West Hampshire
Clinical Commissioning Group

CCG Board

Date of meeting		28 November 2019	
Agenda Item	11	Paper No	WHCCG19/118

Minutes of West Hampshire CCG Committee Meetings

Key issues	To note the publication on our website of the approved minutes of the: • Audit Committee meeting held on 10 September 2019 • Clinical Governance Committee meeting held on 5 September 2019 • Clinical Cabinet meetings held on 12 September and 10 October 2019 • Finance and Performance Committee meetings held on 29 August and 26 September 2019 • Primary Care Commissioning Committee meeting held on 29 August 2019 There are no key issues arising from this paper.
Actions requested / Recommendation	**The West Hampshire Clinical Commissioning Group Board is asked to note the publication of the approved minutes of the:** • **Audit Committee meeting held on 10 September 2019** • **Clinical Governance Committee meeting held on 5 September 2019** • **Clinical Cabinet meetings held on 12 September and 10 October 2019** • **Finance and Performance Committee meetings held on 29 August and 26 September 2019** • **Primary Care Commissioning Committee meeting held on 29 August 2019.**
Principal risk(s) relating to this paper	There are no risks arising from this paper.
Other committees / groups where evidence supporting this paper has been considered.	Audit Committee, Clinical Governance Committee (supported by Clinical Quality Review Meetings), Clinical Cabinet, Finance and Performance Committee and Primary Care Commissioning Committee (supported by Primary Care Steering Group).

Financial and resource implications / impact	There are no financial implications arising from this paper.
Legal implications / impact	There are no legal implications arising from this paper.
Public involvement – activity taken or planned	Not applicable.
Equality and Diversity – implications / impact	This paper does not request decisions that impact on equality and diversity.
Report Author	Various – refer to each set of Minutes
Sponsoring Director	Sarah Schofield, Clinical Chair
Date of paper	12 November 2019

NHS
West Hampshire
Clinical Commissioning Group

Minutes

Audit Committee

Minutes of the NHS West Hampshire Clinical Commissioning Group Audit Committee held on Tuesday 10 September 2019 at 9.00am in the Boardroom, Omega House, Eastleigh.

Present:	Simon Garlick Judy Gillow Alison Rogers Caroline Ward	Lay Member, Governance – Chair Lay Member, Quality Lay Member Strategy and Finance Lay Member New Technologies and Digital
In attendance:	Clarence Mpofu Peter Barber Karen Travers Ian Corless Ellen McNicholas Mike Fulford Andrew Short Terry Renshaw	Director of Audit TIAA Director, Grant Thornton Local Counter Fraud Specialist, Hampshire and Isle of Wight Counter Fraud Service Board Secretary/Head of Business Services Director of Quality (Board Nurse) Managing Director and Chief Finance Officer Associate Director, Finance Governance Manager
Apologies:	Sam Harding Nick McBeath Mike Townsend	Engagement Manager, Grant Thornton Internal Audit Manager TIAA Regional Managing Director, TIAA

Summary of Actions

Minute Ref:	Action	Who	By
	Internal Audit Progress Report:		
5.2.2	• In future within reports identify where draft/published reports are 'operational' and therefore an assurance rating is not required.	**CM**	Ongoing
5.3	• **Specialised Services/ Specialist Commissioning** – Circulate note to the Committee outlining potential timescale for the review to commence.	**EM**	ASAP
5.3	• **CCG Counter Fraud Thematic Review: CHC Individual Placements** – To review key findings on a line by line basis and outline if they have/have not been addressed/or put in place. Confirmation note to be sent to the Committee.	**EM**	ASAP

Minute Ref:	Action	Who	By
5.6	**Internal Audit Recommendations:** • **ICTCS-02 Data Loss Prevention (cyber-security)** – To review revised plan and provide an update on progress/latest position within the next report. • **PPE-01 and PPE-02 Public and Patient Engagement -** When Communications and Engagement Strategy is reviewed at the September Board raise that there has not been oversight/sign off of the top level approach to its direction. • **QIPP-04 QIPP Savings Programme** – Undertake final review of processes and close recommendations. • **AFRM-03 Review of Datix System** – Mike Fulford to provide post meeting clarification that a full post implementation review has been undertaken.	**MF/IC** **Lay Members** **MF** **MF**	ASAP 26.09.19 ASAP ASAP

6.3	**External Audit Progress report:**
	• **Mental Health investment Standard** – Once work has been completed on the Assurance Statement around CCGs mental health spend year on year; reflect back to Committee any areas for WHCCG improvement, exercise to be expanded to include collaborative reflection across HIOW.
	• **Primary Care Networks**:
	  • Include in 12 November 2019 post meeting briefing session an overview of what PCNs are and links to ICS and system reform. To include reflection of outcome of meeting on 4 October 2019 with Audit Committee Chairs and Joanne Shaw.
	  • Session to be scoped and briefing provided to Rachael King.
	• **Clicks and Mortar: Technology and the NHS Estate (page 104)** – To review CCGs progress on what we need to do and highlight what STP is to progress. Mike Fulford to speak to Claire Parker and an off-line update is to be circulated.
		PB
		
		IC/SG
		
		IC/SG/(RK)
		
		MF/(CPr)
			ASAP
			
			05.11.19
			
			31.10.19
			
			27.09.19

7.3	**LCF and Security Management:** • **Fraud, Bribery and Corruption Annual Report 2018/19 (page 28) Nos3.6** – In future reports include commentary around reason behind why score is not green (i.e. not proportionate to test systems where there are appropriate processes in place). • **Fraud, Bribery and Corruption Interim Report Q1 –** Correct typo on last task on page 6 - 31.03.19 to read 31.03.20.	**KT** **KT**	Ongoing ASAP

Minute Ref:	Action	Who	By
8.2	**Finance and Performance Reports – On Future Reports:** • Include summary of Board discussion/outcomes when meeting sequencing allows in the cover sheet. • Cover sheet to include reference to Audit Committee reminders/escalation of issues/concerns to Audit Committee/other Committees.	**MF** **MF**	Immediate Immediate

10.2	**BAF/CRR:**
	• **For Next/Future Reporting** :
	  • Provide more narrative around what has been achieved.
	  • Remove reference to Heather Mitchell and replace with reassigned leads.
	  • Highlight within cover sheet any material changes that due to timing of report sign-off are not included within the report presented to this Committee.
	• **Strategic Objective 6 Comms and Engagement:**
	  • Concern raised around statement 'No risks recorded at present'. To be raised/reviewed as part of September Board discussion on the Comms and Engagement Strategy and Plan.
	  • Further assurance/reflection requested by Lay Members on the operational plan to address the risks around the Comms and Engagement Strategy and work plan and the outcome of the consultation/review of the team/proposed future recruitment. Agreed Lay Members are to meet with Ellen McNicholas, Simeon Baker and key staff to explore if plan fits requirements as to what we need in moving forward/provide sense of oversight/opportunity for discussion. Timing to be clarified pre or post Board discussion.
		MF/(PBr)
		MF/(PBr)
		MF/(PBr)
		
		Lay Members
		
		EM
			5.11.19
			5.11.19
			5.11.19
			
			26.09.19
			
			ASAP

10.5	**Corporate Risk Management Policy and Strategy:** • Requested that in future any policies presented to the Committee highlight changes in red text. • Section 3.1.2 Reporting Frequency – Audit Committee delete reference to frequency being every two months and replace with 5 times a year.	**IC/JZ** **IC/JZ**	On-going Immediate (complete)
11.1	**Meeting with Joanne Shaw, NHS England Audit Committee Chair :** • Additional areas/thoughts for discussion to be sent to Simon Garlick. • Simon Garlick to send to Peter Barber list of potential areas of discussion for sharing with Joanne Shaw in advance of the meeting.	**ALL** **SG/PB**	20.09.19 23.09.19

1. <u>Welcome, Apologies and Opening Remarks</u>

1.1 Simon Garlick welcomed everyone to the thirty-third meeting of the West Hampshire CCG Audit Committee and noted the apologies for absence.

2. <u>Declarations of Interest</u> (Paper AC19/038)

2.1 Simon Garlick directed members of the Audit Committee to the declarations of interest register.

2.2 No specific interests were declared relating to items to be discussed at the meeting. Attention was drawn to the fact that should a conflict arise at any point during the meeting members will need to declare this fact.

2.3 The Audit Committee:

- **Received and noted the Register of Interests.**

3. <u>Minutes of the Last Meeting and Matters Arising</u> (Paper AC19/039)

3.1 The Audit Committee received the draft minutes of the meeting held on 22 May 2019.

3.2 **<u>Matters Arising</u>** – There were no matters arising that were not covered by the action tracker.

3.3 The Audit Committee:

- **Approved the Minutes of the meeting held on 22 May 2019 as being a correct record and commended them for signature by the Chairman and onward submission to the Board, subject to the inclusion of the additional text.**

4. <u>Action Tracker</u> (Paper AC19/040)

4.1 Simon Garlick introduced paper AC19/040 and the items on the action tracker were reviewed. An update was provided on:

1. **<u>AC19/002b) Local Counter Fraud and Security Management: Awareness raising session to be scheduled for Audit Committee members on split of responsibilities for Fraud and Corruption for both Internal and External Audit</u>** – It was reported that an awareness raising session is to be held after the 12 November 2019 meeting of this Committee. **Closed.**

2. **<u>AC19/004a) Audit Planning 2019/20: Mike Fulford to discuss with Heather Mitchell what further clarity is required around outcomes based operational plans/strategic plan and milestones for the next 1 to 5 years</u>** – It was reported that the Balanced Scorecard was reviewed at the Board Briefing in June 2019 and presented to Board meeting held in public in July 2019. Strategic planning for Hampshire and Isle of Wight is in train as part of development of Integrated Care System. It was agreed that this action can be closed. **Closed**.

3. **<u>AC19/004b) Audit Planning 2019/20: Board discussion to be scheduled once next steps are identified</u>** – It was reported that Balanced Scorecard reviewed at Board Briefing in June 2019 and presented to Board meeting held in public in July 2019. Strategic planning for Hampshire and Isle of Wight in train as part of development of Integrated Care System. Following further reflection around receipt of the Balanced Score Card it was agreed that this action is to be **Closed**.

4. **AC19/006a) Draft Internal Audit Plan 2019/20 EPPR: Alison Rogers to meet with Jenny Erwin, Heather Mitchell and Tracy Davies AD of Emergency Planning, Resilience and Response Hampshire Partnership and Portsmouth CCGs** – Meeting is to be rescheduled for September, as original meeting was cancelled by Heather Mitchell in advance of her departure. It was reported that a meeting has now taken place and an update has been provided. **Closed**.

5. **AC19/010 Committee Effectiveness: Arrange an initial scoping meeting to look at connectivity between objectives and delivery of Board and Committee work programme** – Meeting scheduled for end of June cancelled due to Heather Mitchell's absence. Progression of the system reform proposals and the change in CCG leadership during July resulted in this work being paused. Audit Committee Chairman recommends that this action is closed, as the aim of the original action has been superseded. It was agreed that this action can now be **Closed**.

6. **AC19/011 Audit Strategy and Internal Audit Plan: Undertake review of 2 to 3 procurements to check if current procurement activity is taking account of lessons learnt. Clarence Mpofu to speak to Mike Fulford and bring a specification back to the Committee for further consideration** – It was reported that the scope/specification is in the process of being finalised.

7. **AC19/012a) Annual Report and Accounts 2018/19: Heather Mitchell to revisit CAMHS wording pages 36-37 to reflect that there has been a problem with access, in order to provide transparency** – Complete. **Closed.**

8. **AC19/012b) Annual Report and Accounts: Page 49 paragraph 7.1 National Average Column (if available) is blank. If data is not available remove column** – Complete. **Closed.**

9. **AC19/013 Local Counter Fraud and Security Management: Provide a copy of the correct Draft Fraud Self Review Tool Report 2019 for issuing with the minutes** – Complete **Closed.**

10. **AC19/014 BAF: To further review wording:**
    - **Risk #589 Ophthalmology Outpatient Capacity**
    - **Risk #196 Inability of providers to provide the volume and flexibility of staff and skills to deliver services** – Complete **Closed.**

4.2 **The Audit Committee:**

- **Received updates on the actions arising.**
- **Agreed the actions outlined at paragraph 4.1.1 and 4.1.3.**
- **Agreed that nine actions are now complete and can be closed.**

5. Internal Audit

Internal Audit Progress Report (May 2019) (Paper AC19/041)

5.1 Clarence Mpofu introduced the Internal Audit Progress Report for September 2019 with details of the progress and performance of the Internal Audit service against the 2018/19 and 2019/20 Internal Audit Plan for West Hampshire CCG. It was reported that:

- One audit review has been completed by internal audit since the last Progress report and this is:

- **NHS England Mandated Review of Delegated Primary Care Commissioning** – Substantial assurance with two routine recommendations highlighted.

  It was noted that this was included in the agenda pack for the last meeting held in May 2019 but was included again for completeness.

- Three draft reports have been prepared and are awaiting management sign-off:
  - **Care Home Provider Spot Checks** – no assurance given
  - **HR/Workforce** – reasonable assurance provided.
  - **Annual Review of Key Finance Systems** – substantial assurance provided
- The progress report also provides an update on the internal audit key performance indicators and summary of briefings on Developments in Governance, Risk and Control which have been circulated to management. This includes a Counter Fraud Thematic Review of Continuing Healthcare (CHC) Individual Placements.

5.2 The Committee reviewed the following reports:

1. **NHS England Mandated Review of Delegated Primary Care Commissioning** – It was reported that:
   - Work is being undertaken to plan for the next stage which is around contract management.
   - The report will be presented to the Primary Care Commissioning Committee at their October 2019 meeting.

2. **Care Home Provider Spot Checks (draft)** – It was:
   - Questioned as to whether there is anything really important that needs to be brought to the Committees attention at this point. It was stated that there is nothing that cannot wait until the final report is presented at the next meeting and the Committee can take assurance that the team are undertaking action now to address the recommendations made.
   - Reported that the report also provides evidence for what anecdotally was felt to be happening therefore provides a platform for moving forward.
   - Agreed that within future reports there is a need to identify where draft/published reports are 'operational' and therefore an assurance rating is not required.

ACTION: Clarence Mpofu

3. **HR/Workforce Review** – It was reported that Andrew Short has provided a response.
4. **Annual Review of Key Finance Systems** – it was reported that:
   - There has been a change to the way that journals are prepared.
   - A 'wash-up' meeting to discuss the outcome of the review has been held with Andrew Short.

5.3 As a result of discussion around the following reports it was:

- **Business Continuity and EPRR Review** – Reported that following discussions with Tracy Davies, Associate Director of Emergency Planning, Resilience and Response Hampshire Partnership and Portsmouth CCGs, it was proposed this review be undertaken in September 2019. This is because the CCG was in the process of preparing a submission to NHS England regarding Business Continuity and EPRR to be completed end of August 2019. This work is now underway.
- **Specialised Services/Specialist Commissioning** – Highlighted that this was a 2018/19 Review which was to be carried out in late Q4. The Audit Planning Memorandum was approved by the CCG's Director of Quality and Board Nurse. Due to the on-going issues and risks which have been reported to the

Transforming Care Board (Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership and financial risks which are being discussed with NHS England it was proposed by the Director of Quality and Board Nurse that this Review be put on hold. Attention was drawn to the following risks and issues:

- Ongoing use of locked rehab
- Ongoing barriers with providers
- Financial risk associated with Specialised Commissioning Discharges.
- Number of Inpatients is fluctuating is a strategic commissioning challenge.

It was questioned as to when it is likely that the review will be able to commence. It was responded that there are a number of NHS E/I issues around Specialist Commissioning and transfer of responsibilities and Ellen McNicholas agreed to clarify the potential timescale for the review to commence and send a note to the Committee.

ACTION:Ellen McNicholas

- **Counter Fraud Thematic Review of Continuing Healthcare (CHC) Individual Placements** – Reported that TIAA have recently published the results of a CCG Counter Fraud Thematic Review of Continuing Healthcare (CHC) Individual Placements. The review compared arrangements recently in place across 22 CCGs, where TIAA provide Counter Fraud Services, for managing high value individual placements and Funded Nursing Care payments, intending to identify potential opportunities for improving controls and preventing provider over-claims. The review considered payments made in financial year 2017/18. The key results from their analysis was outlined and it was agreed to review the key findings on a line by line basis and outline if they have/have not been addressed or put in place and a confirmation note is to be sent to the Committee.

ACTION: Ellen McNicholas

5.4 **The Audit Committee:**

- **Received the progress report against the 2018/19 Annual Internal Audit Plans.**
- **Received the following internal audit reports:**
  - **NHS England Mandated Review of Delegated Primary Care Commissioning**
  - **Care Home Provider Spot Checks (draft report)**
  - **HR/Workforce (draft report)**
  - **Annual Review of Key Finance Systems (draft report)**
  - **Agreed the actions outlined at paragraphs 5.2.2 and 5.3.**

Internal Audit Recommendation Status Report (September 2019) (Paper AC19/042)

5.5 Mike Fulford introduced paper AC19/042 which summarised the progress made with implementing recommendations made by the internal auditors against the CCG's Internal Audit Plan for 2018/19 and 2019/20.

Attention was drawn to:

- Appendix 1 of paper AC19/042 which provides an update regarding recommendations made within the following internal audit reports previously submitted to the Committee:
  - ICT Review of Cyber Security – Joint Review
  - Continuing Healthcare
  - Patient and Public Engagement
  - Mandated Conflicts of Interest
  - Delivery of QIPP Workstreams
  - Data Security and Protection Toolkit

- Assurance Framework and Risk Management
  - Quality Assurance Processes – Focusing on Southern Health
  - NHS England Mandated Review of Delegated Primary Care Commissioning
- The fact that six recommendations are carried forward to the next meeting.
- Recommendations from audits which were noted as completed at previous meetings have been removed from the appendices and are held on a separate log, available on request.
- The schedule will be populated as new reports and recommendations are received.

