members agreed clarification was required. Separating the risks was suggested along with a summary of individual risks. Dr Julie Davies would discuss this with the Executive Team.

**Action:** Dr Julie Davies to ask for clarification of the risk scores on the GBAF at Executive Team as well as the possibility of separating risks.

**Action:** The wording on Risk 3 to be looked at and discussed further with Executive Team.

10.2 Mr Whitworth explained to members that the constitutional standards would be discussed further at Executive Team and be brought back to committees. He commented that if following mitigations risks are still red there needs to be a rethink on A&E whether a single A&E is beneficial or whether it should go out to tender due
to the possible threat of legal action if issues aren’t resolved. Further discussions could be held at Governing Body also.

**Action:** GBAF to be discussed at Executive Team and feedback to be brought to next meeting

10.3 Members agreed that new objectives should be discussed and set with new Directors once they are in post.

**FPC-2017-05.053 - Any Other Business**

11.1 There were no items of other business to discuss.

*Meeting closed 2.20pm*

**Date of Next Meeting**

*Wednesday 28th June 2017, 12.30pm, Room B, William Farr House*

Signed..................................................................................................................................................
Shropshire Clinical Commissioning Group

MINUTES OF THE
FINANCE & PERFORMANCE COMMITTEE
HELD IN ROOM B, WILLIAM FARR HOUSE, SHREWSBURY, SY3 8XL
ON WEDNESDAY 28th JUNE 2017 AT 1.30PM

Present
Mr Keith Timmis (Chair) Lay Member
Mrs Claire Skidmore Chief Finance Officer
Mr William Hutton Lay Member and Audit Chair
Mr Michael Whitworth Interim Director of Contracting & Planning
Dr Julie Davies Director of Performance & Delivery
Dr Jessica Sokolov Deputy Chair & Clinical Director
Mr Kevin Morris GP Practice Representative Board Member

In Attendance
Miss Rose Howard Personal Assistant/Minute Taker

FPC-2017-06.054 - Apologies
1.1 No apologies were received.
1.2 Mr Timmis welcomed Kevin Morris to the Committee following a period of sickness absence.

FPC-2017-06.055 - Members’ Declaration of Interests
2.1 There were no declarations of interest.

FPC-2017-06.056 - Minutes of Previous Meeting held on 31st May 2017
3.1 The minutes from the previous meeting were agreed as being a true and accurate record.

FPC-2017-06.057 - Matters Arising/Action Tracker
4.1 The Action Tracker was discussed and updated as appropriate. Please see attached.
4.2 Mr Keith Timmis advised that due to the limited time available for this Committee Meeting, there will be no Deep Dive this month. A Deep Dive and the Workplan will be on the agenda for the July Committee Meeting.

FPC-2017-06.058 – QIPP Update
5.1 Mrs Claire Skidmore presented the QIPP Update Paper. She advised that a realistic view has been taken and confirmed that current forecasting suggests that the CCG will only deliver £14.2m of the £17.7m target for QIPP in-year. This is mainly due to SaTH and Non Elective in Primary Care schemes not delivering. Focus has therefore been
given to ‘pipeline’ schemes which Mrs Skidmore is confident will cover the shortfall in QIPP to ensure the CCG meets the £17.7m target for the current year.

5.2 It was confirmed that Mr Mike Taylor, QIPP Lead, was leaving Shropshire CCG on Friday 30th June and a permanent replacement has not yet been sourced. Claire Skidmore confirmed that the post has been advertised and the gap in capacity would be covered by an Interim PMO Lead, Paul Findlay. She confirmed that a key focus for Paul will be to establish a process between Finance, Contracting and Business Intelligence colleagues to ensure requests for information and progress reporting can be met in a timely manner. Mr Keith Timmis asked that Mr Taylor is thanked on behalf of the Committee for his valuable contribution in establishing the PMO.

5.3 Mrs Skidmore confirmed that reporting timetables for Finance, Contracting and PMO have not yet been aligned however this will be completed in time for reporting to the July Committee Meeting.

5.4 Mr Timmis highlighted that the risk of non-delivery of schemes is not immediately clear in the QIPP Programme Update and suggested that a RAG rating against each scheme was introduced.

**ACTION:** Mrs Skidmore will arrange for a RAG Rating to be added against each QIPP Scheme to easily highlight issues with specific schemes.

5.5 Mr William Hutton highlighted that the CCG’s Auditors had raised concerns regarding clinical input and review of QIPP Schemes. The Committee discussed this and it was noted that all schemes have received clinician input and have been taken through Clinical Commissioning Committee with the exception of CHC Schemes, however it was felt that the nursing staff within the CHC Team ensure that this scheme has sufficient clinical overview. Dr Julie Davies also confirmed that QIAs have been completed for all schemes however this may not have been documented sufficiently. Mrs Skidmore confirmed that schemes will be reviewed at the QIPP Board Meeting and Executives will be challenged and held to account for any problems within their respective schemes.

5.6 Mr Timmis advised that the revised report format is much improved but noted that there are still concerns re assurance of delivery which will be worked through at the QIPP Board. The format for presentation to the Public Governing Body Meeting needs to be agreed.

**ACTION:** Mrs Skidmore will agree the appropriate content for the QIPP Report submitted to the Public Governing Body Meeting.

**MONTHLY MONITORING FOR FINANCE AND PERFORMANCE**

**FPC- 2017-06.059 – Finance Report**

6.1 Mrs Skidmore presented the Finance Report for May 2017. She highlighted that there is still work to be completed re outstanding Contract Variations but assured the Committee that this is being completed and that there is no cause for concern at the current time.

6.2 The Committee queried the terminology used within the report, particularly within the table under Item 3 where a line is included titled ‘anticipated’. Mrs Skidmore confirmed that this related to the deficit and links to the titles included in the ledger. She agreed that the terminology is unclear and can be amended to avoid confusion.
ACTION: Ms Skidmore will request that the terminology and titles used within the report is made clearer for easy interpretation.

6.3 Members of the Committee queried the spend against Winter Resilience Monies. Dr Davies confirmed that funds had so far been utilised for Tier 3 Community Beds and Ambulance Handover Nurses at the Royal Shrewsbury Hospital (RSH). She noted that Telford & Wrekin CCG are likely to replicate the Handover Nurse arrangements at the Princess Royal Hospital (PRH). Dr Davies further added that any fines incurred due to ambulance handover delays will need to be funded from the Winter Resilience Monies as there is no other budget available. She confirmed that all schemes requiring funding from the Resilience Monies have received approval from the System A&E Delivery Board (SAED), or its predecessor, System Resilience Group (SRG). Dr Sokolov queried what contingencies are in place for when the system needs to access funding to respond to winter pressures, Dr Davies advised that the SAED will need to agree joint priority areas and business plans will need to be developed to claim any of the funding.

6.4 Mrs Skidmore highlighted that mitigations are still required against a number of risks and assurance of this is needed by NHSE by Month 3.

6.5 Mr Timmis queried if progress has been made against some of the long-standing entries on the Aged Debtors list. Mrs Skidmore confirmed that progress is being made with the LA and is being closely monitored. In relation to the debt associated with Falls Prevention, a meeting is being held between Mrs Skidmore, Mr Michael Whitworth and Mrs Ilse Newsome, to agree a way forward.

6.6 Mr Timmis queried the greater than planned use of cash and the rise in the level of debtors over the same month. Mrs Skidmore said there had not been a problem with paying outstanding invoices but she agreed to investigate the reasons for the figures this month. Her view was that the cash forecast was probably not as accurate as she would have wished.

ACTION: Mrs Skidmore to review the cash forecast and level of debtors as part of next month’s report to the Committee.

FPC-2017-06.060 – Contract Report

7.1 Mr Whitworth presented the Major Contracts Report for Month 1 – April 2017. He highlighted that the number of Bank Holidays in April may have skewed some of the activity figures.

7.2 Mr Whitworth confirmed that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust (RJAH) have now signed up to QIPP after a long process. On the other hand, Mr Whitworth advised that it is likely the CCG will see limited delivery against joint QIPP schemes by SaTH. He advised that some benefit will be seen from the Outpatients Follow-Ups scheme however this is due to the introduction of a national tariff, the Blueted Gainshare arrangement has been ongoing for some time and is yet to be resolved and no joint working is in place for the delivery of the Non Elective scheme. The CCG has been unable to transact contractual QIPP with SaTH. Mr Whitworth highlighted that from next year, the CCG needs to achieve early sign-up from the Trusts to deliver specified schemes rather than agreeing schemes retrospectively.
7.3 Mr Whitworth advised that with regard to the number of Cancer 104 Day Breaches, it has become clear that NHSE are counting those patients who are confirmed to not have cancer after investigation within the figures. Dr Davies commented that she has met with the CCG’s Director of Nursing, Ms Barbara Beal regarding this and expressed her disappointment that the CCG has agreed to review cases as she felt that SaTH should complete this internally. An analysis of Cancer 104 Day Breaches is to be reported to the Governing Body Meeting in July.

7.4 Dr Sokolov queried if any progress has been made with Shropshire and South Staffordshire NHS Foundation Trust (SSSFT) with regard to the provision of Primary Care Liaison Workers. It had previously been agreed in March 2017 that SSSFT would reinstate the Liaison Workers on a cluster basis and assurance had been given to the CCG that this would be in place within weeks of being agreed however this has yet to happen. Mr Whitworth agreed to chase this with SSSFT.

**ACTION:** Mr Whitworth will seek an update from SSSFT with regard to the reinstatement of Primary Care Liaison Workers on a cluster basis and highlight concerns around the delay experienced to date.

7.5 Mr Whitworth confirmed that he attended the SSSFT Service Performance Forum on 23rd June where he raised the significant activity variance against the contract. This is of particular concern as the contractual arrangements prevent the CCG being able to claw back the full amount of funds associated with the underactivity.

**FPC-2017-06.061 – Performance Report**

8.1 Dr Davies presented the Performance Report for Month 1 – April 2017. She highlighted the impact of the high number of Bank Holidays in the month of April on activity levels.

8.2 Dr Davies advised that the report is very focused on ambulance performance following a number of issues. She confirmed that a Handover Plan is almost complete and will be signed up to by both SaTH and West Midlands Ambulance Service (WMAS) following which, the CCG will be able to hold both organisations to account should there be further performance problems.

8.3 Dr Davies confirmed that Cancer and RTT Delivery has greatly improved. She confirmed that a monthly performance teleconference has been established with both Shropshire and Telford and Wrekin CCGs, SaTH, NHSE and NHSI to monitor RTT which is improving however there continues to be a number of issues with fragile services.

8.4 Dr Davies confirmed that there has been no significant improvement in A&E performance and there is currently no plan in place to achieve the 90% target despite significant system-wide effort and the implementation of a number of processes. She highlighted that these performance issues demonstrate the need for Future Fit.

8.5 It was confirmed that Telford & Wrekin CCG have expressed their support to implement a Handover Nurse at PRH similar to that which has been agreed for RSH. Dr Davies commented that this will ensure consistency across the County, particularly for the 26% of Shropshire patients who attend PRH.

**FPC-2017-06.062 – Governing Body Assurance Framework**
9.1 The Committee agreed that the Finance elements of the GBAF require refreshing due to the number of recent changes and developments. An amended GBAF will be presented to the next Committee Meeting.

**ACTION:** Mrs Skidmore will refresh and update the GBAF for presentation to the Committee in July.

9.2 Dr Davies suggested that the risk within the GBAF regarding A&E delivery should be broken down into subsections as the overall risk is unlikely to improve soon however some elements of performance may improve. Mrs Skidmore suggested that this could be done for Committee discussion but the overall GBAF document should maintain the single risk regarding A&E delivery.

**FPC-2017-06.063 - Any Other Business**

10.1 No further business was raised.

**Date of Next Meeting**

**Wednesday 26th July 2017, 10.30am, Room G1, William Farr House**

Signed……………………………………………………………………………………………………………………………………
Shropshire Clinical Commissioning Group

MINUTES OF THE PRIMARY CARE COMMISSIONING COMMITTEE (PCCC)
HELD IN ROOM SEMINAR ROOM 5, SHROPSHIRE EDUCATION & CONFERENCE CENTRE
(SECC) AT 9.00 AM ON WEDNESDAY 14 JUNE 2017

Present

Mr Keith Timmis Lay Member, Governance & Performance (Chair)
Dr Geoff Davies GP Member
Mrs Claire Skidmore Chief Finance Officer
Ms June Telford Interim Primary Care Manager
Mrs Nicky Wilde Director of Primary Care
Dr Ed Rysdale Secondary Care Consultant
Mrs Sam Tilley Director of Corporate Affairs (For item PCCC-2017-06.005)
Ms Rebecca Woods Head of Primary Care for Shropshire & Staffordshire, NHS England
Ms Janet Gittins Locality Manager (North)

In Attendance

Councillor Lee Chapman Portfolio for Health, Adult & Social Care, Shropshire Council
Mrs Jane Randall-Smith Chief Officer, Healthwatch Shropshire
Mr Phil Morgan PMO for GPFV, NHS England
Mrs Sarah Smith Personal Assistant, Minute Taker

Apologies

Mr William Hutton Lay Member
Dr Finola Lynch Clinical Director, Communications and Engagement/Quality
Mr Julian Birch Shropshire Patient Group Representative
Dr Julian Povey CCG Chair & GP Member
Dr Simon Freeman Accountable Officer
Mrs Amanda Alamanos Primary Care Lead for Shropshire & Telford, NHS England

PCCC-2017-06.001 (Agenda Item 1) - Apologies

Apologies were received from Mr William Hutton, Dr Finola Lynch, Mr Julian Birch, Dr Julian Povey and Dr Simon Freeman.

PCCC-2017-06.002 (Agenda Item 2) - Members’ Declaration of Interests

There were no declarations of interests.

PCCC-2017-06.003 (Agenda Item 3) – Minutes/Actions of Previous Meeting and Action Log held on 5 April 2017

The minutes of the last meeting held on 5 April 2017 were agreed to be a true and accurate record.

Action Log from 5 April 2017 – All completed or on as Agenda Item with the exception of:

ACTION 17/06/01 – GPAF – It was noted that information on the GPAF would be reported at the August public PCCC meeting.

ACTION 17/06/02 – Shropdoc monitoring paper - Members noted this paper would go to the August public PCCC meeting.
**ACTION 17/08/01 – Meeting with Steve Bradder and Locality Managers to discuss support available to Practices** – Ms Telford advised now that all the Locality Managers had been appointed she would liaise with Steve Bradder to arrange a meeting for Steve Bradder and the Locality Managers to discuss support available to Practices.

**ACTION:** Ms Telford to liaise with Steve Bradder to arrange a meeting for Steve Bradder and Locality Managers to discuss support available to Practices.

**ACTION 17/10/01 – GP Resilience Funding** – Ms Telford reported work was ongoing with funding transfer issues and the Practices and NHSE were involved in this work. Ms Telford noted the 2016/17 spend had now been agreed and a process was being looked at for the 2017/18 spend. Dr Davies raised concerns over how the funding was being dispersed and spent, commenting he was disappointed with the process. Dr Davies asked for further detail on how funds were being spent for 2016/17 and also going forward for any similar funding.

Discussion was held around the recipients of the resilience funding and what projects it had been allocated for. Mrs Wilde reported there was a tracker process for the resilience funding which NHS England held and advised CCGs had originally been asked to submit information for individual Practices. Mrs Wilde advised that funding would have been passed through to individual Practices on the basis that funding would be used as locality funding and confirmation should have been received from Practices that they had received funding on behalf of the CCG. Mrs Wilde noted that the CCGs would then work on a plan to how the funding would be allocated and used also noting there was a regional workshop of learning exercises being arranged on the back of responses received into NHS England.

Mrs Wilde highlighted that she was aware that some discussions had taken place at the North Locality Meeting with regard to resilience funding, however these discussions needed to move forward rapidly in order for the process to run smooth for the resilience funding and how the money would be spent. The date of submission for the next round of funding was 23 June 2017 and members acknowledged accountability lay with the CCG to monitor and track the progress of the resilience funding with NHS England.

It was agreed that an update on the 2016/17 funding, detailing when and how the money was spent and the recipients of the funding would come back to the August public PCCC meeting. Also a report clarifying the process for the 2017/18 spend. Mrs Wilde advised this work needed to be escalated and done urgently, as the deadline for next year’s funding bid was 23 June 2017. Mr Morgan commented he had been tasked with tracking the impact and outcomes of the 2016/17 monies and confirmed the deadline for expression of interests from CCGs was 23 June 2017 and advised panels would be set up with NHS England which would look at what funding would be allocated and highlighted CCGs would receive confirmation of this shortly.

Members also acknowledged concerns regarding the bidding and funding process through NHS England and it was noted that the way funding was allocated from NHS England was not always suitable. It was suggested that perhaps a better option would be to allocate monies through the STP Footprint and not through a substantively bigger one, however, members also noted the national position.

**ACTION:** Ms Telford to provide an update to the August PCCC meeting with regard to 2016/17 funding and also clarification of the process for 2017/18 spend.

**ACTION 17/11/01 – Quality Dashboard** - Mr Timmis advised he would be looking at the operation of the PCCC meeting with Mrs Wilde along with the work and links with the Primary Care Working Group (PCWG). A work plan for the PCCC would be brought back to the PCCC in the next 2 months along with proposals for PCCC workshop sessions.

**ACTION:** Mr Timmis and Mrs Wilde to liaise with regard to producing a work plan for the PCCC meeting. This would be brought back to the PCCC meeting in the next two months.
ACTION 17/13/01 – Update of PCWG work – Ms Telford advised the main update from the PCWG was regarding the GP Forward View which would be discussed later in the agenda.

ACTION 17/14/01 – Comparison report detailing Shropshire CQC ratings – It was noted that Ms Woods would provide a comparison report showing Shropshire CQC ratings against those of other areas. It was agreed Ms Telford would liaise with Ms Woods to get an update on the comparison report.

ACTION: Ms Telford to liaise with Ms Woods to provide a comparison report showing Shropshire CQC ratings against those of other areas.

PCCC-2017-06.004 (Agenda Item 4) - Matters Arising

GP Access and Shropdoc

Dr Davies highlighted GP access and Shropdoc raising concerns about the support for the Shropdoc service. Members noted the Care Quality Commission (CQC) had rated Shropdoc as an outstanding service and Dr Davies and Mrs Randall-Smith commented that Shropdoc should be fully supported as it was an extremely valuable service.

Primary Care Needs Assessment

Mrs Randall-Smith asked about the Primary Care Needs Assessment and Ms Telford advised the assessment was in the process of being completed and the deadline for this was the end of this month. Mrs Wilde gave assurance this work was ongoing and advised that Mrs Jenny Stevenson was currently progressing this work. Members noted the assessment would be taken to the next PCWG meeting in July and would then come back to the PCCC in August.

PCCC-2017-06.005 (Agenda Item 5) – PCCC Terms of Reference

Mr Timmis advised the PCCC Terms of Reference were taken to the March PCCC meeting and discussions had taken place since this time with Ms Woods, Mrs Sam Tilley and previously Mrs Anne Dray. Dr Julian Povey and Dr Simon Freeman had also had input into the Terms of Reference and Mr Timmis reported the PCCC was 6 months behind on approving the Terms of Reference asking members for their comments on the revised Terms of Reference.

Discussion was held about point 14 on page 5 and it was noted that LES was included in this section. Mrs Wilde raised membership of the PCCC and how conflicts of interest could be managed. Mrs Wilde proposed adding to the Terms of Reference that an external GP sit on the Committee (with no voting rights). She added that having an out of County GP sit on the Committee would add value and there would be no declarations of interests involved. Mr Timmis reported that when Internal Audit had reviewed the PCCC and its Terms of Reference last year it was not clear on how the PCWG linked with the PCCC. Mr Timmis advised the links with the PCCC and PCWG needed to be clearer and the PCCC needed to ensure that regular updates from the PCWG were submitted to the PCCC. Mr Timmis proposed a PCWG update should be put on the PCCC agenda as a standing item at every meeting and noted it would be valuable for the PCCC to be involved and cited on the broader discussions with what is happening within Primary Care, which would also be closely linked to the PCCC work plan.

Mr Timmis referred to page 8 of the Terms of Reference, under number 28. It was noted that last line under this paragraph should read “paragraph 25 above”. Mrs Randall-Smith asked if Health Watch could be amended to read “Shropshire Healthwatch” within the document and Mrs Wilde also reported the Director of Quality title would be amended to read “Director of Nursing, Quality and Safety and Patient Experience”.

Further discussion was held with regard to suitability of the Terms of Reference for Part 2 of the PCCC meeting. Mrs Sam Tilley attended for this item and advised in order for the Terms of
Reference to be consistent with other Committee’s the content of the Terms of Reference was satisfactory and advised with regard to the confidential section part of the meeting it was assumed that those in attendance would not be required to participate in the Part 2 Confidential discussions. Mrs Randall-Smith noted that previously she had been involved in Part 2 discussions and advised there had been some valuable contributions made when all attendees were present at these discussions. Members agreed it would be useful to have views and feedback from attendees and noted there needed to be another engagement mechanism of feeding back thoughts and views into the PCCC on subjects discussed in the confidential Part 2 session. It was important to ensure there were clear links in terms of enabling attendees to relay information, and it was noted that items that were on the agenda of the part 2 session should be also be discussed at an appropriate time in public part 1 session of the PCCC in order to gain feedback from others.

Ms Woods raised concerns over membership and voting rights in the PCCC Terms of Reference and highlighted it was important that it was strategically aligned. Mrs Wilde reported that the PCCC membership included 3 Directors from the CCG and this would be sufficient in terms of feedback and alignment.

It was agreed that subject to the amendments discussed today the Terms of Reference would be agreed and updated accordingly. The Terms of Reference would be taken to the July Board Meeting for approval and the PCCC would be updated accordingly.

**ACTION:** Members agreed that a PCWG Update should remain on the PCCC Agenda as a Standing Item.

**ACTION:** Mrs Wilde to progress work with the PCCC Terms of Reference, make amendments as noted. The Terms of Reference would be submitted to the Board Meeting for approval in July.

**PCCC-2017-06.006 (Agenda Item 6) – GP Forward View**

Ms Telford and Mr Morgan presented the GP Forward View item and the following key areas, risks and concerns were highlighted:

Members noted the GPFV Milestones and Actions and Implementation Plan and also included with the papers was a draft service specification to deliver GP Forward View. Mr Morgan reported he was employed by North Commissioning Support Unit who had been commissioned to provide PMO processes and support for GPFV. Mr Morgan noted there were 2 PMO supports for Shropshire and Staffordshire and they were working closely with Ms Woods on the STP Footprint and also working with CCGs to help deliver GPFV, reporting on the CCG’s behalf.

Mr Morgan advised there were 5 national workstreams and detail would need to be inputted into the GPFV milestones and actions work plan in order to meet national and regional targets and was very much a working document. Mr Morgan said it was about ensuring indicative milestones work as much as possible with the STP footprint and some discussion was held around the Estates Transformation Technology Fund (ETTF).

