NHS
Southend
Clinical Commissioning Group

Quality, Finance and Performance Committee

Minutes of the meeting held on Wednesday 15th October 2014,
13:00 to 16:00, in the Boardroom, Suffolk House

Members present (in alphabetical order):

Name:	Initials:	Title:	Organisation:
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 Kelvin Ng	(KN)	GP Governing Body Member	NHS SCCG
Dr Natverlal Shah	(NS)	GP Committee Member	NHS SCCG
Jason Skinner	(JS)	Chief Finance Officer	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
Shari Payne	(SP)	Head of QIPP and PMO	NHS SCCG
Robert Shaw	(RS)	Programme Director, Operations	NHS SCCG
Sadie Parker (for Item 7)	(SAP)	Executive Lead, Primary Care and Engagement	NHS SCCG

1. Welcome and Apologies for Absence

1.1 Apologies for absence were received from Charles Cormack, Janis Gibson, Dr Krishna Chaturvedi and Dr Paul Husselbee.

2. Declarations of Interest (DOI)

2.1 All GPs present declared interest in item 7. No other declarations of interest were received in relation to the agenda. [JS subsequently declared an interest during finance discussion on CSU stranded costs]

3. Minutes of the Meeting 17th September 2014

3.1 The minutes of the meeting on 17th September 2014 were reviewed. JS requested agreement to reword section 5.4.3.

Post-meeting note: JS provided the following revision to section 5.4.3 of the 17th September 2014 minutes:

3.2 *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.*

Subject to this amendment, the minutes were **AGREED** to be an accurate record of the

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meeting.

4. Action Log

040 – Board to Board meetings: CC has spoken to Alan Tobias, SUHFT Chair, who is keen to hold a Board to Board meeting. Sue Hardy is acting Chief Executive and Cheryl Schwarz is acting Director of Nursing. SUHFT going out to permanent advert for the position of Chief Executive Officer in the new year.

062 – IAPT: LD confirmed that patients in general opt out of the data sharing process but still needs to be confirmed for mental health patients specifically. Action to remain open.

063 – Friends and Family Test (FFT): LD confirmed that this matter has been taken up with the Trust. The Trust has confirmed there should be no charge and will check the system to ensure this is rectified. SD questioned whether it may be the mobile network provider that were attempting to charge; either way, there should be no charge to patients. Action to remain open.

5. Integrated Performance Report

5.1 JS highlighted overall summary position which remains similar to recent performance. The trust is achieving in most areas, other than 62 day cancer target which remains challenging which is similar across Essex.

5.2 QIPP is still amber although monitoring processes have improved and metrics have been developed against these. CCG is not expecting green at this stage. The CCG is still forecasting a deficit position as planned and therefore this needs to remain amber. Finance headlines - £2.1m forecast overspend. SUHFT forecast variance looks lower as some funding has been received (actual forecast remains unchanged). Medicines management recovery plan in place to recover potential risks in excess of the £0.5m forecast overspend in this area. CHC overspend has also been built into forecast. The overall position includes these items but it is becoming tighter to achieve. Next week there is a meeting at which it is anticipated that last year's position with SUHFT will be closed.

5.3 JS added that as outlined in Appendix 3, Finance Paper, detailed work has been undertaken on the financial impact of changes to services taken from Central Eastern CSU and has identified that the financial impact for the CCG is £24k per year. Some of the service specifications have changed so it has been difficult to cost each service line on a like for like basis. Running costs are still above target; risk has moved up from £120k forecast but we are due to undertake a review of the methodology, to confirm whether each service line is charged against running costs or programme costs. The costs would still need to be paid so this is purely around whether the running costs end up overspent against the statutory target.

5.4 Forecast does not take into account rebasing of the methodology; SD queried why the end of year forecast overspend on running costs has effectively more than doubled. JS explained that this is part of the work being done to review the profile and was not an under-stated position in the previous month. Mitigation is through ceasing to use interims, some of which will become permanent positions.

Action: JS to report back on running costs following the detailed review at November meeting.

5.5 A detailed discussion ensued regarding the CCG's liability for stranded costs and the committee agreed to support the letter form Essex CCGs for NHS England. JS declared his interest in this item.

The Committee AGREED to sign up to the letter to NHS England.

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Action: AP to include CSU stranded costs on the corporate risk register.

Quality

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

5.6.1 VTE remains on target and is closely monitored through the CQRG, however, concerns around the prophylaxis which should be 100% but currently sits in the 80% range. LD to raise at CQRG.

5.6.2

5.6.3 C.Diff trajectory – higher than it should be at this time of the year (20 rather than 18). Again CCG monitoring this carefully.

5.6.4 Harm-free care meeting attended by all providers across South Essex (SUHFT, SEPT and SPIRE) and all providers presented their learning from Serious Incidents and Never Events. SEPT also talked about they are managing all their falls. It is hoped that Colchester and Basildon join the next meetings and share their Keogh review experiences.

