**AGENDA ITEM 11a.**

NHS
Southend
Clinical Commissioning Group

# QUALITY, FINANCE & PERFORMANCE COMMITTEE

Wednesday 28th September 2016 at 1300h until 1600h
Priory Suite, Harcourt House, Southend

## MINUTES

**Members present (in alphabetical order):**

| Name: | Initials: | Title: | Organisation: |
|---|---|---|---|
| Dr Krishna Chaturvedi | (KC) | GP Governing Body Member | NHS Southend CCG |
| Melanie Craig | (MC) | Chief Officer | NHS Southend CCG |
| Janis Gibson | (JGL) | Lay Member for PPEI and QFP (Chair) | NHS Southend CCG |
| Margaret Hathaway | (MH) | Chief Finance Officer | NHS Southend CCG |
| Dr José Garcia-Lobera | (JG) | Chair | NHS Southend CCG |
| Dr Kelvin Ng | (KN) | GP Governing Body Member | NHS Southend CCG |
| Matthew Rangué | (MR) | Chief Nurse | NHS Southend CCG |
| Robert Shaw | (RS) | Joint Director of Acute Commissioning and Contracting | NHS Southend CCG |
| Nick Spencely | (NS) | Lay Member for Governance | NHS Southend CCG |
| Dr Taz Syed | (TS) | GP Governing Body Member | NHS Southend CCG |
| **In Attendance:** | | | |
| Laura Bowers | (LB) | Personal Assistant / Minute taker | NHS Southend CCG |
| Lee Bushell | (LBu) | Interim Deputy Chief Finance Officer | NHS Southend CCG |
| Caroline McCarron | (CMc) | Head of Integrated Commissioning | NHS Southend CCG |
| Chris Ratcliffe | (CR) | Associate | Attain |

**1. Welcome and Apologies for Absence**

1.1. Apologies were received from Dr Devesh Sharma and Charles Cormack.

**2. Declarations of Interest**

2.1 No declarations were received in respect of today's agenda.

**3. Minutes from the Meeting Held on 24th August 2016**

3.1. The attendees reviewed the minutes and approved them as an accurate record of discussions held.

***3a.* Action log from the Meeting Held on 24th August 2016**

3.2. The action log was updated, see item 3a.

3.3 Matters arising:

3.3.1 RS fed back on the pan Essex Ophthalmology summit attended by all four providers, University College London partners and Moorfield eye specialists. The hospitals in attendance noted similar challenges to Southend and there was a recommendation to shift management of glaucoma into the community, led by Optometrists. In the interim the CCG

has bought in 4,500 optometry sessions and is slowly starting to see patients being seen in the community.

3.3.2 RS noted it was agreed at the Access Board, the CCG will not pay for a certain range of glaucoma follow ups.

3.3.3 MR flagged the Lambeth and Lewisham example where they are following a similar model to Southend's planned model, and they have seen a 21% reduction in first attendances. MR noted another positive to come out of the summit was, when all Trusts compared their serious incident (SI) reporting figures, Southend was clearly the best at reporting Serious Incidents.

## *4.* Headline Reports *(for noting)*

### *4a. Finance:*

4.1 LBu stated the year to date over spend is £1.6m all within programme costs, yet the CCG is still forecast to achieve the full year financial target.

4.2 In terms of QIPP forecasting, a shortfall in the target of £3.8m has been reflected in the budget adjustment made in month 5. Better payment coding and more timely payment of invoices has helped to improve performance against the required better payment target.

4.3 LBu stated that the CCG meeting the end of year forecast outturn is dependent on the achievement of the Finance Recovery Plan (FRP).

4.4 LBu noted there is a £400k year to date (YTD) variance, in acute which is mainly down to non-contracted activity; it is suspected this is due to seasonality holiday issues. However, if it continues there will be a risk of an overspend in this area.

4.5 In respect of the continuing healthcare (CHC) overspend YTD, LBu stated due to the under provision in last year's accounts and lack of robust data, CHC is the biggest risk area in respect of achieving its QIPP performance.

4.6 The £12.6m of QIPP schemes that were developed at the start of year have been reviewed and it has been established that there is a shortfall which leaves a financial gap for the CCG therefore the FRP is needed. Mitigating factors are small underspend in prescribing, community services, reserves and contingency, which are sums, set aside.

4.6.1 LBu reported changes in month 5, stating an increase in Trusts running costs to the amount of £0.6M with various other adjustments contributing the balance £1.1million. This has increased the CCG's unidentified QIPP budget to £3.8m, with the deliverable QIPP now considered to be £6.6m against the target value of £10.4m.

4.6.2 The key areas to focus on to ensure delivery of the current forecast are the CHC programme (£2m), the prescribing programme (£1.8m) and acute outpatient reduction (£0.4m).

4.7 MR noted it is hard to see the impact of all the positive things the CCG is doing in the area of CHC, due to the end of year accrual. LBu will add a table to the next QFP report to explain the current position and positive changes made within CHC.

**Action: LBu to include a table in next month's finance report to show progress being made in the area of CHC.**

### *4b. Finance Recovery Plan*

4.8 MH introduced Chris Ratcliffe of Attain who is working with the CCG on the Finance Recovery Plan and creating a robust action plan to achieve these savings. Plans to implement a Financial Recovery Group, to provide assurance on the delivery of both the QIPP programme and the Financial Recovery Plan is in development.

4.9 LBu ran through the plan stating the following key points:

4.9.1 The CCG's current forecast is set to deliver a £3.8m deficit from the 2016/17 plan. The financial recovery plan details the recovery actions required to deliver the £3.8m of savings which will ensure the CCG delivers it financial target for the year.

