NHS
Southend
Clinical Commissioning Group

Quality, Finance and Performance Committee

Minutes of the meeting held on Wednesday 17th September 2014,
13:00 to 16:00, in the Boardroom, Suffolk House

Members present (in alphabetical order):

Name:	Initials:	Title:	Organisation:
Dr Krishna Chaturvedi	(KC)	GP Governing Body Member	NHS SCCG
Melanie Craig	(MC)	Chief Operating Officer	NHS SCCG
Dr Suparna Das	(SD)	Secondary Care Consultant – **Committee Chair**	NHS SCCG
Linda Dowse	(LD)	Chief Nurse	NHS SCCG
Janis Gibson	(JG)	Lay Member PPI	NHS SCCG
Dr Paul Husselbee	(PH)	Clinical Chief Officer	NHS SCCG
Dr Kelvin Ng	(KN)	GP Governing Body Member	NHS SCCG
Jason Skinner	(JS)	Chief Finance Officer	NHS SCCG
Robert Shaw	(RS)	Head of Performance and QIPP	NHS SCCG
Dr Taz Syed	(TS)	GP Clinical Lead for Quality	NHS SCCG

In Attendance (alphabetical order):

Angela Paradise	(AP)	Head of Corporate Services and **Minute Taker**	NHS SCCG

1. Welcome and Apologies for Absence

Apologies for absence were received from Charles Cormack, Dr Natverlal Shah.

KC and KN announced that they needed to leave the meeting at 1515 and 1530h respectively.

2. Declarations of Interest (DOI)

No declarations of interest were received in relation to the agenda.

3. Minutes of the Meeting 20th August 2014

The minutes of the meeting on 20th August 2014 were reviewed and the following amendments were requested:

- Page 2, section 5.1, should read "£5m of £8m".
- Page 3, relating to CAMHS – amendment to state that the CAMHS service will not be able to respond "when children are placed out of area".
- Page 6, section 6.1 relating to IAPT, amendment to state that patient can see "counsellors" in other locations, rather than GPs.

Subject to these amendments, the minutes were **AGREED** to be an accurate record of the meeting.

4. Action Log

027 – Specialised Services data: MC updated that she and RS are working together with the Area Team in relation to taking on more specialised services. RS is working the data set for these. LD added that any quality issues identified within specialised services are addressed

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through her team.

040 – Board to Board meetings: CC and MC are in discussions with SEPT about a Board to Board meeting. SUHFT's CEO has resigned so further discussions regarding a Board to Board with SUHFT is on hold.

It was noted that the governing body had not received a formal communication about the CEO's resignation, although it had been communicated in the media. **Post-meeting note: the CCG sent an email to all governing body members regarding this on 22nd September 2014.**

055 – Missing person's alerts: LD confirmed that St Luke's and the out-of-hours service will continue to receive this; GP practices will not. **This action can be closed.**

056 – Rapid Access Paediatric Referrals: LD chasing responses to the two specific issues (a) that a referral was not picked up and (b) whether the use of faxes is appropriate for such referrals.

Post-meeting note: The hospital have shared a copy of the letter they send to GP practices outlining how to process these types of referrals. Relating to the specific case, the comment was that it was too long ago to establish exactly why it wasn't picked up, but that "the child was given an appointment in the rapid access clinic on the 10th June 2014 where they were seen by a consultant paediatrician - fortunately, she did not require immediate assessment".

057 – Integrated performance report – to include contract notices in future reports: RS confirmed that contract notices would be included as standard going forward and that for the purposes of the meeting on 17th September, this had been tabled. **This action can be closed.**

058 – IAPT service redesign: MC confirmed that this had been discussed at the clinical executive meeting the previous week. Following this, Governing Body members will receive an update at their Part II meeting on 25th September. It was noted that this will form part of the CCG's commissioning intentions. **This action can be closed.**

059 – Corporate Risk Register: AP noted that CRR39 is currently receiving attention from the Head of Commissioning as the information was unclear. A full update will be presented to the next committee on 15th October 2014. **This action can be closed.**

060 – Terms of Reference: SD noted that these had been circulated with previous agreed amendments made. JG suggested a further amendment in relation to delegated powers and best value, in that this should also be about quality. In addition, the terms of reference should clearly reflect the link to the CCG's constitution and work plan objectives.

