NHS Wiltshire Clinical Commissioning Group

DRAFT MINUTES OF WILTSHIRE CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY MEETING IN PUBLIC HELD ON TUESDAY 26 SEPTEMBER 2017, 10.00HRS AT CHIPPENHAM TOWN HALL

Voting Members Present:

Dr Peter Jenkins	PJ	WCCG Chair
Peter Lucas	PL	Vice Chair, Lay Member for Audit and Governance
Linda Prosser	LP	Interim Chief Officer
Steve Perkins	SP	Chief Financial Officer
Christine Reid	CR	Lay Member, Patient and Public Involvement
Dr Mark Smithies	MS	Secondary Care Doctor
Dr Richard Sandford-Hill	RSH	GP, Chair West
Dr Andrew Girdher	AG	GP, Chair North and East Wiltshire (NEW)
Dr Anna Collings	AC	GP, Vice Chair NEW
Dr Toby Davies	TD	GP, Chair Sarum

In Attendance:

Mark Harris	MH	Chief Operating Officer
Dina McAlpine	DMcA	Director of Quality
Jo Cullen	JC	Director of Primary Care and Urgent Care
Sue Shelbourn Barrow	SSB	Director of Integration and Transformation
Lucy Baker	LB	Acting Director of Acute Commissioning
Sarah MacLennan	SMac	Associate Director of Communications and Engagement
Neal Goodwin	NG	Associate Director (Interim) Community & Joint Commissioning
Sharon Woolley	SW	Board Administrator
Chris Graves	CG	Chair, Healthwatch Wiltshire
Simon Yeo	SY	Estates Advisor *(until 10.45hrs)*
Tracy Daszkiewicz	TDas	Consultant in Public Health, Wiltshire Council
Lisa Hodgson	LH	Chief Operating Officer, Wiltshire Health and Care *(for item 13 only)*

Apologies:

Rob Hayday	RH	Associate Director of Performance, Corporate Services and Head of Project Management Office (PMO)
Dr Helen Osborn	HO	Medical Advisor
Dr Catrinel Wright	CW	GP, Vice Chair West
Dr Chet Sheth	CS	GP, Vice Chair Sarum
Ted Wilson	TW	Director of Community and Joint Specialist Commissioning

ITEM NUMBER		ACTION
GOV/17/09/01	**Welcome and apologies for absence** PJ welcomed all to the meeting. Apologies were noted as above.	
GOV/17/09/02	**Questions/Comments from the public** PJ informed Members that one question had been received prior to the meeting. The question was raised by Dr Nick Murry, a Wiltshire Councillor and Chippenham Town Councillor representing Monkton Ward, Chippenham, and	

	was in reference to the Strategic Outline Case for North West Wiltshire which was presented at July's Governing Body and was in particular relation to the mention of Chippenham Hospital within the Strategic Outline Case. The question was: "When can we expect to hear these important proposals discussed (publicly) at their draft stage, when there is still an opportunity to influence them?" PJ explained that the Strategic Outline Case did not set out any pre-determined proposals for the location of health services. The July Governing Body meeting agreed the CCG's preferred option for the future model of care for North West Wiltshire, which proposed a model for one community hospital, one community 'spoke' and three Urgent Treatment Centres, alongside the development of primary care estate to increase capacity. Work to understand where these facilities might be located was underway and once this was understood, would be developed into proposals and explain our vision. We would engage with the public widely on these proposals once they were fully developed and the feedback received from the public and our stakeholders would be included for all consideration as we take future decisions. Engagement activity to date included engagement with the MPs from North West Wiltshire, and the proposal to undertake the Strategic Outline Case was presented in public at Chippenham, Trowbridge and Melksham Area Board meetings, with separate briefings to individual Councillors at the same time. Healthwatch Wiltshire had attended planning meetings in the capacity of independent observer. In the meantime, colleagues from the CCG had been invited to meet with Chippenham Town Council in early October to discuss the project further. Dr Nick Murry acknowledged the response. Dr Murry was concerned that the recommended model was a downgrade on services provided and that the recommendation for the location of the model would be brought to the November Governing Body meeting with little consultation. Dr Murry requested confirmation that Chippenham Hospital would not close. SP explained the process, stating that it was identified on the action tracker that the Estates Strategy would be brought to the November meeting, but that the overall business case would follow the Strategic Outline Case in July 2018. The Strategy to be brought to the November meeting would not contain a site recommendation for approval. Therefore, the Governing Body is unable to give any confirmation of the location of future services. A process was to be undertaken over the next six months to consider the location options alongside the growth in population and the gap in primary care services to ensure that the model was fit for purpose.	
GOV/17/09/03	**Declarations of Interests** Members were reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Wiltshire Clinical Commissioning Group (CCG). (This included any relevant interests previously declared on the Register of Interests) There were none. The meeting was quorate.	
GOV/17/09/04	**Minutes of the meeting held on 25 July 2017** The minutes of the meeting held on 25 July 2017 were approved as an accurate	

