NHS Castle Point and Rochford Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Castle Point & Rochford CCG & Southend CCG

Joint Clinical Executive Committee

Thursday, 21st March, 2019

Tickfield Centre, Southend

MINUTES

Members from Southend CCG:			
Dr Jose Garcia	(TS)	GP Governing Body Member (Chair)	NHS Southend CCG
Dr Krishna Chaturvedi	(KS)	GP Governing Body Member	NHS Southend CCG
Dr Kelvin Ng	(KNg)	GP Governing Body Member	NHS Southend CCG
Dr Alex Shaw	(AS)	GP Governing Body Member	NHS Southend CCG
Dr Kate Barusya	(KB)	GP Governing Body Member	NHS Southend CCG
Members from Castle Point & Rochford CCG			
Dr Kashif Siddiqui	(KS)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Mike Saad	(SG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Riz Khan	(RK)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Roger Gardiner	(RG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Sunil Gupta	(SO)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Members that sit across both Southend and CP&R CCG:			
Tricia D'Orsi	(TD)	Interim Accountable Officer	NHS CP&R & Southend CCG
Charlotte Dillaway	(CD)	Director of Strategy & Planning	NHS CP&R & Southend CCG
Simon Wil			
Mark Barker	(MB)	Interim Chief Finance Officer	NHS CP&R & Southend CCG
Jenni Speller	(JS)	Associate Director of Primary Care	NHS CP&R & Southend CCG
In Attendance			
Neil Rothnie	(MT)	Medical Director	SUHFT
Ian Diley	(ID)	Consultant in Public Health	Southend Borough Council
Danny Showell	(DS)	Public Health Consultant	Essex County Council
Sharon Judge	(SJ)	Executive Assistant (Minutes)	NHS CP&R & Southend CCG

Apologies received from:	
	Charlotte Dillaway
Simon Williams	

1.	**Welcome and Apologies**	
1.1	The Chair welcomed everyone to the Joint Clinical Executive Committee.	
1.2	Apologies were noted as above.	

2.	**Declarations of Interest**	
2.1	Members of the Committee were reminded of their obligation to declare any interest they may have on any issue arising at committee meetings which might conflict with the business of CP&R/Southend CCG and that declarations declared by members of the Committee are listed in the CCG's Register of Interests. The Register is available either via the Committee Secretary to the governing body or the CCG website at the following link: https://castlepointandrochfordccg.nhs.uk/about-us/key-documents/2508-declarations-of-interest-governing-body/file or https://southendccg.nhs.uk/about-us/key-documents/320-nhs-southend-ccg-governing-body-declarations-of-interests-register/file All GP members declared an interest as members of the GPHCA and locality hubs.	
2.2	The Chair declared that the meeting was quorate and that conflicts would be raised as the agenda progressed.	
3.	**Minutes from the meeting held on the 7th February, 2019**	
	The minutes from the 7th February, 2019 were agreed as an accurate reflection of the meeting with the following amendment: Page 5, paragraph 12 to say *'AS said that an increasing number of the population of Southend are overweight and some will be referred for bariatric surgery'*	
	Action Log from the meeting held on 7th February, 2019	
	The Action log was updated as attached. ***RK arrived at 1.15pm***	
4.	**SUHFT Update**	
	NR was in attendance to present an update on SUHFT activity and highlighted the following points: The hospital continues to struggle with the 4 hour A&E wait times and the impact this has on staff. As we approach year end NHS England and NHS Innovation become more interested in the 52 and 62 day waits but the hospital is hoping to be back on track with the 52 day wait by 1st April. The 62 day cancer wait is more difficult because of delays with urology but they are working hard to improve pathways. The hospital is going to struggle with the amount of people that are expected to come through. NR stressed that there is lots of good work being done in the hospital and lots of good areas of delivery. The hospital has had a lot of quality visits. Excessive requests for ultrasound scans for hernias and lymphomas ordered by GPs are having a negative impact on services and would be good to reduce. SG asked if DAU was still closed and NR confirmed that it was open but that half of the ward is being used for patients that are medically fit to be discharged and are staying in overnight before discharge the next day. NR reported that the ward was closed for one week as they were unable to secure consultant cover.	

TS asked if DAU was now open to GP referrals and NR responded that the closure was to cover short term staff sickness.

TD said that the CCG have a QIPP target for respiratory and are keen to make it work and asked what could be done collectively to ensure it delivers. NR was aware that Duncan would be presenting at a future Time to Learn but was happy to have a separate conversation outside of this meeting. KS confirmed that the Respiratory Steering Group is still meeting. TD felt it was really important to make this work.

TS has had a conversation with EPUT regarding a Directory of Services (DoS) that will help with the flow into the hospital and felt that it may be a good idea to have a session covering community services that are available in the community for hospital consultants. NR felt it would be good to discuss this with clinical directors and suggested putting it on the agenda for the GP Clinical Interface Group.

KNg asked if excessive requests for ultrasound scans may be because patients are not being examined properly in primary care. MS added that lots of referrals for scans are being rejected due to lack of information.

MS felt that a high BMI is an issue since MSK services were remodelled, mainly because people with joint pains are unable to exercise in order to lose weight and are only happy if they have a face-to-face consultation with a consultant. It was suggested that advice and guidance could be used by the consultant as a reason to reject their referral. NR agreed that advice and guidance could reinforce the fact that outcomes are not as good if weight is not lost but felt it was unhelpful if patients have their hopes raised.

MS went on to say that patients are only happy when they see a consultant as they do not agree with the information given by their GP.

NR was reluctant to increase the advice and guidance for that service as a patient may be unhappy with a letter and will still expect a face-to-face appointment with the consultant.

KC said gynaecologists have put in place a requirement for a patient has to lose weight and come back in three months and suggested adding this to the advice and guidance for ultrasound scans. NR replied that managing weight loss was not a good use of hospital resources.

MS highlighted that there are several templates in use for respiratory referrals and although GPs are told they are using the wrong template they do provide the correct information.

MS felt that a weight loss service in the community may be answer and NR agreed that this was a good way to help patients feel that something is being done to help them.

AS said that a paper on Tier III Weight loss Strategy is being written and felt that it would be good to have a joint strategy.

AS said that all ultrasound scan referrals should be referred into community services and felt that it would be a good idea to send out a communication giving information of things that are covered by both community and hospital services.

TD asked who this piece of work would sit with and JS said that a piece of work is being done on community ultrasound and JC said that it would be necessary to look at the current process and criteria so we know everything goes.

	AS felt that it would be good to include the DoS in induction programmes but acknowledged that registrar's rotated in October and F10s in August. NR said that the induction programme is very heavy at the moment but from a GP perspective it could be added to the August rotation. AS said that primary and secondary care are all working hard and felt there was enough skill to make some positive changes and asked if NR would object to primary and secondary care to looking at pathways together. NR replied that anything that would make working together better would be good. SG pointed out that hip and knee replacements are lasting longer and asked if this would mean that younger people would be offered the surgery. KB asked if we could add SRP to referral criteria to be a reminder for GPs and patients. KB said that SUHFT have not scored very well in the national hospitals on cancer referrals and NR pointed out that this relates to the 62 day wait but stressed that patients are still getting a good quality of care. NR went on to talk about Harm Reviews and said that if a patient has an aggressive tumour their diagnostics are brought forward and added that there are no major harms around patient choice. Urgent chemotherapy and radiotherapy are delivered. The hospital continues to breach the 62 and 104 day waits but the hospital continue to offer good quality care. TD agreed that the Harm Review process is most embedded at SUHFT out of the three local hospitals (Southend, Basildon and Broomfield)/ There is a need for a consultant with neurology experience in certain cancers and this is contributing to some delays. AS said that primary care are acutely aware of how hard it is at the hospital but are working as hard as they can. NR highlighted that lung cancer patients go through quickly. JS informed the Committee that a deep dive with the JCT is in process and will be taken to the Governing Body in March, it will also be brought to this Committee.	
5.	**Social Prescribing/care navigation**	
	ID was in attendance to give an update on stroke prevention and highlighted the following points: Southend Borough Council is attempting to get this in place and a Steering Group has been put in place to help deliver and a workshop will be arranged to help move forward with development. Through the Life Style service there will be an opportunity to develop social prescribing. The Committee were asked to recognise that this is an on-going piece of work and a CCG representative is involved but any input would be welcomed. Public Health has taken lead on this project but would be better to have an independent chair for the steering group. ID is looking at data to see where and how this has worked in the past.	

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RK asked if this was linked to the social prescribing post for each locality and ID replied that it was and that he has been waiting for guidance on social prescribing.

KB asked if this would cover both Southend and CP&R and ID replied that it is specific to Southend as CP&R already have social prescribing in place. KB asked if lessons had been learnt from CP&R and ID replied that he is eager to learn from all areas.

ID to keep the Committee updated on progress.

6.	**Prevention Strategy**	

ID was in attendance to give an update on the Prevention Strategy for Atrial Fibrillation (AF) and highlighted the following points:

The update provided today was to look at how prevention was going to be approached in 2019/20 and ID confirmed that the following was going to be treated as a priority:

- Provision of an effective, accessible and easily identifiable Information, Advice and Guidance (IAG) digital platform to give the local population the tools to help themselves
- The development of a social prescribing/care navigation system for the local area.
- Early detection work and preventative treatment for Stroke/Atrial Fibrillation (AF), Diabetes and Influenza

Five key strategic aims have been agreed with three key areas that are seen as a priority:

1. Proactively support lifestyle behaviour changes in adults with specific long term conditions.
2. Creating community capacity and enhancing community resilience.
3. Improve early detection and treatment of risk factors related to non-communicable diseases.

ID felt it would be helpful to have a CCG representative involved in this work.

Identification and treatment of AF is seen as a priority area for the STP. In Southend there are 92 patients on the AF register without a Chad2Vasc score, 218 have a Chad2Vasc score that is over 12 months old and 640 patients who are not receiving appropriate anti-coagulation treatment.

The Public Health team is happy to support GP practices to identify patients who need a review.

In Southend 30% of the population have not been identified and this equates to 1400 people, 500-600 people on the register are not receiving treatment and 6% of these are at risk of having a stroke.

A high proportion of patients with known AF who experience a stroke are not receiving optimal treatment

Pulse palpation is a simple screening technique that is not always routinely performed in clinical practice. A range of new devices have been developed that work with smart phones and electronic tablets. These are fast and easy to use and are relatively inexpensive at around £80 per device. MS said that his practice use this tool on a smart phone as it is very quick to do and have subsequently bought several devices.