4.9.2 The plan was presented to the area team, who proposed a range of changes, which were duly made by the CCG. Subsequently the final plan was presented to the NHS England's regional director of finance on the 22nd September 2016 and this was well received.

4.9.3 Delivery against the recovery actions are a priority for the organisation and it must routinely monitor the delivery of savings to bridge the identified financial gap by year-end. To do this a requirement of the plan is the establishment of a finance recovery group, which will meet fortnightly.

4.10 MC noted that LBu and Viv Molulu have reviewed the QIPP plans and removed the aspirational schemes leaving only the achievable QIPP schemes that the CCG can be more confident will deliver.

4.10.1 MC noted in support of the plan the CCG has brought in additional capacity from Attain to assist in the high risk areas in the short term. The medicines management team have brought in a skilled pharmacist to support the delivery of the pharmacy QIPP. The CCG have appointed Dr Mark Lim a qualified doctor to work alongside Robert Shaw and the GPs, to review the effectiveness of the service restrictions workstream. By having clinicians and medics working with GPs this will ensure the services the CCG are commissioning are services of complete value.

### *4c. Quality*

4.11 MR previously reported on an increase in MRSA bacteraemia cases; further to the investigations carried out by Public Health and the Infection Control Team (ICT) no links between the cases have been found. The ICT have identified some practice issues and recommendations have been made to improve practice.

4.12 MR stated the committee should be aware of a number of MRSA cases across four wards at Basildon hospital; as a result an internal improvement plan has been created and implemented to address this.

4.13 In respect of transforming care, MR noted there were seven inpatients in September, with one patient having been discharged home with support, and another identified as an inpatient on an older peoples mental health ward.

### *4d. Acute Commissioning and Performance Report*

4.14 RS focused on the Accident and Emergency (A&E) departments which are struggling to deliver the 95% target, stating the main drivers are length of stay which continues to remain

high where high levels of acuity are seen. Flow out of the hospital and back into the community, relates to a significant increase in delays in transfers of care (DToC). The Trust's main issue is intermediate care bed flow and the underlying dependence on the domiciliary market and short term care home and residential placements, with homes reluctant to accept short stay patients.

4.15 RS reported that following the health and social care summit the following recommendations for the following pilots were agreed:

a) An exemplar front door program led by Sally Morris, where the community and social care team are located in the A&E department pulling out patients before they go into the hospital.
b) Create a home first culture, led by Tricia D'Orsi. Plans to focus more on keeping patients at home and recruiting Health Care Assistants (HCA) to deliver this model and reduce our dependence on the domiciliary market. It was noted that Trusts who have already used this model have seen a reduction in reliance on the domiciliary market in particular the expensive double handed packages that we struggle to get.
c) Discharge to assess model, led by Matt Rangué. Plans to take people out of hospital earlier, assess their needs and move them out of the hospital care setting quicker.

These three schemes will run as a 2-4 week pilot, with a quick turnaround, and feedback to finely tune longer sustainable projects.

4.16 MC noted she is confident these three clear programmes will have a positive impact on Southend's DToC figures and highlighted that Colchester's improved position should be used to challenge all Essex hospitals to make similar improvements. MC and JGL noted concerns in the pace of implementing a new way of working to make these significant changes at the Trust. MC and JGL suggested a board to board meeting, due to the risk to the local system of the group hospital model.

4.17 The following questions were recorded:

4.17.1 KC asked has the GP filter made a difference in pulling patients out of A&E. RS noted the GP filter has been redirecting for the last 3-4 weeks, however not a huge amount of impact has been seen as the acuity of patient has been appropriate for hospital admission.

4.17.2 KC asked what the Cancer wait conversation figures are. RS noted the service has seen an increase in two week wait cancer referrals around the late 20% mark; however it has not seen a corresponding conversion onto the 62 day pathway. Therefore cancer diagnosis has not increased.

***4e. Integrated Commissioning and Performance Report:***

*CMc joined the meeting at 1528h*

4.18 CMc asked the committee to note the presented the report, highlighting the following key points:

4.19 CMc reported in respect of the better care fund, the localities work and complex care is progressing at pace.

4.20 End of life care (EOL) progress update, it has been agreed that hospice at home will be extended to another 100 patients, a letter of intent is due to be sent and all is going well.

4.21 The shared geriatrician resource offered by Basildon and Thurrock University Hospital NHS Trust has been agreed and the arrangement will be up and running soon.

4.22 With regards to the new mental health reporting requirements, CMc noted a request for CCGs to monitor their out of area bed specialist usage for mental health. The team are starting to look at this, including staffing and out of hour crisis response across adults and adolescents.

4.23 Concerns regarding the over utilisation of the Psychiatric Intensive Care Unit (PICU) beds is a key focus as the CCG is constantly over utilising the ten funded beds. One of the main issues is system flow, and following the issuing of a contract query, South East Essex Partnership Trust (SEPT) are looking at a remedial action plan for moving patients on. There is an ongoing risk as a solution is not progressing quickly enough.

4.23.1 TS asked are social care involved in these discussions, as the children in these beds have nowhere to go. CMc clarified this situation relates to adults and noted there is no step down process into intermediate facilities before discharge. A £27k cost pressure has been reported across month 1-4 and is due to the over utilisation of PICU beds, this issue is being closely monitored.