5.6 As a result of discussion attention was drawn to:

- **ICTCS-02 Data Loss Prevention (cyber-security)** – It was reported that the cyber security joint review has been pushed back due to Windows 10 upgrade. Roll-out has commenced and still has a January 2020 completion date in place. However, this may slip as the January deadline is not so time critical now as ongoing Window 7 support from Microsoft has been negotiated and support will continue to be provided until August or October 2020. Therefore anxiety level has decreased but there is still a drive to embed and roll-out as early as possible. It was agreed to review the revised plan and provide an update on progress/latest position within the next report.

ACTION: Mike Fulford/Ian Corless

- **PPE-01 and PPE-02 Public and Patient Engagement** – It was highlighted that the Lay Members have met with Simeon Baker and it was noted that the first part of his work will be completed by the end of September then he will take annual leave and return to work for the CCG on a different set of deliverables around system reform. In view of the current level of organisational/ change it has been decided that now is not the right time to recruit to a substantial Associate Director role. It was agreed that when the Communications and Engagement Strategy is reviewed at the September Board that Lay Members will raise their concerns that there has not been oversight/sign off of the top level approach to its direction.

ACTION: Lay Members

- **QIPP-04 QIPP Savings Programme** – The need to undertake a final review of processes in order that recommendations can be closed.

ACTION: Mike Fulford

- **AFRM-03 Review of Datix System –** It was questioned if the full post implementation review has been undertaken. Mike Fulford agreed to provide post meeting clarification.

ACTION: Mike Fulford

5.7 The Audit Committee:

- **Noted the progress to implement Internal Audit recommendations for 2018/19 and 2019/20.**
- **Agreed the actions outlined at paragraph 5.6.**

6. <u>External Audit Report</u> (Paper AC19/043)

6.1 Peter Barber introduced paper AC19/043 and explained that the paper provides the Audit Committee with a report on progress in delivering WHCCG responsibilities as external auditors. It was reported that:

- All deliverables for 2018/19 have been issued and therefore work on the 2018/19 financial year has concluded. The Annual Audit Letter which summarises the key findings arising from the work carried out at the CCG for the year ended 31 March 2019 was issued in accordance with requirements on 7 June 2019, and received by the CCG Board at its meeting held in public on 25 July 2019.
- Work on the Mental Health Investment Standard is currently being planned. This

work will be carried out during September.

- Work will now begin to look to the 2019/20 financial year and begin planning processes for the audit. Formal work will begin later in the year and in the meantime:
  - Regular discussions with management will continue, to inform risk assessment for the 2019/20 financial and value for money audits.
  - Board papers and latest financial and operational performance reports will be reviewed.

6.2 It was highlighted that the report also includes:

- A summary of emerging national issues and developments that may be relevant to a CCG. Particular attention was drawn to:
  - Clicks and Mortar: Technology and the NHS Estate
  - Primary Care Networks explained
  - What does the NHS Long Term Plan mean for the finance function
  - Achieving a Digital NHS
- A number of challenge questions in respect of these emerging issues which the Committee may wish to consider. These are a tool to use, if helpful, rather than formal questions requiring responses for audit purposes.

6.3 As a result of discussion attention was drawn to the £10k charge to CCGs for the review of the Mental Health Investment Standard resulting in a fee of £80k across the patch and in respect of WHCCG this is a lot of money for a straight forward piece of work. It was responded that it is recognised that the audit is retrospective and the work arose as a direct request from NHS E with a deadline of the end of September agreed. The £10k cost was based on NHS E discussions with all firms and national pilots undertaken which highlighted the level of work involved. Recognising the additional responsibility imposed NHS E is to fund the cost of this work. For some CCGs the process will be straight forward whereas for others it will not be so, and the £10k is irrespective of risks and arrangements. It was stated that:

- Year 1 is to inform the approach going forward
- WHCCG has received the £10k reimbursement in full from NHS E.

It was agreed:

- That once work has been completed on the Assurance Statement around CCGs mental health spend year on year to reflect back to this Committee any areas for WHCCG improvement. It was suggested that this exercise should be expanded to include a collaborative reflection across HIOW.

ACTION: Peter Barber

- Following review of the briefing on Primary Care Networks explained - it was agreed to:
  - Include in the 12 November 2019 post meeting briefing session an overview of what Primary Care Networks are and links to the ICS and system reform. To include also reflection of outcome of meeting on 4 October 2019 with Audit Committee Chairs and Joanne Shaw.

ACTION: Ian Corless/Simon Garlick

  - Scope what the 12 November 2019 session is to cover and provide a briefing to Rachael King.

ACTION: Ian Corless/Simon Garlick/(Rachael King)

- There was discussion around Clicks and Mortar: Technology and the NHS Estate and it was agreed to review CCGs progress on what we need to do and highlight what STP is to progress. Mike Fulford is to speak to Claire Parker and an off-line update is to be circulated.

ACTION: Mike Fulford

6.4 The Audit Committee:

- **Noted the External Audit Progress Report**
- **Agreed the actions outlined at paragraph 6.3.**

7. **Fraud and Security Management (Paper AC19/044)**

7.1 Karen Travers introduced paper AC19/044 and provided an update on the 2018/19 annual reports and the quarter 1 2019/20 progress updates against the Fraud, Bribery and Corruption Work Plan and the Security Management Work Plan for NHS West Hampshire CCG. The NHS Standard Contract is published by NHS England and Service condition 24 places an obligation on all commissioners to put in place and maintain appropriate counter fraud and security management arrangements. It was reported that:

- The NHSCFA have produced a policy document entitled, 'Tackling crime against the NHS – a strategic approach', which details the key principle areas of work that underpin both national and local anti-fraud security management activity. Wherever possible, reports do not include detailed identifiable information.
- To meet NHS CFA Standards for commissioners, counter fraud and security management work has been undertaken in each of the four strategic areas. These are: Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

7.2 The Committee reviewed the following reports:

- **Fraud, Bribery and Corruption**
  It was explained that:
  - The annual report details the work undertaken as specified within the Clinical Commissioning Group's Fraud, Bribery and Corruption Work Plan 2018 – 2019 which was prepared in accordance with the 2017-19 Counter Fraud Authority (CFA) Standards for commissioners: Fraud, bribery and corruption.
  - The Quarter 1 2019/20 progress report outlines the key work undertaken since the last Audit Committee meeting and covers the period 1 April 2019 to 30 June 2019.

- **Security Management**
  It was reported that:
  - Clinical Commissioning Groups and their Governing Bodies have a responsibility for oversight of their own security arrangements, currently without any external scrutiny from national security professionals. It is acknowledged that external organisations such as the Health & Safety Executive still have a legal responsibility to oversee and enforce any staff safety issues that are passed to them about the CCG.
  - The annual report details the work undertaken as specified within the CCG's Security Management Work Plan 2018-19, which was prepared in accordance with the existing NHS Security Management Standards for commissioners 2016-17.
  - The Quarter 1 2019/20 progress report outlines the key work undertaken since the last Audit Committee meeting and covers the period 1 April 2019 – 30 June 2019.

7.3 As a result of discussion it was:

- Reported that the Fraud Self Review return has been submitted. The report contains three amber ratings:
  - Nos 1.4 – It was highlighted that this was a new standard issued in February with a March assessment date so therefore the additional work required could not be completed in the time available. It was confirmed that this has now been addressed.
  - Nos 3.6 - Questioned what is required to move the CCG to a Green rating. It was responded that this is down to proportionality in terms of testing the

outcomes of risk assessment on systems that have appropriate processes in place. It was agreed that in future reports to include a commentary around reason behind why score is not Green and that it is not proportionate to test systems where there are appropriate processes in place.

ACTION: Karen Travers

- Nos 4.2 - Reported that all investigations are recorded on FIRST and the case progress updated accordingly. All relevant investigation material including witness statements and exhibits are uploaded to enable submission to Specialist Fraud Division at the Crown Prosecution Service.
- Highlighted that Fraud, Bribery and Corruption Interim Report Q1 has a typo on last task on Page 6 31.03.19 to be changed to read 31.03.19.

ACTION: Karen Travers

7.4 The Audit Committee:

- **Received and provided comment on the two reports.**
- **Agreed the actions outlined at paragraph 7.3.**

8. <u>Finance and Performance Report</u> (Paper AC19/045)

8.1 Mike Fulford introduced paper AC19/045 and explained that the Finance and Performance Reports are reviewed in detail by the Finance and Performance Committee, with key headlines and issues escalated to the CCG Board as part of the Integrated Performance Report.

The reports provided covered the four month period ending 31 July 2019 (Finance) and were based on data as at 8 August 2019 (Performance) were reviewed at the Finance and Performance Committee held on 29 August 2019.

The papers for the 26 September 2019 meetings will be developed in the coming week and will be published on 20 September.

8.2 There was a discussion around the sequencing and reporting of finance and performance information to Board and Finance and Performance Committee and the timing of reporting to this Committee and how reports to this Committee could be made more impactful. It was agreed to:

- Include a summary of Board discussions/outcomes when meeting sequencing allows in the cover sheet to this Committee.
- To also include in the cover sheet reference to Audit Committee reminders/escalation of issues/concerns to Audit Committee from other corporate Committees.

ACTION: Mike Fulford

8.3 The Audit Committee:

- **Reviewed the Finance and Performance Reports, at month 4 2019/20.**
- **Agreed the actions outlined at paragraph 8.2**

9. <u>Information Governance Update</u> (Paper AC19/046)

9.1 Mike Fulford introduced paper AC19/046 and explained that this paper contains two sections and updates the Committee in respect of:

1. **West Hampshire CCG Data Security and Protection Toolkit Action Plan 2019-20** – The purpose of this paper is to provide an update on the CCGs progress in completing the Toolkit and measuring their performance against the National Data Guardian's 10 data security standards.

2. **Information Governance Update Report Quarter 2** – This paper updates the Committee in respect of all items within the Information Governance (IG) agenda as part of the annual requirement to complete an IG assessment submission. The update includes:
   - **Internal Information Governance Audits** - Undertaken by the West Hampshire CCG Information Governance Group (WIGG) Data Custodians and Information Asset Owners (IAOs)
   - **Information Governance training scores and training provided** - The CCG is currently 68.4% compliant for mandatory IG training
   - **Information Governance risks / incidents** - Since the 13 May 2019 to the 23 August 2019 three IG incidents were reported
   - **Policies and procedures** – The suite of IG policies/procedures have been approved by the CCG (details on page 2 of report)
   - **Data Security and Protection Toolkit Update** – An action plan has been created for the new toolkit and will be reviewed with the CCG in September to ensure that all required evidence is in place before March 2020.

9.2 It was highlighted that:

- The Data Security and Protection Toolkit Action Plan is not completed yet and further evidence is awaited to determine if all elements will be achieved.
- The SIRO work book is awaiting completion.
- There will be a formal review of our compliance in October by NHS E with a final audit in February 2020.

9.3 The Audit Committee:

- **Reviewed the Data Security & Protection (DSP) Toolkit Action Plan**
- **Received and provided comment on the Quarter 2 update report.**
- **Noted the Quarter 2 update report includes an update on the remainder of Quarter 1 statistics for Subject Access Requests and Risk Incidents.**

10. Risk Management and Board Assurance (Paper AC19/047)

10.1 Mike Fulford introduced paper AC19/047 and explained:

- As per the CCG's corporate Risk Management Policy, the Board receives the Board Assurance Framework (BAF) at each public meeting. The Corporate Risk Register which informs the BAF was reviewed by the Corporate Risk Group on 18 June 2019 and 21 August 2019. The BAF was presented to the Board at their meeting on 25 July 2019. The BAF is based on the Strategic Objectives of the CCG:
  - Quality and Performance
  - Constitutional standards / performance and KPI, Delayed Transfers of Care (DTOC)
  - Patient Experience
  - Workforce
  - Financial sustainability
  - Working in Partnership for optimum service delivery
  - Developing Local Delivery Systems
  - Developing CCG Workforce
- That at the 23 May 2019 Board meeting there was a request to include Strategic Communications and Engagement as a category of the BAF, this new category was added to the BAF and there were no current risks aligned to this objective. For the July 2019 BAF:
  - There were nine new high risks:
    - #630 Andover ETTF: if the business case approval process is delayed this may impact on delivery of the scheme – 12.
    - #633 Andover ETTF: If the increased costs of the new building are

unaffordable, the services will not be prepared to relocate – 12.
    - #634 Andover ETTF: if the cost of equipping the new build is unaffordable the service will be unable to relocate – 12.
    - #637 Andover ETTF: if planning approval is not granted, an alternative solution for Andover Health Centre will need to be found – 12
    - #640 Andover ETTF: If timetable is impacted due to unforeseen issues this may impact on deliverability and cost – 12.
    - #642 If Health and Social Care Network has not been fully funded and delivered by August 2020 penalties will be imposed by NHS England – 12.
    - #643 if we are unable to fund Primary Care Ad Hoc IT Requests/Bids – 12.
    - #644 If there is a delay in reviewing health assessments for Looked After Children – 12
    - #646 If the risk assessments by Secure Care UK, secure transport providers, are not undertaken, or are not sufficiently robust there is a risk of harm to patients and staff – 12
- One risk has increased its score and been added to the BAF:
    - #215 SHFT not commissioned to deliver national access targets for psychological therapy increased from a 9 to a 12.
- There were nine risks which were downgraded and removed from the BAF:
    - #145 If GPs are not able to access high quality training in adult safeguarding, then they may not meet statutory obligations
    - #270 If the health MASH are unable to sustain navigating the most complex cases
    - #476 Safeguarding Children Teams Resource, Capacity and Succession
    - #533 GP IT service provision
    - #535 HHFT Governance processes and standards
    - #548 If there is a lack of accurate CAMHS performance and activity data
    - #552 System Dermatology Capacity
    - #567 Resources for delivering against the Digital Portfolio
    - #602 Redesign of Andover MIU to meet national UTC standards
    - #616 No common dataset of information about all children eligible for Continuing Healthcare
- The Board have completed their annual review of risk appetite virtually in June 2019 and this remains unchanged. The review paper was provided.
- The Board on 25 July 2019 asked for risk on organisational change to be added to the risk register, which has been done. The Board also asked for a comparison of local care partnership members risk appetite statements, a copy of the comparison is included within the paper and can be found at:
    - Appendix A for the West Hampshire CCG BAF July 2019.
    - Appendix B for the Risk Score Matrix.
    - Appendix C for the Review of the Risk Appetite Statement
    - Appendix D for the Comparison of Local Care Partnership Members Risk Appetite Statements
    - Appendix E for the Corporate Risk Register as at 21 August 2019.

10.2 There was discussion around:

- Future reporting and it was agreed to:
    - For the next and future reports to provide more narrative around what has been achieved.
    - Remove reference to Heather Mitchell and replace with reassigned leads.
    - Highlight within the cover sheet any material changes that due to the timing of report sign-off are not included within the report presented to this Committee.

ACTION: Mike Fulford/(Pippa Brown)

- Strategic Objective 6 Comms and Engagement and:
    - Concern was raised around statement 'No risks recorded at present'. It was agreed that this is to be raised/reviewed as part of the September Board discussion on the Comms and Engagement Strategy and Plan.

ACTION: Lay Members

- Further assurance/reflection was requested by Lay members on the operational plan to address the risks around the Comms and Engagement Strategy and work plan and the outcome of the consultation/review of the team/proposed future recruitment. It was agreed that Lay members will meet with Ellen McNicholas, Simeon Baker and key staff to explore if plan fits requirements as to what we need in moving forward/provide sense check of oversight/opportunity for discussion. Timing to be clarified pre or post Board discussion

ACTION: EllenMcNicholas

10.3 The Audit Committee:

- **Reviewed the Corporate Risk Register to assure that all appropriate risks and processes are in place to control and mitigate the risks to delivery of the strategic objectives.**
- **Agreed the actions outlined at paragraph 10.2.**

WEST HAMPSHIRE CCG CORPORATE RISK MANAGEMENT POLICY AND STRATEGY (Paper AC19/048)

10.4 Mike Fulford reported that the Corporate Risk Management Policy and Strategy is formally reviewed every three years. This review took place between July and August 2019 with no changes required apart from changes to personnel in the risk management chain. The revised draft document is due to be approved at the Policy Sub-Group on 11 September 2019 and ratified by the WHCCG Board on 26 September 2019.

10.5 The Committee reviewed the Corporate Risk Management Policy and Strategy and requested:

- That in future any policies presented to the Committee highlight changes in red text.
- Section 3.1.2 Reporting Frequency – Audit Committee reference to frequency delete reference to frequency being every two months and replace with 5 times a year.

ACTION: Ian Corless/(Jackie Zabiela)

10.6 The Audit Committee:

- **Reviewed the Corporate Risk Management Policy and Strategy, to assure that all appropriate processes are in place to control and mitigate the risks to delivery of the strategic objectives.**
- **Agreed the action outlined at paragraph 10.5.**

11. Other Corporate Governance Matters

11.1 **Meeting With Joanne Shaw, NHS England Audit Committee Chair**

Simon Garlick drew attention to the meeting between HIOW Audit Chairs and Joanne Shaw that is being held on the 4 October 2019 topics for questions to be raised were discussed and it was agreed:

- Any additional areas/thoughts for discussion topics are to be sent to Simon Garlick by the 20 September 2019.