ID is expecting data in the summer on other systems that are being used in other areas. The Public Health Team is able to offer support with the following:

- Helping practices to identify patients who are registered as having AF but do not have a Chad2Vasc score
- Work with practices to identify patients with a Chad2Vasc score over 12 months old
- Work with practices to identify patients with a current score of 2 or more and are not receiving appropriate anti-coagulation medication and support in updating the clinical record
- Work with practices to ensure all patients with a Chad2Vasc score are added to the workload list of the out of hospital teams
- Work with practices to assess the difficulties in consistent recording of INR test results of patients on Warfarin.

DS felt that population screening is not evidenced and should therefore only concentrate on all people diagnosed with AF. But, a decision needs to be made on who should be screened, how should they be screened and how should they be treated.

KS referred to a very good presentation that DS gave at a previous Clinical Executive Committee on AF that resulted in a LES.

KS said it was important to build on what we have already and what we can improve for patients.

ID felt it would be better to focus on the Chad2Vasc scores as this will be a wider STP project building on work that is already done.

SG suggested that ID work with Brian Houston on this.

KB referred to data from 2014 with the new medication NOAX and asked if the risk had reduced and ID responded that clinicians are starting to use NOAX and NICE guidelines are clear on what should be used and state that aspirin should not be used as a mono treatment.

MS remembered undertaking a mini audit after the presentation given by DS and thought that numbers had reduced drastically and said that his practices audits patients annually, at the present time there are only have five on the list.

TD questioned what the best way to influence practices was to consistently apply evidence with clear recommendations and how best to standardise treatment for patients and empower them to make decision about their treatment.

AF patients would automatically have diagnostic tests but locums may be missing this.

ID said that his colleague Pearl would know the numbers of patients diagnosed per practice but probably not by clinician.

It was widely agreed that it would be a good idea to do another audit and AS asked if this could be linked to the use of the device that could become an annual audit.

It was agreed that AF forms are on choose and book.

Next Steps:

- Re-audit practices. ID said that Public Health will assist with the audit and will write to all practices to get the process started.
- LES was 12 month arrangement and is not in place at the moment.

	KNg felt that a LES was unnecessary as each practice can identify any patient that is not on AF through QOF. TD highlighted that the promise of payment does not make it attractive to practices as the same problem exists with LD Health Checks and the Harm Review shows that people died early with respiratory conditions and heart disease through not having these health checks to highlight problems. TD said that a process needs to be put in place to make the checks normal routine for practices and ID suggested including mental health and health checks for 40-74 year olds. **Action: ID to bring back an update back on 21st March.**	
7.	**Falls Strength & Balance**	
	PT was in attendance to present Falls Strength and Balance Service and took the paper as read and highlighted the following points: PT informed the Committee that he had taken over this project with Lauren Edgeley and the Clinical Oversight Group. Looking at the project over both CCGs has identified bit differences between what is offered in CP&R and SCCG. In December, 2018 Southend Borough Council served notice to NELFT. KNg agreed that falls prevention is an extremely important issue and asked if there was any provision in place to provide transport for people that are unable to get to strength and balance classes. PT replied that isolation and people unable to travel to classes would be addressed and said that he would do some research on this and report back to a future meeting. KC was unsure whether GPs are given any feedback on patients that are referred to the falls, strength and balance service. PT said that falls sits nicely within frailty and will be part of the frailty programme. MS finds current process is rather hit and miss and suggested that the service should be redesigned to create a seamless service and should use the voluntary services more. AS referred to page 2 of the specification and asked if the figure for people over the age of Southend was accurate. PT to confirm and report back. RK agreed that this was a very important service and needed some provision for people needing help with transport and should also consider how people will stay engaged for the 36 week course. TS also saw this as an important service but felt that the budget was very small. AS felt this would link well with Live Well but that the DoS would have to be reviewed to see what was available. TS agreed that this was a good opportunity to involve local voluntary services. A question was raised in regards to the falls car and whether it was still in existence and JC replied that the Early Intervention Vehicle (EIV) stopped on 3rd December as it was still answering Category 1 calls but it was recognised that this was keeping people out of hospital. The CCG have redirected the funding to commission occupational therapists	

	aligned to the SWIFT service and discussions are taking place to see if this service can be extended. RG asked if the Falls, Strength and Balance service will involve falls alerts such as Telehealth and PT could see no reason why it would not. PT also said that it will look at how many times a patient has been admitted to hospital and TS added that patients are aging so are very likely to have several falls. KNg asked if it would be a falls prevention service when it was up and running and PT replied that this is specifically about strength and balance. KS does not want this service to be seen in isolation and stressed that GPs would to be kept fully informed about what journey their patient takes. TD said that patients really need to be help away from the hospital but physiotherapy is not available in the community and asked if this needs to be looked at. MS replied to this by saying that the reality is that £180k is not enough for the service that is required and asked for a more in-depth paper to be written on preventing and managing falls. PT added that that it is also about looking at what is in place at the moment and how to make it work more efficiently. MS felt that as this is such an important issue it may need that money has to be moved across from other schemes. TD reminded the Committee that PT is keen to work with clinicians on this project. **Action: Updated paper to come back to Committee on 21st March, 2019.** **Action: Falls to be added to action log, add to work plan.**	
8.	**Any Other Business**	
	MS pointed out that dermatology referrals are being rejected regularly without the consultant being involved in the decision. JC agreed to look into this and said that Lorna Hall who is involved in this project will be in touch with him for more information. KB highlighted that referrals into gastroenterology offer no support for patients and felt that patients are getting a bad deal. MS did say that this has been raised with the GP Clinical Interface Group. TD felt a deep dive with hospital consultants would be a good idea with pathway development between primary and secondary care and said that Cathy Gritzner will be looking ambulatory care whens she joins SUHFT on 4th March.	
	Next meeting: 7th March, 2019 **1pm Tickfield Centre, Southend**	

A Meeting in Common of Audit Committees
Of NHS Castle Point and Rochford CCG and NHS Southend CCG
Minutes

Date:	12th December 2018
Time:	10:00am – 12.00pm
Venue:	Hockley Room, Pearl House, Rayleigh

Members in Attendance:		
Charlotte Dillaway (CD)	Director of Strategy and Planning	CPRCCG & SCCG
Dan Bonner (DB)	Internal Auditor	Mazars
Janis Gibson (JG)	Lay Member Patient and Public Engagement	SCCG
Joe Farnell (JF)	Senior Manager	KPMG
Katie Miles (KM)	Forensic and Investigation Services	Mazars
Mark Barker (MB)	Interim Chief Finance Officer	CPRCCG & SCCG
Nick Spenceley (NS)	Lay Member Governance (Chair)	SCCG
Pauline Stratford (PS)	Lay Member Patient and Public Engagement	CPRCCG
Peter Murphy (PM)	Lay Member Governance (Chair)	CPRCCG
Steve Doherty (SD)	Practice Representative	CPRCCG
Others in Attendance:		
Michelle Angell (MA)	Associate Director of Assurance	CPRCCG & SCCG
Sharon Earl (SE)	Committee Secretary	CPRCCG & SCCG
Apologies:		
Dr Jose Garcia (JGL)	Governing Body Chair	SCCG
Kate Barusya (KB)	GP Governing Body Member	SCCG
Stephanie Beavis (SB)	Director	KMPG
Tricia D'Orsi (TD)	Chief Nurse	CPRCCG & SCCG

1. Welcome and apologies for absence

1.1 The Chair welcomed everyone to the Joint Audit Committee.

1.2 Apologies were noted as above.

2. Declaration of interests

2.1 Members of the Committee were reminded of their obligation to declare any interest they may have on any issue arising at committee meetings which might conflict with the business of CP&R/Southend CCG and that declarations declared by members of the Committee are listed in the CCG's Register of Interests. The Register is available either via the Committee Secretary to the governing body or the CCG website at the following link: https://castlepointandrochfordccg.nhs.uk/about-us/key-documents/2508-declarations-of-interest-governing-body/file or https://southendccg.nhs.uk/about-us/key-documents/320-nhs-southend-ccg-governing-body-declarations-of-interests-register/file

2.2 With reference to business to be discussed at this meeting, conflicts of interest were declared by all Lay Members against item 6, Risk Management Strategy, where there is mention of Lay Member responsibilities.

2.3 The Chair declared that the meeting was quorate and that members would notify of any conflicts that arise against items as the meeting progressed.

3. Minutes of the meetings held on 5th September 2018

3.1 The minutes from the 05.09.18 were agreed as an accurate reflection of the meeting with the exception of:

- Who attended were listed as in attendance rather than members
- Page 2, 6.1 – typing error, changed should read changes.

4. Matters arising and Action Log 5th September 2018

4.1 **CPR**

Item 122 – Fraudulent Patient travel claim – interview to be undertaken in January and is covered in Agenda Item 15. Close.

Item 124 – Data Protection Risk – Captured on Risk Register. Close.

Both

Item 1 – CQC Integrated System Review – is unlikely that the CQC will focus on the same areas. CD will look at this as part of the Integrated Assurance Framework. Close

Item 2 – Annual Audit Letters to be uploaded onto CCG websites – MB to check this has happened.

Item 3 – Reports to still be separate for each CCG. Close.

Item 4 – Secondary Care Consultants are aware of their membership and will endeavour to attend/dial in. Close.

Item 5 – Complete. Close.

Item 6 – Risk register now sits with MA and is under review. Secretary of State referral has been captured on the register. Close.

Item 7 – Wavier process now in place. Close.

Item 8 – PO's are being raised in a timely manner. There is on-going work around reports required from Arden Gem. Close.

Item 9 – BIA – EPRR team will carry out a BIA for all areas. Close.

Item 10 – On agenda. Close.

5. Security Management Strategy

5.1 CD presented the Security Management Strategies for both CPR and Southend. The policy has been updated, with input from Mazars. The changes are not significant but ensure that the corporate responsibility is appropriate for the security of staff. The policies for CP&R and Southend are the same with the exception of the two office localities.

5.2 The Audit Committee noted and **APPROVED** the Southend CCG Security Management Strategy.

5.3 The Audit Committee noted and **APPROVED** the CP&R CCG Security Management Strategy.

6. Risk Management Strategy

6.1 CD presented the Risk Management Policies for both CP&R and Southend CCG.

The current policy was out of date and not in line with best practice. This has now been updated and simplified and training will also be rolled out to all staff to ensure that process is embedded throughout the organisation. Who is responsible/accountable has been clearly laid out in the new strategy.

6.2 PS declared a conflict of interest, but queried the responsibilities that were aligned to the lay members and due to the current Lay Member review, whether this was correct.

Discussion was had around whether the Chair of the Audit Committee should also be the Chair of Remuneration Committee.