Action: AP to make these amendments and recirculate to members.

061 – Information Governance Toolkit Action Plan 2014/15: LD confirmed that she would be undertaking face-to-face Caldicott training in the Autumn and can resume the role of Caldicott Guardian. **This action can be closed.**

5. Integrated Performance Report

5.1 Better Care Fund (BCF)

5.1.1 MC advised that the deadline for resubmission of the BCF plan is 19th September and that the governing body will be asked to note the resubmission at its meeting on 25th September having had delegated authority from the Health and Wellbeing Board. SD raised a concern that the governing body were being asked to approve the BCF plan in retrospect, after

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submission, and queried where the money was being scrutinised at CCG level. MC clarified that the BCF plan was not being taken to the governing body on 25 September for approval but for noting only, following submission on 19 September. MC also confirmed that the delegated authority from the HWB means that this process has been approved and that the governing body has previously received the detailed financial information. JS confirmed that the money was all coming from the £12.7m fund. MC added that the CCG has followed national guidance on and the governing body will receive details on how each scheme has been configured. On Friday 19th September, a group comprising CCG and HWB colleagues will approve the resubmission.

It was noted that £11.6m of the £12.7m is the CCG's element for 2015/16 and is aligned with operational resilience and QIPP. This equates to the avoidance of 656 non-elective admissions.

KC asked about the council's share versus the healthcare share; JS confirmed that the CCG has raised this issue with the council and work is being undertaken to determine where joint working can deliver efficiencies elsewhere. LD added that the pioneer programme will drive integration across the system.

Post meeting note: the BCF plan was submitted without GB approval, and was presented to the GB at its meeting on 25th September for approval, not for noting. MC circulated an update to QFP members by email to explain this before the GB meeting.

Quality Premium Measures

RS reported that there are still issues with quality premiums; the position remains largely unchanged and the CCG is behind target.

PH suggested that the October governing body seminar receives a presentation on the BCF to ensure clarity of understanding. PH also queried what is being done about improving the position on quality premium measures.

Action: AP to add BCF to the October seminar agenda.

RS replied that in relation to quality premium measures, the CCG is still seeing delays at individual practice level. PH added that SEPT appear to assume that practitioners would have rooms available to see patients; as SEPT hold the contract, they should be ensuring that patients are seen. MC questioned whether primary care would pick up the additional cost of this and acknowledged that there are a number of actions that can be taken which are being reviewed. SEPT are committed to working towards a new model and this will be reviewed in January 2015.

It was noted that NHS Castle Point and Rochford (CP&R) CCG have issued a contract performance notice to SEPT to which a comprehensive and robust response has been received. Southend CCG is building a more resilient team with more capacity which will be able to work alongside CP&R.

KN suggested that they may be rooms available in health centres; MC agreed to explore this. KN added that GPs are unable to get information from the Therapy for You service about their own patients and that he has emailed MC and PH about this. MC replied that she is writing to CP&R in relation to KN's email. PH added that patients can withhold their consent to information being shared with their GP. LD stated that there was a need to check whether patients opt in, or opt out, of having their information shared.

Action: LD to check the position on this.

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5.2 Quality

5.2 LD highlighted the following issues from within the quality report:

5.2.1 FFT – there has been a dip in the net promoter score and the response rate remains low. The token system is no longer being used and the text messaging system is in place. Maternity FFT will only be record experiences from the actual birth from October 2014.

AP commented that she had used the FFT text messaging system following a recent appointment. Whilst the service states that replies will be free, a message came up stating that the replies would be charged. **Action: LD to follow this up.**

5.2.2 VTE – it was agreed that prophylaxis would be a better method.

5.2.3 Serious Incidents – there were 9 SIs during August 2014. The CCG is assured that the level of reporting has increased.