	record.	
GOV/17/09/05	**Matters Arising** There were none.	
GOV/17/09/06	**Action Tracker** The action tracker was reviewed and updated. **GOV/17/05/12.1 – CLOSED** **GOV/17/05/13 –** Alison West would review the quality dashboard and send the data over to CR. **ONGOING** **GOV/17/07/10.1 –** The Strategic Outline Case could impact upon the timeframe for the Estates Strategy, but it was hoped it would be brought to the November meeting. **ONGOING** **GOV/17/07/12 –** DToC activity reports formed part of the Integrated Performance Report and would be discussed under item 11. **CLOSED**	**AW** **SP / SY**
GOV/17/09/07	**Chair's Report** PJ welcomed SSB to her first meeting of the Governing Body. PJ spoke of some of the significant areas of work that had taken place during his time as Chair. At the end of 2015 Wiltshire CCG and the wider Wiltshire health economy faced very serious financial issues. The CCG had delivered a recovery plan which brought finances back in line, achieving a balance, and then at the end of the last financial year under SP's stewardship, delivered a surplus back to NHS England. The CCG was perceived to be in a good place by NHS England. Only through transformation and innovation would we keep and sustain a national health service. The CCG requested from NHS England, certainty of transformational funding and support for collaboration to enable those aims for health care in Wiltshire to be achieved, underpinned by a fully delivered prevention agenda and better support for the system and most importantly our colleagues in social care. Wiltshire Health and Care were now a year in on their five year contract for our Adult Community Services, providing services such as, our Core Community Teams; the wheelchair service; community physiotherapy, diabetes and fracture clinics. Their work was central to the CCGs five year plan to bring health care closer to home, with GP practices firmly at the heart of community services delivered through integrated community teams across the county. PJ mentioned a proud achievement of winning the Local Government Association's "Most Effective Health and Well Being Board Award" last year with the Wiltshire's Health and Well Being Board. The relationship between Wiltshire CCG and Wiltshire Council continued to develop, along with our commitment to develop a common understanding on behalf of the Wiltshire population. The work towards the Joint Accountable Officer and Head of Adult Services role continued. Working towards integrated health and social care was the best possible solution to ensuring the best experiences for people in Wiltshire. When PJ became Chairman of the CCG in 2015, the CCG was a membership organisation comprising 58 GP practices. Today this stands at 49 practices. The decrease was a clear indication of the fragility and vulnerability of GP practices in Wiltshire, and reflects what is happening to a greater extent across the country. Practices were working together more collaboratively than ever to ensure patients continued to receive services in a timely way and innovation in new ways of working. More of this type of transformational change should be expected over the next year in Wiltshire, but it would only be achieved alongside a shift in the public's expectation of what their NHS service could do. Good progress continued regarding the proposals for an Urgent Treatment	