Discussion was held around how this work was monitored and members acknowledged work was monitored through the STP footprint and as a CCG. Mr Morgan advised a checkpoint meeting was held monthly which included Mrs Wilde and Ms Telford with an aim of working through the milestones. There was also a North Midlands Board Meeting (known as the umbrella group) every month. The last umbrella group meeting was held yesterday and Mrs Wilde advised she had dialled into this meeting which had discussed the challenges of rolling out the GPFV. Monitoring of the milestones were done at this high level meeting. Mr Timmis asked about flexibility within the responses on the milestones for example with resilience as part of GPFV. It was noted that a certain level of detail was required by NHS England, however Mr Morgan advised this document was very much a working document.
Ms Woods reported there was a huge amount of funding which had been allocated for GPFV and she provided members with detail on the process of GPFV with regard to governance and meetings around the funding. Discussion was held on which meetings the CCG data returns were fed into and how this work aligned with the regional meetings and PMO leads. Mrs Wilde asked for an update on what stage the CCG was at with regard to the 60 milestones in the document. It was noted that Mrs Wilde’s name was against most of the milestones which she advised she would be reviewing and delegating certain areas out for action. Mrs Wilde reported her main concern was getting the correct funding out to GP Practices in a timely manner. Mr Morgan reiterated that it was the CCG’s responsibility to get information back to the checkpoint meetings and region and Mr Morgan said he encouraged CCGs to look at workstreams and milestones under new model of care and not individually. Although GPFV would need to fit into the wider regional footprint, the CCG GPFV was about local work.

Dr Davies highlighted that there was a disconnect with GPFV, what was happening on the ground and what was happening regionally. The funding allocated was very small and advised that GMS funding needed to be looked at. Ms Woods acknowledged the issues raised and the different positions around the Country with GMS funding and apologise if any assumptions had been made about Shropshire in general with regard to funding. Ms Woods noted discussions needed to take place to work through what is best for Shropshire advising it was noted recently at the regional meeting of the immense challenge facing the Country in relation to workforce and the scale of the challenge for the Country. Shropshire perhaps had not been affected as much as some other areas but was still facing a huge challenge. Dr Davies commented that GPs were currently leaving the profession and this needed to be dealt with. Ms Woods noted that currently there was research looking at the reasons why GPs did not want to remain in the profession or join the profession. Dr Davies advised GPs were not willing to take on the new terms and conditions.

Further discussion was held on workforce planning and Ms Woods noted the planning process had been lost within the system and part of this work was to understand the scale of the gap. Members acknowledged GPFV was here to stay presently and could not foresee any imminent changes.

Mr Timmis advised the term in the milestones document ‘left shift’ was not a preferred phrase and asked if this phrase could be changed to something more meaningful such as new models of working. Mrs Randall-Smith asked if the wording in the milestones paper stating PPG completed could be changed to reflect the correct terminology (Patient Participation Group). Mr Morgan agreed that Patient and Public Participation was a key part of all discussions and advised this had been acknowledged at yesterday’s umbrella meeting that patient and public involvement can help inform the GPFV.

Dr Davies raised the draft service specification and discussion was held around extended access and figures. Members acknowledged the figures relating to GPFV and new funding (£10,684 per practice) was an average figure. Dr Davies commented he was disappointed with Locally Commissioned Services and the lack of funding for this which gave no expansion. Ms Telford noted there were proposals to increase funding and the proposals would go through the appropriate channels to be approved. Mrs Skidmore requested she was kept up to date with regard to this work as this would have an effect on other budgets. Dr Davies further reported that there could be potential action from GPs to stop providing some services which would mean this work could result in going back into secondary care and the hospitals. Dr Davies advised GPs were not being allocated enough money to provide these services and it would be more expensive for the CCG to pay for the services to be provided in secondary care rather than in primary care.

Ms Wood advised there was some PMS monies available and re-investment funding, however discussions were on-going with regard to allocations and where this money would be re-invested. Mrs Wilde advised she had had her first meeting last week with the finance team to look at what was currently available within the Primary Care budget and proposed that a more detailed report on finance and budgets come back to the next PCCC meeting. Mrs Wilde agreed to liaise with Mrs Skidmore to produce a more detailed report for the next meeting.
Mr Timmis advised the GPFV would remain on the PCCC agenda as a standing item in order to move this work forward. Mrs Wilde raised concerns about timescales and asked if it was possible to gain delegated authority for approval on GPFV work and service specification. The Committee agreed Mrs Wilde could expedite this work as necessary whilst maintaining updates with Committee members.

**ACTION:** Mrs Wilde to liaise with Mrs Skidmore to produce a detailed report on finance, budgets and the primary care budget for the next PCCC Meeting.

**ACTION:** GP Forward View to remain on the PCCC Agenda as a standing item.

### PCCC-2017-06.007 (Agenda Item 7) – Local Commissioned Services Review Update/TOR

Ms Telford presented this item for information and the following key areas were highlighted:

Ms Telford advised this paper was for information and staff were currently working on services at present noting there had been a group meeting today to discuss any additional funding that was needed to progress these services in particular phlebotomy and minor injuries. Ms Telford noted that Phlebotomy and minor injuries were being prioritised and others also being worked on in order to get them approved by the end of the month.

Mr Timmis asked about activity and data around minor injuries in order to inform the outcomes for patients. Ms Telford an audit had been done and Practices had provided the CCG. Members noted activity and data was important to inform the CCG on what the spending was, what the activity levels were and the outcomes for patients in order to provide value for money. Dr Davies noted that not all data was accurate due to it being recorded differently, however Mr Timmis advised the CCG needed to have an indication of what the activity levels were and where the money had been spent. Mrs Randall-Smith agrees with Dr Davies advising there were possible inconsistencies across the county. Ms Telford advised the CCG did have to make some assumptions on the data provided to use this as basis to inform the CCG on what the possible outcomes were.

Ms Telford advised there were lots of services that needed further work and needed to be commissioned but at present they were looking at the services the budget would cover. Ms Telford said a plan was needed on what services were to be looked at next and also budgets would need to be looked at. Ms Telford advised the phlebotomy service and the minor injuries service would be taken to the Executive Team meeting for views and then for formal Committee approval.

Mrs Wilde recommended the CCG review all enhanced services as a whole with minor injuries and phlebotomy as key services and not review each enhanced service one by one. Mrs Skidmore highlighted she would like to see the whole picture and a proposal for all rather than on an individual basis to aid budget work. It was noted that the enhanced service such as anti-coagulation would need some clinical changes within the service specification, however, Ms Telford confirmed that all enhanced services would be reviewed as a whole with minor injuries and phlebotomy being a priority.

### PCCC-2017-06.008 (Agenda Item 8) – Violent Patients Scheme

Ms Telford updated members on the Violent Patients Scheme and the following points were highlighted:

Ms Telford confirmed she had approached several providers with regarding to providing a violent patients scheme but providers were reluctant. Members noted that Shropdoc were willing to provide a service and Ms Telford advised they were currently negotiating activity levels. Shropdoc had raised concerns with the number of patients being referred across the patch. Ms Telford information had been collected from Practices with regard to the number of patients per year and it was noted this figure was 30 per year which seemed extremely low.

Discussion was held with regard to drafting a service specification and going out for procurement and Ms Telford highlighted it was proving difficult to secure a provider for this service when she had
done soft market testing. Members noted there had never been any provision for this in Shropshire previously and this was a new cost for the CCG. Ms Telford advised she had spoken with Mr Roger Eades from the finance team about the potential costs of this service but highlighted this services was something the CCG would have to commission. Ms Telford noted she was meeting with Shropdoc this afternoon to discuss this service, however from initial discussions, Shropdoc was the only provider willing to do this.

Mrs Wilde asked about the service specification and proposed the service specification was signed off first and then work towards finding a provider and putting this service out to tender. It was agreed Ms Telford would update and provide a service specification for the Violent Patients Scheme for the next meeting and also include information of potential providers who the CCG could procure with.

**ACTION:** Ms Telford to amend and provide a draft service specification for the violent patient scheme and bring this back to the next PCCC meeting.

**PCCC-2017-06.009 (Agenda Item 9) – Finance Update**

Mrs Skidmore advised that further to all discussions around finance held in this meeting, a detailed finance report would be brought back to the next meeting. Mrs Skidmore advised she had been in post now for two weeks and so this would allow more time to provide more concrete figures. Mrs Skidmore advised she would also attend the meeting with Roger Eades and Mrs Wilde to look at figures and the primary care budget. Mrs Skidmore touched on the £1 million from last year and said she was aware of the issues and would be looking at budgets and PMS monies including all sources of funding including bids. Mrs Skidmore advised that work and budgets needed to monitored and aligned with all work and Directorates. Members agreed.

In relation to finance information contained with the PCCC minutes, Dr Davies asked when the PCCC minutes would be published as they were currently not on the CCG Website. Mr Timmis noted the PCCC minutes, once approved at the meeting would be published on the website and therefore minutes approved today from the 5th April would now be published on the CCG Website.

**ACTION:** Mrs Skidmore to bring a detailed finance update back to the next PCCC meeting.

**PCCC-2017-06.010 (Agenda Item 10) – Improvement Grant Process**

Ms Telford presented the Improvement Grant Process report and the following key issues were noted:

Ms Telford informed members there was currently no additional money for improvement grants and Mrs Skidmore noted the report came across as more of an application form rather than a process. Members agreed the process should be made clear and transparent and it was agreed the form needed further work.

Discussion was held on the improvement grant process and members noted the improvement grants were subject to certain criteria and it was not an automatic right that an improvement grant would be given. Members noted that CCG priorities should be looked at, models in primary care and other current projects. Ms Woods added there needed to be clear criteria for prioritisation and for it to be explicit ensuring links were made with estates.

Members went on to discuss funding for this and agreed the process needed to made clearer with regard to the amount of funding available and also the process if funding became available. Mr Timmis highlighted meeting the criteria in order to gain funding for this work would obviously need to benefit patients and this would need to be clear in the document as well as the extension criteria which needed altering to include the aim was to provide smarter buildings not necessarily always bigger buildings. Mrs Skidmore also highlighted the potential cost pressures associated with new builds.
Mrs Wilde asked if the document had adapted due to it having the NHS England logo on the document. Ms Telford confirmed the document had been revised and adapted to meet the CCG needs and it was agreed the NHS England logo be removed.

After considerable discussion it was agreed this document needed further work following suggestions noted and Ms Telford would update the document and bring it back to the next PCCC meeting.

**ACTION:** Ms Telford to update the Improvement Grant document with suggested amendments and bring this back to the next PCCC meeting.

**PCCC-2017-06.011 (Agenda Item 11) – Any Other Business**

Dr Davies advised that this meeting would possibly be his last as he was leaving the CCG and taking a 3 month sabbatical. Mr Timmis thanked Dr Davies for all his hard work and noted his views had been extremely valued. Dr Davies thanked colleagues for their kind wishes.

*Rural Health Conference – Midlands and East - 19th July 2017*

Mrs Randall-Smith advised she had registered on this and the Rural Health Conference due to be held on 19th July 2017. Mrs Randall-Smith noted she would be doing presentation on what it is like being a rural GP and asked for any feedback, comments or views to include in her presentation. It was agreed Mrs Gittins would ask GP members for their feedback on any Shropshire issues, rural challenges and possible solutions through the Locality Managers and the Locality Meetings. Feedback would be requested to be sent back to Mrs Randall-Smith direct.

**ACTION:** Mrs Gittins to ask GP Members on behalf of Mrs Randall-Smith for Feedback on Shropshire issues, rural challenges and possible solutions through Locality Managers and Locality Meetings. Feedback to be sent back to Mrs Randall-Smith direct.

**Questions from the Public**

Mr Timmis thanked Councillor Madge Shineton for her attendance at the PCCC meeting and who was attending this meeting as a member of the public and Councillor. Mr Timmis asked Councillor Shineton for any comments she may have. Councillor Shineton advised she was attending the PCCC to keep up to date with links and was interested in General Practice in particular, interested to see the difference between Brown Clee and Cleobury Mortimer with a view to looking at these two Practices to try and find a way forward. Councillor Shineton said it was about seeing what could be done and she would be feeding back information gained from this meeting into the Health & Adult Social Care Committee at Shropshire Council. Councillor Shineton stressed the importance of links with other organisations and advised that Primary Care Services and the Acute Sector could not be done on its own or in silence.

Councillor Shineton raised the GP appointment system and advised she had severe reservations around rigidity of this system and noted she had previously raised concerns at the last meeting with regard to blood tests for patients. Councillor Shineton gave the example of a patient being examined and having to come back the following day for further tests noting this was not always easy for all patients in rural areas due to the infrequent public transport. Councillor Shineton reported she was looking for linkages as to how it could be better and confirmed she had enormous sympathy for GPs, and with hearing about the bureaucratic systems noted from the meeting this morning, Councillor Shineton asked if any of the administrators could simplify the processes, this would be a great benefit to GPs and ultimately a benefit to patients. Councillor Shineton noted the bureaucracy around strands of work were mind bogglingly stupid and this prevented rather than facilitated work. Councillor Shineton thanked Mr Timmis for allowing her to give feedback to the Committee and left the meeting.
Date of Next Meeting

The next meeting is due to be held on Wednesday 2 August 2017, 9.00 am, in Meeting Room K2, William Farr House, Mytton Oak Road, Shrewsbury SY3 8XL.
MINUTES OF SHROPSHIRE CLINICAL COMMISSIONING GROUP (CCG)  
CLINICAL COMMISSIONING COMMITTEE (CCC) MEETING HELD IN  
K2, WILLIAM FARR HOUSE  
9.00AM ON WEDNESDAY, 21ST JUNE 2017

Present:
Mr William Hutton Lay Member, Chair of Audit Committee (Chair)  
Dr Jessica Sokolov CCG Vice Clinical Chair, GP Member  
Dr Ed Rysdale Clinical Member  
Dr Julie Davies Director of Performance & Delivery  
Mr Michael Whitworth Interim Director of Contracting & Planning  
Ms Claire Skidmore Chief Finance Officer  
Ms Barbara Beale Interim Director of Nursing

In Attendance:
Miss Rose Howard Minute Taker

1. Apologies
Apologies were received from Dr Simon Freeman, Dr Julian Povey, Prof Rod Thomson, Dr Shailendra Allen, Ms Emma Sandbach and Dr Geoff Davies.

2. Members’ Declarations of Interest
Mr Hutton requested that attendees declare any potential conflicts of interest regarding the Committee agenda. No declarations were made.

3. Minutes of Previous Meeting & Matters Arising

3.1 CCC Meeting Minutes
The minutes of the previous meeting which took place on 17th May 2017, were agreed to be an accurate record.

3.2 Matters Arising
No further items other than those on the agenda were raised. The CCC Action Tracker has been updated with progress against actions.

3.3 MSK & SOOS Update
Mr Whitworth confirmed that a helpful meeting had been held with Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust (RJAH) which had been attended by clinicians from both RJAH and Shropshire CCG. Mr Whitworth noted that there were some concerns in relation to timeliness of progress with SOOS however RJAH have committed to the recruitment of a dedicated Consultant to lead the SOOS which was extremely positive. Mr Whitworth confirmed that an intermediate tier for referrals would be introduced which would stream all referrals through the Referral Assessment Service (RAS) and prevent direct referrals by GPs.

Dr Shepherd queried if work was being done around community physiotherapy and other community services, Mr Whitworth confirmed that options are being developed which will ensure consistency across the county and resolve capacity issues. Mr Whitworth noted that there are
currently issues with underperformance against their contract by Shropshire Community Health NHS Trust who currently provide community physiotherapy services.

3.4 Outcome of GP Discussion re Peer Review
Mr Whitworth advised that further information regarding this has now been received by the CCG and will be circulated to Committee Members for information. Mr Whitworth noted that RAS will need to be included in the Peer Review process and it may be necessary for GP colleagues to spend some time working with the RAS Team to ensure compliancy.

ACTION 06/17-1: Guidance received by the CCG with regard to Peer Reviews will be circulated to Committee Members for information.

4. 17/75 Governing Body Assurance Framework (GBAF)
Dr J Davies advised that she and Mr Whitworth would be reviewing the GBAF later in the week to update a number of the actions following discussion at the last Committee Meeting. The revised GBAF would be circulated to Committee Members following this and by 26th June.

ACTION 17/75/01: Dr J Davies & Mr Whitworth will review and update the GBAF and circulate to Committee Members by 26th June for information and comment.

5. 17/76 STP Update
Mr Whitworth advised that KPMG are currently reviewing the Future Fit process. He confirmed that NHSE recommended 3 candidates to sit on the Joint Committee and these have now been approved to ensure a non-CCG majority to enable a decision to be made. The final report from KPMG will be received at the end of July 2017.

Optimity are working on the second phase of the Strategic Outline Case for Out of Hospital Transformation. Mr Whitworth commented that this is progressing rapidly with clear outcomes agreed which will highlight areas for focus at a strategic level. A workshop will be held with a number of stakeholders on 28th June 2017 where Optimity will present some initial findings. A confidential report will be submitted to the CCG’s Governing Body in July.

Ms Skidmore confirmed that each workstream within the STP is producing a 90-Day Plan to be submitted week commencing 26th June following which a collated Plan will be presented to the STP Programme Board in July.

6. 17/77 A&E Streaming Update
Dr J Davies presented the paper circulated to Committee Members which included a Draft Service Specification for Front Door Streaming at the Princess Royal Hospital (PRH) in Telford which has been shared by Telford & Wrekin CCG for information. The Committee discussed some concerns regarding the proposed model at PRH due to it not complying with the national model which may prevent it gaining NHS England approval.

Dr Davies commented that the proposed model in Telford & Wrekin could not be duplicated in Shropshire due to the geography which prevents patients being safely referred to Primary Care.

Dr Sokolov & Dr Rysdale said there were significant issues with the service specification as it is currently written. It was suggested that the PRH model should be subject to clinical review due to concerns with some of the proposed streams.
Ms Skidmore queried the detail around arrangements for the use of Emergency Department premises outlined in the draft specification. She commented that it was unrealistic to expect that no cost will be incurred by the CCG for the use of SaTH premises and this would need to be covered within formal contract arrangements.

It was agreed that Dr J Davies, Dr Sokolov and Dr Rysdale will compose feedback to Telford & Wrekin CCG outlining concerns with the proposed streaming model at PRH.

**ACTION 17/77/01:** Dr J Davies, Dr Sokolov and Dr Rysdale will liaise to agree and submit feedback to Telford & Wrekin CCG outlining concerns with the proposed model at the Princess Royal Hospital (PRH).

The Committee queried the activity figures outlined in the briefing paper presented as it was felt that 153.30 patients per day was fairly low considering a high proportion of these would be of low complexity.

The Committee confirmed its support for the proposed Band 6 Nurse however it was noted that further work is needed to mitigate the cost pressure to the CCG. Dr J Davies and Ms Skidmore will liaise to work through the financial implications of the proposal.

**ACTION 17/77/02:** Dr J Davies and Ms Skidmore will review the financial implications of the A&E Streaming Nurses.

It was agreed that a revised paper will be presented to the Committee for approval in August.

**ACTION 17/77/03:** A revised proposal regarding Primary Care Streaming in A&E will be presented to the Committee in August 2017.

Mr Hutton highlighted concerns regarding the differing approaches between Shropshire and Telford and Wrekin, particularly in view of STP and in regard to having the same provider for both CCGs. It was noted that the differing approaches could lead to inequality and inconsistency for patients and should be avoided wherever possible.

7. **17/78 Faecal Calprotectin Testing in Primary Care**

Dr Davies presented the report circulated to Members. It was noted that patients in Telford & Wrekin have had access to Faecal Calprotectin Testing for some time and the introduction of this test in Shropshire reduces the number of other diagnostic tests required, improving patient experience and outcomes and utilising clinical resources appropriately. Dr Davies advised that activity levels will be monitored as there is a small risk of increased referrals due to the availability of a new test however this has not been experienced in other areas. She advised that this is anticipated to be a cost saving rather than a cost pressure and will also help relieve some of the current capacity pressures in Endoscopy at SaTH.

Ms Skidmore queried how the funding arrangements will be made as a contract variation will be required to remove activity in SaTH. Dr Davies suggested that a discussion will need to be held with both Finance and Operational colleagues at SaTH to negotiate this as there will be benefits to SaTH in reducing internal pressures.
ACTION 17/78/01: A discussion will be held with colleagues at SaTH to negotiate a contract variation relating to reduced activity following the introduction of Faecal Calprotectin Testing.

Dr Shepherd highlighted that there will need to be communication with the GPs regarding the advice for using the new test. Dr Davies confirmed that Ms Bethan Emberton will liaise with the Localities to disseminate information about the test.

ACTION 17/78/02: Communication will be circulated to GPs giving advice for using Faecal Calprotectin Testing.

DECISION 17/78/01: The Committee supported the implementation of Faecal Calprotectin Testing in Primary Care.

8. 17/79 Cancer Report

*Mr David Whiting, Programme Lead for Cancer & Long Term Conditions, attended for this item.*

Mr Whiting presented his paper which is in response to a letter received by the CCG from NHSE and NHSI requesting assurance of support to the Regional Cancer Recovery Plan.

Mr Whiting highlighted that a Regional Cancer Recovery Plan has not yet been completed for the local region however Shropshire CCG already meets the requirements outlined in the letter received and will begin receiving additional information in cancer reporting from providers.

Dr J Davies highlighted a risk around receiving appropriate information from SaTH through CQRM following a breach or long wait to give assurance to the Governing Body that lessons are being learned and actions being taken. This is being picked up through CQRM Meetings currently.

A further risk has been identified due to the CCG’s performance being negatively impacted by Out of Area providers. It is unclear what further action can be taken by the CCG to reduce this risk as colleagues from the Contracting Team are attending meetings and engaging with Providers but no improvement has yet been made. Advice has been sought from NHSE however no further suggestions for resolving these issues have been received.

Dr Sokolov highlighted that the report does not refer to actions being taken following lessons learned.

Mr Whiting commented that SaTH has done significant work on 62 Day Pathways, he noted that most breaches relate to patient choice or complexity issues and analysis of all breaches is reported to the SaTH Planned Care Working Group on a monthly basis.

Dr Sokolov requested further information and assurance that plans being completed are addressing issues and demonstrating learning from past events. She advised that without having sight of the plans to reduce long-waiters, she cannot be assured that this addresses the issues raised by NHSE and NSHI.

Ms Beale advised that the Director of Nursing at SaTH has confirmed that there have been some internal reporting issues that she is investigating.
DECISION 17/79/01: The Committee agreed that reporting arrangements put in place with regard to long-wait cancer patients will give the required level of assurance when properly implemented.

ACTION 17/70/01: The Committee will receive a further report outlining the plan to address cancer long-waits which will include actions taken following improved reporting and lessons learnt.

9. 17/80 WMQRS Report - Care of People with Stroke and Transient Ischaemic Attack (TIA) Pathway Review
Dr J Davies presented the paper that had been circulated to Members prior to the meeting. She advised that feedback received following the review at PRH was being worked through via CQRM Meetings. A risk had been identified regarding the Care Coordination Centre (CCC) as it was felt that this additional step in the pathway could lead to high-risk patients waiting longer for triage. Dr J Davies advised that a separate review of the CCC has been underway for some time and the Committee will receive a report on this in July which will also now include reference to the specific risk identified by the WMQRS and any action recommended to address.