4.23.2 LBu noted there was a PICU focus group, where most commissioners were present. A review of five different delay scenarios from PICU to a standard adult ward were reviewed. From this it was agreed that moving a patient from a PICU bed to a standard ward would be at SEPT's risk and should incur no charge to the CCG. There are a range of patients (long stayers), who should be in a specialist facility, it was recognised the CCG needs SEPT's assistance in pursing funding from NHS England. SEPT also have a gateway assessment where they assess if a patient is considered of a 'forensic nature', once this policy has been signed off then that patient becomes the specialist commissioning team's responsibility. Some patients need ministry of defence sign off however these are low in number and some require an Improving Access to Psychological Therapies (IAPT) placement. For these cases the CCG will manage these on a case by case basis. LBu noted there are plans to get some rigour around understanding where the responsibilities lay in the future and plans to drive the gross numbers down are based on the principles as noted above.

4.24 CMc reported in respect of IAPT, the CCG is still on course to meet the 15% target, although a downwards trend in referrals was seen over the summer, it is still expected the trajectory will be met by the end of the year.

4.25 The annual 50% recovery rate variation seen through the year could be a result in part to the changeover of the SEPT's administration system. A data cleansing exercise is underway to see where the issues lay, to establish 'is the variation in the data recorded or is it that the CCG is not meeting the trajectory'.

4.26 In respect of Dementia diagnosis, CMc reported figures continue to rise and Southend continues to be the best performing CCG in Essex. The CCG had seen a month on month drop since November 2015, however in July to August 2016 a rise was seen, we are happy therefore to be progressing in the right direction.

4.27 CMc reported that early intervention psychosis numbers are low and targets have been achieved, there is a risk however in that, any small variation in those figures, could mean we miss the target, although currently the target is being met.

4.28 In respect of Learning Disability health checks, Southend continues to drive forward the need to reach the set target. There are ambitions to improve the 70% target to 85-90%, it is recognised that lots of work is needed to achieve this position. CMc noted the CCG is actively looking at providing services outside of GP practices and the potential of commissioning a separate service to bring LD check numbers up. MC noted a detailed paper is going to clinical executive next month.

4.29 In the area of Children and Young people, the CCG is making strides into working with the Trust, looking at the level of activity and the finance that sits behind it.

4.30 CMc reported conversion of the special needs statements is underway and the team are half way through the process. The team is issuing education healthcare (EHC) plans for new children referred into the service. A health assessment in support of each child's statement is needed however the Trust is struggling to provide these within the statutory timeframe, due to capacity issues. The CCG is working to resolve these issues.

**5. Detailed Reports *(for noting)***

**5a. Provider Contract Quality and Patient Experience Report**

5.1 MR highlighted that the CCG had issued a contract performance notice in August for the 16 underperforming key performance indicators. The Trust is developing a plan and setting trajectories to improve performance to the required standard. The notice will be withdrawn once a suitable plan is in place.

5.2 MR reported in respect of Ophthalmology, the Trust have provided assurance that they continue to monitor patients through the serious incident protocol to ensure those affected are seen on time and follow up appointments are booked in, making sure patients are not lost to follow up.

5.2.1 In addition the Ophthalmology department have introduced an Eye Care Liaison Officer (ECLO), the post holder signposts patient to support services in the voluntary sector to help them deal with their vision loss.

5.3 MR noted that the Trust have recruited 36 whole time equivalent staff, however this figure needs to be balanced against the attrition rate to show a true position. A recruitment day was held in August 2016 which proved successful with 100 healthcare assistants being recruited.

5.4 In respect of South East Essex Partnership Trust safer staffing report, MR reported that Clifton Lodge is experiencing recruitment difficulties; however an improvement plan is in place to address this.

5.5 MR reported that the expected school nursing CQC inspection scheduled for September has been delayed until early next year.

**5b. Safeguarding**

5.6 MR highlighted in the quarter 1 safeguarding report, there were 10 safeguarding enquiries against the Trust with an increase in number classified as neglect. However after investigation these have turned into complaints about care.

5.7 The outcome of the serious case review, following the death of a CHC patient concluded that no changes to the care provided or circumstances would have affected the outcome.

5.8 In the area of domestic abuse, MR stated since the last report further funding has been agreed from the Transformation Challenge Award to continue with some of the domestic abuse work streams for a further year. This includes the post of Lead for Domestic Abuse in Health which is held by Erin Brenna. A plan to introduce an Independent Domestic Abuse Advocate (IDVA) to Mid Essex and Southend Hospital is underway, and plans to develop domestic abuse training packages for health services across the county.

5.9 MR noted that the Trust have not met the statutory safeguarding training requirement, however there has been an increase in the percentages across all levels compared to quarter 4 in 2015/16.

5.9.1 MR noted safeguarding training was below target and the CCG have issued the Trust with a performance notice. The committee shared the concerns with regards to the Trust getting all staff to complete the statutory safeguarding training. It was recognised that low attainment is unacceptable.

5.9.2 MC noted she and MR attend the Southend adult safeguarding board and the Southend safeguarding children's board, which are statutory boards with an independent chair and minutes published in the public domain. At each meeting the board picks up the safeguarding attainment of on NHS providers. MC and MR have an action to report back on the Trust's attainment at the next board. The board have also questioned the attainment within general practice, recognising that this is within the CCG's domain; the CCG plan to assist all practices in getting their practice staff trained and suggested maybe the larger practices can assist the smaller ones.

5.9.3 TS noted safeguarding attainment within the Trust is regularly challenged through the clinical quality review group. TS and the designated nurse for safeguarding children have offered to go into the Trust and run this training but this offer has been declined.

*Simon Williams joined the meeting*

5.9.4 SW suggested colleagues at Basildon and Thurrock University Hospital Trust who have not completed their mandatory training do not get paid.