	Centre in Trowbridge and Devizes. PJ thanked the Governing Body and all the staff at the CCG for their commitment, contribution and professionalism and wished RSH well as the new Clinical Chair of the CCG.	
GOV/17/09/08	**Interim Chief Officer's Report** LP extended her thanks to PJ and for his contribution and achievements over the last three years. LP highlighted the following from her report: • Good lines of work were being completed through the STP. The session held on 15 September 2017 looked at what had been achieved to date across the footprint. Savings on back office functions had been made without impacting upon frontline services. The Partnership was keen to increase the focus on the strategy for Mental Health and Older People, bringing a step change and preventative approach with earlier intervention. Vigilance was high for the forthcoming winter care programme and partners were preparing for the flu epidemic. The STP continued to be a helpful forum for discussions and collaborations. CR wished to see more involvement of Lay Members in the STP. LP stated that there was a commitment to include Lay Members, particularly when service redesign was in discussion. The strategies for Mental Health and Older People would be the first robust service design which would enforce consultation. The sharing of communications from the STP was important to ensure all were aware of its membership and programme of work. The STP staff team had recently been reconfigured and there was a renewed push to rebuild the group. HealthWatch were to be involved in supporting the development of the new approach. SMac reported that an STP Communications Manager had recently been appointed. • SSB brought a renewed focus to the Better Care Fund and would be undertaking an evaluation of the schemes. • Nationally, a number of Accountable Care Systems (ACS) were being established. Manchester had been given the resource to develop a model and to test ideas. Learning from this would be shared, but it was still early on in the process. Joint commissioning possibilities with Wiltshire Council was being discussed. A recommendation paper would be brought to the November Governing Body meeting concerning the Joint Accountable Officer / Corporate Director post. The function and form of the integration with the Council was being worked through. • LP had attended the national NHS Expo conference, which had focussed on the use of digital technology. The CCG was currently recruiting for a Digital Transformation Manager. ACTION: GOV/17/09/08 – Recommendation paper to be brought to the November Governing Body meeting concerning the Joint Accountable Officer / Corporate Director post. *(LH joined the meeting)*	**LP**
GOV/17/09/09	**Register of Sealing** There had been no sealings since the last meeting.	
ITEMS FOR DECISION		

GOV/17/09/10	**Estates** **a) Strategic Outline Programme Interim Paper** SP recalled that the Governing Body meeting held in July 2017 had approved the Strategic Outline Case (SOC) for Chippenham, Melksham and Trowbridge. The Strategic Outline Programme (SOP) had since been developed to consider the strategic plan for the remaining 16 locality areas of the county. The Programme was in draft form, but was presented to Members to enable a decision to be made on the way forward. The final SOP would be brought to the November Governing Body meeting for approval. ACTION: GOV/17/09/10 – Finalised Strategic Outline Programme to be brought to the November Governing Body meeting. Five further SOCs may need to be produced, taking approximately 28 months to complete if delivered consecutively. Four other options had also been considered within the paper, giving a variation of timescales. Options were mindful of the resources available, the inclusion of support partners, internal input and local stakeholders. A range of procurement options had also been considered. Page 10 indicated the need for a task and finish group to be established to look at recommendations for locality groupings and prioritisation. The suggested membership of the group had been included on page 11. Members were content with this proposed membership, with the suggestion that HealthWatch should also be involved. CR queried the risks associated with the process and options. SP explained that cost was a significant risk, but there was also the staff capacity concern. Overlapping the SOCs and aligning the tendering process would help to minimise the impact. SP was confident that six months was a realistic timescale for option C, once procurement had been completed through the CSU, and would provide more certainty to the support partner. It would also allow for a comparison across the county. Option C would provide easier management of the process, allow for gaps to be identified and manage public expectations. CG suggested that a newsletter system be considered to ensure that the public remain up to date and in touch with the journey. **The Governing Body approved Option C of the Strategic Outline Programme – six months to complete all five SOCs – all completed by July 2018 by running all at the same time.** *(SY left the meeting)*	**SP / SY**
ITEMS FOR DISCUSSION		
GOV/17/09/11	**Integrated Performance Report** DMcA reported against the quality aspect of the report. Page five indicated that the number of Serious Incidents had risen during July. It was noted that the reporting culture was improving within providers and could explain the increase; however the Quality Team would continue to monitor incidents to ensure there were no reoccurrences. The CCG was soon to commence its flu campaign to raise awareness amongst the general public, and in particularly to care homes who could play a significant role in helping reduce flu admissions to acutes. DMcA confirmed that links had already been made with Public Health Wiltshire and Public Health England during the planning of the campaign.	