ACTION 17/80/01: The Committee will receive a report regarding the review of the Care Coordination Centre (CCC) which will include actions taken to address the specific risk identified by WMQRS.

The Committee discussed some concerns around the Stroke Service, particularly around risk-appetite and outcomes for patients, it was agreed that an unannounced visit may be beneficial.

ACTION 17/80/02: Ms Beale will ensure concerns around the Stroke Service are picked up through CQRM.

ACTION 17/80/03: Ms Beale will discuss the options for an unannounced visit by the Quality Team to the SaTH Stroke Service with colleagues in Telford & Wrekin.

ACTION 17/80/04: The paper presented to this Committee will also be taken to Quality Committee.

10. 17/81 Any Other Business
Mr Whitworth tabled the attached paper which had been agreed by the Executive Team the previous day:

Tabled - DMARDS.doc

DECISION 17/81/01: The Committee approved the proposal regarding DMARDS.

No further business was raised.

11. Date of Next Meeting
The next scheduled meeting of the Clinical Commissioning Committee is 19th July 2017, 9.00am in K2, William Farr House.

SIGNED ……………………………………………………………………. DATE ………………………………………
Shropshire Clinical Commissioning Group

MINUTES OF THE QUALITY COMMITTEE (QC)
HELD IN ROOM B, WILLIAM FARR HOUSE SITE
AT 3.00PM ON WEDNESDAY 28 JUNE 2017

Present

Dr Ed Rysdale (Chair) Secondary Care Consultant, SCCG
Mr William Hutton CCG Lay Member
Mrs Barbara Beal Interim Director of Nursing, Quality and Safety and Patient Experience
Dr Julie Davies Director of Performance and Delivery
Dr Finola Lynch Clinical Director, Communications and Engagement/Quality
Mrs Sarah Smith Personal Assistant, Minute Taker

Mrs Sue Aucutt Interim Quality Manager (For Item QC-2017.06.032)
Mr Paul Cooper Head of Adult Safeguarding (For item QC-2017-06.034)
Mr David Coan Children’s Safeguarding (For item QC-2017-06.035)
Mrs Sara Bailey Lead Nurse for Quality (For item QC-2017-06.037)

Apologies

Mrs Helen Bayley
Mrs Jenny Bate
Ms Maria Hadley

QC-2017-06.025 (Agenda Item 1) - Apologies

Apologies were received from Mrs Helen Bayley, Mrs Jenny Bate and Maria Hadley.

QC-2017-06.026 (Agenda Item 2) - Members’ Declaration of Interests

Dr Rysdale welcomed members and attendees to the Quality Committee (QC) Meeting. There were no declarations of interest.

Dr Rysdale informed members that this would be Mrs Beal’s last QC meeting as an Interim Director at the CCG. Dr Rysdale thanked Mrs Beal for all her hard work and wished her well on behalf of the QC and the CCG.

QC-2017-06.027 (Agenda Item 3) – Minutes/Actions from Previous Meeting and Action Log

The minutes of the last meeting held on 24 May 2017 were agreed to be a true and accurate record subject to the following amendments:

Page 9, QC-2017-05.22 (Agenda Item 10) – Provider Exception Report – Under the Shropdoc Section - “Dr Lynch advised it would be beneficial to get a clinical from Shropdoc to attend the Shropdoc CQRM” should read “Dr Lynch advised it would be beneficial to get a clinician from the CCG to attend the Shropdoc CQRM”.

Action Log from 24 May 2017 – All completed or on as Agenda Item with the exception of:

QC-2017-04.008 (Agenda Item 8) – Shropshire Patient Feedback Report – Mrs Beal advised Mrs Blay was currently on sick leave, however, the action reported in the last set of minutes regarding Mrs Blay forwarding patient experience narrative onto Mrs Diamond had been completed. Mrs Beal reported for information purposes that Mrs Blay would transferring to the post of Quality Lead for Primary Care from 1 September 2017.
Mrs Beal reported that Mrs Bailey and Mrs Sue Aucutt had escalated concerns previously raised with regard to a particular surgical termination case. Mrs Beal highlighted this was a long standing issue with the pathway for 13 year olds and terminations and noted she had also raised these concerns with Mrs Chris Morris at Telford & Wrekin CCG.

QC-2017-06.028 (Agenda Item 4) - Matters Arising

Mrs Beal advised that Mrs Dawn Clarke would be commencing her post as Director of Nursing, Quality, Safety and Patient Experience on 3 July and as the current Interim Director Mrs Beal’s last day with the CCG would be 11 July 2017. Mrs Beal advised this QC meeting would be her last before leaving the CCG and proceeded to thank all CCG staff and QC Members for all their hard work and gave them her best wishes to all.

Mrs Beal updated members on the following key matters arising:

**Shrewsbury and Telford Hospitals NHS Trust (SaTH)**

**Neurology, Ophthalmology, Stroke and Radiology**

Mrs Beal advised she had attended the NHSE Quality Surveillance Group (QSG) meeting on 22 June 2017 where the CCG is required to give an update report on their providers. Mrs Beal noted that templates that had previously been presented at the CQRMs were presented at the QSG meeting and NHSE were cited on the issues at SaTH including neurology, ophthalmology, stroke and maternity. Mrs Beal reported there was also soft intelligence to suggest there was a 3 week delay with radiology. Mrs Beal advised she had spoken with Deidre Fowler at SaTH and it had been reported that SaTH were commencing a review of these services and Mrs Beal advised SaTH had noted at the CQRM yesterday, that they were working on a revised trajectory.

Mrs Beal highlighted that following updates from SaTH at the CQRM yesterday, Mrs Brigid Stacey, Director of Nursing at NHSE had requested a phone call to update her on any progress with a possibility that SaTH may need to go into a risk summit. Mrs Beal noted that NHSI and CQC who also attend the QSG meetings were also of the same view.

Mrs Beal advised she had produced and emailed a summary regarding issues for all the Trusts detailing the challenges with each provider and highlighting that SaTH was on enhanced monitoring. Mrs Beal had also verbally updated the CCG Executive Team noting there was a conference call set up to discuss further whether SaTH should go to risk summit. Mrs Beal advised that on the conference call this morning with NHSI and Brigid Stacey, NHSE which also included Chris Morris from Telford & Wrekin CCG, Mrs Bailey and another deputy, services such as maternity, neurology and stroke were reviewed. Mrs Beal said an ongoing review of these issues would take place in August 2017 which Mrs Dawn Clarke would attend. Mrs Beal reported she had also flagged up the 3 week delay in radiology, the boarding of patients and front door issues.

Mrs Beal advised the recommendation was to consider moving to a risk summit meeting and noted the Trust had been cited on this. Mrs Beal noted that subject to outcome this morning, Mrs Chris Morris and Mrs Beal agreed there was sufficient concern and lack of assurance with on all those services at SaTH and that consideration should be given by the CCG and Accountable Officer as to whether these issues should be escalated to a risk review meeting. Mrs Beal highlighted a joint report would be presented and Mrs Beal was taking this to the Exec Team meeting on Monday. Members noted that Mrs Bailey would be working with Telford CCG in order to provide a joint paper for consideration and Mrs Beal noted a letter would be sent to Wendy Saviour, NHSE to ask for her comments on whether a risk review meeting was needed. Mrs Beal advised the timescale for this work was 2 weeks.

Mrs Beal noted she had spoken with the Director of Nursing at NHSE this morning and had advised due processes were being followed. It was noted that Telford & Wrekin CCG had already raised
concerns at their Governing Board meeting where it was concluded that the issues at SaTH should go to a risk review meeting. Shropshire CCG and the Accountable Officer, Dr Simon Freeman, was currently reviewing all the information and going through the appropriate processes.

**Maternity**

Mrs Beal advised they had started a pre-maternity CQRM before the main CQRM highlighting these meetings were well attended and presented Mrs Beal reported SaTH had took presented a report on the Transitional Workforce model for the midwifery Unit which had been embargoed. Mrs Beal advised she supported what they were doing with maternity and advised the CCG would be negligent in their duties not to support their model purely on safety grounds.

Mrs Beal reported a Midwifery Stakeholder Event had taken place where the Transitional Workforce Model was presented. Mrs Beal noted she had taken advice from NHSE with Dr Simon Freeman’s agreement when it was suggested that the proposal be looked at jointly with Telford & Wrekin CCG to produce a paper on whether the CCGs support the model and on what grounds with a recommendation. Mrs Beal noted that a risk assessment was being undertaken and she was currently looking into tools which could be used.

Members noted SaTH proposed to implement the model from 1 July 2017 and the Interim model for 12 weeks. Mrs Beal advised as part of the escalation process 3 maternity units would be closing (Bridgnorth, Oswestry, and Ludlow) with Telford and Shrewsbury remaining open. NHSE have advised that the Trust have the absolute right to make decision on grounds of safety reasons and Mrs Beal said the consensus was that it is health economy process. Dr Rysdale reiterated the work and process should be done by SaTH but with CCG support.

Mrs Beal advised an exception report for the Executive Team on how to move forward was needed and how to progress work with a risk review meeting and the maternity work. Mrs Beal highlighted the importance of communications in this work and noted she had met with the Head of Communications at the CCG to agree a way forward with communications. It had been agreed that a meeting be set up with SaTH communications lead, Telford & Wrekin CCG communications lead, SCCG lead and also with the Directors of Nursing from each of the organisations in order to establish what we need as a central communications plan. Mrs Beal advised the draft communication plan would then be taken to the Executive Team to be approved. Mrs Beal went on to highlight the importance of updating and communicating with NHSE to keep them in the loop advising NHSI were also cited on this work and Mrs Beal would be updating the Executive Team on Monday with a view to moving towards a risk review. Members noted that the review meeting was not requested by Shropshire CCG. Mrs Beal informed members the CQC would be reporting on SaTH the week commencing 10 July 2017 and this had been deferred. Members also acknowledged that NHSI were doing a quality review deep dive on SaTH.

Discussion was held with regard to the stakeholder meeting yesterday which Mrs Beal had reported SaTH had presented on an internal review on how the Trust would manage maternity services over the next 10 years. Feedback sessions were held and Mrs Beal has updated the Executive Team and Dr Freeman from the feedback sessions however, Mrs Beal pointed out that although gaps were identified the totality was not presented and noted SaTH were experiencing recruitment issues which had also had been raised with NHSE. The Committee noted the amount of work to be done at SaTH noting that staff at the Trust needed to be given time, space and resources to implement actions as alongside this work there were also other major pieces of work progressing such as the avoidable death enquiry and the MLU review. Mrs Beal reported the work pressures were recognised at the meeting and noted the huge amount of work to be done with SIs and RCAs. Mrs Chris Morris was the senior officer for LMS and members acknowledged the action plan for this work would need to be submitted by October 2017. Mrs Beal advised that with regard to workforce issues, SaTH had identified risks regarding theatre staff and scrubbing up. It had been suggested that the Trust could get Agency midwives in but the Trust were nervous about doing so.

Members went onto discuss communications and Dr Rysdale advised messages from this work would need to be dealt with appropriately. Mrs Beal noted communications were key and also an area of concern. It was noted there would be several lines of enquiries from public groups for
example and possible complaints. Mrs Beal and Mrs Chris Morris had agreed the best way forward would be to recommend the local programme board be used as a vehicle for an action plan and also to have one action plan which was suggested by SaTH. The recommendation was supported by all parties including NHSE and NHSI and were also supportive of communication discussions.

Dr Rysdale continued with the theme of communications and noted that linking with the Terms of Reference and attendees to the QC meeting which was discussed earlier on the agenda. Dr Rysdale confirmed that previously the QC had proposed that the Medical Director and Director of Nursing from SaTH attend a QC meeting, however, due to the current situation it would be appropriate to defer Trust attendance to a QC meeting until a later date.

Members noted all the information raised and it was agreed to have a standing item on the QC agenda on the review of maternity and SaTH issues.

Mrs Bailey informed members of a potential never event at SaTH in relation to an incorrect swab count. Members noted the patient had come to no harm and Mrs Bailey advised this risk would be reviewed at the SI meeting tomorrow and SaTH were looking at the criteria and would report back the CCG.

**ACTION:** Review of Maternity and SaTH issues to be put on QC agenda as a standing item.

**Robert Jones & Agnes Hunt Hospital (RJAH)**

It was noted that RJAH had given a comprehensive report at the CQRM regarding never events, however, these this work was still not to satisfactory level. Mrs Bailey informed members she had submitted the never events to NHSE for them to review. The feedback from NHSE had been received and it NHSE had noted a lack of engagement, ownership and content of the RCAs. Mrs Bailey advised she had spoken with Mrs Bev Tabernacle at RJAH and had relayed the feedback from NHSE. The Trust had now re-submitted the never events (this afternoon) and never events was down on the agenda to be discussed at the RJAH CQRM tomorrow. Mrs Bailey reported that If the never events were not at satisfactory level after the meeting tomorrow and they were not in a position to be closed, Mrs Bailey has suggested that a meeting be set up to review all never events. Members noted that Mrs Chris Morris had been instructed to phone Brigid Stacey at NHSE with an update after the RJAH CQRM tomorrow to update on whether RJAH was fully compliant. If this was not the case separate discussions would be needed. Mrs Beal advised that Angela Young from specialised commissioning was also attending the RJAH CQRM tomorrow and Dr Lynch noted she was attending also.

Mrs Beal updated members on a recent SI and unexpected death. It was noted the male patient had been transferred to Queens Hospital in Nottingham, and then back to RJAH where the patient subsequently died as a result of multiple problems. Mrs Beal advised NHSE had been cited on this and this incident would go through the normal SI process.

**Shropshire’s Community Trust**

Mrs Beal informed members of a 52 week wait with audiology advised information had been received on this and this would be shared with colleagues at the CQRM. Mrs Beal advised Mrs Chris Morris would be chairing the Community Trust CQRM and Mrs Dawn Clarke would be chairing this meeting from July 2017.

**Redwoods**

Members were informed of a sexual assault which SSSFT had reported. There had been a comprehensive report done by Mr Paul Cooper and subsequently the view from the CQC was this incident could be stepped down to CQRM level. Mrs Beal advised there had been an SI reported last week regarding an alleged sexual assault involving an agency nurse and a patient. Subsequently the agency nurse had been suspended and NHSE have been made aware of this incident and that an SI review will be done.

**Shropdoc**
Dr Davies advised there was some concern at the last meeting that the CCG were not cited on the pressures on the out of hours service. Members noted Shropdoc had had a change in skill mix and with BCPs however Dr Davies advised she had not seen any information about the agreed change in skill mix and raised concerns about whether a risk assessment had been done or whether key metrics had been reported with regard to unattended consequences. Dr Davies further expressed concern over the significant increase of 999 calls but advised she could not decipher whether the calls were in or out of hours.

Members acknowledged there were concerns with all providers and discussion was held about how the individual issues and concerns impacted on one another for example Shropdoc not being able to fill their shift was a cause for concern and how would this affect other Trusts. Dr Lynch suggested progressing work with Shropdoc through the CQRM. Dr Davies agreed to raise this with Mrs Dawn Clarke at the Executive Team meeting.

It was agreed that Dr Davies, Mrs Beal, Mrs Dawn Clarke meet to discuss resources and how the Quality and Commissioning Directorates could both pool resources and capacity to look at this work and Shropdoc activity. Dr Davies would liaise with Mr David Harry to ask him to look at emergency admissions data to try to pin point whether admissions were in or out of hours. It was further agreed Shropdoc Information should be put on the QC agenda for July 2017 where it was anticipated data regarding emergency admissions would be available to report on.

**ACTION:** Dr Davies to raise Shropdoc issues with the Executive Team with Mrs Dawn Clarke as to if this work could be progressed through the CQRM.

**ACTION:** Dr Davies, Mrs Beal and Mrs Clarke to meet to discuss resources and how the Quality and Commissioning Directorates can pool resources and capacity to look at Shropdoc activity.

**ACTION:** Dr Davies to liaise with Mr David Harry to ask him to review emergency admissions data and to decipher whether activity is in or out of hours.

**ACTION:** Shropdoc Information/Emergency Admission Data be put on the July QC agenda.

**Letter Response from Professor Rod Thomson regarding the role of the Domestic Abuse Prevention Co-ordinator, Community Safety Partnership**

Dr Rysdale raised the Safeguarding letter and noted this would be discussed further on the agenda under the Adult Safeguarding item when Mr Paul Cooper would be available to comment.

**QC-2017-06.029 (Agenda Item 5) – SCCG Quality, Patient and Experience Review – WMQR (Standing Agenda Item)**

Mrs Beal gave a verbal update on this item and the following points were highlighted:

Mrs Beal informed members that a West Midlands Quality Review was being held on 11 July 2017. Mrs Beal noted she would be in attendance on this day and Mrs Dawn Clarke had been cited on this work.

Mrs Bailey informed members the Quality Team had had their first planning meeting with Jane Eminson and representatives from quality, performance and contracting would be invited to the review on 11 July. Members noted representatives had been asked to provide evidence such as TOR, agendas, minutes of meetings which team members would submit ready for the review day and all evidence would be available on the day. Mrs Bailey advised she had asked for details of reviewers for the day and was awaiting a response on this. The venue for the review was Shrewsbury Town Football Club and a draft schedule had been prepared with the day starting at 8.00 am and finishing at 6.00pm with a feedback session from 5.00 – 6.00 pm.
Mrs Bailey advised clinical representation would be appreciated and some members would phoning in at certain times too. Members noted that the draft report of the review day would be sent to Mrs Bailey and Mrs Dawn Clarke by 6 September 2017.

**QC-2017-06.030 (Agenda Item 6) – Revised Terms of Reference and QC Work Plan**

Mrs Barbara Beal presented the Revised Terms of Reference and QC Work Plan and noted she had received comments back from members on the Terms of Reference.

Dr Rysdale took members through the revised Terms of Reference (TOR) and members discussed at length the detail of each section. It was agreed the TOR be reviewed and finalised once all amendments had been made. Members acknowledged there could be potential alterations to the TOR following the WMQR which was due to be held on 11 July 2017.

Members noted that amendments and comments in made on the TOR were generally agreed and would remain in the TOR. The following additional amendments were also noted and agreed:

**Page 2, Membership**
- Names to be amended and checked for spelling errors/correct titles added.
- Lay Member for Public and Patient Engagement - Meredith Vivian to be added
- Lay Chair – William Hutton to be added
- Integrated Care Quality Lead/Strategic TCP Lead – Helen Bayley to be added.

**Page 2, Representatives in Attendance**
- Discussion held over clinical lead for Cancer/all services as necessary for any review and relevant clinical lead – Members noted Dr Steve James and Dr Jessica Sokolov could be added into this section here to report on services on behalf of planned care. Also it was suggested that Dr Gill Clements was added here too. Members agreed that Dr Jessica Sokolov should be invited to the next 6 QC meetings due to the heightened work with maternity services. It was also agreed Dr Davies would provide narrative/re-word this section.

**Page 2, Frequency of Meetings**
- Members agreed there would continue to be monthly meetings with a minimum of 10 meetings per year.

**Page 3, Duties, 7.3**
- Items brought to the attention of the Committee ... - Members discussed at length how important information and items would be brought to the Committee and comments that had been put forward was to add representatives from Healthwatch, Patient Groups or GP Locality Managers. After discussion members agreed any information could be passed through Dr Lynch and these views could be consolidated through the Locality Managers (Janet Gittins, Tom Brettell and Jenny Stevenson).

**Page 4, Duties, 7.18**
- Following the Quality Review of Services with providers... – Members agreed that wider reviews should come through the QC including the WMQR.

**Page 4, Reporting arrangements to the Governing Body**
- Members noted the QC reported to the Board on a quarterly basis but it was felt this needed to be monthly at present due to the heightened escalation level.

**Page 5, Reporting arrangements of other Committees and Groups**
- Members noted this section would be picked up as part of the WMQR and Mrs Beal advised Mrs Dawn Clarke would be working on this and noted as part of Mrs Beal’s handover to Mrs Clarke she had provided a draft schedule of work and reports that should go to the QC meeting.

Members agreed a work plan for key pieces of work was needed and discussion was held on how reports and issues that needed to be raised would be managed through the QC meeting.
Dr Davies advised members there was a potentially a CHC Board being set up and asked if this meeting would report into the Quality Committee. It was noted that Mrs Nikki Diamond could feedback any CHC issues through the Quality Committee. Mrs Beal advised the CHC Board and how CHC issues reported through the QC were still being discussed. Mrs Dawn Clarke would be picking this work up.

Page 5, Annual Review of the Committee – Members noted the Terms of Reference needed to be finalised as soon as possible and it was agreed once amended the revised version would go to the next Quality Committee meeting and also the Board meeting for approval.

Mrs Beal highlighted NICE Guidance and reported the CCG were not currently monitoring all NICE Guidance. Members acknowledged this information and it was noted NICE Guidance needed to be looked at.

**Agenda Item 7) – Shropshire and Staffordshire Quality Surveillance Group Update**

Mrs Beal noted that the QSG ratings for Trusts would be discussed further on the agenda and noted that Mrs Bailey had done a tremendous amount of work with the Trusts. Mrs Beal reported this item cross-referenced with the detailed quality update she gave under the matters arising section which detailed QSG information.

**QC-2017-06.032 (Agenda Item 8) – Non-NHS Contracts**

Mrs Sue Aucutt attended to present this item and the following information was highlighted:

- Mrs Aucutt updated members around smaller provider contracts in terms of quality monitoring. Members noted systems and processes were currently being developed and implemented in collaboration with contracting, delivery and performance, to ensure robust monitoring of quality, safety and patient experience across all of the smaller provider contracts.
- Mrs Aucutt advised since January 2017 the quality team has been working to provide consistency around the quality offer in terms of standards and reporting requirements as the new contracts are being prepared for issue to providers. In addition to providing the assurances which come with the roll out of standard contracts, the process has allowed the quality team to become more involved at the contract development stage. This has brought a number of benefits and risks.
- Members noted the risk and benefits contained within the report and some issues were raised in particular about the Community Optometry Service and Mrs Aucutt highlighted there were currently 59 providers for this, however with Domiciliary Care there were approximately 14 but these were unknown due to there being no contracts in place for this. Members confirmed there needed to be a monitoring process in place for contracts.
- Mrs Aucutt reported the number of providers issued a challenge in terms of the resource to undertake site visits and also in identifying the best way in which to receive and interpret information. Members also acknowledged that monitoring quality from these providers was problematic due the processes not clearly being defined.
- Discussion was held around optometry contracts and members noted there were 90 contracts issued in 2015/16 and Mrs Aucutt noted there were 38 registered nursing homes – approximately 50 residential homes in Shropshire.
- Dr Davies suggested for the optometry contracts which were formerly managed through NHSE to have an exception report and any issues raised could be co-ordinated through the planned care leads. Mrs Aucutt highlighted the next steps to enable closer working and members noted the quality team were now holding bi-weekly decision meetings regarding contracts.
- Mrs Beal thanked Mrs Aucutt for all her hard work and it was noted that Mrs Aucutt would be working with the CCG until a substantive post was in place. Mrs Beal advised it was likely that a business case would be done for this.
The Committee noted the content of the report and gave approval. Mrs Beal and the Committee thanked Sue for all her hard work and it was agreed an updated report would come back to the September QC meeting.