CD explained that this policy is reflecting the constitution as it currently stands and agreed that this Strategy would be reviewed and updated as things changed. The Term of Reference for all Committees are also currently being reviewed.

It was pointed out that the Strategy had some errors in its current state around the responsibilities currently aligned to each lay member.

Action: CD to update both Strategies to correctly reflect the current Lay Member arrangements.

6.3 The Audit Committee noted and **APPROVED** Southend CCG risk Management Strategy, with the agreement that the current position is reflected and that further changes will need to be made around the Lay Member responsibilities.

6.4 The Audit Committee noted and **APPROVED** Castle Point & Rochford CCG risk Management Strategy, with the agreement that the current position is reflected and that further changes will need to be made around the Lay Member responsibilities.

7. Board Assurance Framework / Risk Register

7.1 CD presented the Board Assurance Framework, which she explained is currently under review. The BAF was brought to the Audit Committee for noting and will be further updated at the next Committee meeting in March 2019. The top CCG risks were highlighted within the Executive Summary.

7.2 NS felt that the report as it stands shows the top level risks within the summary and then the main spread sheet which is very wieldy and difficult to read.

CD explained that her plan was to keep the main spread sheet but to include an action plan, that will include high level risks, gaps, actions, mitigations, outcomes etc.

7.3 SD queried that there was a respiratory risk and asked what this related to. MA informed that this is an historical risk and was around complex patients and was why a QIPP scheme was developed.

7.4 PM asked how we can have confidence and be assured that the Joint Committee are tackling the issues that fall within our accountability remit. MA informed the Committee how there had been an issue with tele-tracking and this wasn't on the Joint Committee register and so we need to work more closely with the STP governance leads. MB and Viv Barnes are meeting to discuss this further.

7.5 JF felt that it is important to ensure that the action plan targets are feasible.

7.6 The Audit Committee **NOTED** the Board Assurance Framework.

8. EPRR Update

8.1 MA presented the EPRR update and explained that it was a requirement that a quarterly update be brought to the Audit Committee. It was explained that this service is hosted by Mid Essex. The report is to give assurance that mechanisms are in place and so that we can also cross reference against the risk register.

The CCG have recently carried out a lock down exercise which went well and was the best one carried out within the STP. On Call refresher training has been provided.

8.2 JS asked whether or not we had everything in place from a Comms perspective in the event of an emergency, especially regarding the media. MA informed that plans were in place to handle all eventualities.
Action: CD to check media handling procedures.

8.3 Discussion was had around possible risks if there is a hard Brexit from a pharmaceutical point of view and it was confirmed that has been placed on the Risk Register.
Action: MA to discuss the possible pharmaceutical issues post Brexit with James Currell.

8.4 SD questioned how we got partial assurance for 18/19 and MA explained that she believed it was due to the changes within the CCG, but that this was still unacceptable.

8.5 The Audit Committee **NOTED** the EPRR Update.

9. Waivers Report

9.1 MB presented the Waiver report, which supplied a summary of waivers that have been approved since the last meeting. MB informed the Committee that a procedure for raising waivers has been put in place and we are currently in discussions with Arden Gem to ensure that we have timely reports from them for future Audit Committees. He also informed that PO and wavier training has been rolled out to all staff. .

9.2 SD queried the PO process as his practice have had a number of invoices rejected by Wakefield.
Action: MB to look at sending PO procedures to practices to ensure the process made clearer.

9.3 The Audit Committee **NOTED** the Waiver Report.

10. Write Offs Report

10.1 MB presented the Write Offs report that showed one write off due to a company ceasing to trade.

10.2 The Audit Committee **NOTED** the Write Off Report.

11. Losses & Special Payments

11.1 There were no lossses or special payments to note.

12. Annual Report & Accounts Submission Timetable 2018/19

12.1 MB presented the timetable, which was to make the Audit Committee aware of how we are planning to manage the sign off of the yearly accounts.

12.2 There may be a need to convene a special Governing Body or give delegation to the Audit Committee to ensure that deadlines are met. Dates will be confirmed.

Discussion was had around comments being invited last year but due to the tight turnaround timeline it was was difficult for them to be incorporated.

CD informed the Committee that the annual report and wording would be circulated in advance for comments, the accounts will then be slotted in later.

12.3 The Audit Committee noted and **APPROVED** the Annual Report & Accounts Submission Timetable for Southend CCG.

12.4 The Audit Committee noted and **APPROVED** the Annual Report & Accounts Submission

Timetable for Castle Point & Rochford CCG.

13. External Audit – SCCG & CPR CCG Audit Plan and Strategy

13.1 JF presented both the SCCG and CPR CCG Audit Plan and explained that whilst they were separate documents they were of a similar outcome. The following areas were brought to the Committees attention:

- Key Risks
- Materiality
- Management override of control
- Significant Audit Risk – National audit requirement for the report going forward
- Remuneration Report – every member with a disclosure will be asked to sign off on this.
- New Accounting Standards – two new standards which we are already adhering to and a further one is likely around IFRS16.
- Value for money conclusion – no significant risk is anticipated.
- Audit Fees – no increase from last year, but need to be aware that any new standards put in place could have an impact.

The only difference to note between the two CCGs is that the materiality is slightly lower for CP&R.

13.2 CD brought to the Committee's attention that anything that is under £300,000 is not reported and asked whether the Committee were happy with this approach. It was explained that this normally relates to debtors/creditors and does not relate to fraud/mistakes as these are automatically reported.

The Committee agreed that given the full explanation for this they were happy for this practice to continue.

13.3 CD requested that the Remuneration Report is populated earlier to avoid the complications that has ensued last year. Narrative and description needs to be given careful consideration to ensure that any adverse publicity is avoided.

Discussion was also had around STP staff on secondment and whether they are included in the Remuneration Report and it was agreed that this would be done at the scoping stage.

Off Shore staffing pool and IG implications were discussed and CD/JF will discuss further outside of this meeting.
Action: CD/JF to discuss Off Shore staffing / IG implications.

13.4 The Audit Committee noted and **APPROVED** the External Audit Plan and Strategy for Southend CCG.

13.5 The Audit Committee noted and **APPROVED** the External Audit Plan and Strategy for Castle Point & Rochford CCG.

14. Internal Audit

14.1 Southend CCG Internal Audit Progress report was presented by DB and was brought to the Committee as an update for noting. The following areas were highlighted:

- Serious Incidents/Complaints – These reports are currently sitting with the Chief Nurse and will be brought to the Audit Committee in due course. CD explained that there were some areas of concern within these reports and an action plan has been put in place, which will go to the Quality, Finance & Performance Committee and then following this to the Audit Committee.
- CHC Report was tabled today.
- Two audits are due to commence, Cyber and Joint Committee – confident that the deadlines will be met.

14.2 CD felt that Audit recommendation follow up had not been disciplined and going forward the process will be changed to ensure that Executives take ownership.

14.3 CP&R CCG Internal Audit Progress report was presented by DB and was brought to the Committee as an update for noting. There is very little to note with the exception of everything being on track and that many of the outstanding recommendations have now been cleared.

14.4 The Audit Committee **NOTED** both Southend and Castle Point & Rochford CCGs Internal Audit Progress Reports.

15. Counter Fraud

15.1 ***Joint LCFS and LSMS Progress Report***
KM presented the report which was received by the Audit Committee as an update and for noting. The following areas were brought to the Committee's attention:

- More referrals have been received for Southend than CP&R.
- Extra work has occurred due to a member of staff needing support around a court appearance, but won't exceed the 10 day budget.
- Fraud Survey is due in January and Fraud Awareness Training is scheduled for CCG staff and Governing Body members in February 2019.

Action: KM/CD to discuss the timing of the Fraud Survey outside of this meeting.

15.2 ***CPRCCG LCFS Investigations Update***
There is currently one open case that relates to a CQC visit. Practice has now been taken over and GP has been referred to the GMC. From a criminal perspective there was no evidence of anything fraudulent.

Discussion was had around the possible overpayment to the practice and KM informed that an external provider had looked into this. Coding issues were the main problem due to poor administration.
Action: CD to discuss with TD what processes are now in place and what was the outcome from the external provider.

15.3 ***SCCG LCFS Infestigation Update***
There are currently two open cases:

- Patient has been claiming travel expenses inappropriately. It has been agreed that the patient will be interviewed and following this an update will be provided. KM to also check whether the patient has any known mental health issues.

- Patient amended a prescription and tried to obtain additional medication. Individual will be spoken to and a fraud alert will potentially be sent to pharmacists in the area. Due diligence checks currently being undertaken.

KM brought to the Committee's attention a possible Safeguarding issue. A family has registered their five children at various practices across Essex under various different aliases. Concern around practices not carrying out appropriate checks on registration was discussed. KM explained that this is a very difficult situation as there is no actual evidence. Discussion was had around how to ensure that the children are safe and KM will continue to liaise with social care and look at possible fraud alerts. KM will also speak directly with the National Investigation Services team. Update will be given at the next meeting.

15. Receipt of Committee minutes

The Audit Committee NOTED the minutes from the Quality, Finance and Performance Committee.

16.	AOB
	PM asked that it be noted that Michael Spoor was no longer part of the Audit Committee but if we could formally note his valued contribution over the years. **Action: CD to write letter of thanks to Michael Spoor as recognition of his contribution to the Audit Committee.** There being no further business, the Chair adjourned the meeting at 12.10.
	Date of next meeting

6th March 2019
13.00hrs, The Hockley Room, Pearl House,
12 Castle Road, Rayleigh SS6 7QF

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Castle Point & Rochford CCG & Southend CCG
Quality, Finance & Performance Committees

Meeting in Common

20th December 2018 at 3pm
Tickfield Centre, Southend

MINUTES

Attendees from Southend CCG:			
Dr Krishna Chaturvedi	(KC)	GP Governing Body Member	NHS Southend CCG
Dr Jose Garcia-Lobera	(JGL)	GP Governing Body Chair	NHS Southend CCG
Attendees from CP&R CCG:			
Dr Roger Gardiner	(RG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Sunil Gupta	(SG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Kashif Siddiqui	(KS)	GP Governing Body Chair	NHS Castle Point & Rochford CCG
Simon Williams	(SW)	Director of Integration & Transformation	NHS Castle Point & Rochford CCG
Attendees that sit across both Southend and CP&R CCG:			
Janis Gibson	(JG)	Lay Member, PPI (Committee Chair)	NHS CP&R & Southend CCG
Mark Barker	(MB)	Interim Chief Finance Officer	NHS CP&R & Southend CCG
Charlotte Dillaway	(CD)	Director of Strategy & Planning	NHS CP&R & Southend CCG
Tricia D'Orsi	(TD)	Chief Nurse	NHS CP&R & Southend CCG
Peter Murphy	(PM)	Lay Member, Governance	NHS CP&R & Southend CCG
Nick Spenceley	(NS)	Lay Member, Governance	NHS CP&R & Southend CCG
Pauline Stratford	(PS)	Lay Member, PPI	NHS CP&R & Southend CCG
In Attendance:			
James Currell	(JC)	Associate Director Operations	NHS CP&R & Southend CCG
Matt Gillam	(MG)	Head of Nursing	NHS CP&R & Southend CCG
Lorraine Smailes	(LS)	Deputy Chief Nurse	NHS CP&R & Southend CCG
Hayley Waggon	(HW)	Executive Assistant (Minutes)	NHS CP&R & Southend CCG