The report from the recent CQC visit to the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) was awaited. CQCs report concerning Virgin Care had indicated a 'good' rating, with 'outstanding' for care. It had noted that the organisation had a person centred culture.

MS raised concerns regarding the providers timeliness of dealing with fractured neck of femurs. He was aware of the work underway through the Quality Team, but CCG wide work was needed to make a significant difference. LB explained that this had been identified through the Right Care programme. The prioritisation of these patients by the acutes was to be reviewed to understand the pathway. SFT had shown improvement.

SP reported that at the end of month five, an in year surplus of £57k against the CCGs available resources had been recorded. The CCG was required to create a headroom reserve of 1%, of which 0.5% was to remain as uncommitted headroom to address system risk.

Page 20 looked at the key financial performance issues. The three main acutes were showing some over performance and bringing cost pressures. A deep dive would be undertaken to understand the non-elective pressures at the RUH. SFT had taken a positive, proactive nature concerning planned care and additional Referral to Treatment (RTT) activity.

SP referred to the risks shown on page 21. Additional to these, SFTs data viability was also noted. SFT had decided to change back to their old data warehouse, which would impact upon the CCG and SFT. This would be followed up for the November report.

There were no indications of any forthcoming national initiatives or support arrangements, however SP was confident that the CCG was in a good position to deal with any unexpected requirements. The CCG had some residual flexibility.

MS questioned if Members were satisfied that there was sufficient evidence to hold NHS England to account concerning specialist care commissioning. Previous years this had been a concern. SP advised that planned adjustments had been made, but it was still a notable risk to the CCG. The key was to ensure awareness of this as early as possible and to raise it with NHS England. LP felt that the CCG should seek a better understanding of the volume of activity under the NHS England budget. The CCG should work more with the specialist teams and address primary and secondary care level initially.

AG was content with the reported financial situation of the CCG, but wondered if there were lessons to learn to ensure sustainability of this position. SP advised that the lessons learnt through the Financial Recovery Process had instigated best practice across the CCG, and it was noted that the CCG had been materially underfunded in previous years. The last comprehensive spending review had retargeted and refocussed funds, of which Wiltshire had benefitted from. There had been notable successes with the prescribing schemes, which had brought a positive benefit to QIPP. The implementation of the Prescription Ordering Direct (POD) service would further support these savings by reducing medicine wastage.

CG enquired if the CCG had oversight of the performance of those specialist services provided by NHS England; and queried if patients remained the responsibility of the CCG. LP was aware that the CCG was not always sighted on those Wiltshire patients receiving specialist care services, but was working with NHS England to address that. CG offered to raise this at the HealthWatch national network.