**ACTION:** An updated report regarding Non-NHS Contracts would come back to the September QC Meeting.

**QC-2017-06.033 (Agenda Item 9) – Transforming Care Report**

Mrs Beal advised unfortunately Mrs Helen Bayley was unable to attend today to give an update, however, an update would come back to the next QC meeting.

**QC-2017-06.034 (Agenda Item 10) – Adults Safeguarding Update**

Mr Paul Cooper attended to present the Adults Safeguarding Update and to discuss the letter response regarding the Domestic Abuse Prevention Co-ordinator. The following key issues were raised:

*Letter Response from Professor Rod Thomson regarding the role of the Domestic Abuse Prevention Co-ordinator, Community Safety Partnership*

Mr Cooper updated members on the letter received from Professor Rod Thomson and noted that he had chaired the Domestic Abuse Forum yesterday where it was highlighted that issues had appeared not be taken forward as there was no co-ordinator currently. It was suggested the Chair role could be on a rotational basis.

Dr Rysdale asked about funding and Mr Cooper advised funding was discussed at the meeting yesterday noting the funding was due to be allocated in April 2017, however this had now delayed until September 2017.

Members noted the content of this letter and the points raised and it was agreed a meeting should be arranged between Professor Rod Thomson, Mr Cooper and Mrs Dawn Clarke to discuss the options further. Mr Cooper would update members

**Adult Safeguarding Update**

Mr Cooper update members on Prevent advising the end of year returns showed that the Community Trust and Robert Jones & Agnes Hunt Hospital had made significant in year performance in terms of training their staff against the 85% target which NHSE had recently announced. Concerns remained about the performance of SSSFT training levels and a meeting had been arranged with the CCG and NHSE to review their remedial actions.

Mr Cooper advised that SaTH had recovery plan to increase their training levels and advised he would be meeting with SaTH to go through this plan on 7 July 2017.

Mrs Beal raised designated doctor for adult safeguarding and advised she had met with Mr Cooper and Dr Julian Povey to discuss this further. Mrs Beal advised Mr Cooper was preparing a paper for the Executive Team meeting in July and this piece of work would be taken through the appropriate channels with Mrs Dawn Clarke taking this forward. Mr Cooper added he was awaiting costings for this and then the paper would be finalised and ready to go to the Executive Team meeting.

Members thanked Mr Cooper for his report and noted all the contents of the report.

**QC-2017-06.035 (Agenda Item 11) – Children Safeguarding Update**

Mr David Coan attended to present the Children Safeguarding Update and the following points were highlighted:
Child Protection Informatics System
Mr Coan advised the child protection informatics system was now in place across Shropshire and Shropdoc would be going live very soon. Mr Coan noted that although this was good news he was not reassured providers were using is correctly and requested that this be flagged up through the appropriate channels and through CQRM. Mr Coan said he would be happy to attend the CQRM to report on this issue.

Designated Doctor Role
Mr Coan reported the designated doctor role was now becoming an issue and it was essential this was looked at. Mrs Beal noted that she had been liaising with Mrs Erica Crisp with regard to contracting and Mr Coan had had a phone call with the Director of Nursing. Mrs Beal confirmed she would be picking this up with Mrs Dawn Clarke on Monday when she commenced her post and confirmed this issue would be escalated most likely to Accountable Officer level. Mr Coan commented that as things stood, the CCG were currently breaching statutory regulations and it was imperative this was resolved.

Independent enquiry into child sexual abuse
Mr Coan advised the independent enquiry into child sexual abuse was still ongoing around the country.

STP: Shropshire and Telford & Wrekin – Appendix One
Mr Coan updated members on roles noted on appendix one and noted is was worth considering whether detail on appendix one should be included in the Quality Risk Register and circulated to NHSE. It was agreed that Mr Coan pick this work up with Mrs Dawn Clarke and Mrs Beal agreed to input the information into the risk register.

SEND
Mr Coan reported a business case was being taken to the Executive Team meeting on Monday in relation to SEND which included clear strategies. Mr Coan would also be preparing a paper to go to the Executive Team meeting and CCG Board meeting in relation to the Designated Medical Officer Role. Mr Coan noted that Mrs Fiona Ellis, Mrs Nikki Diamond would be working on the paper with Mr Coan in preparing options to fulfil this role.

Further discussion was held on Appendix One and it was agreed that if any detail needed to be confirmed this would be picked up outside the meeting.

Dr Rysdale asked about strategy meetings and conference meetings which had been discussed at previous QC meetings. Mr Coan advised he was liaising with GPs and had spoken with Dr Jessica Sokolov in order to get a clear message to GPs around the processes for strategy and conference meetings. Also being looked at was getting out information regarding safeguarding training. Mr Coan confirmed information would be sent out to Practices in due course and it was agreed to review this work in 6 months’ time to ensure this was embedded.

QC-2017-06.036 (Agenda Item 12) – Looked After Children
Mrs Beal advised unfortunately Mrs Maria Hadley was unable to attend today to give an update, however, an update would come back to the next QC meeting.

QC-2017-06.037 (Agenda Item 13) – Provider Exception Report
Mrs Bailey attended to present the Provider Exception Report and highlighted most key issues had been raised earlier in the meeting. Mrs Bailey raised the following additional key issues:

Serious Incidents (SIs)
Mrs Bailey updated members regarding an SI with ophthalmology and where a follow up appointment had been missed. This case was ongoing and Mrs Bailey advised SaTH had been
asked to look back at clinics to ensure no patients have been missed. Members noted that SaTH had given assurance 18 months ago they had done a look back exercise presented information around this look back exercise. Mrs Bailey reported that the quality team were currently looking back at the presentation, information and evidence that was provided originally to see if things had been looked at and dealt with and to ensure that all actions had been followed up.

Dr Davies asked about the category of the patient of the SI within ophthalmology and raised concerns over the sub-specialty. Dr Davies confirmed that previously ophthalmologists had reported the sub-specialties with zero tolerance were medical retina and glaucoma and advised if the patient fell under one of these categories this was extremely worrying on many levels also the sub-speciality data form the task and finish group could potentially be incorrect. Dr Davies commented that there could be sub-speciality we have missed and the current level of reporting data and assurance does not match.

Discussion was held over follow up appointments and booking and scheduling. Dr Davies reported the administration processes had not been ironed out as missed follow up appointments would have been flagged on the system. Dr Davies advised the booking and scheduling group reported to the Primary Care Working Group (PCWG) and Dr Davies was concerned this piece of work had been dismissed. Dr Davies advised she would request a report from the booking and scheduling group on how follow up appointments are scheduled, booked and flagged through the SEMA system and Dr Davies would share this report with Mrs Beal and the quality team.

Dr Davies reported one other speciality which was scrutinised due to potential harm was cardiology and noted a report on this was being presented at the PCWG on Thursday for the first time. Mrs Beal also confirmed cardiology was raised at the CQRGM yesterday.

QC-2017-06.038 (Agenda Item 14) – Governing Board Assurance Framework (BAF)

Mrs Beal presented this item and updated members on the following areas:

- Mrs Beal noted it had been suggested that the CCG hold a risk workshop to review what the CCG’s risk were. Mrs Beal reported that the risk registers would need to be updated first as there were currently gaps.
- Mrs Beal confirmed the BAF was not the same as the risk register advising the BAF was about the CCG’s core objectives and the risks with delivering the core business to the organisation.
- Mrs Beal advised she had updated the quality risk register and would be reviewing this with Mrs Dawn Clarke on Monday. A copy would be sent to Mrs Sam Tilley. Mrs Beal had also updated the BAF with key pieces of work added into the document such as the WMQR. It was recommended the ratings remain the same (12, high and 9, mitigation) until Mrs Dawn Clarke commenced her post and was able to review the BAF and look at the key pieces of work. The BAF would then come back to be reviewed formally at the next QC meeting and this would be an action for Mrs Clarke. Members agreed with this information and noted the BAF should be updated with the name and date.
- Mr Hutton noted that the CCG Board were due to have a development session in relation to the BAF and about setting corporate objectives which would need to be included in the BAF.
- Dr Davies noted she was currently working on her Directorate risk registers and this would be taken back to the Executive Team meeting. Dr Davies raised concerns over workforce issues and risks and was conscious that some members of staff were carrying an unacceptable level of risk and this needed to be noted. Dr Davies also highlighted it was important to note any areas of risk within own Directorate that could have wider issues and affect other areas. Dr Davies asked if an item could be added to the QC agenda where members could raise any potential risks that could affect other areas. Members agreed to add an item to the QC agenda where Directorate risk register issues could be shared.
- The Committee considered the BAF and noted all the information. The Committee noted the BAF would remain a standing item on the QC agenda and also add a section for Directorate Risk Register issues.
ACTION: Agreed an item be added to the QC agenda under the BAF to enable Directorate Risk Register issues to be raised where appropriate.

QC-2017-06.039 (Agenda Item 15) – (For Information) Copy of Provider/Quality Account SaTH/RJAH

Mrs Beal advised a copy of SaTH’s quality account had been attached to the QC agenda for information. Mrs Bailey had done a great amount of work with Trusts to produce this report and detail included in this report had been previously discussed under matters arising. Members noted the report.

QC-2017-06.040 (Agenda Item 16) – Any Other Business

Internal Audit SI Review
Mrs Beal raised the internal audit SI review advising it was signposted at Audit Committee today, noting an action plan would need to be done and this work would link in with the WMQR. Members noted that Mrs Bailey would be leading on this alongside Mrs Dawn Clarke.

Vitamin D Deficiency
Mrs Bailey raised vitamin D deficiencies advising a high risk group of patients (pregnant patients) were not being flagged up during pregnancy with vitamin D deficiencies. Mrs Bailey raised NICE guidance and members agreed NICE guidance needed to be reviewed. Dr Davies reported the MOU between the CCG and Local Authority should be reviewed. Dr Davies agreed to speak to Mrs Nicky Wilde, Director of Primary Care to ensure this information was fed back through the Primary Care Directorate and medicines management. Dr Davies would also raise NICE guidance at the Executive Team Meeting.

ACTION: Dr Davies to liaise with Mrs Nicky Wilde regarding NICE Guidance and also raise NICE Guidance at the Executive Team Meeting.

Quality Structure
Mrs Beall advised, as members were aware and previously mentioned, the quality structure was being reviewed, noting resources were limited. However, Mrs Beal wanted to point out that the volume of work was extremely high and when looking at work that still needed to be done, advised that subject to the review there may be a case for a business case further down the line to ensure adequate future resources to really assure quality.

Shropshire and Staffordshire QSG Rating for Trusts
Dr Ed Rysdale verbally updated the group on the QSG ratings for the Trusts and cross referenced and reiterated information discussed previously that SaTH remained on enhanced monitoring, RJAH remained on enhanced monitoring with SSSFT remaining on routine monitoring.

Dr Lynch advised the CCG needed assurance around risks with SaTH and around the rigidity of the services if it did not go to risk summit. Members agreed.

Date of Next Meeting

The next meeting is due to be held on Wednesday 26 July 2017 in Meeting Room B, William Farr House Site, Mytton Oak Road, Shrewsbury SY3 8XL, 3.00 – 5.00pm.
## Shropshire Clinical Commissioning Group

### ACTIONS FROM THE QUALITY ASSURANCE PANEL

**Wednesday 28 June 2017**

<table>
<thead>
<tr>
<th>Action Required</th>
<th>By Whom</th>
<th>By When</th>
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<tbody>
<tr>
<td>QC-2017-06.028 (Agenda Item 4) - Matters Arising</td>
<td>Mrs Sarah Smith</td>
<td>Next Meeting</td>
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<tr>
<td><em>Shrewsbury and Telford Hospitals NHS Trust (SaTH)</em></td>
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<tr>
<td>Maternity</td>
<td>Review of Maternity and SaTH issues to be put on QC agenda as a standing item.</td>
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| QC-2017-06.028 (Agenda Item 4) - Matters Arising | | |
| *Shrewsbury and Telford Hospitals NHS Trust (SaTH)* | Dr Davies | Next Meeting |
| Shropdoc | Dr Davies to raise Shropdoc issues with the Executive Team with Mrs Dawn Clarke as to if this work could be progressed through the CQRM. | |
| | Dr Davies, Mrs Beal and Mrs Clarke to meet to discuss resources and how the Quality and Commissioning Directorates can pool resources and capacity to look at Shropdoc activity. | |
| | Dr Davies to liaise with Mr David Harry to ask him to review emergency admissions data and to decipher whether activity is in or out of hours. | |
| | Shropdoc Information/Emergency Admission Data be put on the July QC agenda. | Mrs Sarah Smith |

| QC-2017-06.032 (Agenda Item 8) – Non-NHS Contracts | Mrs Sue Aucutt | September QC Meeting |
| | An updated report regarding Non-NHS Contracts would come back to the September QC Meeting. | |

| QC-2017-06.038 (Agenda Item 14) – Governing Board Assurance Framework (BAF) | Mrs Sarah Smith | Next Meeting |
| | Agreed an item be added to the QC agenda under the BAF to enable Directorate Risk Register issues to be raised where appropriate. | |

| QC-2017-06.040 (Agenda Item 16) – Any Other Business Vitamin D Deficiency | Dr Davies | Next Meeting |
| | Dr Davies to liaise with Mrs Nicky Wilde regarding NICE Guidance and also raise NICE Guidance at the Executive Team Meeting. | |
Minutes of the
North Locality Board Meeting held on
Thursday 8 June 2017
The Venue at Park Hall, Oswestry

Name | Practice/Organisation | Signature
--- | --- | ---
Dr A Booth | Baschurch | Attended
Nicolas Storey | Baschurch | Attended
Dr G Davies | Clive | Attended
Zoe Bishop | Clive | Apologies
Dr N Von Hirschberg | Ellesmere | Attended
Jenny Davies | Ellesmere | Attended
Dr N Raichura | Hodnet | Attended
Christine Charlesworth | Hodnet | Attended
Dr J Davis | Knockin | Attended
Mary Herbert | Knockin | Attended
Dr Mike Matthee | Market Drayton | Attended
Michele Matthee | Market Drayton | Attended
Dr Santi Eslava | Oswestry Cambrian Medical Centre | Attended
Kevin Morris | Oswestry Cambrian Medical Centre | Apologies
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 | Shrewsbury | Attended
Jane Coles | Shrewsbury | Attended
Dr Emma Smart | Wem / Prees | Apologies
Richard Birkenhead | Wem / Prees | Apologies
Dr K Lewis | Westbury | Apologies
Helen Bowkett | Westbury | Apologies
Dr T W Lyttle | Whitchurch – Bridgewater | Attended
Suzanne Lyttle | Whitchurch – Bridgewater | Apologies
Morven Jones | Whitchurch – Bridgewater | Apologies
Dr R Muirhead / Dr M Abey | Whitchurch – Claypit Street | Apologies
Debbie Tildsley | Whitchurch – Claypit Street | Apologies
Dr R Clayton | Whitchurch – Dodington | Apologies
Elaine Ashley | Whitchurch – Dodington | Apologies
Paul Goulbourne | Patient Participation Group | Apologies
Roy Aldcroft | Patient Participation Group | Apologies
Dr Julian Povey | CCG Chair | Apologies
Dr Jessica Sokolov (Acting Chair) | Deputy CCG Chair | Attended
Dr Julie Davies | Director of Performance and Delivery | Attended
Dr F Lynch | Clinical Director - CCG | Attended
Sean Mackey | Head of Medicines Management–Primary Care [Item 5] | Attended
Amanda Laing | Primary Care Support Pharmacist [Item 5] | Attended
Kay Dhesi | Frailty Programme Lead | Attended
Janet Gittins | North Locality Commissioning Manager | Attended
Penny Bason | Shropshire Public Health, Shropshire Council [Items 7&8] | Attended
Kevin Lewis | Help2Change, Shropshire Council [Items 7&8] | Attended
Dr C Tomlinson | MSK Lead [Item 9] | Attended
Nina White | Head of Transformation [Item 9] | Attended
Richard Kubilius | Commissioning Lead for Mental Health [Item 11] | Attended
Sandra Stackhouse | CCG (Minute Taker) | Attended

Dr Sokolov, Acting Chair, thanked those present for attending. Apologies were recorded as above.
Minute No North.2017.06.38 [Item 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.

Minute No North.2017.06.39 [Item 3] - Minutes of Meeting held on 4 May 2017

The minutes of the previous meeting held on 4 May 2017 were accepted as a true and accurate record and were signed by the Chair.

Minute No North.2017.06.40 [Item 4] - Matters Arising not covered on the Agenda

Dr Sokolov 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 – An email had been circulated from June Telford, Interim Head of Primary Care, who was looking into commissioning a new zero tolerance scheme.

[5.0] Accountable Officer/Chair Update – Further to the request for Dr Matthee to arrange to forward to Dr Sokolov examples of cases where difficulties had been experienced in referring patients for assessments. It was reported that representatives from RAS had visited Market Drayton Medical Practice which had proved very constructive and beneficial for both sides. It was recommended for other practices to do this as every practice had different issues which could be talked through with all the practice staff present.

Action: Practices were requested to contact RAS directly if they would like to arrange a practice visit from Sam Duckett and Jo Mason, Clinical Triage Assessors.

Clinical Services Review (CSR) – Dr Sokolov thanked those Members who had volunteered to help with the audit work, however, there was now some dedicated resource to carry out this work.

Dr Lewis had forwarded details of the case regarding the premature baby being taken to Stoke and Dr Sokolov had referred to the Director of Nursing. Dr Lewis had fed back that she was now involved and attending the significant event meeting and was quite pleased with the outcome.

[6.0] Locality Chair Update: Resilience Monies - This item had been included on the agenda under Item 12: Any other business. It was proposed and agreed for a standing item on the GP Forward View and Primary Care be included to be taken forward by Dr Lyttle, new North Locality Board Chair and Janet Gittins, new Locality Manager.

Action: Mrs Stackhouse to add GP 5 Year Forward View and Primary Care as a standing item on future agendas.

[7.0] Prescribing Update – It was not known if any practices had expressed an interest in going on the EPS or whether the EPS had been used. It was understood Dr Steve James would still like to hear if anyone was interested.

Dr Sokolov confirmed she had discussed with Mrs Barbara Beal, Director of Nursing about patients being discharged on NOACs and the concern about whether that was truly an informed decision on the part of the patient. Mrs Beal was looking into this issue.

[9.0] Peer Review on UTIs – Dr Matthee asked if there had been agreed protocol on changes following the peer review undertaken. Although it was considered positive that the locality had scored well in this area, it was agreed it had been identified there were a few issues about the length of prescriptions being issued. Following a short discussion, Dr Vibhishanan informed Members she had been planning to carry out a further audit regarding three day courses for patients and agreed to bring back to the meeting the findings of the self-audit.

Action: Dr Vibhishanan and Sue Evans to bring back to the meeting in three months’ time the findings of the self-audit for further discussion.

Minute No North.2017.06.41 [Item 5] – Prescribing Update

Mr Sean Mackey, Interim Head of Medicines Management – Primary Care, gave updates on the following:

Cost Effective Prescribing Framework (CEPE) – Action plans had been received back from the practices with four outstanding: Hodnet and Westbury who had confirmed they did not wish to take part in the scheme; and Prescott and Clive surgeries currently consider the plans. Members agreed if the four practices decided not to go ahead with joining the scheme, the allocated pump priming monies for those four practices should be apportioned to the remaining practices.
Action: Mr Mackey to take forward the sharing out of the pump priming monies between the remaining practices if the four outstanding practices decided not to join the CEPF scheme.

Dr Hirschberg enquired whether the end targets were based on the practices in the scheme or in and out of the scheme. Mr Mackey confirmed the CCG would not be re-allocating the prescribing budgets to the ‘in’ practices to increase the target required. It would be for the Medicines Management Team (MOT) to work with the practices outside the scheme to ensure the prescribing spend was appropriate. Practices could now call upon those monies based upon the list of items that came with the incentive scheme in addition to last year’s PQOS monies.

Mr Mackey explained there were a few practices that still had not signed the paperwork for 2016-17. There was a MOT meeting in two weeks’ time after which practices would receive the information. Practices had spent just under £1m less than the previous year and a big thank you was extended to everyone for their support, particularly in the north locality, which had seen the largest decrease. The funding would be ring-fenced through prescribing and any underspend on the budget would be retained between the localities.

Dr Matthee highlighted there was still a lack of supplies of certain drugs and it was very frustrating without any formal discussion or any plan when there was no alternative medication. It was requested if it was possible if such information could be included in the bulletins. Mr Mackey assured Members that MOT would be looking at on a weekly basis updating ScriptSwitch with more immediate messages showing alternatives.

Action: Mr Mackey to look into alcohol services and present position regarding the availability of Antabuse.

Dr Vibhishanan queried what was going to happen after this year as it would be difficult to achieve the same percentage improvement in subsequent years. Mr Mackey acknowledged that the same decreasing spend could not be maintained and MOT would be working with the locality boards over the next few months on plans for next year.

ScriptSwitch – Dr Dale Abbotts from Alveley Medical Practice had been commissioned to help dispensing practices reduce prescribing spend. Practices were advised if they wished to discuss with Dr Abbotts to please email Mr Mackey.

Following concerns raised about branded generics, every time there was a switch to a branded generic, there would now be a message inserted stating “branded generic of [name]” so that it was clear. An agency called Interface Clinical Services, used by a number of CCGs, had been sub-contracted to action the simple switches. MOT would, therefore, be contacting practices about confidentiality agreements over the next few weeks in order to give the agency workers remote access. Practices would be required to inform MOT about notifying patients.

Dr Vibhishanan commented that she was not against the principle but raised there had been no communication advising someone was coming into her practice and there had been an issue with an incorrect switch made. Mr Mackey explained this had been noted, should not have happened and was being investigated. A short discussion followed as to where the legal responsibility would lie and it was confirmed that as this was the responsibility of the team, the CCG would be responsible, however, it was raised if the practice had allowed a health care professional to initiate changes, it was unclear. Mr Mackey offered to seek indemnity advice and would write to practices. Mr Mackey confirmed practices would be asked to agree the actual switch and the patient list would be produced whereby patients could be excluded from the switches.

Action: Mr Mackey to seek indemnity advice and to write out to practices advising of outcome.

Gluten free prescribing – At the CCG Board meeting it had been agreed that all gluten free products should no longer be recommended to be on NHS prescriptions in Shropshire, subject to MOT engaging with a number of organisations to inform them of this decision. This was a local decision across the board, which it was hoped to take effect from August and MOT would be writing out to practices. NHSE was running a national consultation that ended at the end of June and based on the outcome of that consultation there would be an 18 months process to decide whether nationally gluten free products should be allowed on prescription and if so the CCG would need to revert back. It was reported other CCGs had taken the same decision on the basis it was food and not medication and other cohorts of patients, such as diabetics, did not receive diabetic food on prescription. It was understood there had been no successful challenges in other areas to date where gluten free prescribing had been withdrawn.