Apologies received from:	
Steve Doherty	Dr Kelvin Ng
Cathy Gritzner	John Spicer
Jacqui Lansley	Dr Taz Syed

1.	**Welcome and Apologies**	
1.1	JG welcomed everyone to the meeting in common of the Southend & CP&R CCG's Quality, Finance and Performance Committee.	
1.2	Apologies were noted as above.	
2.	**Declarations of Interest**	
2.1	Members of the Committee were reminded of their obligation to declare any interest they may have on any issue arising at committee meetings which might conflict with the business of CP&R/Southend CCG and that declarations declared by members of the Committee are listed in the CCG's Register of Interests. The Register is available either	

	via the Committee Secretary to the governing body or the CCG website at the following link: https://castlepointandrochfordccg.nhs.uk/about-us/key-documents/2508-declarations-of-interest-governing-body/file or https://southendccg.nhs.uk/about-us/key-documents/320-nhs-southend-ccg-governing-body-declarations-of-interests-register/file	
2.2	With reference to business to be discussed at this meeting, GP members of the committee declared a conflict for agenda item 15.	
3.	**Minutes from the meetings held on the 22nd November 2018**	
3.1	The minutes from the meeting held on 22nd November 2018 were agreed as an accurate reflection of the meeting with the exception of the following: - Dr Krishna Chaturvedi to be added to the apologies	
4.	**Action Log from the 22nd November 2018**	
4.1	The action log was updated with the following: Action 62 – Gosport Inquiry – this will be discussed as agenda item 13. Closed. Action 71 – Conflict of Interest – JG highlighted that there are still members of the committee who need to complete their conflict of interest training. Members of the committee are to complete the training by the January meeting. Action 74 – Brexit – CD updated the meeting that she is now the Brexit lead for the STP and confirmed that the Police lead will be attending the Clinical Executive Committee on 24th January. A paper will be brought to a future meeting providing an update around this. CD also confirmed that this is on the CCGs risk register. Action 79 – Acute Demand Management Reporting - this will be discussed as agenda item 6. Closed. Action 86 – CD has reviewed the meeting schedule and it is not possible to move this meeting to later on in the month without affecting other committee dates. CD is undertaking a piece of work looking at the committee meetings and the frequency of the meetings. CD to provide further update on this work at future meetings.	
5.	**Chief Nurse Report**	
5.1	TD presented the report and highlighted the following:	
5.2	The trend for cancer breaches continue to increase. The Joint Committee are reviewing this. TD confirmed that a refresh of the Cancer Board has been undertaken and JDS will be part of this. From a quality perspective there is concern in relation to whether harm reviews are being undertaken in a timely way. Rachel Hearn is working with Stephen Mayo on a piece of work around this.	
5.3	In relation to the EPUT Community Services, useful CQRG meetings are held monthly and this is an opportunity to look into different areas of the contract and to make sure EPUT are delivering on their KPIs. TD introduced LS, Deputy Chief Nurse, to Committee members and highlighted that LS will be taking the lead for the EPUT contract moving forwards.	
5.4	TD updated the meeting that there are national changes to how pressure ulcers are reported. TD was part of a telecom this week with EPUT who have put together a proposal around the new reporting process.	
5.5	JGL highlighted that he is helping to carry out a review on SPOR. He has meet with Margaret Allen who will be leading on the review. The number of referrals to SPOR has been reduced; however, it is clear work needs to be done to streamline the process.	
6.	**Acute Demand Management Report**	
6.1	JC presented the report on behalf of JDS.	
6.2	For CP&R CCG A&E attendance for month 7 has shown a continued increase with Southend Hospital being the most pronounced with increase in attendances above plan by 3.7%.	

	Non elective demand management remains an issue. Non elective admissions have increased by 9.5% since last year. Zero day length of stay has increased by 26.1%.	
6.3	For Southend CCG Similar position to CP&R. A&E attendance continues to increase and are currently 3.7% above plan. Non elective demand is still a concern. Non elective admissions have increased by 10.1% on last year. Zero day length of stay has increased by 24.8%.	
6.4	Elective expenditure is up by £574k for CP&R and £437k for Southend across all contracts. The main driver is Barts Health.	
6.5	For CP&R GP referrals were up in month 7, however, this was balanced by a reduction in other referrals. For Southend GP referrals were down in month 7, however, this was balanced by the growth in other referrals.	
6.6	CP&R is currently overspent by £637k and Southend is reporting an overspend of £351k. This is predominantly around the utilisation of London based acute providers.	
6.7	PM queried if the other acute trusts within the MSB contract use the same reporting methodology as Southend. PM was concerned that Southend stand out in terms of A&E attendance and wanted to understand whether this was due to other acute trusts using different reporting information. JC highlighted that the 3 trusts still report their data individually. TD suggested that a formal letter is sent to the Joint Committee for them to provide assurance that the acute trusts are reporting using the same methodology. **NEW ACTION – JC to write to the Joint Committee asking for them to review the methodology each acute trusts use for reporting data.**	
6.8	JG queried if the expenditure around the utilisation of London based acute trusts is what we believe is the right level of overspend. Discussion was had around the system previously in place to make sure the right referrals were going to the London acute trusts. JGL confirmed these processes are still in place; however, the increase may be due to patient choice as they offer shorter waiting times at the London based acute trusts. JGL suggested that this may be a piece of work done within the STP to try and stop people attending the London acute trusts and directing them to one of the other MSB acute trusts instead. CD confirmed she has received a detailed response from the Joint Committee around this and the increase at the London based acute trusts is down to patient choice. The information showed that students are remaining our patients as they are choosing not to register at a closer practice to their university and therefore the cost falls to us locally for attendance. This area might be a good opportunity to do some work on.	
6.9	TD questioned if the capacity numbers have been reviewed against the last census due to the increase in houses in the area. JC did not believe that the size of A&E has been compared to the recent population growth. JC updated the meeting that the A&E department state their capacity is 275, however the new ambulance offload bay service might increase capacity. JC also confirmed that Cathy Gritzner has challenged the council in regards to care home building approvals.	
6.10	TD highlighted to the meeting that at the Clinical Executive Committee the members were alerted to the increased outpatient backlog. TD was concerned that there could be patients in that backlog experience harm. TD asked for JC and LS to work together to establish if harm reviews are being undertaken for the backlogged patients. **NEW ACTION – JC and LS to undertake a review to establish if harm reviews are being undertaken for patients on the outpatient backlog.** *JC left the meeting*	
7.	**Financial Report**	
7.1	MB presented the financial reports for both Southend and CP&R CCGs.	

7.2	For Southend: MB confirmed that Southend CCG are on target to meet the £0 overspend. CSF funding received to date is £1.2m. There has been a small slippage in relation to the QIPP schemes. At the end of month 8 the CCG is forecasting actual delivery against the QIPP programme of £14.3m which is 99% of the plan. The movement of this is due to receiving more detail on how we are performing against the schemes. **Risks** £69k of critical care costs landed in December. Barts continue over performance by £200k and non-elective activity is above the plan. UCL are over performing but we are seeing this over performance decreasing and it is expected that will continue for the rest of the year. Monitoring of CHC and prescribing is continuing. There is a concern in relation to prescribing due to the lack of data we have to forecast on. Specialised commissioning funding of £200k will be transferred over in month 9 which has been factored into the forecast. Year to date QIPP delivery stands at £8.6m with the forecast to deliver £14.3m by the end of the year.	
7.3	NS questioned the QIPP schemes around ophthalmology and asked if any movement will be seen moving forward. MB confirmed that this is heavily impacted on the backlog seen within ophthalmology. TD confirmed that it is expected that the backlog would be reduced by March 2019. TD highlighted that work is being done to look at services within the community that patients could be referred to. The Southend model is also being used as best practice across the other acute trusts within the MSB who have a significant backlog.	
7.4	JG highlighted the variance between practices in relation to prescribing. JG asked if a consistent approach across the patch is in place which might assist with QIPP. SW reported that each practice operates differently but work is being done with some of the prescribing schemes to establish if this process can be spread across the patch. JGL highlighted that the number of clinical pharmacists within GP practices are increasing and they are networking which will improve communication.	
7.5	For CP&R: MB confirmed that CP&R are on target to meet the £0 balance. There are reserves in place which will help mitigate against winter pressures. QIPP is progressing at pace and the CCG is forecasting actual delivery of £12.9m which is 109% of the plan. **Risks** Acute over performance – Barts is seeing a significant increase in non-elective activity. There has also seen an increase at Spire Wellesley which is performing at higher rates than expected. Prescribing risk is the same as Southend CCG due to the lack of data available. Special Commissioning has been factored into the forecast and will be transferred in month 9. QIPP delivery year to date stands at £7.6m.	
7.6	TD raised a concern in relation to the wording on page 3 of the report as it could be interpreted that CHC are not performing when in fact they have a £1.3m underspend. MB agreed to amend the wording on future reports.	
7.7	SG asked if the CCGs have received the budget for next year and the national expectations around targets. MB confirmed that he believes this will be received on 21st December, however, he does not expect to receive the control targets until January. The CCGs need to submit an activity estimate by 7th January and the financial position by	