5.6.5 Serious Incidents are not closed off until the CCG is assured that all actions, including the longer-term ones, have been completed. LD attended a meeting at the hospital yesterday to ensure this happens in all cases and will follow up at a further meeting next week.

5.6.6 Quality Assurance report received from Antenatal and Newborn Screening Programme; one issue had been raised as a serious incident and the other two had been flagged up through their DATIX system. These are also being discussed at CQRG next week.

5.6.7 Ebola was considered at an emergency planning event yesterday; concern that practices need to buy their own personal protective equipment (PPE) and therefore need full guidance on the correct equipment and how to use it. TS noted that GPs were not invited to the event but did receive an email with signposting information to the government website. Processes at the hospitals have been tested but the concern is how practices cope. Expecting guidance from the government that will be reviewed by the infection control nurse to ensure GPs are given the right advice. This must include advice on how to dispose of used PPE. LD confirmed that further information and guidance would be sent out from the quality team.

5.6.8 Action: LD to ensure an alert is sent to GPs and practice managers this week, from the CCG, to confirm what steps will be taken in relation to Ebola. Alert should be marked urgent and will include infection control nurse's contact details.

5.6.9 SD raised a concern relating to the SPIRE and their NHS choices ratings, 2 ½ out of 5 in some areas and also the number of complaints received about BMI, asking what can be done.

5.6.10 LD confirmed that the quality element of BMI's services are picked up through the CQRG (the BMI does not have its own CQRG) but it has been agreed to hold a monthly meeting to look specifically at this issues.

Action: Monthly CQRG to be set up for SPIRE and BMI which will feed into the quarterly contract meeting for these hospitals.

Performance

5.7 RS presented the following performance headlines.

5.7.1 Headline metrics are that A&E standard was achieved for M4 and for the whole of Q2. This has been achieved though high levels of non-elective admissions. Some days where admissions are particularly high at 42%. Discussion with Jon Findlay as to the acuity of patients and whether they should be admitted as it causes a knock-on effect in the hospital

5.7.2

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and the trust is keen to avoid this.

5.7.3 System Resilience Project also coming into play and further detail can be provided if required. Comment had been made that Southend was likely to experience the same dip in achievement during winter. Another theme appeared to be in relation to patients not being able to get through to GP practices and therefore attending A&E.

RTT

5.8

5.8.1 The amnesty for target achievement has been extended to October and November and additional funding has been received for this. Overall aggregate (bottom line) position can be achieved. Still a concern at speciality level for specific areas which will be focussed on whilst still maintaining aggregate level. 15% mark up on the tariff price from the Trust is applicable on this activity in order to be able to deliver this but constructive discussions are underway with the hospital about this. For October and November, putting on 250 additional outpatient appointments and 170 theatre lists in the areas of concern.

5.8.2 Risks going forward include our non-admitted position and also the ophthalmology position.

5.8.3 NS asked whether the same consultant would see a patient in the additional clinics. RS acknowledged that whilst this has happened in some parts of the country, this is not an issue in Southend; SUHFT do not have the physical capacity to undertake some additional work so this is being passed to BMI to undertake. An improvement in referrals in and how these are made needs to be seen and this will be helped by following the service restriction policy.

5.8.4 KN asked whether primary care-based capacity for ophthalmology could be increased.. RS explained that the focus is on this service due to the size of the backlog. This is one of the CCG's largest specialty challenges. We will need to consider community ophthalmology services to reduce the backlog.

5.9 **Cancer**

5.9.1 Achieving all targets with the exception of the 62 day prostate pathway under urology. Looking at one-stop clinics for patients with a PSA of 10 or over. Looking at histopathology and whether improvements can be made there. There are other areas where the results look worse than they are, in smaller areas where the numbers are lower. Prostate pathway is known to be a difficult area.

IAPT

5.10

5.10.1 IAPT target achieved for Q2. Maintained a higher level of patients attending for their first treatment; these run rates need to be maintained for the rest of the year.

5.10.2 NS noted that there is still a 6-week waiting list; RS confirmed that this is just starting to reduce and will be reported on further.

5.10.3 MC noted that there will be new national targets for IAPT waiting times for 2015/16; all planning requirements are being addressed at this month's governing body seminar.

Contract Performance

5.11

5.11.1 RS explained that the CCG has an over-run of £650k on non-elective activity. Seeing a slow decline in spend in relation to non-elective admissions. Also seeing a decline in other areas including paediatrics, although this figure is rising in general surgery. LD and RS to undertake an acuity review to look at this in more detail.

Part of the overrun was funded through July to September and will also now include

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5.11.2 October and November. There is a range of diagnostics being undertaken which continue to be reviewed in terms of whether they are necessary and also whether they should be done as elective. Biggest overspend is in the electives.