It was asked to be noted that, for clarification, the group agreed GPs should not be prescribing gluten-free products. Mr Mackey was currently consulting with the specialties, ie Paeds and Gastro, and working with the pharmacy department at SaTH. Mr Mackey was also meeting with Andrea Harper, the new Head of
Communications and Engagement, on a weekly basis to discuss how this decision would be communicated across the county.

**Baby Milks** – Ms Liz Bainbridge, Dietician, would be undergoing a piece of work looking at baby milks.

**Prescription Order Direct (POD)** – The POD, a call centre based at Severn Fields Medical Centre went live on Monday 5th June, and appeared to be working well. The next practice being considered was Cambrian Surgery.

**Oral Nutritional Supplements (ONS) Pathway** – Ms Liz Bainbridge had seen reductions in spend in ONS sip feeds but had noticed that the ONS pathways were not always being followed up in practices. It was requested for Members to ensure partners were aware of the ‘must’ score and Food First for one month before patients are prescribed sip feeds.

**Care Homes** – The CCG was developing a care home service and had commissioned a GP with a Special Interest (GPwSI), Dr Sunil Angris who has previously worked on Frailty and with Shropdoc. Dr Angris would be working with the pharmacists in developing a de-prescribing model through care homes. It was the aim to conduct between 500-750 reviews of patients’ medication by the end of December.

**Action:** If practices were interested in any of the care home work they were asked to please contact Mr Mackey.

**Clinical pharmacist in general practice** – It was suggested that it would be beneficial to discuss further a clinical model that would include a clinical pharmacist to support workload issues in primary care. The scheme allowed £600k over three years and would cost on average £5k per year per practice for three sessions a week, which was considered good value for money. Mr Mackey was happy to visit practices to further discuss because another part was CEPF monies, which could be used for this purpose also. Following the point raised that practices would have a permanent member of staff at the end of the scheme, Mr Mackey confirmed there had been exceptions for rurality and the pharmacist could be sub-contracted and sessions could be bought directly.

**Action:** Mrs Stackhouse to add item on clinical pharmacist on next agenda for further discussion.

Dr Vibhishanan referred to a query she had directly raised from patients whose children’s nurseries had refused to administer Paracetamol unless it was prescribed and labelled. Following discussion it was clear there were differences across the locality and was discussed whether this could be done in pharmacies with an advice sheet provided therefore avoiding clinician involvement. Mrs Laing confirmed this was being followed up. Dr Mackey had emailed Ofsted requesting confirmation of the process followed in schools and nurseries and would raise at the Local Prescribing Committee (LPC). Once the requirements were confirmed this could be interpreted for schools should there have been a misunderstanding. Dr Matthee added that parents would often receive a phone call requesting them to collect their children if unwell and therefore there was no requirement for the nursery to give medication unless for a long-term condition.

**Minute No North.2017.06.42 [Item 6] - CCG Update**

Dr Sokolov gave a verbal update on the following areas:

**Management Structure** – Claire Skidmore, Director of Finance and Nicky Wilde, Director of Primary Care had commenced in post. Mrs Wilde had been unable to attend but would be attending from the next meeting.

**Finances / QIPP** – Further to the prescribing update, an update on MSK was included on the agenda. It was highlighted that following on from the CCG Board’s discussion the previous day, the CCG was required to save £17.7m. There were schemes in place but the CCG needed to be developing other ideas and Members were invited to forward any ideas they might have to Dr Tim Lyttle or Janet Gittins.

**Future Fit** – The CCG had now appointed an organisation to carry out the independent review into the process around Future Fit, which would commence the following week, the outcome of which would be discussed at the Future Fit Programme Board. Following this it would need to go back to the Joint Committee, which had been restructured to comprise three independent members, an independent chair and two independent clinicians.

Further to the Transformation Team’s presentation at the last meeting, Members had expressed concerns about the assumptions made that underpin the bed base modelling. The CCG had commissioned an additional piece of work by Optimity to look at best practice and different models of care used in Europe. This would inform the second part of the work by translating this information into a model for Shropshire which could be taken forward. Dr Sokolov felt reassured the assumptions were being explored because it had appeared they depended on changes in behaviour that seemed unrealistic.
Community Fit / Optimity Review – It was explained Community Fit was now incorporated within the STP work. Following the first piece of work from Optimity, there were four main strands of work relating to the community, which would report back to the neighbourhood steering group, comprising members from Shropshire Council and CCG. One of these areas of work was related to primary care. The work felt more structured now and for the outline business case for Future Fit, Members were assured it would require an adequate community answer

Community Services Review (CSR) and Frailty – The CSR work was on-going and there was an introductory item on the Frailty programme [noted under item 8 below]. It was hoped these two areas would drive what was needed from Community Fit.

During the ensuing discussion, disappointment was expressed about the Future Fit programme and the feeling the process was starting again; monies had been wasted on renegotiations and reassessments, which was considered would have funded a new hospital as originally suggested. Dr Sokolov responded that the process had not progressed as wished because there had been no community answer and there were political considerations to be borne in mind. An evidence base was required in terms of community care, place based care, managing care out of the acute setting because the system could not continue following a bed based model of care. The community work had taken a different shape over time and the pressures on the workforce had changed as had the CCG’s financial situation over the last 18 months-2 years.

Dr Lyttle said he understood that the whole concept of Community Fit was to move the focus and have a deliberate attempt to define what should be available at a community level and felt this had now been diluted. Dr Sokolov considered the aim was stronger now and the Optimity work was focussing on whether there was the right bed model. There was also the work on Frailty, the Community Services Review and within Public Health about anticipating need. It needed to be recognised the work of Community Fit and Future Fit interlocked. Overall there was an urgent need for a reconfiguration because the Trust was struggling to maintain A&E and ITU services on both hospital sites.

Minute No North.2017.06.43 [Item 7] – Update on the Healthy Lives Programmes

Kevin Lewis and Penny Bason from Public Health, Shropshire Council attended to give an update on the Healthy Lives programme, a copy of which was tabled at the meeting. The Healthy Lives programme had moved forward and Oswestry had been the focus area for Social Prescribing, the aim of which was to make more use of the assets that exist in the community to support patients and practices. Three groups of patients were being explored: 1) frequent attenders at general practice; 2) patients with Diabetes, and 3) patients who are opportunistically referred from either the Community Care Co-Ordinator or one of the practice GPs or nurses. The intent is to scale up to other practices once evaluation had been carried out.

The aim of the meeting was to obtain feedback from Members as well as feedback from patients. Later on in the year there would be a second phase where the Council would be working with Westminster University to do a forward evaluation on the programme to see what impact it has had on patients’ well-being, on their attendance at general practice and other measures specific to their conditions that they are being offered support with. The pilot did not aim to replace any of the assets in the system already, ie Community Care Co-ordinators, adult social care, Let’s Talk Local and the third sector. It was how social prescribing fits within that and how to make the best use of what resource is there already.

Plas Ffynnon Surgery had referred frequent attenders and opportunistically through to the Community Care Co-ordinator. The Team was also working with Caxton Surgery who were sending out letters for the pre-diabetic patients, who would be taken through an information session and would be offered social prescribing. A plan would be devised that would include a range of activities for the person that they would like to engage with.

Dr Clark enquired as to how the files were going to be evaluated. Mr Lewis advised there would probably be a control group. Nationally there had been a lot of research into social prescribing but one weakness was that it lacked control and was not easy but this would be looked at by Westminster University.

In response to a question raised by Dr Vibhishanan on what the proportion of the quality assured providers were from the third sector. Mrs Bason confirmed the majority were. Concern was further raised by Dr Vibhishanan that although this was a pilot project, if this service was to be rolled out then the voluntary sector could be overwhelmed with the number of patients. Mr Lewis confirmed there was national work being carried out on this and expected there would be some provision of support for third sector organisations if this was shown to be helpful in reducing pressure on health and social care.

It was fed back that the pre-diabetes work looked really good and Members would be grateful to receive further information that would be useful for practices, in terms of helping to manage this cohort of patients. It
was highlighted there would be distinct and needed roles for the Community Care Co-ordinator and for the Social Prescriber.

In summary, Members were broadly supportive of the aims of the social prescribing pilot and noted this was a work in progress. In taking part, however, there had been a cohort of patients identified which had unfortunately had added to the workload with the monitoring of patients afterwards. It was recognised there would be a larger cohort of pre-diabetic patients who would benefit from some of the interventions that were being linked through the social prescribing project but it was questioned how these patients would be managed appropriately going forward. It was likely that there would be more information forthcoming which would help inform answers to the concerns raised.

**Action:** Mrs Stackhouse to circulate PowerPoint presentation slides for information for Members.

**Minute No North.2017.06.44 [Item 8] – Frailty Programme**

Dr Finola Lynch, Clinical Director and Kay Dhesi, Frailty Programme Manager introduced themselves and briefed Members on the review of the current state of Frailty, Falls and Fractures, copies of which were tabled. The ultimate aim was to have a vision for Frailty to build an end to end pathway. Frailty was difficult to define but the British Geriatric Society considered it as a distinctive health status related to the ageing process in which multiple body systems gradually lose the ability and bounce back ability. Reference was made to Dr Suzy Thompson’s recent talk on Frailty in which it was suggested Frailty is still evolving and work had commenced looking to see how Frailty could be better managed.

Key areas for analysis were discussed. Attention was drawn to the emergency admissions slide, which gave a picture of the total number of emergency admissions by Frailty into Shropshire and Telford and Wrekin CCGs in 2015/16. Following a survey carried out with key stakeholders across the system, an A3 sized map had been created as Appendix A which showed the current state for Frailty giving an ‘illustration of what currently happens for frail/elderly patients due to no formalised, prescribed local end to end pathway for frailty.’ The current status showed there were services available but the system was very complex and fragmented and was described as having ‘sticking plasters’. This needed to be more joined up and there was an opportunity to look at the whole system and make some fundamental changes. There were assets in the communities already and the aim was to re-focus some of those resources to help to streamline and identify frail patients using an assessment tool.

Dr Matthee pointed out that there had been a similar system before but had ended with a loss of day centres, when it was claimed that some things had gone wrong but was still considered the right place outside of general practice where patients could undergo proper geriatrician and social worker assessments. There were two sets of population: those who were in hospital and those who were frail in the community. What was required was an effective discharge team.

The road map for Frailty was to have a leadership team in place including the localities and health professionals having a team approach to getting people to voice their opinions to be able to shape the model that was required. Work was being carried out with Telford and Wrekin CCG. At present PDSAs (Plan, Do, Study, Act) were being looked at of front door, discharge to assess and care outside of hospital. Dr Julie Davies added that with all the pressures in the system, there were winter monies available to invest in the system across primary care and community services. It could really make a different if the right investment was made in the right place outside of hospital.

Members received the description of the current Frailty services and it was noted there was a lot of resource but was not necessarily joined up. It was recognised that this was an important area to be focussed upon and there was a large piece of work looking at this to get it aligned. There was probably an immediate need to have plans ready before winter and it was anticipated there would be a need for input from the localities.

In response to a query from Dr Lyttle, Dr Sokolov understood that the Integrated Community Service (ICS) was for facilitated discharge and admission avoidance in terms for acute brief intervention.

**Actions:** Mrs Stackhouse to circulate electronic copies of the Frailty presentation for information.

**Minute No North.2017.06.45 [Item 9] – MSK Update**

Mrs Nina White and Dr Chris Tomlinson attended to give an update on the Musculoskeletal (MSK) service. The papers had been presented to the Executive Team and CCG Board meetings around the selection process for provision of the MSK services. The CCG needed to save £4.2m this year and potentially £10m next year. The MSK vision was to have discussions about what the selection process should be, which had not been agreed. Current conversations were being held about a provider model and accountable care organisations and that decision was expected by September.
Shropshire Orthopaedic Outreach Service (SOOS) – The service was currently being provided predominantly in the north because the service was based in Oswestry and there were still ongoing conversations with RJAH. A meeting had been held with RJAH that morning, which had been very productive about extending the service to Shrewsbury and to the south locality. NHSE had issued a document about high impact interventions, which focussed on three key areas including: weekly peer reviews, the MSK pathway and all referrals being electronic and being administered by a triage service; and ensuring patients are redirected to providers who have a lower threshold in terms of referral to treatment times.

Dr Vibhishanan considered it was good that she had received some letters back from Choose and Book asking if the patient had received adequate physiotherapy and analgesia and so were implementing the MSK pathway. Mrs White confirmed RAS were making challenges in line with the Value Based Commissioning (VBC) Policy. The physios across Shropshire had been meeting to discuss how they can provide standardised evidence based treatment that supports the VBC policy and were being supported by Keele University and at the local libraries also. Physiotherapy services were being reviewed and there would be a specification produced.

Patients were still reporting consultants were still advising they needed an operation. This was being addressed in conversations around the SOOS model. From September, there would no longer be paper referrals and all would need to be electronic with a preference for those to go through RAS. Work was ongoing to try and achieve a culture change where patient expectation was lowered in terms of referral to treatment times.

Dr Tomlinson reported he was happy with progress made so far with the project. It was pleasing to see people were working collaboratively. Following an enquiry from Dr Lyttle about urgent referrals under SOOS, Dr Tomlinson explained when a clinical lead had been appointed, it would be part of their role to look at an urgent service for patients to provide urgent assessments. If any Members wished to work with the new clinical lead to develop that, expressions of interest would be welcome.

**Action:** Expressions of interest invited to work with the new clinical lead to develop an urgent service for SOOS to be forwarded to Mrs Nina White and/or Dr Tomlinson.

**Minute No North.2017.06.45 [Item 10]– Good things/Bad things**

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. Members were asked if they wished to raise any positive and/or negative issues, which were noted as follows:

**Good things**
- Dr Booth reported he had finally managed to get someone referred to an ADHD clinic in Telford and Mr Kubilius was trying to set one up in Shropshire.
- Dr Vibhishanan reported she had received good service using the CMHT helpline asking for a call back. Dr Vibhishanan had spoken to CMHT who had explained what had been done even though it was not through CMHT. The manager of the helpline had agreed with Dr Vibhishanan’s concerns and had managed the issue effectively. It was considered it was a good start they were open to feedback to what the issues were and encouraged to get in touch with them.
- Dr Matthee reported Market Drayton Medical Practice was referring more patients to SOOS.

**Bad things**
- Dr Clark raised issues with x-rays being rejected with some considered borderline. An example was given of a patient who would have benefited from a simple ultrasound. These were being rejected predominantly when it altered the management. It could be seen that they were being rejected because of the pathway but it is a clinical decision. Mr Bradbury said Caxton Surgery had experienced this also. **Action:** Dr Clark was requested to forward the details of x-rays being rejected to Dr Julie Davies who would look into this issue.

- Mrs Matthee reported a quality issue in that a message had been received to state there were no typists at Shrewsbury or Telford either being done externally or automatically. Market Drayton had received one that had come back on a hip and actually the x-ray was on an ankle. The concerning thing was the report usually comes back within two weeks and the practice had 5-6 a week that had been taking longer. It was also stated that only the referring doctor or consultant could enquire about result and no patient, secretary or receptionist. Ms Jenny Davies reported her practice had followed this up and SaTH had said they had been unaware of the letter. Mr Storey passed a hard copy of the letter to Dr Julie Davies, which had been forwarded to all practices the day before. **Action:** Mrs Matthee was requested to forward the details of this case to Dr Julie Davies who would look into the contract and with Mrs Beal as a quality issue. Dr Davies to notify Members of the outcome.
Dr Matthee relayed a concern from a GP Partner when the GP was called about a frail patient at 6.45pm on a Friday and following discussion with relatives it was decided the patient needed to be admitted, which was organised through care co-ordination. When paramedics attended they said the patient’s blood pressure was fine and did not convey the patient. The practice received a phone call on the following Tuesday about the patient not realising the patient had not been taken to hospital. Dr Matthee also voiced concern for the ambulance staff when placed in such situations and the feeling that they were being asked to avoid hospital admissions and was considered dangerous.

**Action:** Dr Matthee was requested to arrange to have this issue logged on NHS to NHS concerns and emphasised the importance of logging reports as evidence to enable Dr Davies to challenge the Ambulance Service over such issues.

Dr Lyttle had been asked by Bridgewater’s Practice Manager to ask Members if they had experienced lack of foot screening services. Members agreed, particularly at Caxton and Market Drayton Medical Practices with a clinic being cancelled and it was believed this was due to a capacity issue.

**Action:** Dr Julie Davies to look into decrease in foot screening service availability.

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**Minute No North.2017.06.47 [Item 11] – Update on Mental Health Issues**

Richard Kubilius, Commissioning Lead for Mental Health, presented the following verbal updates:

**Attention Deficit Hyperactivity Disorder (ADHD)** – Mr Kubilius was working with a local provider in Telford and Wrekin to develop a local service, initially to be based in Shrewsbury. At present, patients can be referred to the Telford clinic but it was going through a due diligence process and CQC registration and hopefully a more local service would be provided from September.

**Autism Spectrum Disorder (ASD)** – There was an increasing number of referrals for assessment and diagnosis with no real gatekeeping process. Mr Kubilius was working with the Autism Hub at Louise House as a gatekeeping process and potential to offer alternatives. Currently patients were being offered a service in Cheshire and the Wirral and Mr Kubilius welcomed feedback from GP Partners on this service.

**Crisis** – A new service had commenced with Shropshire Sanctuary, initially looking at an alternative for patients detained under a Section 136. This service is based at MIND, Observatory House in Shrewsbury and would be available 365 days a year, 7 days a week until 3am. Mr Kubilius acknowledged this service would be currently centred in Shrewsbury but transport was available to take patients home once crisis has been averted. The service was an 18-month pilot and the expectation was that once the scheme had been tested with the police it would be opened up to patients presented at A&E for a crisis.

**Children and Young People** – Under the new Emotional and Health and Wellbeing Service, a new service had been procured which was being led by South Staffordshire and Shropshire Foundation Trust (SSSFT) and had commenced on 1st May and at present access was via COMPASS. There had been some initial issues to clear the existing waiting list, which it was hoped would be cleared by the end of August. An online counselling service with peer support was also available and provided by KOOTH. There was also Helios, a remote access service that delivers evidence based interventions, including ASD and ADHD assessments and diagnosis, and is NICE approved.

It was acknowledged Members had felt access via COMPASS was not ideal. SSSFT was aware of previous issues but there would be some engagement work following which it was hoped there would be a difference in access with an approximate timescale of September.

**IAPT and GP Counselling** – Pete Downer and Mr Kubilius would be putting some dates forward and would be conducting engagement about the redesign of psychological therapies in primary care.

**Primary Care Liaison (PCL) Workers** – The latest proposal received from SSSFT of how the PCL workers would be reinstated did not state as soon as possible as originally promised and therefore was not acceptable and was being challenged. Mr Kubilius was awaiting a response.

**Physical Health Checks** – Members were asked to forward any ideas for physical health checks for people with severe mental illness to Mr Kubilius. Dr Matthee advised Dr Jamie Malcolm carried out all the health checks at Market Drayton Medical Practice but had been very disappointed when the PCL workers had been withdrawn, particularly has he had led the initial set-up of the service.

**Action:** Members were requested to forward ideas for physical health checks for patients with severe mental illness.
Dr Matthee referred to a previous discussion on CAMHS when it had been proposed to split the service for Autism/Aspergers, neurological development and patients with mental health issues into specific teams. It was confirmed that part of the central monies allocated had been invested in developmental services and Mr Kubilius would forward to Dr Matthee a copy of the Conditions of Precedent, which included further information about the separate teams.

**Action:** Mr Kubilius to forward a copy of the Conditions of Precedent to Dr Matthee for information.

Dr Matthee raised an important concern over assessments conducted by phone and referred to a patient who had taken an overdose and had been asked to call a number only to be then told they would need to wait 4 weeks for an assessment. It was considered the process was very dangerous and an incident was likely to happen. Furthermore, the process had been put into effect and had not been approved by the Locality Boards.

**Action:** Dr Matthee was requested to ensure a datix report was logged with the details of this case and a copy also to be forwarded to Mr Kubilius to look into concern.

Dr Lyttle suggested, because of the complex changes in the processes within the Mental Health Service, it would be very useful for GPs to receive a simple guide / flowchart of the current process and pathways for referrals to mental health services, including up-to-date contact numbers and charities.

**Action:** Mr Kubilius was requested to arrange a guide/flowchart of the current process for referrals to mental health services.

Mr Kubilius considered it would be the best way forward to wrap the mental health services around the cluster models. It was hoped the review of IAPT and GP counselling would help the build up of services around a cluster model.

Dr Sokolov referred to the last meeting when Members had been broadly supportive of the clusters, however, for chaotic patient groups especially, travel to access treatment needed to be considered as transport in the county was not straightforward.

**Minute No North.2017.06.48 [Item 12] - Any other business**

1. **Local Enhanced Review** – Mr Bradbury referred to a previous discussion about figures for Minor Injuries and Phlebotomy activity and enquired as to the process. It was reported the specification for both had been done. The list had been forwarded to June Telford and if some of the ideas were not included this year were being prepared potentially for next year.

**Action:** Drs Sokolov and Lynch would ask June Telford for an update.

2. **GP Resilience Programme for vulnerable practices** – Nicky Wilde, the new Director of Primary Care, was aware the funding NHSE had allocated to all practices had been paid into separate ‘holding’ accounts and the north locality’s funding was still with Cambrian Medical Practice. June Telford was chasing up and would ensure the monies, approximately 30p per patient, would be paid to practices.

Regarding the commitment that the monies was to be used for collaborative resilience work in the locality, it was understood there had been a suggestion the monies could be used for a pharmacist but Members had not fully discussed this. It was agreed June Telford would do the fact-finding and ensure a plan was submitted to NHSE.