ACTION: ALL

- Simon Garlick will send to Peter Barber the list of potential areas for discussion for sharing with Joanne Shaw in advance of the meeting.

ACTION: Simon Garlick/Peter Barber

12. Annual Report of the Audit Committee 2018/19 (Paper AC19/049)

12.1 Simon Garlic presented paper AC19/049 and explained that in line with good practice the Audit Committee undertook an annual assessment of the activities of the Committee as contained within the Terms of Reference and the report summarised the work of the Committee for the financial year April 2018 to March 2019.

12.2 The Audit Committee:

- **Reviewed the Annual Report 2018/19 of the Committee.**
- **Approved the report for onward submission to the CCG Board**

13. Any Other Business

13.1 **Salary Overpayments**

Andrew Short reported that as a result of the HR Workforce Audit it was recommended that salary overpayment information is presented to the Audit Committee for review. A schedule was presented and it was reported that there has been two overpayments made this year and both have already been partially recovered.

As a result of discussion the Committee were assured that there are robust controls in place for the recovery of over payments.

14. Date of Next Meeting – Tuesday 12 November 2019

Date of Future Meetings

- Tuesday 4 February 2020
- Tuesday 17 March 2020

All meetings will take place from 9.30am to 11.30am in the Boardroom at Omega House, unless advised otherwise.

Simon Garlick declared the meeting closed.

15. Private Meeting

Signed as a true record

Name: **Title:**

Signature: **Date:**

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NHS
West Hampshire
Clinical Commissioning Group

Minutes

Clinical Governance Committee Meeting

Minutes of the West Hampshire Clinical Commissioning Group Clinical Governance Committee meeting held on 5 September 2019 at 9.00am in the Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB

Present:	Caroline Ward	Lay Member: New Technologies & Digital (Chair)
	Charles Besley	Board GP: Totton & Waterside (part meeting)
	Catherine Bowell	Deputy Director of Commissioning: South West
	Jenny Erwin	Director of Commissioning: Mid Hampshire
	Simon Garlick	Lay Member: Governance
	Karl Graham	Board GP: Eastleigh Southern Parishes
	Rory Honney	Board GP: Andover (part meeting)
	Ellen McNicholas	Director of Quality & Nursing (Board Nurse)
	Matthew Richardson	Deputy Director of Quality & Nursing
In attendance:	Carole Berryman	Senior Quality Manager: South West
	Joanna Clifford	Senior Quality Manager: Mid Hampshire
	Pauline Dorn	Head of Continuing Health Care and Funded Nursing Care
	Neil Hardy	Associate Director: Medicines Optimisation (item 14)
	Jackie Zabiela	Governance Manager (minutes)
Apologies:	John Carr	Patient Representative
	Mike Fulford	Managing Director
	Judy Gillow	Lay Member: Quality & Patient Experience
	Adrian Higgins	Medical Director
	Rachael King	Director of Commissioning: South West
	Johnny Lyon-Maris	Board GP: West New Forest
	Sarah Schofield	CCG Chairman
	Stuart Ward	Board GP: Eastleigh North & Test Valley South

Summary of Actions

Minute Ref.	Details	Who	By
4.4	**Action Tracker: CAMHS Referrals / Escalation to the STP.** To arrange a meeting between Jenny Erwin, Ellen McNicholas, Mike Fulford, Lisa James and Carole Berryman to discuss concerns in relation to the pace of work around referral patterns and the need for strategic (STP) commissioning of CAMHS services. To merge outstanding CAMHS actions into one and provide a Post Meeting Note for the minutes.	Jenny Erwin to lead	ASAP

Minute Ref.	Details	Who	By
4.12	**UHSFT: System Discussion.** To refer to the Executive Team to discuss the recommendation that a strategic / system discussion is required in relation to concerns around UHSFT in order to consider taking to Maggie MacIssac, Chief Executive for a broader discussion with the Board.	Ellen McNicholas	ASAP
5.4	**NHS Patient Safety Strategy.** To clarify the Medical Examiner process for mental health deaths.	Matthew Richardson	ASAP
9.15	**CAMHS: SPA Signposting.** To undertake a review on outcomes of signposting (e.g. if a significant number of families come back into the system) to include feedback from parents.	Carole Berryman	7 Nov 2019

This meeting was taken out of sequence in order to accommodate attendees' availability. However the minutes have been set out in the same order as the agenda for ease of reference.

1. WELCOME AND INTRODUCTIONS

1.1 Caroline Ward welcomed those present to the NHS West Hampshire Clinical Commissioning Group (CCG) Clinical Governance Committee. It was confirmed that the meeting was quorate.

1.2 It was noted that this meeting of the Committee had no patient representative in attendance; discussions are underway in relation to identifying additional individuals to ensure service user representation at future meetings.

SECTION 1: BUSINESS

2. DECLARATIONS OF INTEREST (Paper CLIN19/092)

2.1 Caroline Ward referred the Committee to the declarations of members' interest.

2.2 No specific interests were declared relating to issues to be discussed at the meeting. Attention was drawn to the fact that should a conflict arise at any point during the meeting members would need to declare this fact.

2.3 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the register of interests of members.

3. MINUTES OF LAST MEETING – 4 July 2019 (Paper CLIN19/093)

3.1 The Committee received the draft minutes of the meeting held on 4 July 2019.

3.2 It was reported that the following topics were agreed for highlighting to the Board of 25 July 2019:

- **Sepsis: CCG Performance.** The Board questioned the reason for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) being RAG rated as RED. It was responded that local providers perform consistently well for screening patients for sepsis although administration of antibiotics within the hour remains challenging in some areas. RBCHFT currently uses different and more challenging criteria for measuring time from decision to administration of antibiotics. The national criteria refer to clock start for antibiotics from the time a competent clinical decision maker identifies sepsis. RBCHFT use time of arrival in the department/sepsis screen identifying risk of sepsis which is more challenging but takes into account the whole patient pathway.
- **Child and Adolescent Mental Health Services (CAMHS) Waiting List:** To provide a regular update
- **Fractured Neck of Femur Best Practice Tariff:** Provider performance.

3.3 Please refer to Board report references Part I WHCCG19/076 Integrated Performance Report (July 2019).

3.4 It had also been suggested that the following should be highlighted to the Board:

- **University Hospitals Southampton NHS Foundation Trust (UHSFT) – Developing Risk:** to report that there may be a risk developing around UHSFT and the suggestion that a wider review of performance is undertaken.
- **Translating soft intelligence into hard evidence:** Improving feedback mechanisms from GP Practices.

3.5 Whilst these were not highlighted to the Board, actions are ongoing to take these forward (reference Part 1 Action Tracker items CLIN19/032 and CLIN19/034)

3.6 **AGREED:**

The West Hampshire CCG Clinical Governance Committee:

- **Agreed the minutes of the meeting held on 4 July 2019 as being an accurate record of the meeting**
- **Noted the items agreed for highlighting on 4 July which were / were not reported to the Board of 25 July 2019.**

4. ACTION TRACKER (Paper CLIN19/094)

4.1 The Committee received the updated action tracker. Additional verbal updates were provided as follows:

4.2 **CLIN18/060 Medicines Optimisation: Prescribing Comparison.** It was reported that Neil Hardy, Associate Director: Medicines Optimisation is working on this with a report to be developed during November / December and provided to the Committee in January 2020. Action ongoing.

4.3 **CLIN19/001 Supervision of medical professionals working in an isolated manner**. It was noted that a detailed update had been included in the tracker in terms of assurance that appropriate governance arrangements are in place for the supervision of medical professionals working in an isolated manner. The Committee was asked to confirm if it was assured by the response provided or whether further assurance was sought. It was confirmed that whilst the issue had been raised with NHS England, a formal response had not been received. It was agreed that the action could be closed as the Quality Team are assured that providers have processes in place to provide assurance about their practitioners as part of 'Business As Usual' processes.

4.4 **CLIN19/005 CAMHS: GP Referral Patterns**. It was confirmed that the action remained with Lisa James, Head of Strategy & Partnerships via Jenny Erwin. Carole Berryman advised that a group is being brought together as it has been identified that issues with regard to referrals are wider than just in relation to GPs, which has delayed the action in moving forward. Concerns were expressed around pace given the action was originally raised in January 2019. Ellen McNicholas echoed this concern and it was agreed that she, Lisa, Jenny and Carole have a discussion outside of the meeting as to how this might be taken forward, with an update to be provided as a Post Meeting Note.
ACTION: Jenny Erwin to lead

4.5 It was also agreed that the RAG rating should be escalated to RED to reflect the importance of the action / the delay in being taken forward *(actioned).*

Post Meeting Note: To better understand referrals into the Tier 3 CAMHS Service delivered by Sussex Partnership NHS Trust West Hampshire CCG has, in collaboration with the Trust and the Hampshire Partnership of CCGs, begun canvassing for the views and opinions of those referring into the service. A survey has already been circulated to Schools, Colleges and some GPs, and the circulation will be widened to all WHCCG GPs via this week's edition of 'In Practice'.

After the online survey closes on 8 November, commissioing managers and quality leads will review the information (thematic anaylsis etc.), and insights used to improve the referral pathways across the system and the various sources of emotional support available to children, young people and their families (i.e. Tier 1, 2 &3) .

4.6 **CLIN19//028 CAMHS: Escalation to STP**. It was reported that there was no further update to that already provided within the action tracker. A Sustainability & Transformation Partnership (STP) meeting had taken place towards the end of August regarding the work that is ongoing about how to commission strategically. It was agreed that this should be wrapped up into one action with that of CLIN19/005, with Mike Fulford, Managing Director to be included in the discussion, for a Post Meeting Note to be provided, and this action then closed.

4.7 **CLIN19/032 UHSFT Early Warning.** Matthew Richardson reported that this matter had been discussed with James House, Deputy Director of Commissioning: Acute Transformation (South West). He highlighted that the CCG already has monitoring processes in place with regard to UHSFT with discussions around both financial and quality elements, in particular Emergency Department (ED) performance, liaising with

colleagues from Southampton City CCG. It has been agreed that a review of ED will be undertaken, similar to that of last year.

4.8 It was queried at what point does 'Business As Usual' need to be escalated / reflected as an action in the tracker. Matthew's view was that there needs to be further consideration of whether a broader review of the trust is required; the CCG monitors a number of performance and quality metrics, the trust is financially challenged, as are our other providers, so the question is what further monitoring is required over and above normal arrangements.

4.9 Action **CLIN19/034 Soft Intelligence from GPs** is a related issue in that what can we do to improve this i.e. how do our processes ensure that the CCG is aware of issues such as long waits as they arise rather than when an incident occurs or complaints received, only to find that GPs had been aware of problems for some time. It is also about ensuring that patients continue to be monitored whilst on waiting lists.

4.10 Jenny Erwin commented that this could potentially be linked to the existing 10 day reporting processes which includes clear data regarding metrics such as long stays. The next step was to look at speciality based deep dives such as Referral To Treatment (RTT) performance against backlog so there could be an opportunity to add a qualitative process into this, for example what is the qualitative impact of someone waiting a long time. With the new 26 week wait metric requirements from NHS England it will be possible to know how many people are waiting in each speciality.

4.11 Matthew also reported that there are a couple of work streams in train to consider how to widen feedback so that not only does it come from GPs but from commissioners, patients, care homes and acute trusts in order to get a rounded view and so that the onus is not put on GPs.

4.12 Simon Garlick suggested that perhaps a Board discussion is needed. He advised that Mark Kelsey, Clinical Chair, Southampton City CCG had already had the trust in to talk about ED performance and unfortunately representatives from West Hampshire CCG had not been invited. There therefore needs to be a more strategic, system discussion around concerns and then go back to the trust. It was agreed that this matter should be referred to the Executive team to consider taking to Maggie MacIsaac, Chief Executive for a broader discussion with the Board.
ACTION: Ellen McNicholas

4.13 **CLIN19/035 Caesarean Section Rates**. It was reported that data has been requested. One of the asks from the Committee was around benchmarking, not just with comparable trusts in the UK but some of the international benchmarking which has taken longer than initially expected to get the information. This is now being worked on, for which Joanna Clifford has been assisting the Children's Commissioning team.

4.14 Joanna reported that a meeting with collaborative commissioning needed to be rearranged with leads. The intended outcome is to provide a benchmarking report for maternity providers and outcomes for mothers undergoing a C. Section. She clarified that it is data on outcomes for these mothers which is not currently collated, such as breast feeding rates, i.e. an audit against standards that are already required. Action ongoing.

4.15 **CLIN19/037 Cancer Performance.** The Committee were reminded that this action related to two way communication links between CCGs and GPs. Stuart Ward had volunteered to provide some evidence in support of this, however he is currently off sick. Action ongoing.

4.16 The Committee supported the rationale for closing the following actions:

- **CLIN19/016 Balanced Scorecard**: report provided, paper CLIN19/103.
- **CLIN19/022 Primary Care Quality Framework**: update provided appended to tracker.
- **CLIN19/029 CAMHS Risk ID 448**: risk updated as requested.
- **CLIN19/030 LeDeR Risks ID 519 and 520**: risks updated as requested.
- **CLIN19/031 HHFT ED Performance Risk ID 481**: risk updated as requested.
- **CLIN19/033 Primary Care: BMA Recommendations for Payment Risk ID 480: r**isk updated as requested
- **CLIN19/038 Patient Experience Report: Orthopaedic Choice**: confirmed that a full action plan is held by the senior commissioning manager for South West Directorate.

4.17 **AGREED:**

The West Hampshire CCG Clinical Governance Committee:

- **Accepted the updates on the action tracker**
- **Supported closure of the actions detailed above.**

5. THE NHS PATIENT SAFETY STRATEGY (Paper CLIN19/095)

5.1 Matthew Richardson gave a presentation on the NHS Patient Safety Strategy which was launched in July 2019 by Aiden Fowler, the NHS National Director of Patient Safety. The document brings together many of the current developments in patient safety, including the work of the National Patient Safety Collaboratives into one document. This is not a prescriptive strategy but rather a statement of intent around the vision **to continuously improve patient safety.**

5.2 The strategy aims to build:

- A culture of patient safety.
- A system of patient safety.

based on the foundations of:

- Insight (improving the understanding of safety by drawing insight from multiple sources of patient safety information).
- Involvement (equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system).
- Improvement (design and support programmes that deliver effective and sustainable change in the most important areas).

5.3 The following points were highlighted / raised:

- There had been discussion as to whether to include workforce, however the strategy is not trying to duplicate other work which is ongoing and so we will not see mandated workforce standards. It also does not reflect to how NHS England / Improvement (NHSE/I) will work in the new system to facilitate patient safety.
- The document is a framework as to what is expected in an organisation / system that has patient safety at its heart. 'Civility and Kindness' is a key element i.e. the link between being rude and poor patient safety outcomes, such as impact on diagnostic and performance rates. The way that organisations treat staff, staff treat each other and how staff treat patients directly correlates with patient safety.
- There remains a blame culture across the NHS. Actions following incidents such as individuals being required to spend time in reflection / education is a covert way of blaming an individual. This links with 'Civility and Kindness' and 'Psychological Safety'.

Charles Besley arrived.

- Another key element is Insight e.g. cannot currently see details / learning from Serious Incidents (SIs) which occur in other organisations and consequently there is no national learning in a timely fashion.
- The Patient Safety Incident Management System (PSIMS) is a new system which is based on a mobile App which will allow information to be input directly and information to be shared nationally and in more real time. This will also enable more intelligence from primary care; West Hampshire CCG is ahead of the curve in that we have rolled out Datix to GP practices and there is a good reporting culture. It was recognised that independent providers / care homes are not currently included in the system.
- The Patient Safety Incident Response Framework (PSIRF) will have more patient involvement and be less focussed on blame, moving away from if an incident is avoidable or unavoidable. There will be fewer investigations, however reviews will be in more depth.
- Oversight will shift away from CCGs and move to provider boards, so there is more about how organisations work together; there may be a need to think about having a central pool of investigators that can be used across the system.
- There will be more involvement of patient safety partners, empowering patients to speak up and take ownership of their care and challenge. Groups of trained patients will be established who can be tapped into from both trusts and CCGs and will work at various levels, such as sitting on committees or being involved in pathway design.
- A person specification and skill set is being developed for Patient Safety Specialists and every organisation will be required to have one of these individuals; this is not a new role but will probably be developed from existing people. They will not be accountable for their organisation but will be responsible for pushing forward some of the strategy.