**Action: MR to confirm detail on how the adult safeguarding and adult MCA training attainment is calculated and what the actual number is for quarter 1 in place of the rolling average.**

5.10 MR noted the safeguarding annual report was not appended to the QFP papers circulated ahead of today's meeting. MR asked that the committee members review the paper circulated this morning and feedback any comments to MR directly.

**Action: All to feedback to MR on the shared safeguarding annual report.**

**5c. Deprivation of Liberty (DoLs)**

5.11 MR previously reported changes to the legislation for DoLs which will affect people who receive continuing health care funding in Southend. It was noted that these changes would likely require a review of whether the patient's liberty is being deprived and would likely incur a cost to the CCG, also impacting on the CCG's workforce. 38 people have been identified which could mean a cost of £22.8k to the CCG.

5.12 A number of options were proposed within the document and Matt asked that the committee supports option 4. '*Identify existing staff in the CCG (CHC Nurses & Quality Team Nurses) who could be trained to carry out the assessments and make the applications gradually whilst continuing with the existing work load'*

**DECISION: The committee agreed to support option 4.**

**5d. Referral to Treatment and Cancer**

**Cancer**

5.13 RS reported that in respect of cancer the team is focused on reducing the 62 day pathway backlog which currently sits at around 70-80 patients, ideally the CCG would like to see this reduced to 20, to make the service more sustainable. Breaches continue to occur due to internal operational processes and intra hospital transfers, often on day 50 of the 62 day pathway therefore we are likely to breach.

5.14 To date the Trust is around 10% behind its recovery trajectory, RS flagged a concern that the trajectory will not be met by the end of this financial year. There are however, plans to improve this position and each week a three way trust meeting is held and chaired by Ian Stidston of Castle Point and Rochford CCG, to address this. RS noted Southend will not be in a sustainable position until it sorts out the diagnostics and workforce. RA noted the Trust is trying a new approach to assist in the clearing of the backlog. The Trust has failed to recruit a consultant urologist, therefore patients are still being sent to London hospitals for treatment.

5.15 Discussions were had with regards to Southend being awarded the specialist cancer centre. Issues were identified and ways forward suggested, with key item highlighted below:

5.15.1 MC reflected on the likely increase in activity going into the hospital if awarded specialist cancer centre and queried if recruitment into the service would be more appealing if the Trust becomes a specialist cancer centre.

5.15.2 JGL suggested the CCG and GPs look at the current service and ambitions of the specialist cancer centre to see if the centre can cope and deliver being the one centre across all 3 providers.

**Action: JGL to encourage GP colleagues to think of what the service should look like for Southend to deliver as a cancer specialist centre.**

**Referral for Treatment (RTT)**

5.16 RS reported in respect of RTT attainment, Southend is reporting just under target of 92%, with this being driven by high delivery and performance of the non-admitted electives of the incomplete standard. RS noted if these issues are sorted the CCG could easily maintain the 92% target. To note in April the elective backlog was 1200 and in September it is 1500, reasons for this increase are complex long length of stays, hips and knees and spinal work, with much easier operations run through day surgery. £4.2 million across all commissioners of which our share is £1.8m which will not have been done this year, MH and RS put a clauses in the contract where by any activity not done is kept in this year but it is a credit for next year. Given our financially challenged position, we want to make an adjustment around year end of £1 million to reflect the challenges in delivering the elective backlog position.

5.17 MC suggested the Trust provides a plan for when patients on the backlog will be seen.

**Action: RS to request a backlog trajectory from the Trust on when patients are likely to be seen and present to a future QFP Committee.**

**5e. Commissioned Activity**

5.18 RS highlight page 11 which details key areas, giving overall trends and the position in quarter 1. Forecast variance underspend by £242k year to date was largely driven by over

performance in non-elective, day case and out-patient activity which has been offset by underspend in elective performance.

**5f. Emotional Wellbeing and Mental Health Service (EWMHS) Report**

5.19 CMc noted the service is embedding itself since starting in November. Waiting times have increased slightly due to large increase in referrals, although an increase was anticipated it has been over shadowed by staffing issues. The new service requires staff to undertake additional duties and a staff consultation were held. They are now moving into the recruitment phase. The team had seen a 17% reduction in staff vacancies since June and July and have recruited new team members for Southend.

5.19.1 The new non statutory advice from the department of education has made clear what the responsibilities on schools are in terms of the supporting children with their emotional health and wellbeing. The EWMHS service has offered to provide training at schools so school staff can deal with these issues. The team has developed a questionnaire with the lead psychiatrist from EWMHS to go out to schools asking how they currently deal with these issues and what resources they have in place. Once questionnaires have been collated the information will defined an action plan which will be shared.

5.20 CMc reported good news in terms of crisis provision in Southend, stating we now have a 24/7 crisis service, the team are embedding themselves in, and so far they have achieved 100% of all children being seen within 4 hours in A&E.

5.20.1 LBu queried the caseload movements, asking whether these were Essex wide. CMc confirmed they were and in Southend the caseload is circa 900. CMc noted a large increase of referrals was anticipated now the criterion has been relaxed to include more children. LBu raised a concern that the contracted activity budgeted was based on the lower figure and a larger increase in activity could trigger a price review within the contract, which would exposure the CCG to further cost pressures. CMc recognised the CCG needs to monitor to see if it levels out.

**Action: CMc to find out and report back to LBu, what level has been contracted and if larger volumes of activity could trigger a price increase within the contract**

**6. Medicine Management and Prescribing Report**

6.1 SW attended to present this paper, stating in relation to the current QIPP position, some schemes are over and under delivering. SW and Viv Molulu have met on a monthly basis to review QIPP schemes and are now planning to meet every two weeks. Plans to remove the schemes that are not delivering will be made on review of this month's data. SW noted medicines management schemes look set to achieve a £2.6m savings before the new added QIPP.