**Action:** Members were requested to forward ideas on resilience monies direct to Nicky Wilde and June Telford.

**Minute No North.2017.06.49 [Item 13] - Date of Next Meeting**

The next meeting had been arranged to take place on:

**Thursday 27 July at Market Drayton Medical Practice**

**Future Dates for North Locality Board Meetings**
- Thursday 7 September, The Venue at Park Hall, Oswestry
- Thursday 26 October, Market Drayton Medical Practice
- Thursday 23 November, The Venue at Park Hall, Oswestry
- Thursday 25 January 2018, Market Drayton Medical Practice

**Signed:** ............................................................  **Date:** ............................................................
## Actions from the North Locality Board Meeting held on 8 June 2017

<table>
<thead>
<tr>
<th>Minute No.</th>
<th>Action Required</th>
<th>By Whom</th>
<th>By When</th>
</tr>
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<tbody>
<tr>
<td>Minute No North.2017.06.40</td>
<td>4. Matters Arising</td>
<td>ALL</td>
<td>On-going</td>
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<tr>
<td>[5.0] Accountable Officer/Chair Update</td>
<td>Practices were requested to contact RAS directly if they would like to arrange a practice visit from Sam Duckett and Jo Mason, Clinical Triage Assessors.</td>
<td>ALL</td>
<td>Next meeting</td>
</tr>
<tr>
<td>[6.0] Locality Chair Update/Resilience Monies</td>
<td>To add GP 5 Year Forward View and Primary Care as a standing item on future agendas.</td>
<td>Mrs Stackhouse</td>
<td>7 September meeting</td>
</tr>
<tr>
<td>[9.0] Peer Review on UTIs</td>
<td>To bring back to the meeting in three months’ time the findings of the self-audit for further Discussion.</td>
<td>Dr Vibhishanan/Sue Evans</td>
<td>7 September meeting</td>
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<thead>
<tr>
<th>Minute No North.2017.06.41</th>
<th>5. Prescribing Update</th>
<th>ALL</th>
<th>As soon as possible</th>
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<tbody>
<tr>
<td>Cost Effective Prescribing Framework (CEPF)</td>
<td>To take forward the sharing out of the pump priming monies between the remaining practices if the four outstanding practices decided not to join the CEPF scheme.</td>
<td>Mr Mackey</td>
<td>As soon as possible</td>
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<tr>
<td>ScriptSwitch</td>
<td>To look into alcohol services and present position regarding the availability of Antabuse.</td>
<td>Mr Mackey</td>
<td>As soon as possible</td>
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<tr>
<td>Care Homes</td>
<td>To seek indemnity advice and write out to practices advising of outcome.</td>
<td>Mr Mackey</td>
<td>As soon as possible</td>
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<tr>
<td>Clinical Pharmacist in General Practice</td>
<td>If any Members had any further questions about switches they were invited to contact Mr Mackey.</td>
<td>ALL</td>
<td>On-going</td>
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<tr>
<th>Minute No North.2017.06.44</th>
<th>8. Frailty Programme</th>
<th>Mrs Stackhouse</th>
<th>As soon as possible</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mrs Stackhouse to circulate electronic copies of the update presentation on Frailty for information for Members</td>
<td>Mrs Stackhouse</td>
<td>As soon as possible</td>
</tr>
<tr>
<td>Minute No North.2017.06.45</td>
<td>9. Musculoskeletal (MSK) Update</td>
<td>Expressions of interest invited to work with the new clinical lead to develop an urgent service for SOOS to be forwarded to Mrs White and/or Dr Tomlinson.</td>
<td>ALL</td>
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</table>
| Minute No North.2017.06.46| 10. Locality Assurance Framework – Good things / Bad things | To forward details of x-rays being rejected to Dr Julie Davies who would look into this issue.  
To forward the details of delay in letters received and the hospital saying there is a shortage of typists to Dr Julie Davies who would look into the contract and with Mrs Beal as a quality issue.  
Dr Julie Davies to notify Members of the outcome.  
To arrange the issue regarding the frail patient not being taken to hospital logged on NHS to NHS concerns.  
Dr Julie Davies would look into this issue.  
To look into the decrease in foot screening service availability. | Dr Clark / Dr Julie Davies  
Mrs Matthee / Dr Julie Davies  
Dr Matthee / Dr Julie Davies  
Dr Julie Davies | As soon as possible  
As soon as possible  
As soon as possible  
As soon as possible |
| Minute No North.2017.06.47| 11. Update on Mental Health Issues | Feedback welcome on the ASD service provided by Cheshire and the Wirral to be forwarded to Mr Kubilius.  
To forward ideas for physical health checks for patients with severe mental illness.  
To forward a copy of the Conditions of Precedent for information for Members.  
To forward the details to Mr Kubilius and arrange for a datix report to be logged regarding patient who had over-dosed and had been asked to call number and was informed they would need to wait 4 weeks for an assessment.  
To arrange a guide/flowchart of the current process for referrals to mental health services. | ALL  
ALL  
Mr Kubilius  
Dr Matthee / Mr Kubilius  
Mr Kubilius | On-going  
As soon as possible  
As soon as possible  
As soon as possible  
As soon as possible |
| Minute No North.2017.06.48| 12. Any other business  
12.1 Local Enhanced Review  
12.2 GP Resilience Programme | To ask June Telford for an update.  
Requested to forward ideas on resilience monies direct to Nicky Wilde and June Telford. | Dr Sokolov/ Dr Lynch  
ALL | As soon as possible  
As soon as possible |
Minutes of the South Locality Board Meeting held on

Wednesday 17 May 2017

Bridgnorth Medical Practice

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice/Organisation</th>
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<tbody>
<tr>
<td>Dr Matthew Bird</td>
<td>Albrighton</td>
<td>Attended</td>
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<td>Val Eastup</td>
<td>Albrighton</td>
<td>Attended</td>
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<tr>
<td>Dr Dale Abbotts</td>
<td>Alveley</td>
<td>Attended</td>
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<tr>
<td>Lindsey Clark</td>
<td>Alveley</td>
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<tr>
<td>Dr Adrian Penney</td>
<td>Bishop's Castle</td>
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<td>Sarah Bevan</td>
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<td>Dr Stuart Wright</td>
<td>Bridgnorth</td>
<td>Attended</td>
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<td>Sandra Sutton</td>
<td>Bridgnorth</td>
<td>Attended</td>
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<tr>
<td>Dr Shailendra Allen (Chair)</td>
<td>Broseley</td>
<td>Attended</td>
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<td>Dr Bill Bassett</td>
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<td>Vicki Brassington</td>
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<td>Dr Jennifer Howard</td>
<td>Church Stretton</td>
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<td>Emma Kay</td>
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<td>Dr David Appleby</td>
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<td>Julia Thompson</td>
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<td>Dr Graham Cook</td>
<td>Ludlow (Station Drive)</td>
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<td>Dr Jennie Bailey</td>
<td>Much Wenlock &amp; Cressage</td>
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<td>Sarah Hope</td>
<td>Much Wenlock &amp; Cressage</td>
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<td>Dr Richard Shore</td>
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<td>Sheila MacLucas</td>
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<td>Louise Linning</td>
<td>Shifnal &amp; Priorslee</td>
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<td>Sylvia Pledger</td>
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<td>Roland Johnson</td>
<td>PPG South West</td>
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<tr>
<td>Dr Simon Freeman</td>
<td>Accountable Officer</td>
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<td>Dr Julian Povey</td>
<td>CCG Clinical Chair</td>
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<tr>
<td>Michael Whitworth</td>
<td>Interim Director of Contracting and Planning, CCG</td>
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<tr>
<td>Tony Menzies</td>
<td>Interim Project Manager, CCG</td>
<td>Item 6</td>
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<tr>
<td>Nina White</td>
<td>Head of Primary Care Strategy</td>
<td>Item 7</td>
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<tr>
<td>Richard Kubilius</td>
<td>Commissioning &amp; Redesign Lead - Mental Health &amp; Learning Disabilities</td>
<td>Item 8</td>
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<tr>
<td>Sean Mackey</td>
<td>Interim Head of Medicines Management – Primary Care</td>
<td>Item 9</td>
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<tr>
<td>Shola Olowosale</td>
<td>Primary Care Support Pharmacist</td>
<td>Item 9</td>
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<tr>
<td>Sandra Stackhouse</td>
<td>Committee Clerk, CCG (Minute Taker)</td>
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**Minute No SLB-2017-05.38: Item 1 – Welcome & Apologies**

Dr Shailendra Allen, Locality Chair, welcomed and thanked Members for attending. Apologies received were recorded as above.

**Minute No SLB-2017-05.39: Item 2 – Members’ Declarations of Interest**
There were no additional declarations of interests received for items included on this meeting’s agenda.

**Minute No SLB-2017-05.40: Item 3 – Minutes of the Previous Meeting and Actions**

The minutes of the meeting held on 30 March 2017 were agreed as a true and accurate record and were signed by the Chair.

**Minute No SLB-2017-05.41: Item 4 – Matters Arising**

Dr Allen 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:

1. **[2.0] Members’ Declarations of Interest – Mrs Stackhouse reported most Members had submitted their completed Declaration of Interest forms and there were just a few outstanding, which were being chased up.**

2. **Dr Penney raised the point that now some Members were part of the Our Health Partnership (OHP) should this be declared as an interest. It was understood that the OHP partnership was not classed as one surgery but multiple surgeries and did not directly affect the voting system at the present time. However, the voting rules under the current Terms of Reference would be reviewed if partnerships progressed to joining Multispecialty Community Provider vanguards (MCPs).**

3. **[6.0] Community Mental Health Team (CMHT) – On behalf of Mr Richard Kubilius, Commissioning & Redesign Lead – Mental Health & Learning Disabilities, Mrs Stackhouse had forwarded copies of a letter and an email received from South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) regarding delays to the roll out of the new Access service for Adult Mental Health together with an Access leaflet and poster detailing the numbers to call. It was confirmed Dr Povey had asked Mr Kubilius to look into the issues raised previously and Mr Kubilius would update Members during the discussion under Item 8.**

4. **Dr Bailey raised concern that at present there was no service for practices such as Much Wenlock and Cressage. Dr Allen understood from Dr Povey’s last email that it had been suggested SSSFT had agreed to provide community link workers based on the clusters rather than individual surgeries.**

5. **Dr Abbotts reported he had contacted the Bridgnorth Children’s Mental Health Team (CMHT), which had been redirected to a 0300 number. A message had been left stating it was an urgent issue but no reply had been received. After telephoning the third successive morning, Dr Abbotts was informed the issue would be passed on but could not talk to the clinician direct and a letter would be sent informing the GP of the actions taken. It was felt the response had been unprofessional with no follow-up, especially for a patient threatening suicide. The issue was the GP was passing on information to a non-clinician who was unable to assess the urgency of the case and therefore was considered bad practice. It was also not beneficial to deal with such urgent cases through an email, fax or letter as had been previously requested. Dr Abbotts said he would need to call again the next day to check progress with the patient.**

6. **Dr Wright asked if this was a service that the CCG had commissioned or that had been given. It appeared that the previous complaints Members had made about COMPASS had been replicated in the CMHT service. Complaints had been made for a long period of time and Members wished to have a proper referral system. Dr Allen confirmed the new contract for the 0-25 age range had built in a specification for urgent and crisis. SSSFT was keen to work with the CCG and Dr Allen would raise the points made at the CQRM meeting on Friday.**

**Action:** Dr Allen to raise the issue of CMHT’s lack of urgent response after contacting the CMHT central number and GPs unable to speak directly to a clinician. Dr Allen to feedback outcome of discussions at CQRM meeting. [*Dr Allen has actioned.*]

7. **Dr Bird confirmed he had received a telephone call from Paul Cooper, Adult Safeguarding Lead, requesting further details of the issue raised which Dr Bird had been required to chase up and the safeguarding team had not been aware of the request but had resolved the issue immediately. Dr Bird was still awaiting feedback from Mr Cooper and Mrs Stackhouse agreed to follow up with Mr Cooper.**

**Action:** Mrs Stackhouse to ask Paul Cooper for feedback regarding the issue raised by Dr Bird about delays and the original message not getting through to safeguarding team.

8. **11.3 Any other business: Ophthalmology and Neurology Referrals in Shropshire – Dr Penney confirmed he had received a telephone call from Mrs Nina White, Head of Primary Care Strategy and also that Bishop’s Castle had had a Rheumatology referral accepted but the patient was required to attend Newtown, Powys.**

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South Locality Board Minutes – 17 May 2017
Dr Allen referred to an email sent to all practices suggesting a 30-45 minutes meeting and there had been some progress already made. Dr Allen was still awaiting replies from some surgeries and explained his role was to represent Members on the CCG Governing Body Board and was willing to help practices.

**Action:** Dr Allen/Mrs Stackhouse to contact the Practice Managers requesting outstanding meetings.

**Minute No SLB-2017-05.42: Item 5 – Locality Chair’s Update**

Dr Allen referred to the following areas asking if there were any comments or questions:

- **Midwifery Led Units (MLU) Service Review** – Dr Cook asked if there were Members from the Locality Boards feeding into the review, and if so, who was representing the South Locality. It was explained there was a team led by Dr Jessica Sokolov, Clinical Director for Women & Children’s, who met on a monthly basis, and a report was due in June. It was understood all the stakeholders attended that meeting and there would be an opportunity to comment once the report had been finalised or comments could be forwarded earlier directly to Dr Sokolov. Dr Allen requested to be copied in also and would discuss further with Dr Sokolov on the way forward for the locality’s input.

**Action:** Mr Whitworth to organise Membership details of the MLU to be circulated to Members for information.

**Accident and emergency** – Performance had improved month on month from its lowest point in January.

**Fragile Services** – SaTH have declared the following services as fragile: Emergency Departments, Ophthalmology, Neurology, Dermatology, and Spinal Surgery.

**Major incident update** – IT provider (MLCSU) has been worked with other organisations to try to resolve the issue and has installed a range of new security patches on networks where required.

**Key achievements/areas of work** – Contained a list of areas of work achieved so far and the direction for the future.

**CCG’s Financial Recovery Plan** – The Plan, based on six areas, had been approved by the Governing Body.

**Minute No SLB-2017-05.43: Item 6 – Healthcare in the Community: Suggestions for New Ideas**

Dr Allen explained that this item had been added particularly because previously the agenda had appeared to have a top down approach and thought discussion was needed of which areas Members wished to cover. Ideas and suggestions were welcomed and the following points were raised:

- Dr Cook agreed saying that both Dr Povey and Dr Freeman had stated at the Locality Board meeting that the Localities should be driving the CCG and therefore the agenda should be locality-driven.
- Dr Allen affirmed that according to the Constitution, under NHS England’s law, the CCG was accountable to the GP Membership. The Locality’s remit was to direct the CCG Board on what it would like to commission and should feel empowered that it has the capacity to change the direction the CCG was taking within its guidelines.
- ‘Healthcare in the Community’ would be kept as a standing item. The locality had a significant proportion in Shropshire’s health economy and should discuss and work together.
- Members were invited to suggest areas for discussion under this item particularly directed for the locality by the GP surgeries or clusters.
- Dr Beanland raised her involvement in the Community Services Review (CSR) and questioned whether efficiencies had already been decided and was it really to meet the requirement that GPs had participated. Dr Wright seconded this view in that the CSR meeting had almost started with an outcome and the review was working backwards to provide the evidence to support that outcome.
- Narratives demonstrated there is huge variability in services offered in community hospitals.
- Dr Penney argued the CSR should be addressing the community beds were miss-managed.
- It was felt that in the statistics it appeared primary care was responsible for the long delays by not dealing with the right people when actually the patient was an inappropriate admission.
- Mr Whitworth explained that the review carried out by Deloittes had highlighted a number of areas where the CCG should look around its financial recovery and it appeared to be spending £5m more than it would expect to. The Optimity Review was looking at how the health economy could work together differently in developing neighbourhoods and capacity and builds upon those to achieve the best value. There was a workstream based around the community services, looking at beds not just in the community hospitals but other beds accessed.
- Mr Whitworth quoted an example of a committee of GPs, nurses and therapists formed in North Yorkshire that had been given a budget and outcomes required to commission community services. Some difficult decisions had been made but it resulted in excellent local services, for example, for stroke rehabilitation and minor injuries. The CSR was an opportunity to understand what services there are, how it works and what is needed now to best maximise those resources.
- Dr Beanland raised she did not wish it to be the voice of the two representatives in the CSR but the locality’s voice and would like the Locality to express what it wanted out of the community hospitals and what could be done together.
• Dr Allen would like to see GPs get involved to create new services. The GP Forward View was available to invest in these services and robust plans could be put forward to the CCG.
• Dr Wright outlined briefly the plans for the Frailty Service pilot he had been involved in developing with various bodies working together, which had since been curtailed owing to lack of funds. It was these kinds of services that could be offered in places like the community hospitals but there needed to be a hub part way into the communities.
• Members were very wary of partaking in new projects owing to large amounts of work hours invested in developing pilots, which in the end had been taken further. A lot of professional energy and clinical intelligence work had been undertaken and now there were less doctors and professionals to give the confidence to champion these schemes.
• Dr Allen pointed out the GP Five Year Forward View was encouraging the development of such schemes.

**Action:** Mrs Stackhouse to add standing item: Healthcare in the Community to future agendas.

**Members were invited to suggest areas for discussion under this item.**

**Community Services Review**

Mr Tony Menzies, Interim Project Manager, attended to give an update on the Community Services Review (CSR) outlining the remit of the Clinical Reference Group, which is chaired by the clinical leads and includes GP Members from each of the three localities and clinicians from SCHT. At the first meeting, the group had decided that a further clinical audit was required to support the activity data. Mr Menzies stressed that the Group was listening to advice from clinicians and using the feedback in a positive way. There was a large amount of communication and engagement, which was a key part, with the patient participation representatives and other groups such Healthwatch but there had been a request that the same questions should not be repeated.

It was commented that the Urgent Care project had been entirely driven by Shropshire Community Health Trust (SCHT) and the presentation had proved unpopular as it had appeared to be very much a top down approach with changes already decided. It was pointed out that the summing up did not necessarily represent the discussions that had taken place. The next steps would be to:

- Finalise the community bed audit.
- Carry out the clinical audit for all three services.
- Write the current state assessment for all three services.
- The Clinical Reference Group will review the assessment and recommend to the CCG Governing Body whether a case for change exists for any of the three services.
- The CCG Governing Body will make the decision on whether a case for change exists and if so engagement with the public will commence and the next step would be how options will be developed.

Dr Cook commented that it was good to hear that these areas were being looked at but changes had already happened without prior consultation, ie minor injuries, 24 hours to 12 hours cover, midwife units closing ad hoc, and wards being closed. Dr Allen explained that there had been an update at the CCG Board meeting when it had been explained there had been a shortage of midwives in the south at weekends. No decision had been taken so far to shut down or reduce the services.

Mr Menzies stressed that no steps had been taken with community services with this review. If community services were currently being run inefficiently and not providing well, it was an opportunity for primary care to look at those services. At present, 90 per cent of the funding was spent on secondary care and 10 per cent on primary care. Dr Beanland voiced the view that it was unrealistic if the plan was to move all the community services to primary care and somehow was expected to manage and also generate a reduction in costs. Mr Whitworth reassured Members there was no pre-determined solution.

**Action:** Mrs Stackhouse to circulate copies of the CSR update presentation for information for Members. [Actioned on 25/05/17.]

**Minute No SLB-2017-05.44: Item 7 – MSK Update**

Mr Michael Whitworth, Interim Director of Contracting and Planning, and Mrs Nina White, Head of Primary Care Strategy, gave a high level outline of the plans for Musculoskeletal (MSK) services. In 2018/19 the CCG was looking to have an integrated community based MSK service for the whole of Shropshire. The main initiative was around value based commissioning and expanding the Shropshire Orthopaedic Outreach Service (SOOS) or its equivalent to the south locality. A question and answer session took place and the following points were made:

- It was the aim that GPs would have quick access to physiotherapy and if a patient needed a joint injection and the practice provides that would continue. The general pathway would be that the service would decide if the patient required surgery and GPs would not be involved further in decision-making however, there would still be the option for GPs to refer directly.
It was argued that GPs felt completely confident and competent to decide whether a patient should be referred into the physiotherapy pathway and an intermediate tier was not needed.

Dr Allen advised the system of intermediate MSK services, from the point of view of Telford & Wrekin, had achieved £1.5m savings in secondary care. It was suggested that because of the rurality, Shropshire might not be able to generate the same savings.

The overall number of referrals in the south appeared to be lower than other areas but the CCG did stand out as a national outlier. The Right Care figures stated that the CCG was spending £5m more than would be expected. Value based commissioning had potential efficiencies for the CCG but was quality driven.

The process proposed had been run in North Worcestershire for approximately 10 years with the best intentions but ceased as it was found it tended to prolong the patient’s pathway prior to surgery.

There were special skills in the community for treatments and it was requested to offer an enhanced service for treatments such as joint injections

The plan was to have hubs and spokes in each locality with the aim to have localised services.

As regards whether the system created delays, the evidence suggested that for some interventions there were as good or better outcomes from using alternatives.

It was pointed out the proposed system entailed a large team of people to process all referrals.

A year ago, SCHT representatives had promised the south locality a service which had not materialised.

Members welcomed the proposal of local services for patients with conditions, such as carpal tunnel or shoulder problems. Practices located in the South East had previously asked for access to services in Wolverhampton but Telford and Wrekin CCG would not authorise access.

It was questioned what was the point of trying to solve the number of referrals from the north by creating an entirely new service in the south resulting in staff moving leaving no backfill and patchy services.

There were no plans to stop and de-skilling primary care and if practices carried out certain procedures the CCG would wish them to continue.

The CCG was being encouraged to follow national directives to follow the proposed model and the CCG to create a service that works best for Shropshire.

The finance and right outcomes needed to be weighed up with the model which was being developed by Dr Chris Tomlinson, which had been proved better for patients.

There were currently four physio providers and the plan was to rationalise to create an equitable service across the county.

**Minute No SLB-2017-05.45: Item 8 – Update on Mental Health Issues**

Mr Richard Kubilius, Commissioning and Redesign Lead for Mental Health and Learning Disabilities, updated Members on the following:

**Attention Deficit Hyperactivity Disorder (ADHD)** – A paper had been presented to the Clinical Commissioning Committee (CCC) on developing a service for ADHD, which had been broadly approved in favour of developing a more local service initially in Shrewsbury. The current provider does not prescribe which had caused issues for patients. Work was on-going with carers about developing a more accessible diagnostic service. Whilst both ADHD and Autism Spectrum Disorder (ASD) are neurodevelopmental disorders it was hoped in the medium-longer term services would be linked together but in the shorter term, there would have to be an ASD service.

Path House had closed on 31st March and the Shropshire Sanctuary would be starting soon, which would initially be for people who are detained under a Section 136. Shropshire Sanctuary had brought Shropshire MIND and Shropshire Samaritans to work together offering a physical location, Observer House, Shrewsbury for people to attend up until 3am, 7 days a week. The hours had been based upon the data for people experiencing crisis through Section 136 initially but as soon as the model has been tested, the CCG would be looking at setting up pathways from A&E. This was a non-clinical model so was more of a listening service.

Dr Walton queried because both the Samaritans and MIND were charities, how was the service being commissioned and was there a service level agreement. Mr Kubilius clarified the Samaritans was part of the specification but the contract would be with MIND because the Samaritans did not accept any public funding. As this was located centrally and public transport was not ideal, part of the funding had been committed to transport in the form of a taxi firm available 24/7 to take patients home when crisis has been averted.

Going forward, mapping and analysis work would be carried out on the urgent and crisis pathway for people in mental distress. As part of implementing the GP Five Year Forward View, there was additional money available from NHSE to be able to invest into acute and crisis care but analysis needed to be carried out before decisions were made on what urgent and crisis care should look like for Shropshire.

Mrs Pledger referred to the use of taxis and asked whether the drivers would be trained to deal with mental health patients in distress or whether a worker would be in attendance to collect the patients. Mr Kubilius
confirmed if someone was going to be collected then a worker from The Sanctuary would accompany them. When their mental stress had been averted, they would go home without a worker present. Mr Kubilius confirmed the process was to be scrutinised closely with the steering group and would raise this issue there.

Children and Young People – A new service had been procured, which was being led by SSSFT. A partnership had been developed with Kooth, a free online counselling and emotional well-being service for children and young people available up to 10pm daily. Kooth was highly recommended and already available for patients to access. Mr Kubilius was requested to forward guidance on how patients can access Kooth because it was reported problems with gaining access had been experienced if a patient was not registered with the practice on the system. There is also Heallocs, a remote access service that delivers evidence based interventions, including ASD and ADHD assessments and diagnosis, and is NICE approved.