- There are four areas of improvement which have been identified: Preventing deterioration and sepsis; Medicines safety; Maternal and neonatal safety, and Adoption and spread of tested interventions. In addition to this are Mental Health and Learning Disabilities. This will be supported by patient safety collaboratives, with the CCG already heavily involved in a number.
- In terms of implications for primary care, the centrality of Primary Care Networks (PCNs) around patient safety has been recognised. It is envisaged that Primary Care Clinical Directors will be trained and given the skill set to deliver the Patient Safety Strategy; consideration needs to be given to how to support individuals to meet this requirement.
- In terms of the approach, the CCG has already got a number of improvement work streams in place and a great deal is already embedded in the system, although there will be some additional resource and training requirements.
- Ellen McNicholas thanked Matthew for his summary presentation, advising that Matthew had been present at the Patient Safety Congress where the strategy had been launched. She added that he had been in attendance as he had been presenting on work around sepsis and deterioration with the patient safety collaborative; Matthew has been fundamental to some of this work which is why he had been asked to present nationally.
- In terms of the Medical Examiner role, actions are in train with local providers with regard to setting up this role. There will be seven regional Medical Examiners, then local Medical Examiners and then Medical Officers. Medical Examiners need to be medics and the Officers can be anyone on a professional register. All deaths within acute trusts will be reviewed by the Medical Examiner to ensure that death certificates are completed properly, investigated and any issues identified, and ensuring that coroners are informed. Hampshire Hospitals NHS Foundation Trust (HHFT) and UHSFT are already piloting / going down this route. Professionals all appreciate help in writing death certificates and the learning that has come through. The role in the community will need to be considered during 2020 as to how this will be structured. It is a 24/7 role and will probably require 2 to 3 PA for a consultant. This feeds into some of the issues around lone practitioner working and how we can identify themes.
- Clarification was sought as to the Medical Examiner process for deaths within mental health services; it is likely that this will be in the second phase along with community, however Matthew will look into this.
  ACTION: Matthew Richardson
- It was agreed that a presentation on the Strategy should be provided to Clinical Cabinet to ensure that GP colleagues are sighted, with a focus / link as to how it is envisaged that PCNs will deliver this / where all the work is going to end up. Matthew pointed out that this is a high level strategy with not much detail around PCNs although there is more on primary care. The challenge will be how to set the right culture within PCNs i.e. our local culture and systems. The update should include a focus on the Medical Examiner role which will be much more difficult to deliver in the community. It was also agreed that it would be helpful for the Board to receive an update *(logged, see item 18)*.
- Caroline Ward commented that she was struck by the psychological and cultural elements of implementing change. What was missing was the

responsibility of patients, carers and families themselves to be kind, courteous and respectful, notwithstanding that they could be in pain / worried etc, as without this the rest might be a little harder to do.

- Jenny Erwin commented that 'Culture' and 'Psychological Safety' are key i.e. if people do not feel they can take risks together without someone being ultimately responsible, transformation will not happen. We need to be able to call this out i.e. rudeness is not OK – I do not feel safe. This could be considered by the Learning & Growth Group as to how to support this i.e. what do our teams need to help them feel more equipped. Communications should also go out to Primary Care to inform practices about what is going on and the direction of travel.

5.4 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the NHS Patient Safety Strategy.

Rory Honney left the meeting.

6. HAMPSHIRE CCGS SAFEGUARDING GOVERNANCE COMMITTEE: TERMS OF REFERENCE (Paper CLIN19/096)

6.1 Matthew Richardson introduced paper CLIN19/096 and explained that this paper contains the Terms of Reference (ToR) for the Hampshire Safeguarding Governance Committee, which is established with the purpose of:

- Strengthening current governance arrangements by providing a dedicated focus on safeguarding adults, safeguarding children and looked after children, including system risks as an important aspect of the quality agenda.
- CCG's are statutorily responsible for safeguarding adults and children and the committee will support the CCGs in meeting their statutory obligations.
- Ensuring that assurance mechanisms are in place within the CCGs, relevant work programmes and within commissioned services.
- Providing optimum opportunity for sharing learning and ensuring that learning is shared and embedded appropriately.
- Providing a conduit for strategic developments requiring or impacting the safeguarding agenda.
- Providing for a consistent and aligned approach within the CCGs.

6.2 The Safeguarding Governance meeting has been running for one year and this constitutes the annual review of the ToR by the Clinical Governance Committee; it was confirmed that there has been no change since the last review.

6.3 It was suggested that consideration should be given to how the ToR may need to be amended in light of moving to an Integrated Care System and to reflect working more closely together with Southampton City CCG, who are currently not included in this meeting. This will be considered moving forward, however it was clarified that there is a pan-Hampshire Safeguarding Partnership which Southampton and Portsmouth CCGs are part of.

6.4 **AGREED:**

The West Hampshire CCG Clinical Governance Committee approved the Terms of Reference for the Hampshire Safeguarding Governance Committee as a sub-group of the Committee

7. SAFEGUARDING ADULT AND CHILDREN'S POLICY: A FAMILY APPROACH (SAFEGUARDING POLICY FOR THE 5 HAMPSHIRE CCGS) (Paper CLIN19/097)

7.1 Matthew Richardson presented the Safeguarding Adult and Children's Policy: A Family Approach CLIN/011/V1.00 and explained that West Hampshire CCG hosts safeguarding children services on behalf of the five Hampshire CCGs and hosts safeguarding adult services for three of the Hampshire CCGs (North Hampshire CCG, North East Hampshire and Farnham CCG and West Hampshire CCG). South Eastern Hampshire CCG manages the adult safeguarding services for South Eastern Hampshire and Fareham and Gosport CCGs.

7.2 Although West Hampshire CCG hosts the safeguarding service on behalf of these CCGs, the other four Hampshire CCGs retain the statutory responsibilities for their population in regards to safeguarding adults and children at risk (to include children and young people who are in the care of the local authority).

7.3 A refresh of the two existing safeguarding policies was needed and as it was felt that the CCG should role model the Think Family approach, these policies should be brought together into one. The following policies are therefore now obsolete:

- Safeguarding Adults Policy CLIN/009/V4.04
- Safeguarding Children Policy CLIN/008/V4.06

7.4 This new policy pulls together the statutory guidance for safeguarding adults and children, incorporating principles from local safeguarding boards' guidance on the family approach and the strength based approach. These principles have been developed by the safeguarding partners in the Hampshire area and are reflected in the 'Joint Strategic Needs Assessment'.

7.5 The policy was reviewed at the Hampshire CCG Safeguarding Governance Committee of 22 August 2019 where minor amendments were requested and it was agreed that Ellen McNicholas would take Chair's action to approve the final version, the final policy was agreed on 2 September 2019.

7.6 Reference was made to earlier discussions about the need to ensure that Southampton City CCG are considered in such arrangements, and it was queried if the policy covers areas identified through past investigations etc, i.e. where there have been issues with safeguarding in the past. Matthew confirmed this, advising that there is more within the policy with regard to the Mental Capacity Act and addresses the fundamental issue within previous guidance where children have been treated separately to adults, such as adult safeguarding concerns when children are in the house and vice versa.

7.7 **AGREED:**

The West Hampshire CCG Clinical Governance Committee:

- **Approved the Safeguarding Adult and Children's Policy: A Family Approach CLIN/011/V1.00 for ratification by the CCG Board.**
- **Noted the following policies are now obsolete:**
    - **Safeguarding Adults Policy CLIN/009/V4.04**
    - **Safeguarding Children Policy CLIN/008.V4.06**

SECTION 2: KEY RISKS

8. RISKS REGARDING QUALITY ON THE CORPORATE AND QUALITY RISK REGISTERS (Paper CLIN19/098)

8.1 Matthew Richardson reported that currently there are nine risks from quality and safeguarding that meet the Corporate Risk Register threshold assessed as scoring 12 or above and 28 risks on the Local Quality Team Risk Register. All risks have been reviewed. Only risks rated above ≥6 (moderate risk) were presented to the Committee. The following risks were highlighted.

8.2 **NEW Risk ID 658: Quality Impact of UHSFT Emergency Department performance**
If University Hospitals NHS Foundation Trust (UHSFT) do not meet the Emergency Department performance waiting times, then there may be an increased risk of impact on quality for patient outcomes, safety and experience. An ED review will be repeated as undertaken last year as performance is still not where we would want it to be.

8.3 **NEW Risk ID 649: Mental Capacity Act (MCA)**
If the resource within the CCG is insufficient to embed the Mental Capacity Act as core business then there is a risk that there will not be full compliance with the statutory duty and people's human rights will not be upheld. This reflects the work that needs to be done in relation to MCA champions and bringing in some of the children's safeguarding team when traditionally this has been within the remit of adult safeguarding. It is also around making it everyone's duty, rather than just safeguarding.

8.4 It was reported that since writing the paper a new risk had come to light. A letter has been received from NHS England regarding GP safeguarding reports for case conferences. The letter is essentially asking CCGs to pay for both attendance and for GP reports to child safeguarding conferences, which has both logistical and cost pressures to the CCG and if enforced on the deadline of 1 November 2019 could potentially impact on timely provision of reports coming from GPs.

8.5 Work is ongoing at STP level to clarify what is covered under the statutory duty to share information to protect children, and what is additional to the General Medical Services (GMS) contract i.e. what is chargeable, which could be a significant financial risk depending on the scope of what is covered.

8.6 It was reflected that there had been discussion at both the Finance & Performance Committee and the Primary Care Commissioning Committee meetings of 29 August 2019 that there is a risk regarding workforce in Southern Health NHS Foundation Trust (SHFT) community teams where issues continue; given the Long Term Plan to move from secondary to community care, it was queried if this should be reflected on the risk register. This is about all community workforce and not just to SHFT and is as big a risk to the NHS as anything else. In response it was pointed out that this is also about ensuring that there is evidence to support what the actual risk is. Members were reminded of a conversation which took place at the Finance & Performance Committee about a large piece of work being undertaken specifically around SHFT because whilst some of the concerns raised may be valid, they had been raised without necessarily having the data behind it. A period of four weeks has been allowed to draw the data together to triangulate and ensure the level of risk is identified before taking this any further. There are generic workforce risks which are reflected on the risk register, although it was noted that this does not mention SHFT. It was agreed to wait until the work being undertaken by both commissioning teams and the quality team is completed.

8.7 Lay members present expressed concern with regard to the format of the Risk Registers (for all Committees) which are hard to read and it was queried if the format could be amended so that key points for the Committee to be aware of are highlighted or perhaps some of the risks consolidated to make it easier to digest. It was pointed out that there needs to be a balance between capacity in the team and the amount of additional time needed to do this, alongside changing requests between committees wanting more or less detail. It was suggested that assurance should come from leaders and it is their responsibility to articulate the key risks. It was noted that this will be discussed further at the Audit Committee

8.8 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the quality risks on the corporate and quality risk registers.

SECTION 3: ASSURANCE

9. DIRECTORATE QUALITY REPORTS (Paper CLIN19/099)

9.1 The Committee received directorate quality reports, which were supported by a cover sheet in an SBARD format (Situation, Background, Assessment, Recommendation, Decision) with the issues selected either because they had the greatest consequence or impact on patient safety, experience or clinical effectiveness, or because the controls put in are not considered to fully mitigate the risk. Updates on the key current and previous risks or issues for the Committee to be aware of were included within the directorate reports provided.

Key issues highlighted to the Committee were as follows:

Millbrook Hampshire Wheelchair Service (MHWS) – Mid-Hampshire Directorate

9.2 The service currently has three senior occupational therapy vacancies (Bands 6 and 7) and a senior rehabilitation engineer vacancy. The existing clinical governance manager who has been on long-term sick has also resigned from the post; this position also covers the designated safeguarding officer role. The member of MHWS

staff who was being trained to bridge the paediatric skills gap has resigned meaning the skills gap will widen.

9.3 Due to the existing demand pressures on the service, there is a risk vacancies within the service may increase, with recruitment into wheelchair services being challenged nationally. The latest exit interview identified the lack of autonomy over caseload (due to long waiter prioritisation over specialty) as a key contributory factor to the individual's departure.

9.4 MHWS continues to struggle to recruit locally (as such, the risk has increased to high risk). The provider is undertaking a number of actions to try and mitigate the risk, this includes:

- Having a peripatetic occupational therapist (Band 7) in place who will be supporting the team commencing in September.
- Having the support of two locum occupational therapists who have been in post on a long term basis and therefore are established with local processes; however, one of the locum staff will not be available to work for three weeks during September due to other commitments.

9.5 The CCG is working with MHWS to explore maximising community provider support through expansion of the community assessment prescriber project, and also sub-contract arrangements to increase handover clinic opportunities.

University Hospitals Southampton NHS Foundation Trust (UHSFT) Ophthalmology – South West Directorate

9.6 The Committee has previously been updated regarding the substantial backlog of Ophthalmology appointments. There remains a patient safety risk with regards to the patients currently waiting for ophthalmology appointments that have passed the recommended clinical wait time for an appointment.

9.7 There remains a recognised patient safety risk with regards to the patients currently waiting for ophthalmology appointments that have passed the recommended clinical wait time for an appointment. The current position is as follows:

- **Glaucoma Cohort:** The total backlog in February 2019 was reported as 3561 in June 2019 this is now reported to have reduced to 3121.
- **Diabetic Cohort:** Although this cohort has been the most promising, the patient numbers have gradually increased over the past four months, with a total backlog of 272 in June 2019, 158 patients above predicted.
- **West Hampshire Commissioned Community Glaucoma Pathway:** development of this two phase model continues. Phase One**:** Glaucoma Referral Refinement to commence 1 July 2019 with the Ocular Hypertension and suspect Chronic Open Angled Glaucoma monitoring service due to commence 1 September 2019 (subject to recruitment). Phase Two**:** developing glaucoma diagnostics and management pathway and cataract pathway, service due to commence January 2020.
- **Minor Eye Conditions Service:** Has now commenced which allows patients to attend their locally registered Optical practice for minor acute eye disorders which ordinarily would require a visit to Eye Casualty. There have been

difficulties in implementation of this service, with learning identified around training. Several patients have been directed back e.g. some have been given prescriptions that local pharmacies do not know what to do with. These medication issues are being addressed, with UHSFT and commissioners working together on how to get messages out.

- **Additional actions to reduce backlog:** These include continued additional clinics and locum shifts for Glaucoma patients and improved administration processes to improve validation of patients and cross referencing with diabetic retinal screening with continual focus to increase clinical capacity for Diabetic patients. Continued investment and expansion to Lymington Hospital.
- **Potential solutions to reduce backlog being considered:** These include insourcing support to focus on high risk patient care, further outsourcing for Glaucoma screening for low and medium risk patients and review of repatriation of Fareham and Gosport patients back to Portsmouth care.
- **Super Saturday model and Virtual pathway:** These continue with moderate affect.
- **Ophthalmology Overarching Action plan:** Reviewed by commissioners regularly.

Southern Health NHS Foundation Trust (SHFT) Integrated Community Services Workforce – South West Directorate

9.8 Attention was drawn to the workforce data provided within the report in relation to SHFTs Integrated Community Service teams, which was clarified as being accurate data as of June 2019. As noted in paragraph 8.6, an exercise is underway collating workforce data and triangulating with other information, including SHFT's narrative around this, how this is being addressed and identifying what the residual risks are. This also includes how the trust is managing the current workload, what the plans are to reduce the number of vacancies and match against what has been contracted.

9.9 It was highlighted that one of the things that does not show up in data is that sometimes there is a sudden increase in the number of vacancies as SHFT have identified that additional resource is needed and so have increased the headcount but not yet recruited into vacancies. It was clarified that the RED High Risk rating relates to SHFT's risk; the risk for the CCG has not yet been fully assessed as this is part of the work that is being undertaken.

9.10 The Committee was informed that twice a year a SHFT CQRM agenda is devoted to workforce, with the next meeting scheduled for 25 September. The trust's HR director and his team provide an update on delivery of the trust's workforce strategy and discuss workforce issues. An open invitation was given for Committee members to attend, for which Jackie Zabiela would forward the meeting invitation *(actioned).*

Sussex Partnership NHS FT (SPFT) Children's and Adolescent Mental Health Services (CAMHs) – Strategy & Partnership Directorate

9.11 Waiting times for WHCCG patients have not been meeting national waiting time standards since the start of 2018. The contract notice period is 12 months and the service is just starting the fourth year of an initial five year contract period.

9.12 All teams continue to face significant challenges with meeting the waiting time targets. There are four teams which require further investigation in terms of increasing their initial assessments, Eastleigh, New Forest, Winchester, Fareham & Gosport. All teams are investigating the possibility of increasing their initial assessments which will have an impact on the treatment allocations but as a short term measure will also provide some signposting and immediate treatment options for some who may then be discharged.

9.13 There are now ten GP practices interested in holding CAMHS assessment clinics in their surgeries in the Winchester area. As of July 2019, there are 225 children and young people registered with the ten interested practices (of these, 117 are GP referrals).

9.14 Continued pressures and demand within the Single Point of Access (SPA) sites remain. However, June 2019 has seen signposting to other services increase to its highest level for the last six months at 47%; this could be because they are using more of their own teams in the SPAs. It was queried if this is a marker of quality / means good care; this is down to the criteria that CAMHS accept referrals in. This is not just about the detail within the referral; the SPA team will contact the referrer to obtain more information if there is not enough on the form; it could be that with this additional data the referral does not actually meet the criteria. However, there are also other individuals present within the SPA who are not part of CAMHS but who could take children directly such as MIND or Barnados, who will then review jointly.

9.15 It was queried what this actually means on the ground. A recent case was provided where a referral was made to CAMHS detailing all the resources that the mother had accessed, however she still received a standard letter directing her to all the resources which she had already been to. This had not been helpful as despite all this input the child still had issues, hence the GP referral. It was suggested that a review is undertaken on outcomes of signposting, for example how many come back into the service, is it therefore appropriate signposting (if a significant number of families come back into the system), with perhaps a questionnaire to be developed to take forward a quality piece of work to obtain feedback from parents as to how it feels to receive such letters.
ACTION: Carole Berryman

9.16 Carole Berryman reported that she had recently taken part in a peer review of the New Forest team and had spoken to parents. It was consistently reported that parents were really pleased with the quality of care once their child starts receiving support, however they were really frustrated about the waiting time. They did feel that they were very supported by the team once the referral was accepted, with information about signposting being used whilst waiting to be seen. One parent did say that they had to escalate concerns about their child and relayed that the process as described by Carole in previous meetings was followed i.e. they were provided with a contact number, spoke to a duty clinician who assessed that their child needed to be seen urgently, sent out the emergency response team within 24 hours and then continued with a short period of intensive care. It was pointed out however that this does not demonstrate whether this could have been prevented in the first place.