	ACTION: GOV/17/09/11.0 – CG to raise the involvement of CCG's in specialist care services at the national HealthWatch Network. LB reported that delivery of the RTT target had been achieved in July, achieving 92.29%. The focus was now to sustain this, despite the additional patient impact through the winter pressures. SFT had continued to improve their reporting and the Trust delivered 93.88% performance for Wiltshire in July. RUH performance remained under trajectory at 90.47% for Wiltshire. A team had been brought in to the RUH to improve performance. The Trust had been issued with a Contract Performance Notice and a revised Remedial Action Plan and trajectory was to be developed to ensure minimal impact on patients. The WCCG Winter Elective Plan had been shared at the Wiltshire Local Delivery Board on 14 September 2017. This included pre-referral outsourcing, which would ensure patients were seen quicker. The CCG breached the 99% under 6 week standard for diagnostic waiting times, achieving 98.1%. SFT had delivered 99.6% against their trajectory. RUH delivered 96.8% with ongoing issues in cardiology diagnostics. RUH cardiology patients were now being outsourced. Oxford had agreed to provide additional neurophysiology capacity for GWH. The CCG delivered against all nine Cancer targets in July 2017. Risk remained around the two week wait and 62 day delivery. Patients waiting over 104 days continued to have full Root Cause Analysis undertaken. It was noted that although Cancer targets were green, sustainability of this level would be a challenge. Honest discussions were needed with providers to ensure patients were redirected if needed. MS had concerns on the waiting times for Rectal Cancer patients. LB explained that diagnosis capacity issues had been identified, the right pathway for patients needed to be ensured. There had been a significant increase in cancer referrals. Funding bids had been submitted to enable additional activity to be undertaken to accelerate recovery. Virtual review of rectal referrals was also starting to be carried out. MH updated on the QIPP workstreams. Page 30/31 provided the monthly figures, but weekly figures are received to ensure that the CCG was able to support the system and partners. Urgent care schemes impacted upon a number of directorates. There were two key targets of focus: • A&E 95% target against the four hour wait – there had been a push on providers to improve significantly in this area, to achieve 90% by December and 95% by March. JC explained that the CCGs involvement in gold escalation calls was that of support to providers. Silver tactical/operational calls were provider led; these were escalated to gold calls when there were extreme pressures on the system that required input from the CCG. As a commissioner, the CCG did not get involved in Silver calls, but supported colleagues to underpin the system to become more resilient. The proactive support was appreciated by providers. • Delayed Transfer of Care (DToC) or bed days lost. The national target was 3.5%, providers were a significant way from achieving this. There would be a focus on ensuring all patients were discharged as quickly as possible, not just those who were noted as delayed. SSB and Wiltshire Council would be reviewing the Better Care Fund actions and the utilisation of the additional Adult Social Care monies to ensure areas were tested to impact where needed most, making best use of resources for the best patient flow. RSH felt that the A&E attendance figures shown on page 32 of the report indicated the good performance of Wiltshire's primary care. This was a Trust	**CG**

	wide figure. It was suggested that a comparison to Swindon CCG figures would be beneficial. LP explained that acuity of patients had been raised as an issue for Swindon. WCCG needed to focus on DToC to support Swindon in that area and ensure the use of Treatment Escalation Plans. The urgent care system was complicated, especially for WCCG in working with three acutes. JC explained that the Local Delivery Board was responsible for overseeing patient flow and assurance had been given that triggers and system escalation points were being looked at in the acutes and with community teams. Domiciliary care resources were being reviewed. A winter plan was being developed and would be brought to the November meeting, but it was noted that there were now all year round system pressures. SSB explained that an evaluation of all Better Care Fund workstreams would be undertaken to prioritise those that had a winter plan impact. ACTION: GOV/17/09/11.1 – Winter plan to be brought to the November Governing Body meeting. MH referred back to the report, section three contained an update on the workstreams contributing to QIPP targets. There was commitment to define the lead indicators for the Better Care Fund. Clinical policies had brought notable savings and was ensuring consistent policies across the STP.	**JC**
GOV/17/09/12	**Integrated Urgent Care Procurement Update** JC reported that a Joint Governing Body meeting had been held on 21 September 2017 involving BaNES CCG, Swindon CCG, Wiltshire CCG and Wiltshire Council to make a decision concerning the procurement of the Integrated Urgent Care service. This was now in the ten day standstill stage. Formal announcement of the contract award would be made on 3 October 2017. Further details would be brought to the November Governing Body meeting. PL wished to note thanks and congratulations to RSH, JC and her team for the success of this well designed piece of work. ACTION: GOV/17/09/12 – Confirmed details of the Integrated Urgent Care service contract award to be brought to the November meeting.	**JC**
GOV/17/09/13	**Wiltshire High Intensity Care Programme Progress Update** Lisa Hodgson, the Chief Operating Officer at Wiltshire Health and Care (WH&C) gave a presentation on the progress of the Higher Intensity Care (HIC) Programme. The programme identified patients that were at risk of deterioration and ensured observation and care was increased. LH provided a case study of a patient that had recently been supported by the programme through its Community Teams and Home First Rehab Support Workers. The episode outcomes evidenced that the patient wishes and needs had been met whilst remaining at home. New models had been developed to support the different requirements, expectations and the complex needs. Variation had been removed to standardise the process. The programme provided seven days a week clinical support and assessments. The flow chart on slide six indicated the stages of the model of care. A future model of virtual wards were being considered through the Multi-Disciplinary Team (MDT). This would be progressed through the primary care localities. Five areas of change had been identified against service areas. It would be ensured that these were interchangeable. Next steps for the programme	