The new contract began on 1st May and at present access was via COMPASS. It had been acknowledged there were known issues with COMPASS which, along with the pathways, was being prioritised for improvements. Mr Kubilius was a member of the Implementation and Assurance Group and said it did feel very different and it looked like there would be an emotional and health and wellbeing service that is fit for purpose. It was in its infancy and it would take time and Mr Kubilius would keep Members updated. Feedback was welcomed on how Members would like to access the service.

Psychological Therapies in Primary Care – Access to service in primary care is not equitable and this was being reviewed shortly after the purdah period when the locality would be contacted for feedback and input on how that should look like and hopefully there would be a more localised service. It was queried why internal conversations could not take place during purdah as there were no political issues involved. Mr Whitworth outlined the guidance why CCGs were discouraged to hold commissioning conversations.

There needed to be a review in primary care of psychological therapies. There was an access target of 15.8% this year, increasing to 25% by 2021. For this reason the baseline access to psychological therapies needed to be right in primary care in order to continue with the on-going work which was increasing the access and doing the integration with the long term conditions also. Mr Whitworth explained the funding for this service had been ring-fenced.

Dr Wright argued that much concern had been expressed about the service over the past year and a patient receiving a phone call three weeks after referral to inform the patient they are on the waiting list is not access and the start date of treatment would be considered as access.

Dr Bailey also raised there were obstacles for people getting into the service in the first place. Some patients were very anxious and had difficulty making contact by phone. GPs had been told they could not email in and Dr Bailey had experienced difficulties trying to refer patients. Dr Beanland added there was a real issue that patients of 17 years of age were offered a vastly inferior service than an 18-year-old.

Action: Mr Kubilius to feedback comments made to the Mental Health Trust.

Mr Kubilius to forward to Members guidance on accessing the Kooth online counselling service.

Community Remodelling – It was acknowledged there had been communication issues over the community remodelling services. Attempts were being made to improve the lines of communication and Mr Kubilius would take feedback back to SSSFT.

Reference was made to the earlier conversation under Item 4, Matters Arising, 6.0 when Members had voiced they did not like COMPASS. The question was asked if this service had been commissioned and specified by the CCG or had been given by SSSFT then could the CCG commission another service.

Mr Kubilius referred to the guidance circulated about the Access Services for Adult Mental Health, which commenced on 1st May but there had been some delays in certain areas. Members shared experiences and Mr Kubilius said he would feedback to SSSFT and state more GP input was required. Dr Beanland complimented the previous service recounting an instance when the health professional asked for her patient to be directed to them straightaway and wished this immediate response could continue.

It was also pointed out that the phone number quoted was for Shropshire’s entire population and the health professional could find themselves overwhelmed and could there be one dedicated GP. Mr Kubilius confirmed this had been raised before but had been refused. It was pointed out that practices were expected to provide a professional line and so SSSFT were not following the standards of the provider. Dr Allen and Mr Kubilius would pick up this query.

Action: Dr Allen/Mr Kubilius to raise with SSSFT whether a dedicated GP / professional line could be provided. [Actioned.]
Mr Sean Mackey, Interim Head of Medicines Management – Primary Care, and Shona Olowasale, Locality Primary Care Support Pharmacist for the South, attended to give updates on the following using presentation slides, a hard copy of which was tabled:

- April 2016-February 2017 Prescribing spend growth
- Prescribing spend per Net Ingredient Cost per Age, Sex and Temporary Resident Originated Prescribing Unit (NIC/ASTRO-PU) comparison.
- Practice Actual Cost Growth – Colour-coded with practices highlighted in green if there were no concerns and red if there were. Generally across the south locality all practices had done really well.

Cost Effective Prescribing Framework (CEPF):

**Practice mandatory action plans** – All practices’ actions plans had been discussed at the Medicines Optimisation Committee and had been approved. This would allow the second pump priming payment to be made available to claim against as shown in the third and fourth columns on the chart. At a PLT session there had been some interest at looking at using the funding to pilot the use of pharmacists. The south locality had a total of £180K from last year’s and this year’s scheme in order to do that.

**Drug switches** – Commencing from June the Medicines Optimisation Team (MOT) would be running all the drug switches in practices so data sharing agreements were required to ensure the Team could access systems remotely. It was hoped these would be completed by end July/beg August.

**Oral Nutritional Supplements (ONS) pathway** – Prescribing spend was decreasing and Ms Bainbridge had continued with the work of patients who did not need to be on ONS. However, it had not been noticed some new patients had been started on ONS without going through the ‘must’ and weight scores. It was requested if Members could remind their partners, clinicians and practice members to adhere to the ONS pathway.

**Selfcare pathway** – Campaigns will be run with the media around advising patients to purchase certain over the counter drugs, as agreed in the action plans. Dr Abbotts had some ideas for dispensing practices being able to sell some of these items in rural areas and if there were expressions of interest to discuss further Members were invited to contact Dr Abbots.

**Scriptswitch adherence** – Members were reminded to use the feedback button if there are medications included on the system they were not happy with.

**Remote access** – Practices were encouraged to sign the data sharing agreements as soon as possible and the Team would be able to action the switches as soon as possible.

**Practice specific action plans** – Practices had specified actions that the Team would be assisting with.

Optional: **Prescriptions Ordering Direct (POD)**: The system was scheduled to go live on the 5th June at Severn Fields Medical Practice and it had been recommended that the next be offered to a practice in the south locality. In answer to Dr Allen’s question about whether practices required electronic prescribing for most of the patients who ring in for POD, Dr Mackey confirmed it was a possibility and this was being looked into, ie looking at whether a connection to a printer could be used.

Other schemes:

**Wound Care Pilot Project** on direct order system to be done within the south locality due to increase in growth spend. There will be three phases: District Nurse base team, Nursing Home and practice base. A positive outcome of the pilot would lead to a tender process in partnership with Telford CCG. The suggested DN based is Albrighton and Shifnal. Nursing care home: The Cedars (managed by the Albrighton Practice); practice prescribing: Shifnal & Priorslee Medical Practice. It was confirmed this arrangement would affect dispensing practices that usually dispensed their own supplies and further discussions were needed. In other areas there had been shown to be a 20% reduction in volume of dressings when supplying one dressing at a time. Dr Abbotts advised that the initial feeling was that dispensing practices would lose some income but at the same time would lose the inconvenience involved in ordering and distributing in packs. Dr Abbotts was to look at this further and interested practices were asked to contact Dr Abbots.

**Traffic Light Formulary** – An agreement had been reached with SaTH and the Formulary Committee to agree a traffic light formulary system. This was considered a real positive move and long awaited. The online formulary accessed will be a whole health economy approach and will be the same for: SaTH, the CCG, Primary Care, the Shropshire Community Health Trust (SCHT), SSSFT and Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH).

**Care Home Team** – The Team was setting up de-prescribing reviews over the next nine months with input from a GP with a Special Interest (GPwSI) support with pharmacists. If practices were planning to carry out CHAS reviews, they were requested to link in with the Team to do a ward round approach with the pharmacists to obtain a holistic review.

**Dietetic support** – Ms Bainbridge’s next project after the ONS work was to look at a new baby milks pathway and formulary around August-September 2017.

**Respiratory Formulary Update** – Ms Olowasale had been working with Dr Wilson and a COPD folder was to be produced containing a small number of new drugs, which would help with efficiencies, for example a
new brand of Tiotropium had recently been launched: Braltus Zonda and consideration should be given to switching clinically appropriate adult COPD patients on Spiriva Handihaler to the Braltus. For dispensing practices, Dr Abbotts had met with the representatives and practices should automatically be signed up by the wholesaler.

Currently the CCG was £1m underspent on prescribing compared to the previous year and in the last month a 10% drop had been seen compared with the previous month. Practices had been supporting the team and it was really appreciated.

**Action:** Members were invited to contact Mr Mackey via email with any further queries they may have on items discussed to: smackey@nhs.net

Practice Members were asked for their continued support in using ScriptSwitch suggestions and were requested to continue to use the feedback button.

Mrs Stackhouse to circulate copies of the Prescribing update presentation for information for Members.

**Minute No SLB-2017-05.47: Item 1 – Locality Assurance Framework (LAF)**

The most recent copy of the Locality Assurance Framework (LAF) had been previously circulated for information for Members with hard copies tabled with the meeting papers.

Regarding the issue of violent and aggressive patients previously raised by the North Locality. June Telford, Head of Primary Care, was liaising with SecureUK, the Telford and Wrekin provider and Shropdoc, about a potential service for Shropshire patients. Ms Telford would be able to provide an update on the commissioning of a pilot shortly. There were no further comments or feedback. It was raised that there was an understanding that there was already a system in place and Dr Allen offered to find out.

**Action:** Dr Allen to investigate further into whether Shropshire CCG already had a system in place to address the issue of Violent and Aggressive Patients.

**Minute No SLB-2017-05.48: Item 11 – Any other business**

**11.1 Locality Clusters**

Dr Beanland drew attention to Dr Povey’s recent letter regarding the suggested Locality Clusters and asked how these had been formed. It was understood for practices in OHP but not for other groups, such as Cleobury Mortimer grouped with the Ludlow practices as historically the Ludlow practices would have normally be partnered with Craven Arms.

Dr Wright confirmed the clustering had been based on the mental health clusters. Dr Allen explained that geographically the area had been divided purely for commissioning purposes so that it would be easier for clusters to access the various providers in a particular locality. There was no problem envisaged if there was an affinity for one surgery to work with another. Concern was raised that both the Ludlow practices had just less than the NHSE requirement of 30,000 patient list size to join OHP and urgent conversations were requested with practices on the way forward.

Mr Whitworth explained the CCG had planned to group practices together into units that community services could be wrapped around, such as mental health services, where equity of access could be achieved as there was an awareness it was difficult over a rural area. Attempts were being made to combine these services with the local authority’s neighbourhood and prevention work and the CCG was asking the localities to have those discussions because it needed to be decided what community services were required which could be wrapped around practices.

Owing to the limited meeting time available, it was agreed this item would be debated more fully at the next meeting and, in the meantime, Members could continue conversations via email.

**Action:** Members requested to consider clustering arrangements for debate at the next meeting.

Mrs Stackhouse to add a dedicated item on the next agenda.

**Minute No SLB-2017-05.49: Item 12 – Date and Time of Next Meeting**

The next meeting has been scheduled to take place on **Thursday 29 June 2017** at The Mayfair Centre, Church Stretton at 4.30pm.

**Dates of Future Meetings:**

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<tr>
<th>Date</th>
<th>Location</th>
<th>Practice</th>
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<tr>
<td>Wednesday 23 August</td>
<td>Bridgnorth Medical Practice</td>
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Thursday 5 October  
Wednesday 15 November  
Thursday 4 January 2018  
Mayfair Centre, Church Stretton  
Bridgnorth Medical Practice  
Mayfair Centre, Church Stretton

Thursday 22 June  
Wednesday 11 October

Signed: ........................................ Date: ........................................

Acting Locality Chair
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<tr>
<th>Minute No.</th>
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<tr>
<td><strong>Minute No SLB-2017-05.41: Item 4 – Matters Arising</strong>&lt;br&gt;6.0 Community Mental Health Team (CMHT)</td>
<td>To raise the issue of CMHT’s lack of urgent response after contacting the CMHT central number and GPs unable to speak directly to a clinician. Dr Allen to feedback outcome of discussions at CQRM meeting. [Actioned.]&lt;br&gt;To ask Paul Cooper for feedback regarding the issue raised by Dr Bird about delays and original message not getting through to the safeguarding team.&lt;br&gt;To contact the Practice Managers regarding outstanding meetings.</td>
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<tr>
<td><strong>Minute No SLB-2017-05.42: Item 5 – Locality Chair Update</strong>&lt;br&gt;Midwifery Led Units (MLU) Service Review</td>
<td>To organise Membership details of the MLU to be circulated to Members for information.</td>
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<td><strong>Minute No SLB-2017-05.43: Item 6 – Healthcare in the Community</strong></td>
<td>To add as a standing item on future agendas.&lt;br&gt;Members invited to suggest areas for discussion under this item.&lt;br&gt;To circulate copies of the CSR Update presentation for information for Members. [Circulated on 25/5/17.]</td>
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<td><strong>Minute No SLB-2017-05.45: Item 8 – Update on Mental Health Issues</strong></td>
<td>To feedback comments made to SSSFT/Mental Health Trust.&lt;br&gt;To forward to Members guidance on accessing Kooth.&lt;br&gt;To raise with SSSFT whether a dedicated GP/dedicated line could be provided. [Actioned.]</td>
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<tr>
<td><strong>Minute No SLB-2017-05.46: Item 9 – Prescribing Update</strong></td>
<td>Members were invited to contact Mr Mackey via email with any further queries they may have to: <a href="mailto:smackey@nhs.net">smackey@nhs.net</a>&lt;br&gt;Practice Members were asked for their continued support in using ScriptSwitch suggestions and to continue to use the feedback button.</td>
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<td>Minute No SLB-2017-05.47: Item 10 – Locality Assurance Framework</td>
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<td>To investigate further into whether Shropshire CCG already had a system in place to address the issue of Violent and Aggressive Patients.</td>
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<td>Dr Allen</td>
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<th>Minute No SLB-2017-05.48: Item 11 – Any other business</th>
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<td>11.1 Locality Clusters</td>
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<td>Requested to consider clustering arrangements for debate at the next meeting.</td>
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<td>To add a dedicated item on Locality Clusters.</td>
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<td>Mrs Stackhouse</td>
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Minutes of the Shrewsbury & Atcham Locality Board Meeting  
held at 2.00pm on Thursday 18 May 2017  
at The Severn Fields Health Village, 
Sundorne Road, Shrewsbury SY1 4RQ

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<tr>
<th>Name</th>
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<tr>
<td>Dr D Shepherd (Chair)</td>
<td>Locality Chair &amp; Locum GP</td>
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<tr>
<td>Dr J Pepper</td>
<td>Belvidere</td>
<td>Apologies</td>
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<td>Caroline Davis</td>
<td>Belvidere</td>
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<tr>
<td>Dr M Fallon</td>
<td>Claremont Bank</td>
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<tr>
<td>Jane Read</td>
<td>Claremont Bank</td>
<td>Apologies</td>
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<tr>
<td>Dr E Baines</td>
<td>Marden</td>
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<tr>
<td>Joy Baker</td>
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<tr>
<td>Dr A Cameron</td>
<td>Marysville</td>
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<tr>
<td>Izzy Culliss</td>
<td>Marysville</td>
<td>Apologies</td>
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<tr>
<td>Dr S Watton</td>
<td>Mytton Oak</td>
<td>Apologies</td>
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<td>Adrian Kirso</td>
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<tr>
<td>Dr R Bland</td>
<td>Pontesbury</td>
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<td>Heather Brown</td>
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<tr>
<td>Dr N Russell</td>
<td>Radbrook Green</td>
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<tr>
<td>Dr Des Clesham</td>
<td>Riverside</td>
<td>Apologies</td>
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<tr>
<td>Tracy Willocks (Vice Chair)</td>
<td>Riverside</td>
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<tr>
<td>Dr D Martin</td>
<td>Severn Fields</td>
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<td>Steve Ellis</td>
<td>Severn Fields</td>
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<td>Dr L Davis</td>
<td>South Hermitage</td>
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<td>Caroline Brown</td>
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<tr>
<td>Dr E Jutsum</td>
<td>The Beeches</td>
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<tr>
<td>Kim Richards</td>
<td>The Beeches</td>
<td>Apologies</td>
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<tr>
<td>Jo Beason</td>
<td>Whitehall</td>
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<td>Tim Bellett</td>
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<tr>
<td>Dr K McCormack</td>
<td>Worthen</td>
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<tr>
<td>Cheryl Brierley</td>
<td>Worthen</td>
<td>Apologies</td>
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<tr>
<td>Roland Brown</td>
<td>Severn Fields PPG</td>
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<tr>
<td>Jenny Birch</td>
<td>Belvidere PPG</td>
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<tr>
<td>Dr Simon Freeman</td>
<td>Accountable Officer</td>
<td>Attended</td>
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<tr>
<td>Dr Julian Povey</td>
<td>CCG Chair</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Steve James</td>
<td>Clinical Director – CCG</td>
<td>Apologies</td>
</tr>
<tr>
<td>Sam Tilley</td>
<td>Director of Corporate Affairs</td>
<td>Attended</td>
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<tr>
<td>Michael Whitworth</td>
<td>Interim Director of Contracting and Planning [Item 8]</td>
<td>Attended</td>
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<tr>
<td>Nina White</td>
<td>Head of Primary Care Strategy [Item 8]</td>
<td>Attended</td>
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<tr>
<td>Dr Kevin Eardley</td>
<td>Unscheduled Care Group Medical Director &amp; Renal Consultant, SaTH [Item 8]</td>
<td>Apologies</td>
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<tr>
<td>Dr Mark Cheetham</td>
<td>Scheduled Care Group Medical Director &amp; Consultant Surgeon, SaTH [Item 6]</td>
<td>Attended</td>
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<tr>
<td>Kate Shaw</td>
<td>Associate Director of Service Transformation, SaTH [Item 6]</td>
<td>Apologies</td>
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<tr>
<td>Louise Jones</td>
<td>Clinical Programme Manager, SaTH [Item 6]</td>
<td>Attended</td>
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<tr>
<td>Sean Mackey</td>
<td>Interim Head of Medicines Management – Primary Care [Item 9]</td>
<td>Attended</td>
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<tr>
<td>Sandra Stackhouse</td>
<td>Committee Clerk/Personal Assistant – CCG (Minute Taker)</td>
<td>Attended</td>
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Minute No S&ALB-2017-05.27: Item 1 - Welcome & Apologies

Dr Deborah Shepherd welcomed Members to her first locality meeting as Chair and thanked Members for attending. Apologies were noted as above.
There were no declarations of interests received for items included on this meeting’s agenda.

Dr Shepherd advised there was still a very small number of Declarations of Interest forms still outstanding and asked for the remaining forms to be forwarded to Mrs Stackhouse at the meeting or as soon as possible. If there were any further queries regarding conflicts of interest, Members were requested to contact: tracy.eggby-jones@nhs.net

**Minute No S&ALB-2017-05.29: Item 3 - Minutes of Meeting held on 16 March 2017**

The minutes of the previous meeting, held on 16 March 2017, were accepted as a true and accurate record and were signed by the Chair, with the following amendments: Page 3, par 7, line 5: after ‘Dr Steve James’ insert ‘and Dr Julian Povey’. Page 7, par 6, line 1: amend ‘Dr’ to ‘Mr’ Mackey.

**Minute No S&ALB-2017-05.30: Item 4 - Matters Arising**

Dr Shepherd 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:

7. **Local Digital Roadmap and IT Update** – Mrs Stackhouse reported Dr James had confirmed he had fed back comments from the previous discussion to the Digital Enabling Group (DEG).

Dr Shepherd understood there had not been many expressions of interest received to take part in the web based consultation systems and reminded Members if there were any practices keen to take forward, to please contact June Telford, Interim Head of Primary Care or Nigel Crew.

**Action:** Polite reminder for practices to consider take up of the web based consultation systems and if interested to please contact June Telford june.telford1@nhs.net or Nigel Crew nigel.crew@nhs.net

8. **Community Services Review** – Referring to the action point for Mrs Anne Dray to forward a note to Members confirming running costs per head. Finance had advised the running costs target was set at approximately £21 per head of population. Dr Freeman pointed out this was a national figure and the figure for Shropshire would be £6m.

9. **Prescribing Update** – It was reported 40 out of 43 practices had joined the Prescribing Incentive Scheme, with one practice still considering and two that had declined the offer.

12. **Any other business: 12.2 DMARDS** – A DMARDS paper had been presented to the Clinical Commissioning Committee (CCC) meeting, which Dr Povey and Mr Freeman had been unable to attend. The paper had included a costed version of the service specification that had been developed between the Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) and the CCG about initiation and the initial up-titrating of medications until the patients were stable. Mrs Baker raised her practice was still sending patients out of county. Dr Povey advised Mrs Nina White would be consulted later in the meeting for an update and timescale.

There were no further matters arising.

**Minute No S&ALB-2017-05.31: Item 5 - Chair’s Update** - Dr Povey gave brief updates on the following areas:

- **Board Practice Representative** – Two practice managers from the north locality: Sue Evans and Kevin Morris had put their names forward for the role of Governing Body Practice Representative. An election had taken place and Kevin Morris had been elected for a three-year term as the practice representative on the Board.

- **Locality Managers** – Dr Povey apologised for the delay in the recruitment process but was pleased to confirm the three Locality Managers had now been appointed. The Shrewsbury and Atcham Locality Manager who would be working closely with Dr Shepherd, Locality Chair would be Mrs Jenny Stevenson. Mrs Stevenson would also be attending the Locality Board meetings in the future. Dr Freeman stated that the intention would be for the Locality Managers to be spending at least 80 per cent of their time in the locality and not at the CCG. Mrs Willocks commented that this was a welcome appointment. The other Locality Managers appointed were: Tom Brettell for the south locality and Janet Gittins for the north locality.

- **Finance** – The CCG had achieved its target of £25.9m deficit. There were six major QIPP schemes for 2017/18, which were largely transactional but there were still some small unidentified schemes. One scheme that would affect practices was value based commissioning and Procedures of Limited Clinical Value (PLCV), which would include areas such as MSK and adapting the Shropshire Orthopaedic Outreach Service (SOOS) or an alternative intermediate service. If any practices would like help, the CCG would be happy to support. Dr Chris
Tomlinson was developing a new pathway for 2018/19, which would entail adapting the SOOS or alternative intermediate service in the north to be rolled out to the Shrewsbury and Atcham and south localities.

Community Services – As a result of Shropshire showing as an outlier in its community spend compared to other comparable areas, the CCG was looking to redesign Community Services. Community beds had been shown to be poor value for money for the size of population based on outdated models.

Non-elective variation and demand – There was a significant variation between practices on rates of emergency admissions. The CCG would be looking to hand over this work to the localities to look into the variations and how the locality was going to address this, ie by conducting a peer review or other method. Also under consideration was a Settings of Care Policy and national proposals looking at elective care.

MSK – All MSK referrals must go through intermediate triage referrals and this might be an area of work the localities could undertake. Further discussion took place under Item 8, page 6 below.

Future Fit – In December it had had been agreed there would be an independent review to check the process of the option appraisal had been adequate. An external body had been identified and had agreed to conduct an independent review of the process up to the present stage. It was envisaged this work would commence following the general election and the outcome of the review would go before the Programme Board and the Joint Committee, the constitution of which had been altered to avoid an imbalance of Shropshire and Telford and Wrekin GPs and CCGs. The Committee would comprise three independent Members, nominated by NHS England (NHSE) and NHS Improvement in addition to an independent chair and two independent clinical Members. Shropshire CCG had agreed to the changes proposed to the Terms of Reference by Telford and Wrekin CCG but it would still be a joint decision.

Maternity Review – The CCG was participating in the desk top review, initiated by Jeremy Hunt, by providing all the information that was required. This was a desk top review with an independent midwife appointed by NHSE.