9.17 Reference was made to earlier conversations about how the CCG gather's soft intelligence. We therefore need to determine what it is that we feel we do not know

and then ask the lead commissioners how this information / assurance can be provided.

9.18 It was acknowledged that once in receipt of services the support is good and if a child is in an emergency situation there is a good reaction, but it is about what happens whilst a child is waiting and the preventative work that is undertaken; it was noted that CAMHS do already undertake preventative work such as running events and input into schools.

9.19 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the Directorate Quality Reports.

SECTION 4: IMPROVEMENT

10. QUARTERLY QUALITY COMPARISONS REPORT (Paper CLIN19/100)

10.1 The Committee received the fourteenth Quarterly Quality Comparisons Report produced for its providers and which provides both local and national comparison. The report utilises readily available quality performance metrics. The report does not contain analysis of the data as the intention is for providers to individually review the information and their performance. This may be facilitated during CQRMs or via another appropriate route.

10.2 Key areas which have been / are being followed-up with providers include:

- **Fractured Neck of Femur (# NOF):** Hampshire Hospitals NHS Foundation Trusts (HHFT) quarter one 2019/20 #NOF best practice tariff (BPT) data for West Hampshire CCG patients shows a 21.5% point improvement in comparison with quarter four 2018/19. As previously reported HHFT have an action plan in place in response to the National Hip Fracture Database (NHFD) 2018 and the next report will include comparison of BPT for all providers.
- **Staff Friends and Family Test (FFT) data:** HHFT staff FFT data for care has shown approximately a 2% decrease quarter on quarter since quarter one 2018/19. If this continues into quarter two 2019/20 this will be classed as a trend. Similarly, the HHFT staff data for recommending the trust as a place to work remains low (the lowest of all our acute providers) with quarter one data being the lowest (60%) in four years. HHFT are in phase 2 of their culture change programme (results of which will be presented at a future CQRM in 2020) and Culture Change Champions are in place. HHFT has a recruitment and retention plan (currently draft) which focuses on enhancing the organisations reputation as an employer of choice, developing career pathways and engaging and involving staff. It is hoped that the interventions in place together with those planned will have a positive impact on the staff FFT data.
- **Mixed Sex Accommodation (MSA):** Salisbury NHS Foundation Trust (SFT) continues to be a higher reporter of MSA breaches. The majority of these are as a result of front door demand. CCG commissioning managers are working with the trust to improve flow throughout the hospital which should have an

impact on the number of breaches. NHS Improvement (NHSI) was satisfied with the transparency of SFT reporting and the actions they had put in place to protect patient privacy and dignity. Further national guidance is awaited.

- **12 Hour Trolley Breaches:** According to data, the Royal Bournemouth and Christchurch Hospital (RBCHFT) and SFT are both positive outliers in respect of 12 hour trolley breaches and have been for the last two years. In our other providers the majority of the breaches involve patients with a mental health need. The Quality Manager is liaising with RBCHFT and SFT to see if there is any learning from this that could be shared across the system.
- **Pressure Ulcer Serious Incidents:** According to data RBCHFT and SFT are both positive outliers in respect of reporting pressure ulcers as serious incidents having not reported any during 2018/19. The Quality Manager is liaising with RBCHFT and SFT to see if there is any learning from this that could be shared across the system. It was confirmed that this will also include checking that there were actually no incidents which should have been reported.
- **National Data – FFT Outpatient Data:** Whilst Croydon Health Services NHS Trust has a low FFT response rate for inpatients (in comparison to HHFT – medium acute trust) it considerably exceeds all the other medium acute trusts included in our report for outpatient responses. The quality team will be liaising with Croydon CCG to see if there is any learning with regards to gaining feedback from outpatients which can be shared with our providers.

10.3 The Committee agreed that it was useful to see this comparison data.

10.4 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the Quarterly Quality Comparisons Report.

11. LEARNING FROM SERVICE USERS PROGRAMME (Paper CLIN19/101)

11.1 Ellen McNicholas presented paper CLIN19/101 and explained the paper reviews the current status of the Learning from Service Users Programme, which arose from the CCGs response to the Mazar's report. The need for change was explained with options for future working as follows:

1. Add this programme to the role of the new engagement manager post who will link with the Patient Experience and Complaints Team.
2. Rely on existing sources of evidence (complaints, existing surveys and CQRM reports)
3. A service development manager in the South West and Mid-Hampshire commissioning directorates takes on this role.
4. Commission Healthwatch Hampshire to complete the survey element of the work (potentially commission jointly with the Hampshire CCG Partnership).

11.2 Ellen reported that the CCG had recently undertaken a consultation around the restructure of the Communications & Engagement Team; one of the new roles will be an engagement manager who will link closely with the Patient Experience & Complaints Team and it was therefore her recommendation for Option 1 in order to

continue to gather, monitor and act on intelligence so that we do not lose the information; she confirmed that there is capacity for this.

11.3 **AGREED:**

The West Hampshire CCG Clinical Governance Committee approved Option 1: to add the Learning from Service Users Programme to the role of the new engagement manager post linking with the Patient Experience and Complaints team.

SECTION 5: ITEMS FOR INFORMATION

12. HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP QUALITY FRAMEWORK (Paper CLIN19/102)

12.1 The Hampshire and Isle of Wight (HIOW) Quality Board is a formal board of the Sustainability and Transformation Partnership (STP) made up of all CCG, health providers, local authorities and regional organisations (such as Health Education England, Academic Health Science Network) in the Hampshire area. The Board was established with a strategic quality oversight and improvement remit (not assurance) with the task of ensuring consistency in the approach to quality across the Integrated / Local Care Partnerships.

12.2 The Quality Framework has been developed to ensure a shared approach to quality governance and improvement within Integrated Care Partnerships (ICPs). The Framework goals are to deliver:

- A streamlined approach to quality, which avoids duplication and aligns resources (aligns with the CCG's efforts to streamline the Serious Incident process and CQRMs).
- A clear, unified definition of quality governance across HIOW, promoting a reduction in unwarranted variation (supporting the CCG's objectives for population health improvement).
- Better use of standardised data sets to triangulate and benchmark quality intelligence and information (supporting providers that cover more than one ICP and allowing learning to be shared across systems).
- New provider / commissioner alliances which support the safe delivery of reconfigured services (supporting the integrated governance toolkit).
- Adoption of an evidence based approach to defining, measuring, analysing and use of established methodology for quality improvement (aligns with the NHS Patient Safety Strategy on measurement).

12.3 The Committee was reminded that it had already given substantial feedback on the initial draft (2 May 2019), as had other organisations. This is a framework and is a step in the direction of having a unified approach across HIOW

12.4 It was noted that the voluntary sector is not mentioned and is important in ensuring things happen; Ellen will ensure that this is fed back. It was clarified that mental health is implicit in everything.

12.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the HIOW Quality Framework.

13. BALANCED SCORECARD (Paper CLIN19/103)

13.1 The Committee received a paper which provided an update on the Balanced Scorecard which had been developed to illustrate delivery against West Hampshire CCG strategic priorities, including improving the health of our population. The scorecard is comprised of relevant measures which relate to our mission, 'Quality Services, Better Health' and four strategic areas:

- Financial Sustainability
- Organisation and Governance
- Collaboration and Development of Systems
- Enabling Strategies

13.2 The scorecard was presented to the CCG Board on 25 July 2019 and will continue to be provided every six months. The Board welcomed the development of the scorecard which provides visibility around outcomes, maps to the Operating Plan and Integrated Care Model and provides a focus for Local Treatment Centres, Mental Health, Autism and Children's Services.

13.3 Since the Board meeting work has been carried out with Public Health colleagues to strengthen some measures which will be shown in the next iteration of the report in January 2020. Other measures will be added as they are developed.

13.4 It was commented that the scorecard was useful, however its purpose was not clear in terms of the 'golden thread' regarding what is the priority for development i.e. the most important thing the CCG wants to do this year and how is progress being made. It was recognised that a lot of work had gone into its development, however this will be further discussed by the Audit Committee on 10 September 2019.

13.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the WHCCG Balanced Scorecard

14. MEDICINES OPTIMISATION TEAM ANNUAL REPORT 2018/19 (Paper CLIN19/104)

14.1 Neil Hardy introduced the Medicines Optimisation Team Annual Report for 2018/19 which provided an update on the activity of the team and that had already been provided to both the Primary Care Steering Group and Primary Care Commissioning Committee.

14.2 Neil drew attention to the section on poly pharmacy de-prescribing, advising that PRIMIS PINCER3 is a national tool that identifies patients on problematic medicines combinations which facilitates conversations with patients at the start of treatment to

inform them that they might not be on medications life long as their conditions might change. West Hampshire CCG is in a good position when compared with other CCGs in the country with regard to the numbers of patients on lots of medications and is an area of good practice. This also fits in with the new contract and with community pharmacists within Primary Care Networks.

14.3 Attention was drawn to the table in Section 2 of the report which showed the change in prescribing spend and prescription items for 2017/18 and 2018/19 when compared against the rate of England and it was commented that it looked as though there should be approximately £1m of spend that we could be saving. It was clarified that most of this is about the use of anticoagulants for Atrial Fibrillation; in terms of savings the medicines optimisation team has delivered its QIPP (Quality, Innovation, Productivity and Prevention) plan. It is anticipated that as the CCG is ahead of the curve this will flatten off.

14.4 It was noted that at the Primary Care Commissioning Committee which took place on 29 August, there had been a clear statement that the availability of flu vaccinations would not be affected by Brexit, however the following day it had been reported in the media that it is. Neil responded that delays in availability are not Brexit related; every year there are stories regarding potential delays in flu vaccinations. A process has been put in place to ensure that medicines will continue to be supplied across borders; the delay is in relation to taking a bit longer to grow the vaccine.

14.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the Medicines Optimisation Team Annual Report 2018/19

15. SAFEGUARDING ADULT, CHILDREN AND LOOKED AFTER CHILDREN ANNUAL REPORT 2018/19 (Paper CLIN19/105)

15.1 The Committee received the Safeguarding Adult, Children and Looked After Children Teams Annual Report for 2018/19. The annual report brings together the activity undertaken by the teams and celebrates the achievements over the past year; it also highlights the assurance that the Safeguarding Teams offer the CCGs in delivering a high level of safeguarding oversight across Hampshire's health economy. It demonstrates how the teams work in collaboration with multi-agency partners and the Hampshire Safeguarding Children and Adult Boards to continually identify areas for improvement and seek to improve outcomes for adults and children. Finally, the report focusses on the safeguarding teams' priorities for the forthcoming year.

15.2 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the Safeguarding Adult, Children and Looked After Children Annual Report 2018/19.

16. MINUTES FOR INFORMATION (Paper CLIN19/106)

16.1 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the minutes from the Clinical Cabinet of 13 June 2019.

SECTION 6: ESCALATION & CLOSE OF MEETING

17. RISKS / ISSUES

17.1 The following potential risk has been identified:

- Southern Health NHS Foundation Trust: work underway to determine the level of risk around workforce and impact on community services.

18. BOARD

18.1 The Clinical Governance Committee agreed that the following topics should be highlighted to the Board of 26 September 2019:

- NHS Patient Safety Strategy.
- Comparisons Report: to highlight as it sets out context for how the CCG's providers are performing against national measures.
- To mention that there has been an increase in signposting with regard to the CAMHS service and that further investigation is required from a quality perspective.

19. ANY OTHER BUSINESS

19.1 No items of Any Other Business were raised.

20. DATES OF FUTURE MEETINGS

20.1 The next meeting of the West Hampshire CCG Clinical Governance Committee will be held from 9.00m to 12.00pm on Thursday 7 November 2019 in the Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB.

Dates of future meetings:

9 January 2020 5 March 2020

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NHS
West Hampshire
Clinical Commissioning Group

Minutes

Clinical Cabinet Meeting

Minutes of the West Hampshire Clinical Commissioning Group Clinical Cabinet meeting held on Thursday 12 September 2019 at 09.30am in the Boardroom, Omega House

Present:	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes and Clinical Director, ICT **CHAIR**
	Liz Angier	Clinical Director, Primary Care and Community Services
	Charlie Besley	Clinical Locality Director, Totton and Waterside
	Sue Cochrane	Acting Consultant in Public Health
	Ian Corless	Board Secretary and Head of Business Services
	Jenny Erwin	Director of Commissioning, Mid-Hampshire
	Roland Fowler	Clinical Director Children and Families
	Mike Fulford	Managing Director and Chief Finance Officer
	Emma Harris	Clinical Director, Medicines Management
	James House	Deputy Director of Commissioning South West (deputising for Rachael King)
	Ellen McNicholas	Director of Quality and Safety (Board Nurse)
	Katrina Webster	Clinical Director, Mental Health
In Attendance:	Joanna Clifford	Senior Quality Manager: Mid Hampshire (Item 6.1)
	Sophie Douglas	ST3 Trainee GP
	Matthew Richardson	Deputy Director of Quality (Item 6.2)
	Terry Renshaw	Governance Manager
Apologies:	Helen Cruickshank	Consultant in Public Health Medicine
	Adrian Higgins	Medical Director
	Rory Honney	Locality Clinical Director, Andover
	Rachael King	Director of Commissioning, South West
	Johnny Lyon-Maris	Clinical Locality Director, West New Forest
	Lorne McEwan	Locality Clinical Director, Winchester
	Maggie McIsaac	Chief Executive
	Beverley Meeson	Deputy Director Service Development
	Sarah Schofield	Clinical Chairman
	Caroline Ward	Lay Member New Technologies and Digital
	Stuart Ward	Locality Clinical Director, Eastleigh North and Test Valley South

Summary of Actions:

Minute Reference:	Action	Who	By

4.1.3
 	
4.1.4
	Action Tracker:
	• **CC19/052 SHFT Clinical Strategy** –Terry Renshaw to contact Adrian Higgins to check if response has been received to 27 August 2019 letter to Karl Marlowe. If response is available copy to be shared with Cabinet.
	• **CC19/053 Digital Presentation:**
	  • Further clarification required around use of secure email addresses.
	  • Claire Parker to work with Comms Team to refresh previous messaging and review/extend who contact is made with.
	  • Review secure email addresses from/to private health providers and provide advice on what is/is not acceptable.
		TR/(AH)
		
		KG/CPr
		
		KG/CPr
		
		KG/CPr
			ASAP
			
			ASAP
			
			ASAP
			
			ASAP

6.4.2	**SW and NMH LDS Report : Choose Well Campaign** – To clarify process for linking with GPs and share with GPs what is in the plan.	**JH/(RK)**	ASAP
8.2	**DXS** - It was agreed that Karl Graham and Liz Angier will work with Claire Parker to provide a briefing on the new arrangements to the October meeting.	**KG/LA/CPr**	10.10.19

The meeting was taken out of sequence but for ease of reference the minutes are set out in accordance with the sequence of the agenda.

1.	**<u>WELCOME, APOLOGIES AND CONFIRMATION OF QUORACY</u>**
1.1	Karl Graham welcomed members present to the Clinical Cabinet meeting and apologies for absence were noted. It was confirmed that the meeting was not quorate and any decisions made will need to be ratified post meeting. (**Post meeting note**: Email sent 16 September 2019. Responses received. Decisions subsequently ratified)
2.	**<u>DECLARATIONS OF INTEREST</u> (Paper CC19/055)**
2.1	Karl Graham directed members to the Declarations of Interest Register.
2.2	Karl reminded Committee members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of NHS West Hampshire Clinical Commissioning Group.
2.3	No further specific interests were declared relating to items to be discussed at the meeting.

3.	**MINUTES OF LAST MEETING (Paper CC19/056)**
3.1	Clinical Cabinet reviewed the minutes of the last meeting, held on the 11 July 2019.
3.2	**AGREED:** **Clinical Cabinet:** • **Agreed the minutes of the Clinical Cabinet meeting held on the 11 July 2019 and commended them for signature by the Chair.**
3.3	**OUTCOME OF AUGUST VIRTUAL BUSINESS CASCADE (Paper CC19/057)**
3.4	Cabinet received paper CC19/057.
3.5	**AGREED:** **Clinical Cabinet:** • **Received and ratified the outcome of the August 2019 virtual business cascade.** • **Noted the points of clarification raised/comments/questions received and responses provided.**
4.	**ACTION TRACKER (Paper CC19/058)**
4.1	Karl Graham introduced paper CC19/058 and the items on the action tracker were reviewed. An update was provided on:
	1. **CC19/044 AOB Clinical Reference Group: Draft Clinical Reference Group proposal for Cabinet consideration –** It was reported that we have a platform now on Kahootz. Training will be organised from mid-September on administration of the platform. Craig Wartnaby will help with the admin and we are identifying another back up administrator. Once we have platform running we will invite members to join the Clinical Reference Group. Highlighted that in moving forward it is hoped that this will enable us to come alongside pathways at Southampton and will enable Public Health, community and hospital contribution to the review of pathways.
	2. **CC19/049 Mental Health IFR Report : Explore with Karen Gregory the potential to blend the two panels together** – It was reported that Adrian, Ellen and Beverley met on the 30 July 2019 and agreed a meeting is to be arranged with Chris Ashdown, Ellen, Adrian, Beverley, Ciara Rogers and Katrina Webster. The meeting was held on the 22 August and the following actions were agreed: • That the monthly meetings set up with the team will continue to support Chris Ashdown with triage. • That those cases that from these meetings are recommended for a panel review, as there may be some exceptionality, should go through to the IFR panel. They will then take and record the decision. It was agreed that this action is now compete and can be **Closed**.