6.2 On review of the budget, based on July's data the medicines management team will be 450k underspent. In terms of achievement, presented data show that the CCG's regional position has improved.

6.3 To note the medicines management team have performed lots of training with GPs and prescription clerks, who have gone on to perform audits in practice. A reduction in the issuing of antibiotic shows an improvement across the region.

6.4 Gluten free prescribing dropped to a cost of £1k in July compared to previous months where this was around £7-8k per month. SW acknowledged the process around the patient consultation went well.

6.5 SW noted with QIPP his team are looking at how they can be best deployed to assist practices and are considering working extra hours to assist in delivering this QIPP.

6.6 A risk has been identified in regards to our shared care protocols for disease modifying anti-rheumatic drugs. The medicines management team and GP leads are working with local trusts to improve the robustness of the current system.

6.7 SW raised a risk in respect of prescribing steroid inhalers being lower than expected. As these are the main preventative treatment for respiratory disease and given our admission rates for such disease is high, this is an area which requires further investigation and is being taken to the clinical executive committee for discussion.

6.8 MC asked is there targeted work going on to reduce the dispensing of over the counter drugs through prescription and how are we handling this. SW noted messages are being rolled out to GPs, and the team are waiting for communications to take effect. The team have already recorded a £10K reduction month on month on over the counter medicine, however it is recognised there is a lot more work we can do on this.

6.9 JGL suggested installing banners or posters in practices to aid communication between GPs and patients when explaining the cost implications of supplying some medications on prescription when it can be purchased over the counter directly

6.10 MC requested that next month a by practice spend chart and updated report is brought back.

**Action: SW to add spend chart within report for discussion at the next committee.**

**7. Patient Transport Service Update**

7.1 LB gave an overview of the reasoning and recommendations of stopping the tender for the collaborative patient transport scheme. To note only one bidder came through and the price was in excess of envelope, therefore the collaborative did not award the contract. The CCG is now in negotiation with East of England Ambulance Service Trust (EEAST) to extend its existing contract to cover this transport stream. LB asked the committee to approve the recommendation to conclude the procurement process without award.

**Decision: The committee agreed these recommendations.**

**8. East of England Ambulance Service Remedial Plan**

8.1 RS noted the recovery plan is based around the failure of red 1 and red 2 targets, and a recovery scheduled has been agreed centrally through NHS England and EEAST. This plan details to commission extra patient transport services and staff to bring the service up to an agreed trajectory. The agreed liability profile for Southend is £375K, which is slightly less than the original risk position we had assumed of £400k.

8.2 RS asked the committee to approve the recommendation to take to Governing Body for approval and sign off.

**Decision: The committee approved this recommendation.**

**9. Information Governance Policies and Framework**

9.1 LBu noted the information governance framework and policies have been updated by Basildon and Brentwood CSU who are responsible for our information governance. To note there are no substantial changes, therefore the committee is asked to approve the updated IG framework, and updated polices.

**Decision: The committee agreed all policies and the IG framework.**

**10. Minutes of Other meetings**

**10a. Drugs and Therapeutic Committee of 6th July 2016 - Approved**

**10b. Clinical Executive Committee of 11th August 2016 - Approved**

**10c. SUHFT Clinical Quality Reference Group of 29th July 2016 (amended) - Approved**

Concerns were raised in relation to the performance notices issued for statutory and mandatory training levels at the Trust. It was noted that the final decision to issue these notices sits with the CCG. However, discussions remain ongoing with the Trust.

**11. Committee Administration**

***11a. Items for Exception Reporting to the Governing Body (for approval)***

No items were discussed.

***11b. Committee Work plan (for noting)***

The work plan was reviewed within the group.

***11c. Any Additional Items Previously Circulated to Committee Members (for noting)***

There were no additional items circulated to the committee members.

**12. Any Other Business *(for noting)***

There were no matters of any other business to note.

-End-

NHS
Southend
Clinical Commissioning Group

# QUALITY, FINANCE & PERFORMANCE COMMITTEE

Wednesday 26 October 2016 at 1300h until 1600h
Priory Suite, Harcourt House, Southend

## *PART ONE MINUTES*

**Members present ( in alphabetical order) :**

| Name: | Initials: | Title: | Organisation: |
|---|---|---|---|
| Melanie Craig | (MC) | Chief Officer | NHS Southend CCG |
| Dr José Garcia-Lobera | (JGL) | GP Governing Body Member and CCG Chair | NHS Southend CCG |
| Janis Gibson | (JG) | Lay Member for PPEI and QFP Chair | NHS Southend CCG |
| Margaret Hathaway | (MH) | Chief Finance Officer | NHS Southend CCG |
| Jacqui Lansley | (JL) | Director of Strategy, Commissioning & Procurement | NHS Southend CCG and Southend Borough Council |
| Dr Kelvin Ng | (KN) | GP Governing Body Member | NHS Southend CCG |
| **In attendance:** | | | |
| Lucy Godsell | (LG) | Quality and Patient Safety Support Officer (Minutes) | NHS Southend CCG |
| Emily Hughes | (EH) | Head of Commissioning, Acute Commissioning and Contracting | NHS Southend CCG and Castle Point and Rochford CCG |
| Paul Taylor | (PT) | Head of Complex Case Management | NHS Southend CCG |
| Simon Williams | (SW) | Head of Medicines Management | NHS Southend CCG |

**1. Welcome and Apologies for Absence**

Apologies from Matt Rangué, Robert Shaw, Nick Spenceley and Dr Taz Syed.
It was agreed to re-order the agenda and discuss item 8 after item 4b.