5.11.3 Critical care remains relatively the same month on month in terms of performance. Coding issues need to be explored. Two particular long-term stays have also been factored in.

5.11.4 SD noted that maternity activity was starting to increase, the risk being that it will begin to over-perform.

5.11.5 RS highlighted cataracts as a big issue in terms of activity but it was acknowledged that the three consultant vacancies contribute to this.

QIPP

5.12

5.12.1 SP outlined that the minimum QIPP delivery this year is £6.3m. This month is showing an under-delivery of £281k and a worsening position of £50k from last month and the focus is to make this up. Metrics in place now for planned and unplanned care through the service restriction policy and comparing this with last year. Overall metrics are based on the better care fund.

5.12.2 QIPP leads update their trackers and metrics weekly and next week sees the start of weekly meetings with leads to discuss their schemes. Work has also begun to look forward to 2015/16 schemes, but overall good progress is being made this year.

5.12.3 MC acknowledged that SP has put in place a good process and the committee must not underestimate the work that is required to deliver this. SP is working closely with the recovery director and the biggest focus has to be on planned care and unplanned care and the CCG is considering options as to how this can be achieved. Committee members and GPs need to be fully aware of the risks associated with this.

5.12.4 SD asked whether there was a QIPP working group. MC confirmed that all QIPP leads have to update on their areas at the clinical executive. The weekly executive group consider QIPP schemes overall and SP's weekly QIPP working group will ensure each QIPP scheme receives full, detailed consideration. KN added that there is constant communication between the management and clinical sides and not all meetings require clinical input. SP added that the flow should be from the QIPP working group into the weekly operational executive and then on to clinical executive.

Better Care Fund

5.13

5.13.1 RS confirmed that the final submission has been made and the CCG is awaiting its final review at the end of the month. Weekly team meetings with the council are in place to obtain some of the required detail. Arrangements need to be in place by 1st April 2015.

5.13.2 The CCG has agreed to extend MEDE Analytics for a further six months while NELLIE is installed. The minimum contract extension for MEDE is six months however the NELLIE transition is expected to be complete by December. There may be additional costs though not significant to the CCG from the transition period.

<u>Procurement of CHC Care Home Placements</u>

6.

6.1 LD presented this item and highlighted the current difficulties across the system. There is an Essex-wide process which the CCG can join and discussions have taken place with Arden. The focus is on five different bands of patients and the costings are set out in the paper. Service specification is currently missing from care home monitoring and this is being addressed bearing in mind the Essex-wide model. It is essential that the CCG takes this proposal to care home providers and the CCG's Integrated Care Programme Director is

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undertaking detailed work in this area.

6.2 Cost of care bundles was discussed; LD confirmed that there is a capacity issue but the CCG must be consistent with other providers. LD noted that there will be ongoing work to determine the costs of the Care Bundles, working closely with all stakeholders, especially providers, and that she is working closely with the Essex procurement working groups to confirm how the pricing structure will be arrived at. A further paper will be brought back to this committee in relation to care bundles.

6.3 LD highlighted the risk that the CCG would be liable for void costs if beds that have been blocked are not filled. If members agree the proposal, the next step will be to work up the further detail with the procurement team. NS asked whether consideration has been given to CQC reports; LD confirmed that these are always considered and the quality team would be heavily involved with care homes where embargoes have been put in place. This paper, however, is more about the placements.

The committee APPROVED the proposal in principle.

<u>Bid Process for Primary Care £5 per Head Funding</u>

7.

7.1 SAP attended for this item which follows on from a paper presented to the Clinical Executive Committee (CEC) last week. The £5 per head primary care transformation scheme has been considered at a number of previous CEC meetings and members have considered a number of options, including the option not to invest the money this year. Benefits and risks are set out in the paper. CEC members have previously raised concerns about the potential for disengaging member practices if the £5 per head was not committed, balanced against the risk to the CCG's financial position if it was released.

7.2 Also important to note that there was no consensus at the CEC on how to progress this matter. The CEC agreed by majority to bring this paper to this committee for decision around the process for approving schemes in line with our CCG governance.

7.3 The CCG Chair had submitted his comments on this paper including the recommendation for an independent lay person on the panel and secondly that larger practices may feel they have lost out bearing in mind their larger contribution.. The application form is based on NHS England's form for bidding for primary care funding, but has been simplified. It is acknowledged that some practices may need access to data to help them complete their forms. As the Governing Body has previously agreed to withhold all discretionary spend in the Recovery Plan approved in July, , there is a need for the Governing Body to consider investment the £5/head which would reverse their earlier decision.