	3. **CC19/052 SHFT Clinical Strategy : Draft Cabinet response to presentation** – It was reported that the letter was sent on the 27 August 2019 and a copy is attached at Appendix A of paper CC19/058. It was agreed that Terry Renshaw is to contact Adrian Higgins to check if a response has been received to the 27 August 2019 letter to Karl Marlowe. If response is available it was requested that a copy is shared with Cabinet. **ACTION: Terry Renshaw/(Adrian Higgins)**
	4. **CC19/053 Digital Presentation : Produce comms around nhs.net and alternative secure email channel in respect of HHFT (Office 365) and Care Homes sharing Personal Identifiable Data** – There was further discussion around the use of secure email addresses and what has been communicated to Practices. It was agreed: • Further clarification is required around the use of secure email addresses and Claire Parker is to be asked to work with the comms team to refresh previous messaging and review/extend who contact is made with. **ACTION: Karl Graham/Claire Parker** • To review secure email addresses from/to private health providers and provide advice on what is/is not acceptable. **ACTION: Karl Graham/Claire Parker**
	5. **CC19/054 Policy Statement 54: Chalazia : Cabinet discussed the timescales for referral, interference with vision and spontaneous resolution and requested that the criteria be further tightened/reviewed in respect of these areas** - Action is complete. **Closed.**
	6. **CC19/055a AOB: UHS Contracting Standards: Share Karl Graham email with Rachael King** – It was reported that the email has been shared. **Closed.**
	7. **CC19/055b) AOB: UHS Contracting Standards : Discuss email content at Locality Leads meeting** – It was reported that these issues have been discussed at locality leads and a plan agreed to write formally to UHS. **Closed.**
4.2	**AGREED:** **Clinical Cabinet:** • **Received updates on the actions arising.** • **Agreed that four actions are now complete and can be closed.**
5.	**MANAGING DIRECTORS REPORT**
5.1	Mike Fulford introduced the Managing Directors Report covering the following matters:
	1. **Leadership Changes** Maggie McIsaac has taken over accountability for seven CCGs and following recent structural changes and future change around the commissioning landscape and movement towards becoming an Integrated Care System Maggie has taken the decision to create two Managing Directors for Southampton and South West Hampshire and a Chief Operating Officer

	across the CCG Partnership. These three individuals will support Maggie to take day to day responsibility for the management of operational delivery, finance and performance for their respective areas. Following a competitive process the following appointments have been made: James Rimmer – Managing Director Southampton City CCG Mike Fulford – West Hampshire CCG Roshan Patel – Chief Operating Officer CCG Partnership Initially this arrangement will be in place until Quarter 4.
	2. **Development of Commissioning Reform** Currently looking at options for managing the cover arrangements for when Zara Hyde-Peters leaves the role of Managing Director at North Hampshire CCG in November to take up her new role as Chief Executive of UK Athletics. Formal arrangements will be shared once the way forward has been decided.
	3. **Finance and Performance** Due to pressures at ED in Southampton and financial and performance pressures in the Southampton and South West system this is on the radar at regional and national level. Performance in our systems has been escalated to regional level. Improvement trajectories are being met currently and there are concerns regarding financial performance across the North and Mid System and is subject to regional level scrutiny and development of a recovery plan. It was questioned as to which part is subject to specific concern. It was responded that it is across the whole system with a potential deficit of upwards of £20m. Locally there are concerns around the cost of Out of Area Placements and for us it is the risk around year end forecast control totals. The importance of getting back into financial balance was stressed and it was reported that urgent action is currently being taken to develop a 2-3 year recovery plan to put a financial trajectory in place to level off position and bring us back on track.
5.2	**AGREED:** **Clinical Cabinet:** • **Noted the Managing Directors Report (September 2019)**
6.	**ITEMS FOR NOTING/APPROVAL**
6.1	**Wheelchair and Posture Service (Paper CC19/059)**
6.1.1	Jenny Erwin introduced paper CC19/059 and explained that this paper presents the Service Specification and Key Performance Indicators for the new Wheelchair and Posture service currently being procured by West Hampshire CCG, Southampton City CCG and Isle of Wight CCG. The Service Specification and Key Performance Indicators will be published as part of the ITT stage of the procurement week commencing 11 November 2019. A summary of the service specification and KPIs including any key changes to the existing service model was provided and covered the following:

- Service Specification
  Section 1 (National & Local Context)

  There is a recognised lack of national evidence and benchmarking available upon wheelchair services, however, the specification is underpinned by NHS England's model specification and the "Operating Model for NHS Commissioned Wheelchair Services" developed by the National Wheelchair Managers Forum. The specification also addresses the feedback provided throughout our robust patient & carer engagement exercise.

  Section 2 (Scope)
  The key changes to the service model are:
  - **Direct Issue & Community Prescribing -** The provider will be expected to develop and implement a Trusted Assessor model with local health and care providers. This has been implemented in other areas nationally and a local pilot of this approach has commenced very recently. The approach aims to maximize utility of highly skilled community therapists, enabling them to directly prescribe wheelchair equipment to reduce the need for unnecessary repeat assessments within the wheelchair service. This improves patient experience by negating additional patient contacts, but also helps support the wheelchair workforce where there is a nationally recognised shortage.
  - **Personal Wheelchair Budgets -** The provider must provide and actively promote the essential features of Personal Health Budgets within the wheelchair service to support a local offer of Personal Wheelchair Budgets which will ensure services are personalised and offer increased choice and control for service users accessing the service.
  - **Supporting inpatient care –** The provider is expected to work with local Acute Hospitals to provide training and develop appropriate sub-stores of equipment to support timely discharge from hospital. The provider is expected to take a similar approach in the provision to specialist schools within the geography.
  - **Supporting children under 36 months old -** The provider will accept referrals for children under 3 years if they have postural support needs or functional wheelchair support needs which cannot be accommodated in a normal commercially available buggy that a parent would normally be expected to fund. Currently this age range is met via the Individual Funding Request process.
  - **Digital Innovations –** A number of digital implementations have been mandated from the point of service commencement which are currently lacking within existing service provision. This will be supported by further digital innovations being included within the Service Development and Improvement Plan (SDIP).

  Section 3 (Best practice, quality standards and outcomes)
  The purpose of this section is to bring together all provider "must dos" in regards to national best practice, operational requirements, quality requirements and importantly the outcomes expected from the provider. These have been collated under the Care Quality Commission's (CQC)

	five key lines of enquiry to support the continual internal and external monitoring of service delivery from commencement of the contract. Scorecard In line with section 3 the service scorecard is sectioned under the CQC's key lines of enquiry, and combines key performance, quality and finance measures. The aim of this scorecard is to give a holistic view of service delivery at any given time; individual KPIs triggering an overall RAG rating of the line of enquiry. For example, the scorecard may demonstrate the service is not 'responsive', however, is not impacting upon 'safety' at that point in time.
6.1.2	As a result of discussion it was: • Reported that Solent Healthcare have already trained ten individuals in direct issue and community prescribing with more in the pipe-line to be trained. • Highlighted that the style and design of a wheelchair is important to children and individuals who have an interest in sporting activities so increases have been made to personal wheelchair budgets. • Important to note that the wheelchair services scorecard that contains 98 KPIs which enables us to monitor capacity and demand and measure the quality of care across the pathway. • Reflected that with more rigorous KPIs repeat requests/referrals around for example broken wheelchairs/cases being closed and reopened should reduce. • Highlighted that feedback received from the Neurology Group is that the experience is that there is a good explanation received from the engineer at the beginning of the pathway but individuals have to repeat the same information on a number of occasions which sometimes results in them being moved back on the pathway. It was questioned if work has been undertaken to map the ideal pathway for this specific patient group. It was reported that the commissioning team and the quality team have been working closely together to ensure that we get this right for people, we have also engaged with the public and stakeholders in the development of the Specification and account has been taken from complaints, work-shops and user groups resulting in a well-informed specification. Steve Trembath also is a member of a National Reference Group which has also helped to inform the process. • Questioned if account has been taken of all requests for wheelchairs for example when a GP is asked to complete a request form to the Red Cross; which is quite an intensive process. It was responded that the referral form is being reviewed and St Francis Practice has expressed an interest in being involved in this work. It was noted that this will be kept under review as part of the Network Development Process.
6.1.3	**AGREED:** **Clinical Cabinet:** • **Approved the Service Specification and KPIs for the Wheelchair and Posture Service subject to post meeting ratification.**

6.2	**Safeguarding Service Specifications (Paper CC19/060)**
6.2.1 6.2.2	Matthew Richardson introduced paper CC19/060 and set the context around the development of each of the Service Specifications. It was reported that this submission contains three revised or new service specifications relating to the safeguarding services currently provided by Southern Health NHS Foundation Trust (SHFT). Each Service Specification was presented on an individual basis. **Children in Care Service from Southern Health NHS Foundation Trust** (revised) The following key changes were highlighted: • Move to improve productivity and sustainability through addition of clinic settings for Looked After Children for Review Health Assessments • Agreement with the Local Authority to run clinics during school hours • Use of the health questionnaire as an alternative for face to face Review Health Assessments • Increased use of digital
6.2.3	**Multi-Agency Safeguarding Hub (MASH) Think Family Specification – Children's and Adult's MASH and High Risk Domestic Abuse** (revised) The following key changes were highlighted: • Brings together the current separate specifications for children and adult MASH into one Think Family approach • Commissions the new High Risk Domestic Abuse service within the MASH • Revises the model of MASH provision by diversifying the workforce to make greater use of practitioners to meet increasing demand
6.2.4	**Safeguarding Children and Adult 'Think Family' Specification (new)** Key changes: • This is not a newly commissioned service but for the first time outlines the statutory duties and requirements of SHFT's Safeguarding Team • SHFT have traditionally had a block contract for safeguarding stemming from Primary Care Trust days and the merger of community and mental health services (unlike other providers where safeguarding is within overheads/contract)
6.2.5	It was reported that: • All of the Service Specifications have been developed in conjunction with the Designated Safeguarding Team at the CCG and SHFT. • The ambition is to bring these new service specifications in within current budget although there may be a cost pressure to the CCG from the Children in Care budget. • On approval of these service specifications by the Clinical Cabinet, the CSU will negotiate the implementation and financial cost of these specifications. Final approval of budget will be required by the CCG.
6.2.6	Cabinet reviewed each of the Service Specification and in respect of the second Service Specification Multi-Agency Safeguarding Hub (MASH) Think Family Specification – Children's and Adult's MASH and High Risk Domestic Abuse it was highlighted that following a GP completing a referral form there is no response back as to the outcome of the referral and it was questioned if anything

	is to be done to address this. It was responded that the duty to inform sits with the Local Authority and the Local Authority are aware of this 'gap in process and it is subject to discussion. On concluding the discussion Ellen McNicholas commended Matthew Richardson for the amount of work he has undertaken in respect of the development of the new Service Specification on Safeguarding Children and Adult 'Think Family'.
6.2.7	**AGREED:** **Clinical Cabinet:** • **Approved the Service Specification so that the CCG/CSU can proceed to negotiation of these Specifications with SHFT subject to post meeting ratification.**
6.3	**Clinical Reference Group** – Covered under item 4 Action Tracker 4.1.1.
6.4	**South West and North and Mid-Hampshire Local Delivery System Report (Paper CC19/061)**

6.4.1	Jenny Erwin introduced paper CC19/061 and explained that the Sustainability and Transformation Partnership (STP) for Hampshire and the Isle of Wight defines seven core programmes focused on transforming the way both physical and mental health care is delivered. Alongside this are four enabling programmes to create the necessary infrastructure, environment and capabilities to ensure successful delivery. These programmes form the shared system delivery plan for transformation in Hampshire and the Isle of Wight and are at the heart of the CCGs strategic priorities. Local Delivery Systems have been established to ensure local implementation of the seven core programmes for a defined population through collaborative working. This report sets out an update on:
	• Progress against the core STP programmes and key priority work streams at a local delivery level, with a focus on:
	    • New care models through the implementation of five key interventions
	    • Urgent and emergency care, including effective patient flow and discharge so that people only remain in hospital for the acute phase of their illness or injury, with timely transfer or discharge and the right support to maximise their independence.

6.4.2	Particular attention was drawn to:
	• Urgent Care where at HHFT performance is hovering at 83-85% at an aggregate level and Cabinet were briefed on the following areas:
	    • Discharge target and pathway.
	    • Winchester and Social Care bed days lost to capacity which will feature on the A&E Delivery Board agenda next week.
	    • Deep Dive into NEL pressures including GP direct admits
	    • Data recording issues.
	• UHS where position is similar to other areas. A&E flow target is 95% achieving at 70-80%. Cabinet were briefed on the following areas:
	    • Recovery Action Plan content and monitoring arrangements.
	    • Choose Well Communication Campaign that has received £40k funding to support the campaign. A dedicated Communications and Campaigns

	Manager is now in post. The campaign will be supported by: • A new web-site https://usetherightservice.com/ • Radio advertising (Hearth and Smooth FM) • Social Media campaign • Bus stops and Bill-Boards • Materials to schools, leisure centres, volunteering groups, council tenants, residents etc. Clarity was requested around how GPs are being engaged/linked into the campaign. It was responded that GP comms are within the plan and it was agreed to clarify the process for linking with GPs and share with GPs what is in the plan. **ACTION: James House/(Rachael King)** • Outcome of the recent deep-dive exercise and there was discussion around attendance and conversion rates, population growth, repeat attendances, cultural issues, discharge and staffing ratios. • The exercise to be undertaken to ask people why they are choosing to attend ED rather than alternatives such as Primary Care Hubs, Pharmacy, GP etc.
6.4.3	**AGREED:** **Clinical Cabinet:** • **Noted the report and received the urgent care update.**
6.5	**Collaborative Commissioning Report (Paper CC19/062)**
6.5.1	Jenny Erwin and Ellen McNicholas introduced paper CC19/062 and explained that the purpose of this paper is to provide an update to the Clinical Cabinet on the key collaborative commissioning strategic and operational issues being managed by West Hampshire Clinical Commissioning Group. This report provides a reminder of the 2019/20 work programmes and an update on activities in June and July. Actions for the next two months and risks are also summarised. Changes to the structure and work plan of the children and families team are also reported.
6.5.2	Particular attention was drawn to: • Children's Hubs – In the process of being rolled out. Andover is proceeding well and the Hub in Winchester Rural North is being progressed and is due to start September/October 2019. A meeting is scheduled with Salisbury to start discussions around Avon Valley, which it is hoped will be in place by the end of the year. • Mental Health ECRs and Out of Area Placements are on the national radar. We have currently reduced our Out of Area Placements from 75 to 60. Actively looking at ways to further decrease this number. • Mental Health Strategy – Presentation next month to Cabinet on overview of mental health in the STP and the development of the Mental Health Strategy in response to the Long Term Plan. • Learning Disability Transforming Care Programme – Attention was drawn to the fact that although the SE Region is the worst performer in terms of the programme in respect of getting patients out of hospital, it is not the same for HIOW whose performance is slightly ahead of trajectory and there is a good level of confidence that HIOW will continue to meet its trajectory. It was

	reflected that we do not talk enough about these cases and an example was quoted of an individual who had been in hospital care for 46 years. It was suggested that at a future meeting of Cabinet they might like to receive some case studies to hear the difference this programme has made to the lives of individuals. • CHC are on track to meet targets for a fourth month in a row despite an increase in demand/referrals. This is due to staff decisions/assessments being undertaken in a timely way. • The fact that the Divisional Beds Model pilot has been running over two months and is showing positive results. Learning arising from the pilot is to be shared.
6.5.3	**AGREED:** **Clinical Cabinet:** • **Noted the report.**
7.	**RISKS AND ISSUES IDENTIFIED AS A RESULT OF ITEMS DISCUSSED AT THE MEETING** • Acute care system pressures and how it plays out into winter.
8.	**ANY OTHER BUSINESS**
8.1	**OMNES** (Concordia) An update was provided on the current status. There was discussion around call system, recruitment, discharge process/summaries and clinic letters.
8.2	**DXS** It was reported that the contract ends in December 2019 and the work involved in the practicalities of transferring documentation to another platform was outlined. It was agreed that Karl Graham and Liz Angier will work with Claire Parker to provide a briefing on the new arrangements to the October meeting. **ACTION:Karl Graham/Liz Angier/Claire Parker**
8.3	Sophie Douglas reported that today is her last attendance at Cabinet as her fellowship finishes and she is moving to her new role as a Partner at New Horizons Partnership in Totton starting in October 2019 and she thanked the Committee for allowing her to observe and learn from their meetings. Cabinet extended their best wishes to Sophie for the future.
9.	**DATE OF NEXT MEETING**
9.1	The next meeting of the Clinical Cabinet will take place on Thursday 10 October 2019 from 09.30am in the Boardroom, Omega House, Eastleigh.