5.2.4 No new cases of MRSA have been reported; Clostridium Difficile (C.Diff) remains under constant scrutiny.

5.2.5 Children's safeguarding – it was noted that a little more context in the report would be helpful and this will be actioned going forward.

5.2.6 Rapid response – LD confirmed a full root cause analysis will be undertaken. It is hoped that NELFT will be used to provide this service in the future.

5.2.7 Court of protection – the CCG has three patients who may require a court of protection. It is currently unknown how may additional patients will require this but the CCG is taking advice from the local authority who have experience in this area. LD is also arranging training from a law firm to ensure the CCG is aware of its responsibilities.

5.2.8 CQC report – deadline for the hospital to send back comments on factual accuracy is this week; the CQC will then issue their final report.

5.2.9 Care homes – the CQC have sent positive reports on care homes.

5.2.10 CHC – LD is meeting with Arden on 19th September to discuss priorities for 1st October onwards. The CCG's section of the current CHC team is being TUPE transferred into Arden and it is anticipated that vacancies will be filled this week.

5.2.11 In relation to Appendix 7.1 relating to complaints, which was tabled at the meeting, there was a request to make the "relating to" column clearer.

5.3 Performance

5.3.1 RS presented the following performance headlines.

5.3.2 Delivering effective care – the CCG is still not getting the data and RS is meeting with the hospital on Monday 22nd September. TS is also attending his first mortality review group on 6th October which is a positive step forward for the CCG.

5.3.3 Delivering responsive care – the Trust has achieved this for may through to August although there was a slight dip in August due to additional calls on non-emergency beds. A&E continues to deliver.

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5.3.4 Cancer – the hospital continues to deliver against cancer targets with the exception of urology and prostate pathways. This was highlighted at the Q1 assurance meeting and is due to issues with histopathology. The hospital has to submit a revised plan for December 2014 and it was noted that this is a common issue across the country.

5.3.5 Two week waits are rising in numbers but the hospital has reacted flexibly and there are no breaches. Patient choice breaches are high and the target does not differentiate between these.

5.3.6 KC asked whether there is a specific issue contributing to the problems with the prostate pathway. LD replied that the deep dive into this area will address this. KN asked whether patients who chose an alternative hospital subsequently receive all related appointments at that hospital. SD replied that this is the case for all specialties other than maternity.

5.3.7 RTT – the hospital were requested to drop their performance in order to clear the backlog and whilst this is in progress, referrals remain high. Technically this means the hospital is failing the target although this has been agreed nationally. Outpatients still remains the biggest risk; the CCG wants to support the hospital in achieving and maintaining its RTT position. The hospital needs the appropriate level of capacity to support its chief operating officer. RS added that his role is changing in order to be able to work more closely with the hospital particularly in relation to RTT and waiting lists. SD noted that cancelled operations and mixed sex breaches are to be included in the report.

5.3.8 SEPT – RS advised the committee that Shari Payne is now in post as Head of QIPP and PMO and has a background in mental health as well as strategy and programme management. Shari will be assisting SEPT with managing their underlying run-rate.

5.3.9 Ambulance service – the CCG is still awaiting this month's data; it was agreed that RS would ensure this is sent with the minutes.

Action: RS to supply ambulance data to be issued with the draft minutes.

5.3.10 RS commented that challenges across Essex have been predicted and mitigation is being put in place; RS also now joins their monthly contract meeting. SD commented that Southend is the only area showing green; RS replied that Southend benefits from its geography. LD added that the ambulance service is on the agenda for quality surveillance group and that the quality element will also be added to the report.

5.3.11 IFRs – LD offered to supplement the figures with additional information relating to the types of IFR requests received; it was noted that LD continues to sit on all IFR panels. **Action: LD to provide context for IFR decisions.**

5.4 <u>Finance</u>

5.4.1 JS presented the following financial headlines:

5.4.2 The CCG has received GPIT funding of £196k and £786k RTT funding.

5.4.3 The CCG has a £1.316m year to date deficit and is slightly behind plan partly due to QIPP delivery (£1.4m of the required £6.2m). The key financial challenges remain within CHC and medicines management, It was noted that the prescribing pricing authority forecast has been approximately only £50k different to our forecast. The CCG has no unallocated contingency but remains confident it can achieve its agreed end-of-year financial position albeit reliant on the £6.2m QIPP delivery.