	included building relationships with primary care, continuing dialogue with colleagues to reach the aim of 20 caseloads a month through the programme, and considering the support to nursing and care homes to avoid unnecessary admissions to hospital. DMcA advised linking with the CCGs care home project that was soon to launch. In answering questions, LH advised that development and training continued for the HIC team and they continued to build their relationship with primary care colleagues through the MDT. Resources would be amalgamated within the MDT's to reduce duplication. Treatment Escalation Plans would be in place for each patient to record patient's wishes. Death of the patient was not necessarily a poor outcome if adequate support had been in place. LH explained that she had implemented her own 100 day plan since joining WH&C to show her commitment to the organisation. This included ensuring that cases did not remain on the programme longer than needed and that discharges were appropriately supported. LH's role was to link with other providers and localities to join up systems and integrate teams and care co-ordinator roles where possible. WH&C as an organisation was ensuring it had the correct skill set through its recruitment and retention plans and that there was adequate capacity to deliver programmes. *(LH left the meeting)*	
GOV/17/09/14	**Update on Delegated Commissioning of Primary Care** JC explained that there were 49 areas to work through to realise the full transfer of delegated commissioning of primary care. 11 areas had fully transferred to date, seven were in transition and the remainder would be completed over the next six months. The transition of functions would impact upon a number of directorates and their resources across the CCG. The six main areas of risk had been identified as resourcing, supporting contracts and information, communication, the inter-dependency with Primary Care Support England, remaining functions with NHS England and hosting of transactional services to BaNES CCG. There were also operational finance risks. Clarity of processes was needed. Data and information needed to be robust to mitigate risks and to ensure quality of services. An audit was to be carried out in quarter three by PwC to understand processes, monitor progress and learn from the actions. LP requested that a presentation was brought to a future Governing Body meeting to report against the work undertaken to shift the primary care support and the expected future gain of full delegation. ACTION: GOV/17/09/14 - Presentation to be brought to a future Governing Body meeting to report against the work undertaken to shift the primary care support and the expected future gain of full delegation.	**JC**
GOV/17/09/15	**RightCare** LB reported that the plans against phase two of the RightCare programme had been assured and work progressed on the three prioritised programmes to meet the 40% threshold. The next step was to use the Clinical Advisory Group to assist with priority setting using the deep dive information and logic models. From this further actions would be identified.	
GOV/17/09/16	**Any Other Business** There were none.	

ITEMS FOR RATIFICATION AND NOTING		
GOV/17/09/17	The Governing Body noted and ratified the following items: a. Items as approved at the Audit and Assurance Committee: • Audit and Assurance Committee meeting minutes – July 2017 • Board Assurance Framework and Risk Register b. Items as approved at the Finance and Performance Committee: • Finance and Performance Committee meeting minutes – July 2017 c. Items as approved at the Quality and Clinical Governance Committee: • Quality and Clinical Governance Committee meeting minutes – July 2017 • Quality and Clinical Governance Committee Annual Report d. Health and Wellbeing Board meeting minutes – July 2017	
	The meeting concluded at 12.15hrs.	

Date of next Governing Body Meeting in Public:
28 November 2017, 10:00hrs at Southgate House, Devizes