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NHS
West Hampshire
Clinical Commissioning Group

Minutes - REDACTED

Clinical Cabinet Meeting

Minutes of the West Hampshire Clinical Commissioning Group Clinical Cabinet meeting held on Thursday 10 October 2019 at 09.30am in the Boardroom, Omega House

Present:	Adrian Higgins	Medical Director **CHAIR**
	Liz Angier	Clinical Director, Primary Care and Community Services
	Charlie Besley	Clinical Locality Director, Totton and Waterside
	Ian Corless	Board Secretary and Head of Business Services
	Helen Cruickshank	Consultant in Public Health Medicine
	Roland Fowler	Clinical Director Children and Families
	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes and Clinical Director, ICT
	Neil Hardy	Associate Director, Medicines Optimisation deputising for Ellen McNicholas
	Emma Harris	Clinical Director, Medicines Management
	Rory Honney	Locality Clinical Director, Andover
	Rachael King	Director of Commissioning, South West
	Johnny Lyon-Maris	Clinical Locality Director, West New Forest
	Katrina Webster	Clinical Director, Mental Health
In Attendance:	Annie He	ST3 Trainee GP
	Kit Murtha	Commissioning Manager Planned Acute Care, Mid-Hampshire (Item 6.1)
	Matthew Richardson	Deputy Director of Quality (Item 6.6)
	Caroline Ward	Lay Member New Technologies and Digital
	Terry Renshaw	Governance Manager
Apologies:	Jenny Erwin	Director of Commissioning, Mid-Hampshire
	Mike Fulford	Managing Director and Chief Finance Officer
	Judy Gillow	Lay Member Quality
	Lorne McEwan	Locality Clinical Director, Winchester
	Maggie McIsaac	Chief Executive
	Ellen McNicholas	Director of Quality and Safety (Board Nurse)
	Beverley Meeson	Deputy Director Service Development
	Sarah Schofield	Clinical Chairman
	Stuart Ward	Locality Clinical Director, Eastleigh North and Test Valley South

Summary of Actions:

Minute Reference:	Action	Who	By
4.1.2	**Action Tracker CC19/052 SHFT Clinical Strategy** – Adrian Higgins to progress chase response to his 27 August 2019 letter to Karl Marlowe in respect of the issues/concerns raised.	**AH**	ASAP
5.1 5.2	**Managing Directors Update**: • **Commissioner Reform : Long Term Plan** – Circulate dates for local engagement events being held. • **1st Draft HIOW Strategy Delivery –** Circulate document to Cabinet.	**IC**	10.10.19 Actioned
6.2.2	**Policy Recommendation 002: Assisted Conception Services (Reviewed) :** • Neil Hardy to liaise with Chris Ashdown regarding producing guidance around appropriate shared care prescribing, specialty treatment and private treatment prescribing. • Neil Hardy to investigate area of GP investigations and clarify to Practices what private tests/investigations are appropriate to be carried out in Primary Care.	**NH/(CA)** **NH/(CA)**	ASAP ASAP
6.4.2	**General Practice Forward View : 2019-20** – Clarify rules around funding in terms of what happens if a PCN does not spend its full allocation.	**RK**	ASAP
6.7.3	**LDS Report** – Rachael King to discuss with Jenny Erwin the request to include an update/overview of the Andover MIU transition within future reports.	**RK/(JE)**	ASAP
6.8.2	**Collaborative Commissioning Report : Mental Health Services Report** – Correct error on page 4 - Target 4 WHCCG SMI health checks=0% to read 11.00%	**(JE)**	ASAP
8	**AOB Community Pharmacy Contract** – Neil Hardy to invite Deborah Crockford Chief Officer, Community Pharmacy South Central to attend a future Cabinet to go through the changes to the Community Pharmacy contract.	**NH**	10.10.19

1.	**WELCOME, APOLOGIES AND CONFIRMATION OF QUORACY**
1.1 1.2	Adrian Higgins welcomed members present to the Clinical Cabinet meeting and apologies for absence were noted. It was confirmed that the meeting was quorate. A special welcome was extended to Dr Annie He who has joined the CCG for fourteen months as an ST3 Trainee GP.

2.	**DECLARATIONS OF INTEREST (Paper CC19/063)**
2.1	Adrian Higgins directed members to the Declarations of Interest Register.
2.2	Helen Cruickshank asked to be added onto the register. Annie He stated that she has no interests to declare. Adrian Higgins reported that he is a GP Locum and will be working in West Hampshire Practices. It was noted that the register will be updated for the next meeting.
2.3	Adrian Higgins reminded Committee members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of NHS West Hampshire Clinical Commissioning Group.
2.4	No further specific interests were declared relating to items to be discussed at the meeting.
3.	**MINUTES OF LAST MEETING (Paper CC19/064)**
3.1	Clinical Cabinet reviewed the minutes of the last meeting, held on the 12 September 2019.
3.2	Clinical Cabinet ratified the approvals made, subject to post meeting clarification, on the 12 September 2019.
3.3	There were no matters arising from the minutes that are not covered by the action tracker.
3.4	**AGREED:** **Clinical Cabinet:** • **Noted the post meeting ratification responses received.** • **Agreed the minutes of the Clinical Cabinet meeting held on the 12 September 2019 and commended them for signature by the Chair.**
4.	**ACTION TRACKER (Paper CC19/065)**
4.1	Adrian Higgins introduced paper CC19/065 and the items on the action tracker were reviewed. An update was provided on:
	1. **CC19/044 AOB Clinical Reference Group: Draft Clinical Reference Group proposal for Cabinet consideration –** It was reported that Claire Rowe and Craig Wartnaby will be supporting the platform. Currently trying to arrange a training date with NHSE in October. Once clear on platform application and functionality the aim is to send out invitations in late October. It was highlighted that this launch coincides with the ending of support to the DXS platform in line with non-renewal of its contract with the ending of the GP SOC National Framework for this product. Therefore it is envisaged that

	there will be the opportunity for wider participation within the Clinical Reference Group.
	2. **CC19/052 SHFT Clinical Strategy : Draft Cabinet response to presentation** – It was reported that to date no response has been received from Karl Marlowe. Cabinet asked Adrian Higgins to progress chase a response to his 27 August 2019 letter to Karl Marlowe in respect of the issues/concerns they had raised. **ACTION:Adrian Higgins**
	3. **CC19/053 Digital Presentation : Produce comms around nhs.net and alternative secure email channel in respect of HHFT (Office 365) and Care Homes sharing Personal Identifiable Data** – It was reported that this is two different products and are subject to different licensing arrangements. Noted NHS Mail is available to care providers and care homes, subject to Data Protection Tooklit requirements. **Closed**.
	4. **CC19/056 SW and NMH LDS Report: Choose Well Campaign : To clarify process for linking with GPs and share with GPs what is in the plan** – It was reported that Simeon Baker has advised that the comms team have written to all GPs (electronically) about the campaign and have asked them to get involved and make suggestions etc. They are also sending a written letter with a pack of leaflets and flyers to GPs, for distribution, in their surgeries. James House has also suggested to Simeon that he might want to look at how we specifically engage with the GP locality leads and he will follow this up. It was stated that visibility has also been raised at Locality meetings. It was reflected that the Campaign is being promoted as ‘South West and Southampton’ and attention was drawn to potential issues for patients on the border as some services offered are different in each of the CCGs. It was responded that the current focus is to relay the wider message and joint work is ongoing to ensure consistency.
	5. **CC19/057 DXS : It was agreed that Karl Graham and Liz Angier will work with Claire Parker to provide a briefing on the new arrangements to the October meeting** – It was reported that Claire Parker has sent out an email to Practices to inform them. Refer to agenda item 6.5, minute reference 6.5. **Closed.**
4.2	**AGREED:** **Clinical Cabinet:** • **Received updates on the actions arising.** • **Agreed that two actions are now complete and can be closed.**
5.	**<u>MANAGING DIRECTORS REPORT</u>**
5.1	Rachael King introduced the Managing Directors Report covering the following matters:
	1. **Commissioner Reform** Following Maggie MacIsaac taking up the Accountable Officer role for West Hampshire as well as Southampton City CCG and the Partnership

	discussions have continued on how the commissioning organisations in HIOW will work together going forward to deliver the ambition of the Long Term Plan. The three Boards have agreed the next steps in the process including Joint Board Workshops over the next three months looking at the options for working together. The focus is to be on how we work together differently to achieve more together for our populations in terms of outcomes we want to deliver A number of engagement/drop-in events have been scheduled, which are open to clinicians, NHS staff and the public. One was held earlier this week in Basingstoke and another is taking place on the Isle of Wight later today. There are also events scheduled for Southampton and Portsmouth next week. It was agreed to circulate these dates to Cabinet. **ACTION: Ian Corless**
	2. **HIOW Strategy Delivery Plan** The draft STP plan was submitted to NHSE/I at the end of September. It is a high level plan scaling the level of challenge and ambition. This is a work in progress ahead of the full submission in mid-November. Key messages are there is substantial transformational change required to meet the financial and commissioning requirements and further work is required on the individual work programmes. More detail is to be provided at the November Cabinet. It was agreed that a copy of the draft HIOW Strategy Delivery Plan will be circulated to Cabinet, recognising that a copy may have already been received from another source. **ACTION: Ian Corless** As a result of discussion it was questioned if money is taken 'out of the system' to support community programmes what impact this will have on front-line care. It was responded that the implications are currently being worked through and a wider discussion is needed with Cabinet around how we achieve financial balance this year and next year and how we engage the clinical community within this.
	3. **Finance and Performance** National picture is very challenging and this is mirrored locally. We have a £14m risk to our break even control total and only have plans to mitigate some of that risk. We have to submit a formal North and Mid-Hampshire Financial Recovery Plan following Regional escalation last week. The 2019/20 Recovery Plan is due to be submitted in two weeks with a medium term plan in six weeks. A follow up meeting in London is to be scheduled. The requirement to hit plan next year will be absolute and we will need to develop the plan to deliver that in the three months CCG wide. This will impact on desired investments for 2020/21. The Recovery Plan schedule is under development with further work to be scheduled including working with Cabinet over the next two months.

5.2	**AGREED:** **Clinical Cabinet:** • **Noted the Managing Directors Report (October 2019)** • **Agreed the actions outlined at paragraph 5.1.1 and 5.1.2.**
6.	**<u>ITEMS FOR NOTING/APPROVAL</u>**
6.1	**<u>Update Regarding Status of WHCCG Community ENT Service (Provided by Omnes Healthcare)</u> Commercial In Confidence (Paper CC19/066)** **REDACTED**
6.2	**<u>Priorities Committee Recommendations</u> (Paper CC19/067)**
6.2.1	Adrian Higgins introduced paper CC19/067 and explained that this paper outlines recent recommendations made by the Hampshire Priorities Committee and subsequently reviewed by the Joint West, North and Southampton CCGs Restricted Treatments and Procedures Steering Group on the 21 August 2019 and supports the following recommendation. **Policy Recommendation 002: Assisted Conception Services (reviewed for update)** The management of infertility includes both primary and secondary care assessment; diagnosis; and interventional support (for example, lifestyle changes that may improve a couple's chances of conceiving) and patients/couples who require specialist infertility treatments must meet the criteria described in the Policy document. Specialist assisted conception treatments, including In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI), will be commissioned for patients who meet the criteria for access described in the Policy document. Outside of the defined access criteria, all assisted conception treatments remain a low priority for routine NHS funding. This Policy statement has been reviewed in line with latest evidence and to include considerations to ensure fair and equitable access for lesbian, gay and transgender couples. **Key recommendations include:** 1. Patients/couples requesting specialist infertility treatment and meeting the eligibility criteria must be referred for specialist infertility treatment(s) by an NHS Consultant Gynaecologist; 2. The CCG Commissioners will confirm funding, and advise the patients' managing clinician of the preferred provider of their infertility treatment. NB: NHS-funded specialist assisted conception services are commissioned only from approved providers. 3. The NHS-funded specialist fertility unit will be responsible for the whole pathway and the HFEA fee. 4. All fertility drugs, such as anti-oestrogens, (e.g. clomiphene citrate), gonadotrophins, (including gonadorelin analogues), and progestogens, should be prescribed only by the treating consultant. GPs are advised not

	to prescribe any drugs for fertility. 5. There are existing, related commissioning policies specific to addressing PGD and gamete storage, which CCGs may wish to refer to in conjunction with this policy recommendation. A contractual 30 day notice period to providers to be issued together with a refreshed on-line version of the overarching IFR and RTAP Policy for 2019-20.
6.2.2	As a result of discussion it was agreed: • Neil Hardy is to liaise with Chris Ashdown regarding producing guidance around appropriate shared care prescribing, specialty treatment and private treatment prescribing. **ACTION: Neil Hardy/(Chris Ashdown)** • Neil Hardy is to investigate the area of GP investigations and provide clarification to Practices as to what private tests/investigations are appropriate to be carried out in Primary Care. **ACTION: Neil Hardy/(Chris Ashdown)**
6.2.3	**AGREED:** **Clinical Cabinet:** • **Reviewed, approved and adopted Policy Statement 002** • **Agreed the actions outlined at paragraph 6.2.2**
6.3	**Overview of IFR Decision September 2018- September 2019 (Paper CC19/068)**
6.3.1	Adrian Higgins introduced paper CC19/068 on behalf of Karen Gregory and explained that this paper gives an overview of activity from the Independent funding Panel for the previous twelve months.
6.3.2	Cabinet received and reviewed the report and the Chair extended a vote of thanks to Karen for her continued work in support of this function.
6.3.3	**AGREED:** **Clinical Cabinet:** • **Reviewed the report, which gives an overview of activity from the Independent Funding Panel over the last twelve months.**
	Overview of IFR Decisions – From Children's April 2019 (Paper CC19/069)
6.3.4	Adrian Higgins introduced paper CC19/068 on behalf of Angela Murphy and explained that this paper gives an overview of activity from the Independent Funding Panel since April 2019.
6.3.5	**AGREED:** **Clinical Cabinet:** • **Received and reviewed the report.**
	IFR Mental Health Report (Paper CC19/070 – withdrawn)
6.3.6	Katrina Webster provided a verbal update and explained that seventeen mental

	health IFR cases have been received in this last time period for WHCCG of these only three were referred for clinical discussion, most are managed at an administrative level and are subject to desk-top approval/decline. It was reported that it has been agreed to manage mental health IFRs in the future for those where it is not possible for Chris Ashdown and his team to confirm the request is within existing services, by referring them to the main IFR panel. This has been agreed with the IFR panel Chair, Ellen McNicholas, Beverley Meeson and Chris Ashdown.
6.3.7	**AGREED:** **Clinical Cabinet:** • **Received the verbal update.**
6.4	**General Practice Forward View 2019-20 (Paper CC19/071)**
6.4.1	Rachael King introduced paper CC19/071 and explained that this report provides a summary of the key priorities in 2019-20 delivered through the West Hampshire Primary Care General Practice Work Plan 2019-20. The plan has been developed in line with the requirements of the National Primary Care Network DES and the West Hampshire CCG 2019-20 Operating Plan, building on the National GP Forward View Plan.
6.4.2	The following highlight report was provided: 1. **Primary Care Networks (PCNs):** • WHCCG has thirteen established Primary Care Networks. All forty-eight WHCCG's Practices are member Practices of a PCN. • All PCNs have a signed network agreement and an accountable Network Clinical Director. • PCN Forum continues to meet monthly to ensure awareness of national guidance and facilitate shared learning. The Local Medical Committee has recently joined the Forum. • The CCG continues to support the development of PCNs. Network Plans are under development and work is taking place to agree the funding of Network plans and priorities are being considered in line with local need. STP funding has been received to support development and is in the region of £30k for each PCN. A template has been provided to PCNs to identify priority developments, one network priority service development and PCN Clinical Director development. These will then be collated to identify key themes that could be commissioned on a wider basis. The output of this work will be shared with Cabinet. It was highlighted that this exercise has been undertaken within a short timescale and will need to be further refined and figures will be subject to clarification. As a result of discussion it was: • Highlighted that some networks do not have sufficient funding to recruit Pharmacy Link Workers. It was responded that work is being undertaken to look at the possibility of funding joint roles between Primary Care and Secondary Care. Clarification was requested on the rules around funding in terms of what happens if a PCN does not spend its full allocation. **ACTION: Rachael King**

	2. **Supporting People To Stay Well :** • Attention was drawn to the NHS Investment Funding for Immunisation and Screening and that work is being undertaken to clarify the arrangement. • Social Prescribing Link Workers (SPLW), all Practices are in the process of recruitment. There are four SPLWs in post with four more due in post by the end of November.
	3. **Primary Care Mental Health Service Model:** • Phased implementation from January 2020. GP leadership has been confirmed. • Development Plan for four PCNs with partners has been created, implementation due January 2020.
	4. **Musculoskeletal Services (MSK), Implementation of First Contact Practitioners**: • Pilot in Mid-Hampshire Practices (Andover) commenced 1 May 2019, to be fully evaluated. • MSK First Contact Practitioners commissioned within the Extended Access Hubs. In place from 1 July 2019.
	5. **Referral Support Service:** • Implementation of RSS across 19 Practices to date. The service is also live with PHL, TLC and ESPN as part of the appointments+ service. Four Practices are due to be implemented in October 2019. • Full roll-out across WHCCG by March 2020.