	14th January.	
7.8	SG asked if the CCGs are planning to allocate more money for the London based acute trusts due to the over performance seen this year. MB highlighted that this may not be the case, work needs to be done on reducing activity to secondary care locally which may mean people are less likely to choose a London based acute trust instead. TD highlighted the increased number of suicide attempts which can lead to patients receiving trauma care in London, TD questioned if this is having an impact on finances and performance levels. MB stated that the statistics are not showing that this is the case, the performance is mostly around critical care and non-elective activity but when we receive more business intelligence data this is something that could be reviewed.	
7.9	PM queried if work has been done to look at how long people are staying in the London acute trusts and whether the local system are pulling patients back in an efficient timescale. MB confirmed that sometimes, due to local capacity, patients are staying longer at London based trusts. One of the QIPP schemes is to look at patient flow around discharge which would hopefully mean patients can be returned to the local acute trusts quicker. *KC left the meeting.*	
8.	**Integrated Performance Report**	
8.1	CD presented the report and noted the key items which are included in the executive summary.	
8.2	Southend CCG remains above target for dementia. CP&R CCG achieved 66.7% against the 67% target.	
8.3	There has been a slight backwards trend for this month in relation to IAPT. Jacqui Lansley is working on a recovery plan. An assured NHSE trajectory to achieve the target is in place.	
8.4	TD updated the meeting in relation to performance for LD Health Checks. An action and recovery plan are in place. Figures compared to last year show a significant improvement but there is more work to be done. LS will now chair the LD Health Task & Finish Group. TD updated the meeting that she has taken on the DoN role for Transforming Care and improving health checks across the county will fall into this work.	
8.5	CD highlighted some risks in relation to the My COPD app, the CCG have been notified that some licenses will be removed, however, the CCG are pushing back to make sure this does not happen.	
8.6	Staff vacancy rate for the new joint structure remains high. This is in part deliberate due to the job freezes to protect the financial position. If a director requires a post to go out for advertisement this is taken to CMT for agreement beforehand.	
8.7	Staff sickness is higher within Southend CCG. HR are working with the teams around this.	
8.8	PS wanted to gain assurance around the IAPT backlog that people waiting over 90 days are being prioritised to reduce patient harm. TD confirmed that when a referral is received there is a triage system which takes place within 3 days and suicidal ideation is discussed. Based on this triage, there is then prioritisation of patients.	
8.9	NS highlighted the importance of focusing on mental health issues. He was happy to see the amount of data included in the appendices around mental health hotspots but questioned if a development session could be arranged so members of the committee could have a better understanding of what this data means. TD agreed that she would support this and would contact EPUT to arrange a development session. **NEW ACTION – TD to liaise with EPUT to arrange a development session for the Committee around mental health data.**	
8.10	Discussion was had around how mental health is commissioned and it was felt that the committee would need to explore the options around this further. It was agreed that TD and CD would work closely on this to review the options of mental health commissioning for adults and children. **NEW ACTION – JL and CD to review options for mental health commissioning for adults and children and to provide a report to the committee.**	
9.	**Improvement Plan Update**	

9.1	CD presented the report and noted the following:	
9.2	As of the 1st December 2018 there are 78 actions rated as blue, 9 rated as green, 6 are rated as amber and 4 actions are red.	
9.3	The red actions are set out in the executive summary with the actions for this. - Review of SOs and SFIs: work is near completion. - Governance Review: phase 1 is ongoing with phase 2 going out to tender. - Training for finance team: a training plan has been developed for the finance team. - A&E discharge letters: the project plan has been agreed.	
9.4	CD highlighted that Rachel Webb will start the process of interviewing staff members in the new year.	
9.5	JG noted on behalf of the committee the good progress and thanked CD and the team for the work around this.	
10.	**Joint Committee Update**	
10.1	TD reported that Rachel Hearn has reviewed the structure of the quality team in Essex. There will be no recruitment into the posts which will be covered by the 4 DoNs. TD is seeing better communication and more open dialogue. There has also been a shift for the CCGs to have a more local focus in relation to the acute trusts.	
11.	**Learning Disability Update**	
11.1	TD summarised the report for the committee. There is a lot of good progress being made around Learning Disability health checks and we hope to be in a better position in March. Next year will see a trajectory which is split throughout the year to avoid the peaks in January to March. Information sharing between the practices and CCGs is better and work has been done to cleanse the registers which are more accurate. There has been increased engagement with the LD community this year.	
11.2	PS was comforted by the progress shown within the report and was pleased to see progression on the action plan.	
11.3	JG thanked the team on behalf of the committee for their work around this.	
12.	**Deprivation of Liberty Assessments**	
12.1	TD updated the meeting on the significant risk the two CCGs have been carrying in relation to deprivation of liberty assessments. TD highlighted that there could potentially be a further risk which would impact on activity and finances.	
12.2	Currently the responsibility to undertake these assessments sits with the Local Authorities. Southend Borough Council and Thurrock Local Authority are on track to ensure all patient assessments are undertaken. However, there is a significant backlog of 3,500 assessments for Essex County Council. Essex County Council have moved to a prioritisation model, however, the DoNs are not assured around the progress being seen. This has been escalated through the Quality Surveillance Group and Health Executive Forum.	
12.3	The responsibility for these assessments will transfer over to the CCGs in 2019 and this may include the backlog from Essex County Council. TD confirmed that she will be working closely with MB to look at the financial risk and there needs to be work undertaken to understand how many CP&R patients are within the backlog numbers.	
12.4	There was a pilot in Southend which was led by the Safeguarding Adult Lead Nurse which highlighted 30 patients in both localities where assessments should be undertaken and the funding for this falls to the CCG due to the patients being CHC funded. At the time it was decided that these assessments will not be carried out and the risk was carried by the CCGs.	
12.5	JG questioned if Essex Legal Services are used by other CCGs. TD confirmed that other CCGs do use this service. CD asked if a formal tender process needs to be had if we were to use the service going forward. TD confirmed this would not be the case because they are a specialised service.	
12.6	In relation to the scoping that is required, TD highlighted that one potential way of getting assessors for these assessments could be upskilling the CCGs CHC assessors so they are able to undertaken the DoLs assessments. PS questioned if this would be a conflict of interest and the need for these assessments to be independent and there may be a	

	requirement for advocacy to be part of the process.	
12.7	TD confirmed that costing around this would be taken through CMT as this is an additional cost.	
12.8	The Committee supported the proposal, however, highlighted that this would need to go to CMT and Governing Body for approval.	
13.	**Gosport Inquiry**	
13.1	TD presented the report which detailed the recommendations coming out of the Gosport Inquiry. TD asked the committee to support the request to use this action plan to make sure recommendations are embedded locally. TD would then bring the action plan back to the committee in April to show progress. **NEW ACTION – TD to provide a paper to the April QFP Committee Meeting for progress on the Gosport Inquiry action plan.**	
13.2	The committee were in support of the team using the action plan for the report and looked forward to receiving the update on the progress in April.	
14.	**CCG Benchmarking Tool**	
	MB informed the committee of the new benchmarking tool which can be used by CCGs to compare data against similar size or type CCG. MB agreed to send the document to committee members following the meeting and was happy for the finance team to take people through the tool if necessary. **NEW ACTION – MB to send the CCG Benchmarking Tool to Committee members.**	
15.	**Intermediate Care Beds Procurement**	
15.1	GP Members of the Committee declared a conflict of interest in relation to this agenda item. SW provided a summary of the report and highlighted the key points as followed:	
15.2	This report is regarding the intermediate care beds currently being provided by Uplands. Back in 2016, 17 beds were commissioned at a rate of £1900 per patient per week. This was reviewed in the summer of 2018 and the beds were reduced to 13 and the CGG was able to renegotiate a price of £1750 per patient per week, a block was put on these beds. Patient satisfaction in Uplands is high, length of stay has been reduced with the average at 3 weeks and patients are leaving Uplands with noticeable improvements.	
15.3	SW and the team have taken advice from Attain and the procurement committee and they feel there is now more competition in the market to enable us to go out for procurement. The proposal is looking to bring the number of beds being commissioned down to 10 and to include medical cover within the specification which has not be included in the past.	
15.4	MB was concerned with the pricing of the beds which are extremely costly compared to other beds we commission. Currently the £1750 per patient per bed is double what we pay other providers. The meeting discussed the reason for this and it was felt that these beds would provide more intervention for the patients. MB felt that the proposal should be taken through CMT and for the Governing Body to have final approval. MB suggested this is also taken to CEC for clinical input.	
15.5	PS highlighted that for these services there needs to be the right assessment undertaken to make sure the right people are benefiting from these beds.	
15.6	RG suggested the model similar to the discharge to assess may be able to be used. The longer the patient remains within the service the less we pay, this will encourage rehabilitation of patients.	
15.7	JG summarised the feelings of the committee members and asked for SW to carry out further work on the questions raised at the meeting. This would then need to be taken through CMT and Governing Body for approval.	
16.	**NHS Funded Care Report**	
16.1	*CD left the meeting.* MG presented the report for NHS funded care.	
16.2	CP&R CCG are near the national average at 43 with Southend behind the average at 77. There is a key NHS target for CHC assessments undertaken with acute settings. Both CCGs are over 90%.	

16.3	There is a spotlight on CHC for all care packages to be delivered under personal health budgets. The CCGs have an action plan which will be going to CMT in January.	
16.4	The IRN framework for care home procurement is ongoing and being led by Essex County Council.	
16.5	The teams are developing a CHC training programme with the Local Authorities which starts in January and will look at standardising decision making for assessments.	
16.6	There is a deficit of staff within the Southend CHC team which is a risk. CMT have approved recruitment for some of these posts. Paul Taylor will also be leaving the team in January and MG confirmed he will be stepping up into that role for the interim period.	
16.7	PS asked if the team are currently managing with the number of requests for personal health budgets. MG confirmed the teams are able to respond to the number of request currently being received.	
16.8	JG acknowledged the good work being undertaken by both teams on behalf of the Committee.	
17.	**Local Authority SEND Inspection Report**	
	TD updated the meeting that the statement following the SEND inspection has been published. TD attended a meeting with the Local Authority and an action plan will be put in place to address the recommendations following the inspection. The action plan will largely focus on the joint commissioning of services. The action plan is due to CEC in January and will be brought to the January QFP meeting.	
18.	**Minutes**	
18.1	The minutes from other committees were taken as read.	
19.	**AOB**	
19.1	There being no further business, the chair adjourned the meeting at 5pm.	
	Next Meeting Date: 24th January 2019, Audley Mills	

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Castle Point & Rochford CCG & Southend CCG
Quality, Finance & Performance Committees
Part I