7.4 KN asked whether this is a one-off or recurring funding. JS confirmed it is non-recurrent. KN commented as to whether practices would be interested for the remaining months of the year. Practices can bid for more or less so may not be exactly £5 per head. SAP added that the guidance is that CCGs should set out £5 per head of population but it is guidance rather than policy. No further guidance has been issued on this subject in relation to how to take this forward. KN noted that the aims remain the same but the remunerations are different in scale. NS asked whether this applies to GMS and PMS, which it does.

7.5 KN observed the duplication and similarities in the resilience fund, admission avoidance DES and the £5/head scheme which are all aimed at slightly different but complementary areas of health care. These are all national processes and not designed by the CCG. SAP confirmed that 35 practices signed up to the admission avoidance scheme but subsequently many have confirmed their inability to deliver.

7.6 MC added that we received £2.2 million resilience funding (across both SCCG and CPRCCG) which is to support capacity and resilience over Winter and ensure achievement of the A&E standard.. All practices were invited to bid for this although only one did. MC

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confirmed that the Governing Body in September approved the allocation of resilience funding and the list of schemes.

7.7 Members discussed the availability of funds to pay for the £5/head scheme and also the risk that improvements may not be delivered. SD confirmed that the committee is being asked to approve the process, not the funding which is a Governing Body decision.

7.8 After much debate, it was agreed not recommend to the Governing Body that we do not invite practices to bid for £5/head funding for the short period of time remaining this year, particularly when practices will be busy with QOF and winter pressures. Instead, the CCG would budget for 12 months' funding for the £5/head scheme to commence in April 2015. Over the next five months, CCG management team would work with practices to provide data and information and help co-produce schemes. Working to support practices with development of bids is likely to produce a better quality of bid and schemes. The process would be adapted to recognise this.

Action: MC to present recommendation to GB Seminar on 30th October 2014.

1530h - KN left the meeting.

Corporate Risk Register

8. JS presented the risk register and re-iterated the recommendations from the paper.

8.1 It was noted that CRR39, which was in relation to effective use of the service restriction

8.2 policy, has been fully scrutinised and is recommended for closure.

It was AGREED that CRR39 should be closed.

8.3 There was a discussion in relation to whether or not to escalate CRR32, Failure to provide CHC patients in nursing/care homes with safe, high quality care and positive patient experience, and CRR34, Disbanding of Safeguarding Children's Clinical network, to the GBAF as their scores have remained high, at 12, for many months.

8.4 In relation to CRR32 (CHC), LD confirmed that this should remain on the CRR as we don't have a separate risk for each provider. AP suggested that clearer linkage between the CRR and the Governing Body Assurance Framework (GBAF) would provide adequate assurance here.

8.5 In relation to CRR34 (Safeguarding Children's Board), LD confirmed that she expects this risk rating to decrease over the next couple of weeks due to fundamental shift in that Southend now chairs the professionals' meetings.

It was AGREED that both risks should remain on the Corporate Risk Register (CRR) for the above reasons.

Action: LD to include linkage between CRR and GBAF for CRR32.

8.6 The additional descriptors on the risk scoring matrix were reviewed. SD commented that business continuity should certainly be included.

The proposed additional risk descriptors were APPROVED.

Policies for approval

9. LD confirmed all policies go through the policy assurance group, which follows the CCG's

9.1 policy for policies.

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9.2 The IFR policy has been slightly amended to reflect the fact that NHS Basildon and Brentwood CCG now host this service. The legislative change that came into effect this month will result in a more comprehensive review of the policy content, which will be brought back to the committee in the new year. Members were assured that the CCG is represented by the Chief Nurse on IFR panels with the appropriate level of delegated authority.

9.3 MC queried implementation of policies particularly where these are relevant to GPs (e.g. media relations).

Action: AP to bring to Weekly Operational Executive Group implementation plans for the three new policies and an overall process going forward.

The committee NOTED the IFR policy and APPROVED the Media Relations, Fire Safety and First Aid policies.

Minutes of Other Meetings for Noting

10.

10a) Clinical Executive 11th September 2014

SD noted that the committee have had a further £5 per head discussion since the minutes were issued.

10b) Clinical Quality Review Group (CQRG) 18th August 2014

LD confirmed that September's minutes have not yet been approved but will be at the next CQRG meeting next week.

a) Items for Exception Reporting to the Governing Body

None.

b) Items for the next meeting agenda on 19th November 2014

i) JS to provide an update on stranded costs.

ii) LD to provide an update on the procurement for care home placements.

c) Any other business

i) It was noted that stranded costs were discussed earlier.

ii) LD raised that Southend University Hospitals Foundation Trust (SUHFT) are going to undertake their own "CQC" style monitoring of the standards and will be seeking people to make up the investigating teams.

11. Date of next meeting: 19th November 2014, 1:00 - 4:00pm in the Boardroom at Suffolk House. Please send apologies to Lucy.godsell@nhs.net

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