GP 5 Year Forward View – Dr Povey reported an NHS-led area meeting had been held and the CCG was waiting for Nicky Wilde, the new Director for Primary Care to be in post to take this work forward.

Resilience Monies – This funding had been distributed on a population basis to all three localities. However, there had been challenges as the total had been split into four and paid to four separate holding accounts at four practices: one each in the north and south and two in the Shrewsbury and Atcham locality.

Online Consultations – Expressions of interest had been sought for practices to take up online consultations. It was hoped Nicky Wilde would develop a scheme which would be moved out to practices, perhaps tied in with practices working on some of the ten high impact areas.

ETTF – Through NHS England’s Estates and Technology Transformation Fund (ETTF) there were on-going plans for voice technology, which had been re-procured, however, not for the virtualisation aspect of the scheme.

Action: Mrs Tilley requested to investigate the outcome of the joint ETTF bid with Telford and Wrekin CCG.

Medical Placements – Dr Povey had received a request from Shrewsbury University College of Chester, which was setting up a medical school and were seeking expressions of interest from practices in the Shrewsbury area about the possibility of uptake of medical students from 2020. This was considered an excellent initiative for the recruitment of GPs in the area.

Action: Practices interested in offering GP/Primary Care placements for medical students from 2020 to contact Dr Povey, who would inform the Head of the Medical School.

With regard to the Five Year GP Forward View, it was asked if there had been mention of the extended access scheme and what was happening locally and what was the timeframe. Dr Povey explained that locally the service had been procured initially across a number of organisations. It was believed that if any one CCG was not going to proceed the contract would fall through, however, there would be scope to extend the contract but three months’ notice was required. Negative feedback had been expressed from other CCG representatives who had attended the regional event about whether the service was needed and it created a bigger workforce challenge.

In connection with data sharing agreements, Mr Ellis advised discussions had been held with EMIS and it was considered there was an interest with the Shrewsbury Practice Managers to try and develop that work. Dr Povey highlighted that currently NHSE resource was very limited with just two members of staff covering Staffordshire, Shropshire including Telford & Wrekin. With the new Director of Primary Care and Locality Managers in post there would be a stronger team to take this work forward. Mr Freeman advised that under
the STP there was a drive towards CCGs sharing management teams and the CCG would be wise to plan in advance should this include Shropshire in the future.

**Minute No S&ALB-2017-05.32: Item 6 - Transformation Update**

Mr Mark Cheetham, Scheduled Care Group Director and Consultant General and Colorectal Surgeon, and Louise Jones, Clinical Programme Manager, 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). Also for discussion were the concerns around the bed base and the plan for ambulatory emergency care. 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)

Programme update on Future Fit:
- Further work on the Integrated Impact Assessment – impact of the proposed changes on Women and Children.
- External review commissioned by the CCGs on the Future Fit process – including the appraisal process.
- Joint Committee of the CCGs (6 members each) with 3 external members to meet and review additional information.
- Public Consultation during 2017.
- For the Trust (in addition to supporting the above):
  - Considering deliverability options in terms of phasing.
  - Working on the non-site specific elements of the programme to progress to the FBC.
  - Progressing the workforce transformation – 5 year plan.

A schematic diagram was presented showing the Sustainable Services Programme and the current system of uncoordinated flow of patients and the future plan to improve co-ordinated patient flow.

Planned Care Site – showing the options for the PRH and RSH sites.
Emergency Site – showing the options for the PRH and RSH sites
Both site maps showed proposed new builds depicted in red and a list of proposed departments and services for each site. It was explained that quite a lot of the work included a backlog of work on the two sites. There was quite a difference in the costings to upgrade the two sites but unless the backlog maintenance work at RSH was addressed it would not be fit for purpose in a few years.

Also discussed were concerns around the bed base; and the plan for ambulatory emergency care. A slide was presented showing the SSP proposals which would include seven additional critical care beds in Shropshire. Looking at demographic growth, over the timeframe, an additional 51 beds would be required.

During the ensuing question and answer session it was raised about whether the uncertainty of the two hospital sites impacted on recruitment and it was confirmed SaTH had now been able to recruit critical care consultants. It was acknowledged this work should be joined up with community and primary care and there needed to be shared responsibility of services. The figures quoted were based on 2015/16 activity. There was a prediction of a demographic change and the patients that 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 at the appropriate site.

Dr Freeman confirmed the CCG was initiating a large piece of work on community and if there was to be a transfer of work it needed to go with resource. Mr Freeman pointed out that for Shropshire to be sustainable there needed to be less beds in the community and SaTH, and a better way of managing patient beds.

The question was asked if an elective patient became very ill how well placed would the planned care site be in order to be able to cope with the care of that patient. Mr Cheetham explained that 80% of elective surgery would be carried out on the planned care site. There would be a threshold of elective surgery patients and any major surgery, such as bowel surgery, would be performed at the emergency site.

It was questioned about what thought had there been as a consultant body or specialist group of how secondary care would support patients in the community. It was considered it would be very difficult with the split with primary and secondary care and the differentiation would become much greyer with patients spending less time in hospital. There would be patients with more complex needs who were going to require more care in the community and it would be interesting to look at models where there was better access to specialist advice and support for GPs or directly to patients.
Mr Cheetham explained the consultants would work across boundaries. The acute trust already provided a lot of outreach services across Shropshire and Mid Wales but there needed to be balanced access and efficiencies and there would be hard choices to make. An example was given of Dr Eardley currently working up a Frailty team. Dr Shepherd added the CCG was currently conducting a review of frailty services in the community and suggested the two projects needed to be joined up.

From the PPG’s point of view it was regarded that it was much better if access to all services was based in one location as it brought the two services together thereby reducing travel and wait times. Mrs Birch gave an example of Ludlow patients suffering from Osteoporosis who had travelled to Gobowen to access the services of the main scanning equipment. Mr Cheetham explained that in principle, care should be provided closer to home where it could.

The Trust had hoped to go out to public consultation in the Autumn but this depended on an agreement being reached. Mr Freeman reminded Members that before going out to consultation, the decision needed to go through an NHSE assurance process. SaTH considered the process had been open and transparent but maintaining critical services was proving difficult.

Mr Brown thought the biggest concern was that patients had engaged with the process for a number of years now and until the two CCGs merged it was difficult to see a way forward. In response, it was pointed out that this did not only include the two CCGs but Telford and Wrekin Council had objected to the preferred option.

**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.** [Circulated on 25/05/2017.]

**Minute No S&ALB-2017-05.33: Item 7 - Locality Chair’s Update**

Dr Shepherd reported that during her initial time as Locality Chair she had attended introductory 1:1 meetings with CCG staff discussing areas of work and roles. Mrs Jenny Stevenson was expected to commence in her new post as Locality Manager at the beginning of June. Following the in-house PLT session planned for 8th June, there would be an opportunity to meet with some members but Dr Shepherd hoped to visit individual practices with Mrs Stevenson to discuss any issues or concerns. Mrs Stevenson would continue to attend the Practice Managers’ meetings and would confirm meeting dates.

Areas of work would include a workforce survey to enable the CCG to commence the process of workforce planning. It was explained that the primary care information already included on the web tool included head counts but did not clarify further detail such as whether staff were employed full or part-time staff and services that were already in place.

Support would also be offered to practices to look at performance and QIPP targets. It was suggested the nurse assessors who carried out the clinical reviews of the Procedures of Limited Clinical Value (PLCV) should also be invited to attend this meeting to explain more fully the referral criterion.

The programme and format of the meetings was discussed and the dates included on the agenda were agreed. There had been a request for the locality meetings to revert back to monthly meetings and Members were requested to continue to reserve the third Thursday of every month from September. It would be later decided which out of next year’s dates would be formal meetings and PLT events together with one joint localities AGM meeting. It was also suggested to have less formal meetings incorporating a workshop layout for part of the meeting to facilitate engagement and the sharing of ideas.

Dr Shepherd and Mrs Stevenson would assist in developing the programmes for the PLT sessions but it was still to be decided by the locality whether these would be organised on a locality or cluster basis. It was considered there were not sufficient PLT events and education should be prioritised with an example given of other areas taking part in up to ten sessions per year. Dr Shepherd said she would take back to the CCG as the budget and primary care education was currently under review. It was suggested splitting the sessions between cluster and in-house events and practices covering for each other when hosting the PLT events.

**GP Resilience Money** – Mrs June Telford had asked for practices to be reminded about looking at the 7 day 8-8 access and how as a locality they were going to provide the targets to be in place by the end of March 2018. The question was asked what would happen if practices did not wish to offer extended access. It was explained that this was a priority for the CCG and would need to be commissioned either by primary care or a third party organisation. If the practices did opt out then this funding would be lost to the primary care collective. It was suggested that the extended access did not necessarily need to be GP time but could include, for example, HCA or chronic disease clinics in the evenings, however, the challenge would be available workforce. It was agreed this was an item that could be further discussed at the next or subsequent meeting.
Members requested to note confirmed future dates marked on the agenda and to continue to reserve the third Thursday of the month from September excluding December. [Update: The CCG Governing Body AGM this year is scheduled to take place on Wednesday 12th July 2017 at Shrewsbury Town Football Club, Oteley Road, Shrewsbury SY2 6ST.]

Dr Shepherd to feed back to the CCG, Members’ request to hold more PLT events.

Mrs Stackhouse to include an item on GP Resilience Money on next or subsequent meeting.

**Minute No S&ALB-2017-05.34: Item 8 - MSK Update**

Mr Michael Whitworth, Interim Director of Contracting and Planning, and Mrs Nina White, Head of Primary Care Strategy, gave a high level outline of the plans for Musculoskeletal (MSK) services. In 2018/19 the CCG was looking to have a functioning specialist community based MSK service for the whole of Shropshire with a hub and spoke model where patients can access the service. The current view was that there would be a single provider for most of the services. This year the main initiative was around Value Based Commissioning (VBC) and expanding the Shropshire Orthopaedic Outreach Service (SOOS). There is a clear evidence base with benchmarking that identifies why the CCG should be looking at this area and doing things differently.

It was requested if a referral was rejected by RAS would it be possible to forward a letter also to the patient because patients were returning to GPs with the understanding it was the GP who had refused the procedure. This request was also seconded by Mrs Birch as a patient representative. It was agreed Mr Whitworth and Mrs White would look into whether a letter could be forwarded to the patient in addition to the practice.

Dr Shepherd asked what was happening to the provision of the other alternatives to surgery in order that practices were aware of the guidelines. For example, whether patients should be referred for more physiotherapy to reduce the need for surgery bearing in mind at present there were issues with supply and access to that service. Mr Whitworth explained that the CCG needed to understand the position and was looking at equity of access. It was acknowledged more capacity was required and within the CCG’s savings plans there was funding to expand physiotherapy capacity but needed to ensure it was the right capacity.

Mrs White reported that work had already commenced which would help to inform the present capacity and the physiotherapy leads were working together with the CCG’s support and of Keele University to create an evidence base of the physical standard of physiotherapy which should be delivered for different conditions. One of the things that had been highlighted was people’s perception there was a variation in practice. It was felt the service was supply driven, which was why the value based commissioning was really quality based.

It was important that the model and way forward was referrals would go into the intermediate tier so would be specialist MSK services and referrals that went into RAS that did not score for a procedure would go into the SOOS service. The pathway had been reviewed but the access to the risk needed to be assessed. It might be that some surgeons were seeing patients later but hopefully that would improve. Dr Povey added that RAS did not add any clinical detail to the referral but interpreted information contained in the referral letter but SOOS was able to clinically assess patients to determine where patients would go for treatment.

Dr Russell highlighted that in making sure alternatives were available was really crucial because quite reasonably patients held expectations built upon by experiences and if the patient was held on a waiting list to go to SOOS and there was no access to physio and it was not being replaced, this would make it quite difficult for patients. So some of it was around expectation and making sure the system worked and there was education and it was consistent. There was also an issue about provision and a risk of promoting inequality.

It was stressed that the changes that would be proposed were not about de-skilling GPs and removing local access. There would be some patients who would not need to go into SOOS and could be cared for in primary care. For instance, there would also be GPs who administered joint injections, which the CCG would not wish to stop. The general pathway would be that the service would decide if the patient required surgery and GPs would not be involved further in decision-making. Practices were thanked for the feedback received so far and were encouraged to continue to do so.

**DMARDS** – Dr Shepherd referred to the point under matters arising and enquired as to the developments with the commissioning of DMARDS. Mr Whitworth reported negotiations were still very positive. RJAH needed to work out further calculations and it was hoped there would be an agreed proposal in the next few weeks. Current advice for practices was that if patients were likely to require DMARDS, they could not be referred to RJAH unless the practice was prepared to initiate DMARDS for Rheumatology. RAS would be able to provide advice for patients to go out of county for treatment. A further update would be provided as soon as possible.
Minute No S&ALB-2017-05.35: Item 9 - Prescribing Update

Mr Sean Mackey, Interim Head of the Medicines Optimisation Team, attended to give brief updates on the following using presentation slides, a hard copy of which was tabled:

- April 2016-February 2017 Prescribing spend growth.
- Prescribing spend per Net Ingredient Cost per Age, Sex and Temporary Resident Originated Prescribing Unit (NIC/ASTRO-PU) comparison.
- Practice Actual Cost Growth – Colour-coded with practices highlighted in green if there were no concerns and red if there were in prescribing spends.

Currently the CCG’s underspend on prescribing was £1m compared to the previous year. Mr Mackey thanked Members for supporting the team and it was really appreciated.

**Cost Effective Prescribing Framework (CEPF):**

**Practice mandatory action plans** – All practices’ actions plans had been agreed at the Medicines Optimisation Committee. This would allow the second pump priming payment to be made available to claim against as shown in the third and fourth columns on the chart.

**Drug switches** - Starting from June the Medicines Optimisation Team (MOT) would be running all the drug switches in practices so data sharing agreements were required to ensure the Team could access systems remotely. It was hoped these would be completed by end July/beg August.

**Oral Nutritional Supplements (ONS) pathway** – Prescribing spend was decreasing and Ms Bainbridge had continued with the work of patients who did not need to be on ONS. However, it had not been noticed some new patients had been started on ONS without going through the ‘must’ and weight scores. It was requested if Members could remind their partners, clinicians and practice members to adhere to the ONS pathway.

**Selfcare pathway** – Campaigns would be run with the media around advising patients of the minor ailments service whereby patients are asked to purchase certain over the counter drugs. Posters would be available for practices. Dr Abbotts had some ideas for dispensing practices being able to sell some of these items in rural areas and if there were expressions of interest to discuss further Members were advised to contact Dr Abbotts.

**Scriptswitch adherence** – Members were reminded to please use the feedback button if there are medications included on the system they were not happy with.

**Remote access** – Practices were encouraged to sign the data sharing agreements as soon as possible to enable the Team to action the switches.

**Practice specific action plans** – Practices had specified actions that the Team would be looking into.

**Optional: Prescriptions Ordering Direct (POD):** The system was scheduled to go live on the 5th June at Severn Fields Medical Practice and it had been recommended that the next be offered to a practice in the south locality. It was hoped next to move possibly to Market Drayton, Bridgnorth and Cambrian Medical Practices and moving on to other practices thereafter. Mr Mackey would keep Members informed of developments.

**Wound Care** – A project was being piloted in Shifnal and Albrighton where district nurses would order dressings and would not be asking GPs to prescribe dressings for their patients in the future.

**Other schemes:**

**Traffic Light Formulary** – An agreement had been reached with SaTH and the Formulary Committee to agree a traffic light formulary system. This was considered a real positive move forward and long awaited. The online formulary accessed will be a whole health economy approach and red if there were in prescribing spends.

**Care Home Teams** – The Team had recruited extra staff to support de-prescribing reviews over the next nine months with input from a GP with a Special Interest (GPwSI). If practices were planning to carry out CHAS reviews, they were requested to link in with the Team to do a ward round effect with the pharmacists to obtain a holistic review.

**Dietetic support** – Ms Bainbridge was looking at a new baby milks pathway and formulary around August-September 2017.

**Respiratory Formulary Update** – MOT had been working with Dr Wilson and a COPD folder was to be produced containing a small number of new drugs. For example, a new brand of Tiotropium had recently been launched: Braltus Zonda and consideration should be given to switching clinically appropriate adult COPD patients on Spiriva Handihaler to the Braltus. Following a query raised by Mrs Birch, Mr Mackey would contact EMIS regarding advertisement pop-ups appearing on the patient access system.

**Action:** Members were invited to contact Mr Mackey via email with any further queries they may have on items discussed to: smackey@nhs.net

Members requested to contact the Medicines Optimisation Team with any queries from patients by email to: MOTqueries@nhs.net
Mr Mackey would contact EMIS with query raised regarding advertisement pop-ups appearing on the patient access system.

Mrs Stackhouse to circulate Mr Mackey’s PowerPoint slides for information for Members.

[Circulated on 25/05/17.]

Minute No S&ALB-2017-05.36: Item 10 - PPG Update & Feedback

Mrs Birch reported a Shropshire Patient Group (SPG) meeting had been held the previous day at which it had been agreed that Mrs Gill George would not be representing SPG at meetings going forward.

It had also been raised by Mrs Jane Randall-Smith, Healthwatch, that some patients who had call bars on their phones were experiencing difficulties receiving call backs from the hospital and Shropdoc. It was suggested this might be problem with BT’s new version of call guarding and the algorithm being over-cautious and therefore it was not the intention to block calls.

Mrs Birch had been asked by Mrs Karen Higgins for contact details of PPG members. Mrs Birch did have some contacts details but wished to mention she might need to contact some Practice Managers for contacts she did not hold.

Minute No S&ALB-2017-05.37: Item 11 - Key Messages for CCG Board & Locality Assurance Framework

The Locality Assurance Framework (LAF) spreadsheet, used to log and track queries and issues of concern from the localities, had been updated and distributed to Members. Members’ attention was drawn to the update regarding violent and aggressive patients raised by the north locality from Mrs June Telford, Head of Primary Care, who was sourcing a potential service for Shropshire patients. Members confirmed there were no further issues to be noted.

Minute No S&ALB-2017-05.38: Item 12 - Any other business

12.1 Clusters

Mrs Davis raised the clustering of practices and asked if there was any reason why Belvidere Practice had been paired with the north and south localities. Belvidere was requesting to change because historically the ties had always been with the Shrewsbury locality. It was explained the clusters had very much been suggestions based on district nursing teams and Shropshire Council areas. Dr Povey said he was happy for localities to discuss and move forward. It was agreed Dr Shepherd and Mrs Stevenson would discuss more natural pairing with Belvidere representatives during the practice visit.

Action: Dr Shepherd and Mrs Stevenson to discuss further clustering arrangements with and for Belvidere Medical Practice during practice visit.

Minute No S&ALB-2017-05.39: Item 13 - Date and Time of Next Meeting

It was agreed the next formal meeting would be held on: Thursday 20 July 2017 at the Severn Fields Health Village, Sundorne Road, Shrewsbury, SY1 4RQ commencing at 2.00pm.

Future Meeting Dates

2017
Thursday 21 September 2017
Wednesday 27 September (PLT session)
Thursday 19 October
Thursday 16 November
Thursday 18 January 2018

All Thursday afternoons, 2.00pm start at Severn Fields Health Village, Sundorne Road, Shrewsbury

Signed: ........................................... Date: .................................
<table>
<thead>
<tr>
<th>Minute No.</th>
<th>Action Required</th>
<th>By Whom</th>
<th>By When</th>
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<tbody>
<tr>
<td><strong>Minute No S&amp;ALB-2017-05.30: Item 4</strong>&lt;br&gt;Matters Arising</td>
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<tr>
<td>4.7 Local Digital Roadmap and IT Update</td>
<td>Polite reminder for practices to consider take up of the web based consultations systems and if interested to place contact June Telford (<a href="mailto:june.telford1@nhs.net">june.telford1@nhs.net</a>) or Nigel Crew (<a href="mailto:nigel.crew@nhs.net">nigel.crew@nhs.net</a>)</td>
<td>ALL</td>
<td>As soon as possible</td>
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<tr>
<td><strong>Minute No S&amp;ALB-2017-05.31: Item 5</strong>&lt;br&gt;Chair’s Update</td>
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<td>ETTF</td>
<td>Requested to investigate the outcome of the joint ETTF bid with Telford and Wrekin CCG. Practices interested in offering GP/Primary Care placements for medical students from 2020 to contact Dr Povey who would inform the Head of the Medical School.</td>
<td>Mrs Tilley</td>
<td>As soon as possible</td>
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<td>Medical Placements</td>
<td></td>
<td>ALL</td>
<td>As soon as possible</td>
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<tr>
<td>Dr Povey</td>
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<td><strong>Minute No S&amp;ALB-2017-05.32: Item 6</strong>&lt;br&gt;Transformation Update</td>
<td>Members were invited to contact the SaTH Transformation Team if they required further information by emailing: <a href="mailto:transformation@sath.nhs.uk">transformation@sath.nhs.uk</a> or by telephoning: 01743 261183 To circulate electronic copies of the Transformation Update presentation for information for Members.</td>
<td>ALL</td>
<td>As soon as possible</td>
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<td>Mrs Stackhouse</td>
<td>As soon as possible</td>
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<tr>
<td><strong>Minute No S&amp;ALB-2017-05.33: Item 7</strong>&lt;br&gt;Locality Chair’s Update</td>
<td>RAS Nurse Assessors to be invited to attend a future meeting to discuss the referral criterion. Members requested to note confirmed future dates marked on the agenda and to continue to reserve the third Thursday of the month from September excluding December. [Update: The CCG Governing Body AGM this year is scheduled for Wednesday 12th July 2017 at Shrewsbury Town Football Club, Oteley Road, Shrewsbury SY2 6ST.] Dr Shepherd to feedback to the CCG, Members’ request to hold more PLT events. Include item for discussion on GP Resilience Money on next or subsequent meeting.</td>
<td>Mrs Stackhouse</td>
<td>September meeting</td>
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<td>ALL</td>
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<td>Dr Shepherd</td>
<td>As soon as possible</td>
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<td>Mrs Stackhouse</td>
<td>Next or subsequent meeting</td>
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| Minute No S&ALB-2017-05.34: Item 8 | To look into whether RAS referral outcome letters could also be sent to the patient. | Mr Whitworth  
Mrs White | As soon as possible |
|------------------------------------|-------------------------------------------------------------------------------------|----------------|----------------|
| Minute No S&ALB-2017-05.35: Item 9 | Members were requested to contact Mr Mackey via email with any further queries they may have on Prescribing areas discussed to: smackey@nhs.net  
Members requested to contact the Medicines Optimisation Team (MOT) with any queries from patients by email to: MOTqueries@nhs.net  
Mr Mackey would contact EMIS with query raised regarding advertisement pop-ups appearing on the patient access system.  
To circulate Mr Mackey’s PowerPoint slides for information for Members. | ALL  
ALL  
Mr Mackey  
Mrs Stackhouse | On-going  
As soon as possible  
As soon as possible  
As soon as possible |
| Minute No S&ALB-2017-05.38: Item 12: Any other business | Dr Shepherd and Mrs Stevenson to discuss further clustering arrangements with and for Belvidere Medical Practice during practice visit. | Dr Shepherd  
Mrs Stevenson | As soon as possible |