Meeting in Common

24th January 2019 at 3pm
Audley Mills, Rayleigh
MINUTES

Attendees from Southend CCG:			
Dr Jose Garcia-Lobera	(JGL)	GP Governing Body Chair	NHS Southend CCG
Dr Taz Syed	(TS)	GP Governing Body Member	NHS Southend CCG
Attendees from CP&R CCG:			
Steve Doherty	(SD)	Practice Manager Representative	NHS Castle Point & Rochford CCG
Dr Roger Gardiner	(RG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Sunil Gupta	(SG)	GP Governing Body Member	NHS Castle Point & Rochford CCG
Dr Kashif Siddiqui	(KS)	GP Governing Body Chair	NHS Castle Point & Rochford CCG
Simon Williams	(SW)	Director of Partnerships & Integration	NHS Castle Point & Rochford CCG
Attendees that sit across both Southend and CP&R CCG:			
Janis Gibson	(JG)	Lay Member, PPI (Committee Chair)	NHS CP&R & Southend CCG
Mark Barker	(MB)	Interim Chief Finance Officer	NHS CP&R & Southend CCG
Charlotte Dillaway	(CD)	Director of Strategy & Planning	NHS CP&R & Southend CCG
Tricia D'Orsi	(TD)	Chief Nurse	NHS CP&R & Southend CCG
Cathy Gritzner	(CG)	Interim Accountable Officer	NHS CP&R & Southend CCG
Peter Murphy	(PM)	Lay Member, Governance	NHS CP&R & Southend CCG
Nick Spenceley	(NS)	Lay Member, Governance & Risk	NHS CP&R & Southend CCG
John Spicer	(JDS)	Director of Primary Care	NHS CP&R & Southend CCG
In Attendance:			
Sharon Connell	(SC)	Head of Safeguarding	NHS CP&R & Southend CCG
Hayley Waggon	(HW)	Executive Assistant (Minutes)	NHS CP&R & Southend CCG
Apologies received from:			
Pauline Stratford		Jacqui Lansley	
Dr Krishna Chaturvedi		Ian Diley	

1.	**Welcome and Apologies**	
1.1	JG welcomed everyone to the meeting in common of the Southend & CP&R CCG's Quality, Finance and Performance Committee.	
1.2	Apologies were noted as above.	
2.	**Declarations of Interest**	
2.1	Members of the Committee were reminded of their obligation to declare any interest they may have on any issue arising at committee meetings which might conflict with the business of CP&R/Southend CCG and that declarations declared by members of the Committee are listed in the CCG's Register of Interests. The Register is available either	

	via the Committee Secretary to the governing body or the CCG website at the following link: https://castlepointandrochfordccg.nhs.uk/about-us/key-documents/2508-declarations-of-interest-governing-body/file or https://southendccg.nhs.uk/about-us/key-documents/320-nhs-southend-ccg-governing-body-declarations-of-interests-register/file	
2.2	With reference to business to be discussed at this meeting, there was no further declarations of interest made.	
3.	**Minutes from the meetings held on the 20th December 2018**	
3.1	The minutes from the meeting held on 20th December 2018 were agreed as an accurate reflection of the meeting with the exception of the following: - 8.10 wording to be amended to "It was agreed that JL would review the options of mental health commissioning for adults and children". - Action 90 to be amended to "JL to review options for mental health…"	
4.	**Action Log from the 20th December 2018**	
4.1	The action log was updated with the following: Action 71 – Conflict of Interest – JG confirmed that the link for the training has been recirculated. It was agreed that HW would contact Committee members who have not completed this training so this is completed by the February meeting. Action 74 – Brexit – CD confirmed that a paper providing the Committee with an update and assurance around Brexit will be brought to the February Committee. Action 86 – Committee Meeting Dates – CD confirmed this is still being reviewed and an update would be brought to the Committee when available. 87 – Reporting Processes for each MSB Trust - JDS to bring update in February for this. 88 – Harm Reviews – JDS and TD confirmed that harm reviews are being carried out and is being monitored by Rachel Hearn, Director of Nursing for Mid Essex. The committee were assured that the reviews are taking place and being monitored and agreed to close the action. Closed. 89 – Mental Health Data – TD confirmed that she has had a discussion with Andy Brogan who will be attending the March Committee meeting to present for half an hour on mental health data. TD asked committee members to bring to that meeting any questions around the mental health services and the KPIs. Closed. 90 – Mental Health Commissioning – TD confirmed that there is ongoing work taking place around the procurement of the EWMHS contract. It was agreed that JL would bring an update on this for the June Committee meeting. 91 – Gosport Inquiry Action Plan Progress – TD confirmed a paper will be brought to the April Committee meeting. 92 – CCG Benchmarking Tool – this was circulated to Committee members after the January meeting. Closed.	
5.	**Chief Nurse Report**	
5.1	TD presented the report and highlighted the following points for the Committee's attention.	
5.2	TD confirmed that the Trusts performance for community respiratory/home oxygen is at 38% which is significantly below the target of 92%. This is subject to CPN, EPUT have reviewed and provided assurance that no clinical harm to patients have been identified.	

5.3	TD highlighted the increasing trend being seen around cancelled appointments for EPUT mental health services. Work was carried out with EPUT in 2016/17 to reduce the cancellation rate which was around 30% at that time, however, this now seems to be increasing again. It was felt that a review into this should be undertaken to establish why this is increasing. It was agreed that TD would ask SW to review this and provide an update to the Committee. **NEW ACTION: TD to ask SW to undertake a review to establish why cancelled appointments have been increasing.**	**SW**
5.4	The performance for the First Response Team is significantly lower than the target, currently at 49%. Patients are being stratified and reviewed at weekly meetings, however, TD was concerned that if patients are deteriorating they may attend ED for access to the Raid service. This is being monitored through CQRG.	
5.5	TD highlighted that the influenza uptake figures have not superseded the data from this time last year. These are not the complete figures and it is expected that there will be an increase in the last quarter, however, TD stressed the importance of reviewing this to consider what can be done for next year to improve the uptake. TD also highlighted that GPs are starting to receive information around ordering vaccines for 2019/20 and work needs to be undertaken to make sure the correct vaccines and stock are being ordered. SW queried if the delay in the vaccines arriving has had an impact on uptake numbers. SW was concerned that due to clinics having to be cancelled whether these patients did receive the vaccine. TD confirmed that Vicky Cline and Alison Birch have been in contact with practices around this who have confirmed that people due to attend the cancelled clinics have or are booked on to receive the vaccine which will be shown within the data.	
5.6	Complaint numbers have seen a slight increase for the reporting period; however, there has been a significant increase in patient concerns being brought to the attention of the CCG. These are dealt with outside the formal complaints process but take significant amount of work for the team who liaise with other teams/services to deal with the concern being raised.	
5.7	Arden and Gem currently provide the service around CHC retrospective reviews and they are coming to the end of the number of reviews undertaken. TD confirmed that at the February meeting an update around CHC will be brought to the Committee. TD noted that one retrospective review was upheld which had a significant financial impact of £183k. TD noted that there is also an appeal against a decision made on behalf of the CCG by Arden and Gem which has raised concerns around the processes they use. TD confirmed she will bring a paper to the February Meeting around this. **NEW ACTION: Paper around the processes for CHC retrospective reviews to be brought to the February Meeting.**	**TD**
5.8	RG questioned if the new provider who will be undertaking the continence service in April 2019 will have the same staffing issues as currently being seen. TD felt this would not be the case.	
5.9	NS asked how the coaching slots being offered across the STP would work for the two CCGs and the impact this is expected to have on retention and recruitment. TD highlighted that locally the GP WTE was increased by 4 over the last month. There are currently 3 schemes in regards to recruitment and retention; the first 5s (the newly qualified GPs), the wise 5s (GPs who are considering retirement) and the VTS schemes. Interviews with the newly qualified GPs have shown that they are expressing keenness with portfolio roles and working differently within primary care. Targeted interviews with GPs who are considering retirement are undertaken to establish if there is a different way of working they would consider. In regards to the VTS scheme we are planning a large recruitment event to encourage these students to remain in the area after	

	qualifying. TD highlighted that current GPs are interested in the coaching they could offer to newly qualified GPs or those in need of pastoral support. TD confirmed that Governing Body GPs have been asked to undertake the coaching training. JGL confirmed that he undertook this course and would encourage other GPs to undertake this. JGL also confirmed that at the March Time to Learn session the workforce team will be giving a presentation on the work they are undertaking to give GPs a better understanding of this so they are aware of what is on offer. TD highlighted that the local press are covering the 15 minute appointment scheme. There are currently 2 pilot sites across the STP who will be moving to 15 minute appointments and learning will be reviewed following this. JGL highlighted that this also has good attention from NHSE and having spoken with GP colleagues there are a number of practices who are very keen to see if this is something that could be done following the pilots. KS highlighted that Biju Kuriakose stressed the importance of encouraging the trainees who are in their final year of the VTS scheme to stay in the area. KS felt it was important that GP colleagues attend a VTS session to discuss career opportunities locally with the trainees. TD highlighted that the workforce team who are now a team of 5 have contact with all students on the VTS scheme and will be in contact with them to carry out bespoke interviews to establish what they are looking for to stay in the area. TD welcomed the support of GP colleagues around this. JGL highlighted that there will also be a workshop career fair event where practices and trainees can meet to look at what can be offered to attract them to stay in the area after qualifying. TS stated that he had undertaken some training on the VTS scheme and was talking to the students and felt that by the final year the students already knew where they would be going after qualifying. TS stressed the importance of reaching out to the first years to attract them to stay and highlighted the need to show them what we can locally offer outside of medicine. JG congratulated TD and the workforce team on behalf of the committee for the work being undertaken around recruitment and retention.	
5.10	CD questioned if it was expected that there were no new Serious Incidents (SI) raised for November and December. TD confirmed that the process has been audited and is content that the process if working. TD did highlight that we now only receive SIs from GP practices or from the community services due to the responsibility for Mental Health, SUHFT and IC24 being transferred over to other CCGs. Data has shown on average we received 1 SI per annum from community services, however, noted that GP practices tend to raise SIs as critical incidents. TD has asked Vicky Cline to produce a communications piece to send out to GP practices around this.	
5.11	JG highlighted that the EPUT KPI data is showing a number of cases where there are significantly off the KPI. TD confirmed that performance contract notices are being raised at the next CQRG.	
5.12	TD attended the ESCB Assembly and there was discussion around how risk is assessed within meetings. They are moving towards the risks being brought to the start of the meeting and then reviewed at the end of the meeting to make sure risks are being considered and discussed.CD supported this way forward and suggested that the quality, finance and performance directorate risk registers rotate for each meeting so they are considered every 3 months. The Committee were happy to start this method at the February meeting. **NEW ACTION: Directorate risk registers to be brought to future meetings and added to the start and end of the agenda.**	**HW**
6.	**Acute Demand Management Report**	
6.1	JDS presented the report and highlighted the below.	
6.2	The position for both CCGs worsened in month 7.	