**2. Declarations of Interest**

No declarations of interest were received for part one of today's agenda. EH confirmed that only those members who had submitted a conflict of interest form which had been approved by the procurement team would be permitted to stay for the part two discussion.

*JL joined the meeting at 13:18h*

**3. a) Minutes of the Meeting held on the 28th September 2016**

The minutes of the meeting held on the 28th September 2016 were reviewed for accuracy.

3.1 The minutes were agreed as an accurate record of the meeting subject to the following amendments:

3.1.1 Page one, Dr José Garcia-Lobera is to be added to the attendees list.

3.1.2 Page 11, section 6.8 to be amended to read *"JGL suggested installing banners or posters in practices to aid communication between GPs and patients when explaining the cost implications of supplying some medications on prescription when it can be purchased over the counter directly."*

**b) Action Log from the Meeting held on the 28th September 2016**

3.4 The action log was reviewed and updated, please see item 3a.

## 4. Headline Reports

### a) Finance Headline Report

4.1 The CCG's financial position reflects a year to date overspend of £1.9m against plan. The CCG has recently submitted the financial position to NHS England (NHSE) in recognition of the CCG's identified gap of £3.7m as part of financial recovery. When the figures were produced for this report the CCG had not recovered any of the money however, the CCG is expecting to recover the position by year end.

4.2 Continuing Healthcare (CHC) is currently predicting a £2.2m deficit which is expecting to remain at year end. This is thought to have been caused by both the CHC team and the Individual Placements Team (IPT) overspend. The biggest contributor is the year end missed accrual which has caused an additional pressure of £2m.

4.3 MH stated that the team is not confident of the transactions which are coming through the ledger and questioned how robust the forecasting is for CHC. The data and information received to date from Arden and GEM Commissioning Support Unit (CSU) is currently being cleansed; this piece of work has taken a long time but will enable the team to accurately forecast year end once completed (anticipated completion is expected by month seven). It is believed there may be an additional £4m pressure from CHC caused by QIPP delivery through the Uplands service; this is currently under close scrutiny. In addition to this last year's outcomes were suppressed and therefore not accounted for in this year's budget.

*KN joined the meeting at 13:36h*

4.4 Quality Improvement Productivity and Performance (QIPP) delivery stands at £6.6m leaving a shortfall of £3.8m compared to the £10.4m target value set within the CCG's budget base.

4.5 JL asked for some clarity regarding the mental health overspend and shortfall on the transformation budget. MH stated that the CAMHS transformation budget was provided last year and this year the figure was included in the base line with no budget set. As there is no allocation, spend is a pressure.

4.6 JG questioned the funded nursing care (FNC) price increase. MH stated that there is a 40% uplift backdated for this financial year stemming from a letter received from NHSE regarding the central negotiations. FNC costs for the CCG is small, around 100K. It was noted that it would be interesting to identify whether the low FNC figures are related to the CHC overspend.

### b) Quality Headline Report

4.7 An overview of the report was presented to the committee. It was noted that the Southend, Essex and Thurrock (SET) Mental Capacity Act Policy, guidance and form have now been signed off, published and are now available on the CCG website. JG asked whether the CCG has a duty to advise or extend the policy to make other organisations aware. It was noted that there were no fundamental changes made to the Mental Capacity Act and that the adherence to the Mental Capacity Act will be included in provider contracts.

4.8 With regards to looked after children, it was noted that discussions remain on going between Southend Borough Council (SBC), the CCG and Southend hospital regarding agreeing the responsibility for commissioning the role of Adoption Medical Advisor.

4.9 JL reiterated the implications of the funding not yet being approved. There are a high number of reports which remain outstanding; the adoption panel has now been cancelled and children in the service cannot be matched with families until the medical has been performed. These children are now being placed back in fostering services at a cost of around £27K per placement.

4.10 Across the country it appears that the agency funds the cost of medicals, in Southend's case SBC are the agency however they feel that it is health's responsibility to commission the post. It was noted that Essex County Council currently fund the posts with their local hospitals and therefore the CCG expects that SBC would do the same to remain consistent with the Sustainability and Transformation plan.
**Action: MC to write to SBC to fully explain the CCG's position in relation to the commissioning of the Adoption Medical Advisor.**

4.11 A discussion was had in relation to the South East Continence Service. It was noted that the report states South Essex Partnership Trusts (SEPT) believes the service is not sustainable going forward however; it is not clear exactly what is meant by not sustainable.
**Action: MR to provide further clarity regarding SEPT's views of the continence service sustainability.**

4.12 The report noted ongoing adult safeguarding concerns in a local care home. JG asked whether the CCG continues to place patients within the home whilst investigations are ongoing. PT confirmed that SBC will make a decision over whether to place an embargo on the home.
*SW joined the meeting to present item eight at 14:11h*

**8. Medicines Management Update – Pharmaceutical Rebates**
Previously the CCG approved a paper which agreed the CCG could enter into a contract with a small number of pharmaceutical companies that were able to offer rebates on a limited number of medicines. At the time there was some scepticism regarding the schemes and their legality. These schemes are now relatively common with the majority of CCGs signed up to a number of contracts.

8.1 It was proposed that the CCG adopts further schemes whilst still following the governance principles set out in the paper. The committee **AGREED** to increase the number of schemes to which it is currently signed up whilst ensuring the governance route is adhered to.

*SW left the meeting at 14:25h*

**4. c) Integrated Commissioning and Performance Headline Report**

4.13 An update was provided in relation to the development of localities. Work has begun to ensure that a named resource is allocated for each locality. Each practice within the East Central locality has been provided with information surrounding complex care and the details of their assigned care co-ordinators and navigators. A focus has been placed on the East Central locality where the pilot will start prior to rolling out to other localities over the next few months.