5.4.4 JG questioned whether the resignation of the Chief Executive of Southend University Hospitals NHS Foundation Trust (SUHFT) would have any risk to the CCG. JS replied that any uncertainty is unwelcome and the CCG is working with the hospital to close off any

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outstanding actions. MC added that Paul Sly (PS), Interim Recovery Director is moving into a different role to help with the closedown on 2013/14; PS will work with JS and James Peskett, the new Director of Commissioning who joins the CCG in October, to ensure resilience and delivery.

5.4.5 The QIPP schemes are starting to deliver particularly on CHC and medicines management. With respect to the overspend of £370k **YTD** in the CCG's running cost allowance, SD asked what the CCG plans to do differently between now and the end of the year to ensure financial delivery. JS replied that the CCG is finalising its recruitment position which will alleviate the need for interims although the forecast is subject to confirmation from NHSE around treatment of CSU stranded costs which, if considered running costs, would be in addition to the £120k.

MC added that the 2015/16 staffing structure is affordable within the reduced running costs. There is also an expectation that CCGs pay stranded costs as a result of CSU transition and this could be anywhere between £260k and £400k. JS has built £260k into the forecast but not as running costs. MC confirmed that full details of this will be brought to the committee as a regular report on running costs, included in the integrated performance report.

5.4.6 KN asked if GPs still contact the CSU for IT support. JS confirmed this and it was agreed to circulate the contact details for IT and other CSU services to GPs.

5.5 Contract Performance

5.5.1 RS tabled additional detail relating to contract performance in response to a request from the previous meeting to include this information each month.

5.5.2 RS explained that the last few months' data had been an estimate predominantly driven by A&E performance which has had a significant impact on the hospital's RTT target. It was noted that Basildon and Thurrock University Hospitals NHS Foundation Trust are on target.

5.5.3 There is a slight under-spend at SPIRE and a slight over-spend at the BMI. The CCG needs to drive down non-elective spend but still experiences difficulty getting timely data from the hospital. JS added that the CCG has now agreed timeframes with the hospital but will always be two months in arrears. There was a discussion around what was meant by flex and freeze data in that flex is unconfirmed (flexible) and freeze is confirmed data. It was noted that some months' data is frozen at different months; RS confirmed that the CCG is working on obtaining the best fit in terms of timing and data.

Action: RS to provide trends and context in future reports as well as uncoded activity at SUHFT.

6.0 Corporate Risk Register

6.1 JS introduced the corporate risk register. It was noted that CRR27 is closed and should be removed from the summary page.

6.2 AP commented that progress was being made against the equality delivery system action plan (CRR40). MC added that CRR2 is under full review and will form part of the discussions around commissioning intentions that Paul Sly will be leading on. PS will be proposing a more interactive process for commissioning intentions this year; JG asked whether commissioning intentions could be brought to the Patient Participation Group for their input.

7. Minutes of other meetings

7.1 The minutes of the clinical executive committee meeting held on 7th July 2014 and the clinical quality review group held on 21st July 2014 were noted.

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[1530h – KC and KN left the meeting.]

8. Items for escalation to the governing body

8.1 AP noted that further to PS's feedback from the July governing body meeting, committee chairs were required to provide short summary reports to the governing body on the work of each committee. AP had previously emailed each committee chair offering to help prepare these summaries, however, in the interests of time and governing body papers due to be sent the following day, it was AGREED that for the September governing body, each committee chair would provide a verbal update. These updates are therefore be required as follows:

SD – Quality, Finance and Performance
JG – Audit and Risk Committee
PH – Clinical Executive Committee

9. Any other business

None raised.

10. Date of the next meeting

15th October 2014, 1:00 - 4:00pm in the Boardroom at Suffolk House.

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