	In CP&R CCG, elective expenditure was up by £739k, which was mainly driven by other acute hospitals over performance. For Southend CCG, elective expenditure was also up by £466k and the main driver was over performance by other acute hospitals.	
6.3	A&E attendance is above expected for both Southend and CP&R CCGs. Southend have seen attendance rising above plan by 5% with CP&R 4% above plan. Non elective continues to be above plan for both CCGs and we are working to establish what is driving this over performance.	
6.4	JDS expressed his concerned with the spend being seen for the London Hospitals. CD confirmed that herself and MB meet with the CSU to discuss business intelligence data which is hoped will provide more detail as to why this over performance at the London Hospitals are being seen. JGL felt that some of this over performance may be down to patient choice. *SG left the meeting.*	
6.5	TD highlighted that the CCG used to sit on the Barts contract meeting and asked if we should be pushing for a seat at this meeting again. MB confirmed that we are pushing for a seat or a seat for the Joint Committee at these meetings. MB highlighted that there is a potential to modify the MSB contract to place responsibility of activity drifting to the London Hospitals onto the MSB.	
6.6	RG questioned the overspend being seen outside the block contract. Ophthalmology activity is seeing an overspend of £160k due to the demands for the MSB to clear the backlog.	
6.7	JG thanked JDS, CD and MB for the investigative work being carried out to establish why we are seeing an over performance at the London Hospitals. CD suggested that she would work with JDS to pull together the actions being undertaken around performance so these are included in the reports moving forward.	
7.	**Financial Report**	
7.1	MB presented the financial reports for both Southend and CP&R CCGs.	
7.2	For Southend CCG Southend CCG remains on target to meet a breakeven position at year end. The element of risk for the finances is reducing month on month and we are now in a position where we are confident we have established the risks that could be seen over the next few months. To date we have received £1.2m of CSF funding, we are expected to receive a further £1.1m based on performance for month 9 and this will be seen within month 10. The final CSF funding allocation of £1.2m is expected to be received in month 12 based on successful delivery of a balanced position at the end of February. The acute services overspend is currently 0.8m year to date. This is mainly due to over performance within 3 London Hospitals: UCLH, BHR and Barts. It is expected there will be an improvement with Mental Health and LD by year end. For non JCT managed services, there is an underspend within Primary Care of £0.5m. Other acute overspend is £1m which is expected to rise to £1.3m however we have reserves to offset this. Prescribing forecast spend has reduced by £200k, CHC spend is down by £300k and BCF funding is £400k forecast outturn less than last month.	

	Reviewing of the QIPP has removed the assumed saving of £0.5m to recognize that delivery is unlikely in year. Risks: There is a risk to the CCG if QIPP is not delivered and acute overperformance with the London based hospital trust continue. There is also a risk around CHC with winter pressures which may impact on funding levels. MB confirmed that the SUHFT settlement for 2017/18 has been finalised and there is no longer a financial risk for both CCGs. MB highlighted that the QIPP achievement within the block contract is behind by £1.6m, whilst there is no financial risk to the CCGs, work needs to be done in this area so future block contracts with the MSB group can be discussed. CG thanked MB for the work he has put into negotiating some of these positions. JG agreed with this comment and thanked MB on behalf of the committee for the work he has done.	
7.3	For CP&R CCG CP&R CCG remain on target to breakeven at year end with little risk of this not being achieved. The forecast overspend within the Joint Committee acute services is £1m. Again there is over performance with the London Hospital trusts, mainly with UCLH, Imperial, Barts and BHR. There is currently an underspend of £900k from the Primary Care budget and this is expected to grow to £1m. Acute NCAs is a significant problem. There has been a reduction in ophthalmology expenditure of £200k, however, CHC spend is expected to be £200k higher. Reserves have decreased to offset the risks by £500k. Risks: Continued achievement of the QIPP target is essential. Acute over performance is expected to continue for the year, this is being reviewed by the Joint Committee team. Prescribing data is based on month 7 which may be a risk for the CCG, however MB feels this will be a relatively small risk. As stated in Southend, the SUHFT settlement for 2017/18 is no longer a risk to both CCGs. MSB QIPP is behind to around £1.2m, whilst this presents no financial risk to the CCG this may discourage the MSB group for future block arrangements. MB highlighted that the Joint Committee believe that the MSB intend to continue with the block contract for 2019/20. SW queried what the level of risk would be to each CCG if the block contract was not agreed. MB confirmed that £70m would sit across the 5 CCGs, however, £40m would sit with MEHT and the remaining £30m is fairly split across SUHFT and BTUH. KS asked how quickly the underspend within the Primary Care budget could be used by the localities. MB confirmed that a programme of work is being developed with the localities looking at the different schemes being piloted and he is confident that the money could be used fairly quickly once the schemes have been identified. SD was disappointed to see that the underspend in Primary Care is being used to offset the acute overspend. SD highlighted that some localities are not as developed as others which might delay the schemes progressing. SD queried if premises for localities are being considered. CD confirmed that a paper on Primary Care estates will be going to CMT on 25th January around this. MB expects for 2019/20 the starting point will be to commence with the budgets from this year. The uplifts and adjustments will go on top of this. PM wanted to note that achieving a balance position is an achievement in itself. PM wanted to ascertain how we are using the next 10 weeks to prepare for 2019/20 and to	

	make sure QIPP schemes are being delivered next year. MB confirmed that over the next 10 weeks it is hoped that the business intelligence data will be received and this would allow a better understanding on QIPP schemes/performance and will allow better planning for 2019/20.	
8.	**Integrated Performance Report**	
8.1	CD presented the report and noted the key sections below. CD highlighted that the format of the report has been updated, however, CD would like the format to change further.	
8.2	CD confirmed that LD Health Checks is showing an upwards trend but is still not where it needs to be. There are action plans in place around this.	
8.3	In relation to IAPT there is a recovery plan in place which has been submitted to NHSE. Thurrock's plan has been shared and work is being undertaken with JL to incorporate this in. A contract notice with EPUT was issued in October and monitoring of this is continuing.	
8.4	Appendix 7 shows the IAF and details how the CCG is performing against similar CCGs as well as all CCGs in England.	
8.5	CD highlighted that workforce is stable across both CCGs, however, are slightly higher than the national average in terms of sickness absence. CD confirmed that the CCG is actively managing these absences with line managers and HR.	
8.6	Staff mandatory training figures remain a concern. The training post holder is now in post and will be supporting people to complete their mandatory training.	
8.7	Briefings around the NHS long term plan have been sent to CCG stakeholders. The communications team are continuing with Monday Motivation which is promoting good news stories within the area.	
8.8	CD confirmed that the constitution has been approved by the Joint Clinical Executive Committee and will continue through the governance process. This will incorporate changes to committee structures and frequency of meetings.	
8.9	JG thanked CD for a clear report and noted the pace this has been developed.	
9.	**Improvement Plan Update**	
9.1	CD presented the report and noted the following:	
9.2	CD confirmed that she has reviewed the improvement plan, the evidence to support the plan and how well these are embedded within the organisation. Following this review, CD has amended some action ratings which have meant that the progress of the plan looks slightly different to what was reported last month. CD highlighted the key changes to the committee. - Succession plan developed for senior staff and GB members: whilst there was a succession plan for senior staff this was not extended to include GB members. - Review of the Staff Involvement Group: this has been undertaken, however, the group has not met recently. CD confirmed she will be the executive lead for the group and diary dates have been arranged. - Budget holder meetings: Whilst the meetings were in the diary it was felt these were not progressing as they should. Evidence will be needed to show that budget holders are included in the budget planning for 2019/20. - Review of QFP Committee: this is included within the constitution.	

9.3	CD feels that this is now a true reflection of where the CCG is at with the improvement plan. CD highlighted that Rachel Webb will be starting the interviewing process shortly. CD has discussed with Rachel the actions that are felt to be more time critical than others and these will be the ones the CCG focus on first.	
9.4	NS welcomed the candour being shown by CD regarding this and felt it was right to review the ratings to allow everyone within the CCG and committee members to have a true reflection of progress. Other members of the committee agreed with this comment and felt that NHSE would appreciate the critical awareness the CCG have on the progression of the plan.	
10.	**Joint Committee Update**	
10.1	Committee members did not have any further updates around the joint committee for this month.	
11.	**Local Authority SEND Inspection Report**	
11.1	Unfortunately JL was unable to attend the meeting today but CG has asked her to send the report to committee members virtually. An update would then be provided at the February Committee meeting. **NEW ACTION: JL to send the Local Authority SEND Inspection report to committee members virtually. An update on the Inspection to be added to the February agenda.**	**JL**
12.	**QIPP 2019/20**	
12.1	MB confirmed that a detailed paper will be going to Governing Body on 30th and 31st January.	
12.2	It is expected that the CCGs will need to find 3% for 2019/20. The current QIPP schemes outlined to 70% of which 50% is included within the MSB contract.	
12.3	The executive team have already begun to discuss QIPP proposal schemes and these will be taken to Governing Body. The Governing Body are being asked to review the proposal schemes to establish if these are something they would like to take forward, whether they are schemes they would not like to progress further or if more information needs to be provided on the schemes. CG confirmed that this will be done within part I of Governing Body whilst members of the public are in attendance. These schemes will then be shared with SUHFT and EPUT.	
13.	**Information Items**	
13.1	The minutes from other committees were taken as read.	
14.	**AOB**	
14.1	There being no further business, the chair adjourned the meeting at 5.05pm.	
	Next Meeting Date: 21st February 2019, Tickfield Centre Southend	

Background

Since the last update to the Mid Essex CCG Board, the Mid and South Essex STP CCG Joint Committee has met in public on one occasion and considered and addressed the following issues:

Part I Meeting held 8 February 2019

- The committee received a Lead Accountable Officer update report which highlighted the key deadlines for submitting information on planning for 2019/20 to NHS England. The committee was also advised that the first assurance meeting between the Joint Committee and NHS England was held on 4 February 2019. An update on the referral of the acute hospital reconfiguration plans by the Southend and Thurrock Health Oversight and Scrutiny Committees to the Secretary of State was also provided.
- The committee was advised that the CCG Directors of Nursing were considering how all services within the remit of the JC could be effectively scrutinised by the Patient Safety & Quality Sub-Committee and that Clinical Quality Review Group (CQRG) meetings with the msb group had been reinstated. Areas to be focused on included the timeliness of discharge letters to primary care.
- The Performance Report highlighted that referral to treatment times in general had declined since December. Performance against the 62 day cancer standard was also challenged across the three acute hospitals. Performance against ambulance handover standards remained challenged. The STP Stroke Board would be reviewing performance against stroke standards, particularly 'front door to scan' performance and the ability to place patients directly into stroke units. However, there had been an improvement against the cancer two week wait standard, which reflected some of the work that the CCG Macmillan GPs had carried out to ensure that patients were made aware that an emergency referral had been made.
- The Finance report highlighted a forecast deficit of £12.3 million, representing 1% of the total budget, which was mainly driven by the acute hospitals. A contract finance recovery plan had been developed and would be considered at the next meeting of the JC's Finance & Performance Sub-Committee.
- The JC reviewed its risk register and agreed to close four risks. A copy of the JC risk register will be submitted to future Mid and South Essex CCG Board meetings.
- The JC received copies of the minutes of the Patient Safety & Quality Sub-Committee meeting held on 20 November 2018 and the Finance & Performance Sub-Committee meeting held on 21 December 2018.
- Terms of Reference for the Patient Safety & Quality Sub-Committee were approved, subject to inclusion of responsibility for monitoring the Transforming Care agenda.
- The JC approved its 2019/20 work plan.