4.14 JL highlighted some changes in early intervention in psychosis (EIP) relating to service requirements. The requirement is that by 2020/21 60% of people referred should be receiving treatment within two weeks of referral in line with NICE recommendations, rising from 50% in the current year. In addition to this, from September 2016 the reporting requirement changed to include compliance with NICE recommendations and the local specialist early intervention in psychosis service cannot meet all aspects of that requirement. The CCG is no longer meeting the NHSE standard. South Essex Mental Health Commissioners and SEPT staff have been working together to agree additional staffing and expenditure required to meet the standard going forward, this will need to be addressed through contract negotiations.

4.15 JL informed the committee that the terms of reference have now been agreed to undertake a comprehensive review of the Essex palliative integrated care services, in order to provide insight into service delivery and the role of the services within the children and young people's end of life pathway. It was noted there are currently staffing concerns.

**d) Acute Commissioning and Performance Headline Report**

4.16 It was noted that Southend Hospital's Accident and Emergency (A&E) department is currently the second worst ranking in the region in terms of ambulance handover delays. More detailed work is planned to reduce the pressures moving into winter.

4.17 The referral to treatment backlog recovery continues to be a significant challenge with the anticipated completion date currently at May 2017.

4.18 It was noted the Trust is not going to meet the cancer targets through October 2016. Many of the issues have been attributed to inter-hospital transfers which are being tackled through the Success Regime wide cancer group.

4.19 It was noted the CCG understands the issues currently being faced by the Trust however the committee does not feel assured that standards will be recovered as per the trajectories. The CCG needs to focus on the areas which it can have influence over both prior and post admission.

4.20 Concerns were raised in relation to imminent staff changes and the impact this could have on staff morale within the Trust.

4.21 JGL asked what assurance has been provided by the hospital. EH confirmed that flow through A&E itself is not a major issue at present, the significant challenges are moving patients from A&E into beds within the hospital which is impacted by a considerable rise in delayed transfers of care (DToC). The hospital is in the process of introducing the concept of red and green days and is aiming to ensure that all patients have the necessary tests and reviews as soon as possible in order to shorten their stay.

## 5. Detailed Reports

**a) Transforming Care Detailed Report**

5.1 The Care and Treatment Review (CTR) process was introduced to ensure the monitoring and review of people with learning disability who had been inpatients in assessment and treatment settings for many years and to then plan appropriate discharge pathways. Currently the CTR process for adults is being managed by the CCG utilising existing staff members.

5.2 Currently the community CTR for children and young people are also arranged and led by the CCG and not CAMHS; this creates an additional cost to the CCG and impacts on the current workforce. Some other CCGs have voted in favour of a central CTR team.

5.3 It is thought that carrying out these CTRs using the in house team will be beneficial as it aids the ongoing management of the individual's concerned leading to better outcomes. Work is ongoing to identify the capacity required in order to ensure the continuation of the in house service. It has been confirmed that the CCG can choose to run the service themselves despite others choosing to go with a central team.

**b) Individual Funding Requests (IFR) Detailed Report**

5.4 MH stated that she is keen to see a breakdown of the themes and costings for each treatment and the reasons for either approving or declining an IFR. EH confirmed that the cost effectiveness of treatments is considered as part of the IFR review, the public health representative also carries out research into the clinical effectiveness of treatments. The cost of the IFR treatment is also compared to cost and benefit of alternative treatments.
**Action: In MR absence, EH to liaise with the IFR team to request a one off breakdown report of the themes costings and reasons for accepting or rejecting IFRs.**

5.5 KN asked who takes the requests to panel. EH confirmed that the GP or consultant is responsible for submitting the requests; patients cannot submit applications themselves. A hospital consultant would usually submit but they will only do so if they believe there is

clinical exceptionality.

5.6 EH confirmed that the team are looking at producing a new format report. It was noted that the figures in table 2.2 do not add up.
**Action: EH to ask IFR team to identify what has happened to the extra IFR recorded in column one of the table.**

**C) Mental Health, Dementia and Learning Disability Detailed Report**

5.7 As a result of the work carried out with the Boston Consulting Group there is now an Essex, Southend and Thurrock Mental Health Strategy which outlines the plans to meet the five Year Forward View going forward. The strategy will be shared with the Governing Body in November or December 2016.

5.8 In April 2017 the Police and Crime Bill comes into force which will make a number of amendments to the Mental Health Act. These amendments will have significant implications for the provision of health based places of safety under section 136 of the Act. Currently a place of safety can be a police cell or a dedicated mental health assessment suite. From April 2017 no-one under the age of 18 may be detained in a police cell, they may only be used for adult patients if they are exceptionally violent.

5.9 A review of the refurbishment of 136 suites is being undertaken and the team is exploring the role of section 12 doctors to assist with patient flow.

5.10 With regards to improving access to psychological therapies (IAPT), Southend's performance has previously been good with an average spend of £45 per head, lower than the national average of £55 per head. Over the last few months the position has changed, and a cumulative effect of a decrease in the number of people entering the service is now being seen and waiting lists are growing.

5.11 SEPT are developing a new online app for Cognitive Behaviour Therapy which goes live in January 2016 and committee members are encourage to publicise the use of this.

5.12 MH noted that mental health services are an outlying area of cost for the CCG; the Five Year Forward View expects additional investments however, it is not clear how CCGs are going to meet this.