Recommendations

Members of the Board are asked to:

- Note the business conducted by the STP CCG Joint Committee at it Part I meeting on 8 February 2019 and
- Receive the minutes of the Part I STPJC meeting held on 7 December 2018.

NHS Southend Clinical Commissioning Group

Primary Care Co-Commissioning Committee
Part I
Minutes

Date: Wednesday 14th November 2018
Time: 1:00pm – 2:00pm
Venue: Committee Room 3, Civic Centre, Southend Borough Council

List of attendees
Pauline Stratford (PS), Lay Member Patient Participation Rep (Chair)
Vicky Cline (VC), Quality & Patient Safety Senior Nurse for Primary Care
Tricia D'Orsi (TD), Chief Nurse
Mark Barker (MB), Interim Chief Finance Officer
Janis Gibson (JG), Lay Member Patient Participation Rep
Jenni Speller (JS), Associate Director of Primary Care
Nick Spenceley (NS), Lay Member Governance & Risk
Dr John Wier (JW), External GP Representative
Alison Birch (AB), Head of Primary Care Development
Andrew Bradshaw (ABr), Essex LMC
Sharon Judge, Executive Assistant (Minutes)
Andy Payne, (AP), Good Governance Institute

Members of the public in attendance
There were no members of the public in attendance

Apologies
David Barter (DB), NHS England
Dr Sunil Gupta (SG), CPR Governing Body Member
Sally Simmons (SS), Head of Primary Care Contracting
Simon Williams (SW), Interim Director of Partnerships & Integration

Item	Subject	Action
1	**Welcome & Apologies**	
	The Chair welcomed everyone, including members of the public, to the meeting and apologies were noted as below: • David Barter, NHS England • Dr Sunil Gupta, CPR Governing Body Member • Sally Simmonds, Head of Primary Care Contracting • Simon Williams, Director of Partnerships & Integration •	
2	**Declarations of Interest**	
	There were no declarations of interest to note.	
3	**Minutes of last meeting held on 19th September 2018**	
	The Minutes of the meeting held on 19th September 2018 were approved	

	as an accurate account of the discussion following the changes below: Peter Murphy to be added to the list of apologies. Page 4, paragraph 7 – the last sentence should read JS gave detailed assurance that patient engagement followed a robust programme of stakeholder events.	
4	**Action Log**	
	All actions on the Action Log were complete.	
5	**Quality Report**	
	VC presented the Quality Report which was taken as read. VC highlighted the following points: In CPR all practices were rated as good by CQC with the exception of one that is requiring improvement. In SCCG all practices were rated as good by CQC with the exception of one that is requiring improvement. Carnarvon Road Surgery are expecting a CQC inspection at the end of November. Serious Incidents There has been one serious incident in CPR regarding an information governance breach. The practice has completed a 30 day and 60 day report in line with the current protocol. There have been no serious incidents reported for SCCG. Complaints VC is waiting for month 2 data and will bring this to a future meeting. Friends and Family test There have not been as many responses as hoped but the current data does not include data relating to iPlato. NHSE have undertaken a Quality Workshop to look at how the quality of services delivered by practices can be improved. An update will be brought to a future meeting. TD suggested adding a column to the dashboard showing changes to list sizes and PS asked how open or closed lists are identified, VC replied that this is normally highlighted in red. EU GP Recruitment In CPR there are two practices taking part in the scheme, one candidate has completed the programme and one is in the preparatory stage. In SCCG one candidate has had their placement terminated, one is waiting their simulated surgery results and one is waiting for a work placement to allow the conditions to be lifted off of the performers list.	

PM asked why the placement had been terminated and TD replied that there is a limit to how many times the MCQ test can be re-done and this has been set at three.

TD went on to say that ICS are working with the EU countries involved in the scheme so that the doctors complete the MCQ in their home country allowing them to focus on other aspects of the programme once they arrive in the UK.

GP Patient Survey

VC talked through the GP Patient Survey that was taken as read and highlighted the following points:

VC said that a number of questions had been included within the survey that were marked against the national average.

With regard to patients being able to get through on the phone CPR scored 62% and SCCG 64% against a national score of 70%.

Helpfulness of reception staff scored 87% and 88% for CPR and SCCG respectively against a national score of 90%.

Patient satisfaction came close to the national average of 74% with CPR achieving 73% and SCCG 74%.

VC will triangulate data within the GP Patient Survey to see if anything needs improvement within practices and put an action plan in place if required.

JG felt that the overall experience was not far below the national average but scores appear to be going in the wrong direction and would be interested to find out how practices have responded to the results.

JS said that there has been lots of change for GPs recently and lots of press about pressure on primary care and felt that it can sometimes take a while for improvements to come through. This is a subject that will be discussed at patient groups. PS asked if the information could be broken down to practice level.

TD pointed out that the wording has changed this year but was pleased to say that nurse satisfaction was rated at 99%. TD added that practices are aware of the outcomes and are disappointed with the decrease in results.

JW felt it would be good to look at the reports for the past 5 or 6 years rather than just the previous year.

NS questioned the reliability of the data and asked what is being done about the missing data and quick wins.

VC did point out that practices are only required to advertise the Friends and Family questionnaire and do not have to make patients fill it in and do not have to record that a patient does not fill it in.

TD said that lots of work has been done with practices but some practices do not want to engage. VC will continue to work closely with practices.

	PM felt it would be helpful to see an Essex wide comparison and not just a national picture. TD said that the Primary Care Programme Board have done this and she will bring back to a future meeting. TD said that lots has been done with the public about using on line services but there are still lots of people that do not know about them. PM felt it would be a good idea for top performing practices to buddy up and work with poor performing practices. JS added that online services should be available to all patients by December. TD felt that both organisations have been through lots of changes but are now in a position to focus on these issues. PS asked if practice managers from poorly performing practices attend regular practice managers meetings and TD replied that they do not. PS referred to satisfaction with helpfulness of receptionists and said that the CCGs do have a budget for training and asked if the poorly performing practices would be targeted with this training. AB replied that she is aware of all staff booked onto these training sessions from each practice. JW felt that it might be better to reword some of the questions in the survey as this may change the answer. TD pointed out that the top 4 practices that patients have problems getting through on the phone are smaller single handed practices. **Action: TD agreed that this would be taken to the next CRG.** PS said that a recent Commissioning Reference Group meeting asked for the results of the GP survey to be put on their agenda. JW asked if anything is being done about the Out of Hours service as it continues to get low scores. TD replied that Out of Hours is commissioned through the IC24 contract that has lots of KPIs in place to pick any issues up. However, if we are not happy with anything this can be raised with the lead commissioner. **Action: TD to raise OOH concerns with IC24.** NS asked if the care navigation training is showing any results and TD felt this would not become apparent until next year.	
6	**Finance Report**	
	MB presented the Finance Reports for both CCGs and highlighted the following: The current balance position for both CCGs is showing that they will achieve both their statutory and controlled targets. Risks do not have any values attached to them but litigation is in place to ensure both CCGs reach their balanced positions.	

	There are opportunities as a number of budgets have not yet been committed and this is linked to transformation. Localities are going to be explored further. There are some pressures in managing acute pressures and putting money into primary care. MB to bring back full report next month. MB stressed that each CCG much reach its controlled budget. There are potentials to expand localities and practice support and resources are available for this. PS asked if this money will be recurring or a one off spend and MB replied that funding is recurrent to create structure for the future to utilise primary care better. JS asked if this funding excluded the £3 per head and MB confirmed that it was. PM asked if there would be any slippage and MB confirmed that slippage would not be it might not significant. TD asked what the GP training cost of £2.9m was linked to and MB said he would confirm in a full report next month. There is also £25k extra money available for LD healthchecks.	
7	**Contract Update Report**	
	JS presented the Contract Update report taken as read and highlighted the following points: There have been two applications for partnership changes processed and confirmed that neither practice will be left as a single handed partnership. QOF results have been published and results are being reviewed and triangulated with other practice information.	
8	**Work Plan 2018/19 including GPFV Delivery Plan**	
	JS presented this report which was taken as read and highlighted the following points: Procurement has begun for the Enhanced Access Service and JS is confident it will be delivered. iPlato data is starting to show a big impact on DNA results and feedback from staff and patients is very positive. Digital transformation is progressing and actions are moving forward. JS is working collaboratively with other CCGs. Leading edge practices are working together and 6 of 7 practices have	

	identified what they want to work on. Dragons Den provides practices an opportunity to highlight good work they are doing. Of three bids submitted one was successful. Quality improvement programme is building capacity and capability by looking at what would work in practices and make life easier. JS will bring a full report to a future meeting. Several public engagement events have been held and were very helpful with lots of ideas from patients to help them work with us. JG referred to the patient engagement programme and wanted to point out that the history in Southend is very different to CPR and there has been lots of good work done in Southend but it is important to find a way to reach more people. JS said that that was a key comment at the events she attended. JG added that lots of work has gone into this in the past so we may have to look at it in a different way. PM found that previous reports make it very difficult to assess whether the plan is actually on track. The report reads very positive but are we today where we thought we would be in April, are there things that are we are doing better or worse than expected. PM did not feel the report gave me assurance that things are good. JS said that the work plan that came to the committee last month and was colour coded but at the present time she does not have the capacity to work on this. However, she is in discussions with PMO team to see if they can offer any help. PM asked JS if she was confidence with current position and she replied that she felt very positive with the way practices are working hard and moving ahead with things. JS said that there is a big work plan with many things interlinked but there needs to be some work done on the best way to present the information. TD referred to the QIPP section in the report and said that there is lots of work coming through from NHSE on care homes. As work streams have been cut into sections across the STP TD suggested removing care homes from the work plan and moving it into a separate paper. PS asked if JS could include whether there is any slippage in future reports.	
9	**Items for Decision**	
	There were no items for discussion.	
10	**Any Other Business**	
	There were no other items for discussion.	
12	**Questions from the public relating to the agenda**	

	There were no members of the public in attendance.	
	Date of Next Meeting, Venue & Time	

Wednesday 12^{th} December, 2018
Developmental Session 1-3pm
Venue to be confirmed