5.13 It was noted there is an increased risk for the CCG in relation to the number of complex unwell patients, there is not enough money in this area to cover everybody's needs.
JG asked whether anyone closely tracks each patient's journey and whether information is shared between the organisations involved to measure the patient outcomes. JL stated the contract is not outcome based however, the CCG needs to be clear that what is being funded is producing the right outcomes for patients and are delivered through the right services.

5.14 MC noted that since the risk share was lifted there is not enough money to meet the need and asked committee members to appeal to GP colleagues on other Boards for solutions as we are not currently getting the best value for money.

5.15 JGL stated the CCG should aim for control of the CCG's elements of the contract, as there is uncertainty over what is being commissioned and provided. The contract is renewed annually via negotiations. MH stated there is not much in the contract which the CCG could have control over if the CCG were to have access to it.

**6. Continuing Healthcare (CHC)**

The establishment of the in house CHC team has already enabled closer scrutiny and changes in practice. Since the middle of September 2016, new funding rules have been established and all cases need to go through the head of complex case management and lead nurse for CHC, before primary health needs and funding are agreed. This will ensure

that all cases are genuinely the responsibility of the CCG and provide the appropriate level of scrutiny and challenge. The team is confident that a number of savings will be made this financial year.

**7. Quarterly Information Governance (IG) Report**

It was noted the CCG is at a reasonable stage with the IG toolkit and overall compliant. In addition to this there were no freedom of information request breaches for Southend CCG during quarters one and two.

7.1 A discussion was had regarding the continually changing regulations and guidance regarding the sharing of data. It was suggested the CCG may wish to create a clear and concise prompt card for staff.

**9. Commissioning Intentions**

The commissioning intentions paper was sent out overnight and was shared with GPs and commissioning managers this morning (26th October 2016) with a request for feedback to be shared with the central team. It was noted that this year the commissioning intentions have been developed by a central team through the Success Regime.

9.1 MH raised her concerns surrounding the list of potential QIPP schemes and that these may not be included within the commissioning intentions.
**Action: RS, EH and MH to meet to discuss the inclusion of the QIPP schemes in the commissioning intentions.**

9.2 It was noted a commitment had been made to share the document with providers on Monday 31st October 2016. The committee was therefore asked whether they would agree to delegate the decision to MH and MC. MC and MH would review the document and return by close of play Friday to ensure the Monday deadline is met.

9.3 Concerns were raised regarding the lack of GP input and that this piece of work has not been clinically led. It was noted that the CCG will feedback the concerns surrounding the lateness of the documents with the Success Regime team. However, it was noted that Robert Shaw and EH are heavily involved in the production of the commissioning intentions.

9.4 EH provided further assurance to the committee that input has been sought through the local commissioning intentions. It was noted the CCG requires assurance that the comments and feedback are included in the version circulated to providers on Monday.

9.5 Concerns were raised regarding the 'common offer' section of the document. It was confirmed that this had been raised previously and would be removed. MC and MH confirmed that they would check to ensure that this does not appear in Monday's version. Service restriction elements of the intentions will be removed as they will require public consultation.

9.6 The Castle Point and Rochford CCG and Southend CCG commissioning teams are aligned and therefore the response can be sent jointly via MC and MH with further discussions taking place on Monday involving Ian Stidston and MC to identify whether a further extension of the deadline is required. It was noted the CCGs have previously been granted an extension and a further one is therefore unlikely to be approved.

9.7 It was noted that further work will be done with the Clinical Executive post submission. There are no contractual arrangements in place at the moment and it was highlighted to the committee that it may not be too late to make amendments if the CCG remains dissatisfied with the contents.

9.8 EH reminded the committee that freedom of information requests can be submitted for the commissioning intentions and therefore the CCG should ensure that they do not include

anything which the CCG would not want the public to see.

9.9 The committee members **AGREED** to delegate responsibility to MC and MH.

**10. Corporate Risk Register**

A proposed new risk was explained to the attendees. This related to GBAF20 and the overall financial challenges the CCG faces now and for the rest of 2016/17 and moving into financial recovery. A template has been produced and was shared with the committee detailing the risk and associated actions. The proposed risk score associated with this risk is 16 placing it within the extreme category.

10.1 In addition to the above there was one risk proposed for escalation. This relates to GBAF18 regarding the CCG's QIPP programme. There is now a significant risk that the CCG's QIPP programme will not deliver the financial savings in line with the financial plan. It was proposed that the risk score be increased from 12 to 14 therefore placing it into the extreme category with a high likelihood of the event occurring in most circumstances.

10.2 One risk was proposed for closure; this related to CRR50 and the numbers of children and young people needing hospital admissions due to a lack of mental health crisis support out of hours. The service is now in place and functioning well.

10.3 The Committee members **Approved** the three proposals.

10.4 The committee members were made aware of a developing risk relating to the bed status at Southend hospital. There are currently extreme pressures on the availability of beds relating to the lack of on-going packages for patients to be discharged to. There is a general lack of domiciliary care packages and short term nursing home care for patients to move to, leading to blockages in discharge beds.

**11. Minutes of other meetings for noting**

**a) Drugs and Therapeutic Committee of 3rd August 2016**

11.1 Noted.

**b) Clinical Executive Committee of 8th September 2016**

11.2 Noted.

**12. Committee Administration**

**a) Items for exception reporting to the Governing Body**

12.1 None.

**b) Committee Workplan**

12.2 Agreed.

**c) Committee Terms of Reference (ToR)**

12.3 It was noted that the main change to the ToR is the addition of a part two.
**The revised terms of reference were approved.**

**d) Any additional items previously circulated to Committee Members.**

12.4 None.

**13. Any Other Business**

None.

~End~