6.4.3	Attention was drawn to:
	• **The Integrated Urgent and Emergency Care Services 24/7:**
	    • Clarification was sought in terms of this contract and the previous model with regard to mental health workers and equity of access. It was responded that this is detailed within the Service Specification but if there are any specific concerns these should be raised direct with Rachael King.
	    • The difficulties around seeing/booking appointment slots was raised, especially at Lymington at the weekend. It was responded that the CCG are aware of the issues and are working with PHL to address.
	    • It was questioned whether an interim evaluation report is needed in view of the fact that the full evaluation will not take place until March 2020. It was responded that we are working closely with the Locality Clinical Director and it is still early days for the service and further thought will be given to this request.
	• **Infrastructure: Technology** and the fact that a number of deadline dates have passed and it was questioned if this needs to be refreshed. It was reported that this has been picked up with Claire Parker and a more detailed report is to be presented to the Primary Care Commissioning Committee in October.
	• **Estates** – With regard to exploring additional bids for capital funding to support development in line with the agreed estates plan attention was drawn to the Community Infrastructure Levy which is a planning charge introduced by the Planning Act 2008 as a tool for Local Authorities in England and Wales to help deliver infrastructure to support development

	in their area and it was questioned if local developers are being encouraged to put money in to support health. It was responded that this is being discussed at STP level and a consistent process is required to access funding/take every opportunity to access available funding.
6.4.4	**AGREED:** **Clinical Cabinet:** • **Noted the General Practice Work Plan 2019-20.** • **Agreed the action outlined at paragraph 6.4.2**
6.5	**DXS**
6.5.1	Karl Graham provided an overview of the DXS platform that covered: • Background to the implementation of the platform • Funding arrangements • Functionality and access • Content management • Practice engagement/usage and explained that the contract will not be renewed with the ending of the GP SOC National Framework. It was reported that the plan is to establish a web-site portal hosting the same range of DXS information plus the addition of medicines management formularies and guidance to provide a one stop shop to access information. The majority of information will be available on an open access basis with some password protected information.
6.5.2	As a result of discussion it was: • Stated that it is important that the new system links with RSS. • Highlighted the need to ensure connectivity with EMIS Web, SystemOne and ERS. • Stated that the new platform is at the vision/in-development stage and it will be a challenging time to get to the 31 December 2019 deadline. Currently working within a tight timeframe and the reality is that it will be launched in a functional state not end state. • Recognised that communication of the change is key and articles have been published/are planned for publication in In-Practice. • Stated that the Clinical Reference Group will have a key role to play around content management/uploading of new forms etc.
6.5.3	**AGREED:** **Clinical Cabinet:** • **Received the briefing on the new arrangements.**
6.6	**The NHS Patient Safety Strategy Paper CC19/072)**
6.6.1	Matthew Richardson introduced paper CC19/072 and explained: • The NHS Patient Safety Strategy was launched in July 2019 by Aiden Fowler, the NHS National Director of Patient Safety. • The document brings together many of the current developments in patient safety, including the work of the National Patient Safety

	Collaboratives into one document.
	• The document is not a prescriptive strategy but rather a statement of intent around the vision **to continuously improve patient safety.**
	• The strategy aims to build:
	  • A culture of patient safety
	  • A system of patient safety
	• Based on the foundations of:
	  • Insight (improving the understanding of safety by drawing insight from multiple sources of patient safety information)
	  • Involvement (equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system)
	  • Improvement (design and support programmes that deliver effective and sustainable change in the most important areas).
	• The West Hampshire CCG Clinical Governance Committee received this Strategy at their meeting on the 12 September 2019 and as a result this was escalated to the Board as part of the Director of Quality and Nursing – Quality Update on the 26 September 2019.
	• The Clinical Governance Committee recognised in terms of the implications for Primary Care, the centrality of Primary Care Networks is key and it was agreed that a presentation on the Strategy should be provided to Clinical Cabinet to ensure that GP colleagues are sighted, with a focus / link as to how it is envisaged that PCNs will deliver this / where all the work is going to end up.

6.6.2	Matthew drew attention to the following areas within the overview report: • Key messages • What's not included • Features of a Patient Safety Culture • Blame – Just Culture • Safety Systems • Challenge/implications for Primary Care • Conclusion
6.6.3	As a result of discussion: • The importance of ensuring there is consistent communication/messaging with patients/carers and families in order to help them to facilitate self-care. • The need not to underestimate the feature of 'civility and kindness' as this has a direct impact on clinicians. • Attention was drawn to workload and how workload impacts on patient safety especially in Primary Care. It was responded that the Strategy does not mandate workforce levels or specifically address shortages, this is covered in The Interim NHS People Plan, but it does recognise the link between capacity and safety. • It was suggested that it might be helpful to re-run the QPS Safequest Safety Climate Cultural Survey within PCNs. • It was highlighted that in respect of Datix there is a need to ensure that the wider workforce is protected to enable then to confidently raise safety issues. It was stated that there is to be a consultation on Datix and consideration is to be given to open up the system to care homes etc. in order to increase the richness of information available.

6.6.4	**AGREED:** **Clinical Cabinet:** • **Received and noted the presentation.** • **Noted the concerns around further overload for PCN Clinical Directors and the need to think how we can take this forward in a supportive way.**
6.7	**<u>South West and North and Mid-Hampshire Local Delivery System Report</u> (Paper CC19/073)**

6.7.1	Rachael King introduced paper CC19/073 and explained that the Sustainability and Transformation Partnership (STP) for Hampshire and the Isle of Wight defines seven core programmes focused on transforming the way both physical and mental health care is delivered. Alongside this are four enabling programmes to create the necessary infrastructure, environment and capabilities to ensure successful delivery. These programmes form the shared system delivery plan for transformation in Hampshire and the Isle of Wight and are at the heart of the CCGs strategic priorities. Local Delivery Systems have been established to ensure local implementation of the seven core programmes for a defined population through collaborative working. This report sets out an update on:
	• Progress against the core STP programmes and key priority work streams at a local delivery level, with a focus on:
	    • New care models through the implementation of five key interventions
	    • Urgent and emergency care, including effective patient flow and discharge so that people only remain in hospital for the acute phase of their illness or injury, with timely transfer or discharge and the right support to maximise their independence.

6.7.2	Rachael drew attention to the 26 September 2019 Annual General Meeting held in Lyndhurst that show-cased the work of the South West Directorate and thanks were extended to Charlie Besley and Johnny Lyon-Maris for their support at the event.
6.7.3	As a result of discussion: • It was questioned when the Primary Care Network Plans will be available to see. It was responded that the plans are at an early stage of development and all PCNs are at a different point. There will be a focus at the next Network Forum as there is a need to obtain visibility of priorities at a network level. • Challenges around the Minor Eye Conditions Service was highlighted. Rachael asked that issues are raised with her as they arise in order that they can be explored/addressed. • It was requested that an update/overview of the Andover MIU transition is featured in future reports. Rachael King agreed to discuss this with Jenny Erwin. **ACTION: Rachael King/(Jenny Erwin)**
6.7.4	**AGREED:** **Clinical Cabinet:** • **Received the report.** • **Agreed the action outlined at paragraph 6.7.3.**

6.8	**Collaborative Commissioning Report (Paper CC19/074)**
6.8.1	Adrian Higgins introduced paper CC19/074 and explained that the purpose of this paper is to provide an update to the Clinical Cabinet on the key collaborative commissioning strategic and operational issues being managed by West Hampshire Clinical Commissioning Group. This report provides a reminder of the 2019/20 work programmes and an update on activities in August and September. Actions for the next two months and risks are also summarised.
6.8.2	It was requested that an error is corrected on page 4 – Target 4 WHCCG SMI Health Checks =0% to read 11%. **ACTION: Jenny Erwin**
6.8.3	**AGREED:** **Clinical Cabinet:** • **Noted the report.** • **Agreed the action outlined at paragraph 6.8.2.**
7.	**RISKS AND ISSUES IDENTIFIED AS A RESULT OF ITEMS DISCUSSED AT THE MEETING** • Community ENT Service (OMNES). • DXS migration • NHS Patient Safety Strategy – Associated workforce implications
8.	**ANY OTHER BUSINESS**
8.1	**New Community Pharmacy Contract** It was agreed that Neil Hardy is to invite Deborah Crockford, Chief Officer, Community Pharmacy South Central to attend a future Cabinet meeting to go through the change to the Community Pharmacy contract.
8.2	**GP IT Procurement** Caroline Ward highlighted that she will be involved in reviewing the responses to the pre-qualification and asked that if there are any specific areas that Localities would like her to focus on/probe that they contact her direct.
9.	**DATE OF NEXT MEETING**
9.1	The next meeting of the Clinical Cabinet will take place on Thursday 14 November 2019 from 09.30am to 12noon in the Boardroom, Omega House, Eastleigh.

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NHS
West Hampshire
Clinical Commissioning Group

Minutes

Finance and Performance Committee

Minutes of the Finance and Performance Committee meeting held on Thursday 29 August 2019 from 11.15am to 12.45pm in the Boardroom, Omega House, Eastleigh, SO50 5PB

Present:	Alison Rogers	Lay Member Strategy and Finance, **CHAIR**
	Charlie Besley	Locality Clinical Director Totton and Waterside
	Mike Fulford	Chief Finance Officer and Deputy Chief Officer
	Simon Garlick	Lay Member Governance/Audit
	Judy Gillow	Lay Member Quality
	Adrian Higgins	Medical Director
	Rachael King	Director of Commissioning – South West
	James Lawrence-Parr	Deputy Director of Commissioning – Mid-Hampshire
	Johnny Lyon-Maris	Locality Clinical Director, West New Forest
	Lorne McEwan	Locality Clinical Director, Winchester
	Maggie MacIsaac	Chief Executive: Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups; Southampton City Clinical Commissioning Group; West Hampshire Clinical Commissioning Group
	Ellen McNicholas	Director of Quality and Board Nurse
	Sarah Schofield	Clinical Chairman
	Jim Smallwood	Secondary Care Consultant
	Caroline Ward	Lay Member New Technologies and Digital
In Attendance:	Ian Corless	Board Secretary/Head of Business Services
	Jackie Zabiela	Governance Manager (Minutes)
Apologies:	Jenny Erwin	Director of Commissioning – Mid Hampshire
	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes
	Rory Honney	Locality Clinical Director, Andover
	Stuart Ward	Locality Clinical Director Eastleigh North and Test Valley South

Summary of Actions:

Minute Ref:	Action	Who	By
4.1.3	**Escalation around UHS system** – Update to be provided at next meeting following meeting with the Executive Team on 13 September 2019	MF	26.09.19

1.	**WELCOME, APOLOGIES AND CONFIRMATION OF QUORACY**
1.1	Alison Rogers welcomed members present to the meeting of the NHS West Hampshire Clinical Commissioning Group (West Hampshire CCG) Finance and Performance Committee and noted apologies for absence.
1.2	A special welcome was extended to Maggie MacIsaac who explained that she is now accountable for seven CCGs and this arrangement will ensure that we are able to realise the benefits of working together across our geography and will enable us to continue working effectively as individual statutory organisations. This is especially important as we head into winter and work together to respond to the day to day operational challenges faced by our local systems. Arrangements are to be put in place to create two Managing Directors for Southampton and West Hampshire, and a Chief Operating Officer across the CCG Partnership. These three individuals will support me to take day to day responsibility for the management of operational delivery, finance and performance for their respective areas. We will continue to work together on the next phase of our development as we discuss how we work together locally and at scale to deliver our day to day business, as well as consider how we move towards becoming an Integrated Care System for Hampshire and the Isle of Wight.
2.	**DECLARATIONS OF INTEREST (FPC19/040)**
2.1	Alison Rogers directed members to the Declaration of Interest Register.
2.2	Attention was drawn to the fact that should a conflict arise at any point during the meeting members will need to declare this fact.
2.3	**AGREED** **The West Hampshire CCG Finance and Performance Committee:** • **Received and noted the Register of Interests.**
3.	**MINUTES OF THE PREVIOUS MEETING (FPC19/041)**
3.1	The Finance and Performance Committee received the draft minutes of the meeting held on the 25 July 2019.
3.2	**AGREED** **The West Hampshire Finance and Performance Committee:** • **Approved the minutes of the meeting held on the 25 July 2019 with no matters arising.**

3.3	**Matters Arising - 25 July 2019** 1. Simon Garlick recollected that lay members had expressed a desire to discuss with UHS their financial performance and what more we can do and there was a suggestion that they attend/be invited to a meeting, however this did not appear to be recorded in the minutes. This was reflected upon and it was mentioned that there had been a discussion regarding how to manage financial pressures in the South and South West System, which could be touched on later in the meeting as there will be a need to discuss what we focus on in moving the system forward. 2. Terms of Reference – Alison Rogers reported that lay advisors, Sarah Schofield and Mike Fulford had met prior to this meeting and have agreed to put on hold any review of the Terms of Reference due to the current level of change. The Committee all agreed that this was reasonable and an open invitation was extended to Maggie MacIsaac.
	ACTION TRACKER (FPC19/042)
3.4	Alison Rogers introduced paper FPC19/042. The following updates to the action tracker were noted:
	1. **FPC19/005 M3 Finance: Review mis-match between graphs on page 10 and narrative –** Revised report circulated to Committee members 1 August 2019. **Closed.**
	2. **FPC19/006a) Savings Programme: More pro-active comms required around Orthopaedic Choice** – It was reported that an article is to be placed in In-practice setting out the action being taken by WHCCG working with SHFT to reduce waiting times for the Orthopaedic Choice service to a maximum of 6 weeks. It was reported SHFT are actively recruiting. There is a need to agree right time for any communications as we do not want to flood the team with referrals. It was agreed to leave the action amber until delivered.
	3. **FPC19/006b) Savings Programme: Add resourcing the scale/challenge around the change programme and pressures driving the system onto the action tracker** – It was reported that this has been added to the action tracker rather than the risk register. Alison Rogers commented that it is important not always to imply/reference that a system solution is the answer to everything and that we need to keep our eye on the ball locally.
3.5	**AGREED** **The West Hampshire Finance and Performance Committee:** • **Received the updates from the action tracker.** • **Agreed that one action is complete and can now be closed.**
4.	**FINANCE**
4.1	**2019/20 Finance Report for Period Ending 31 July 2019 (Month 4) (FPC19/043)**
4.1.1	Mike Fulford introduced paper FPC19/043 that provided an update to the Committee on the financial performance as at Month 4. It shows: • Emerging over performance on acute contracts **£8.3m** within which UHS, HHFT and SCAS have a combined forecast over performance of **£7.3m**. • CHC forecast overspend of **£1.7m.**

	• Forecast underspend in Primary Care **£0.3m** but this is now at further risk.
	• The overall forecast is still set at **Breakeven** to plan at this stage whilst the emerging contract positions and remedial actions are being investigated.
	• Gross risks remain at **£18.6m** and potential mitigations of **£4m** giving net unmitigated risk of **£14.6m**. The risk position has now been reset to the level anticipated at plan stage because of the emerging over performance on the three key budget areas noted above.
	• The delivery of the planned position is now subject largely to the CCG achieving remedial action in the following areas:
	  • Correct the budget over performance on UHS, HHFT, SCAS and CHC **£9.0m** including addressing non delivery of QIPP impacting on these contract outturns **£3.2m**
	  • Further work on closing the plan gap due to unidentified QIPP **£8.2m**

4.1.2	Attention was drawn to the following highlights: • Continue to see pressures developing and increasing mainly in the acute sector. However, still forecasting formally to NHSE breakeven year to date and at year end, but formally reporting a £14.6m risk against delivery of the control total. • UHS continues to overspend substantially across a range of areas particularly unscheduled care, reflecting the picture across a wide range of services both locally, regionally and nationally around unscheduled care, as well as a significant increase in unscheduled activity. We are seeing a 7-8% increase in activity and this unusually is also being reflected in Southampton City CCG (SCCCG) as well. • Also seeing pressure particularly around non-elective at HHFT. A significant proportion of risk is mitigated at present as have a contractual arrangement which is not under straight PBR but within system substantial pressures are being driven by non-elective, plus pressures around non delivery of QIPP which is more serious in HHFT than UHS. • Elective is still substantially down in performance and finance; there is substantial growth around waiting list which is building up a pressure particularly when looking at UHS. This is likely to crystallise into additional activity and therefore increased spend in the last four or five months of the year. • HHFT increase in activity is greater in North Hants at Basingstoke site than in Winchester with both systems operating at higher levels of activity than initially planned. • Heat in unscheduled care system around SCAS 999 contract with across patch increase in activity of 6%+ materialising in substantial pressure across all CCGs, this equates to approximately £800k for WHCCG. It was reflected that at this time of the year we would not be expecting to see this level of activity. When this is correlated with ED activity they are up 8% or so year on year, where you would normally expect to see 3 or 4%. • Increases in activity in both PHT and SFT. Predominantly unscheduled care driving over performance. • CHC forecast overspend has reduced reflecting delivery of QIPP targets and managing in year pressures. Pressures predominantly small number of very high cost placements. The cost of the care package has decreased and numbers are flat with the team managing placements through normal evaluation and assessment processes. • There is £9.7m unidentified QIPP combined with pressure of £14 - £14.5m risk to the end of year position. It was stated that this is clearly not the place we would want to be therefore, a recovery action plan will be brought formally to the next meeting of this Committee and will detail all actions that are in train focusing on contractual areas of overspend and also regarding non delivery of QIPP.

	In conclusion it was stated that there are limited options available this year compared with last year for example substantial non recurrent support which enabled us to break even last year which is currently not available. Options are therefore currently being sought to support the CCG's position. It was stressed that the reduction of recurrent spend is critical and a recurrent solution needs to be identified.
4.1.3	As a result of discussion it was: • Stated that with regard to the SCAS 999 overspend, whilst the number itself is not the biggest problem this could be seen as a leading indicator for drivers in other areas, which should not be happening at this time of the year and it was questioned as to whether we have any analytics and reason's for why this is. It was responded that a workshop is being held next week bringing together commissioning groups across STP footprint to try and understand what is driving this as it is an unexpected situation. This is reflected in an increase in conveyance rates, 111 usage has increased with more cold calls to 111, more 999 dispositions and more people presenting in ED. Those attending ED are also resulting in a higher number of admissions, some of which are quite short term but picture is across all elements and colleagues would say that it feels the same within Primary Care, although, there is not data available to support this. The aim is that the workshop will identify some issues for which actions can be put in place for example proactive actions that can be done now particularly before winter which could be very challenging if pressures increase and this is before talking about the quality and performance elements. It was highlighted that we can build on the work already underway with SCAS for example see and treat, why patients are being transported to ED when they could be seen in Lymington New Forest Hospital and the focused piece of work on High Intensity Users which includes funding a demand practitioner in SCAS to put proactive care management plans in place so individuals do not continually turn up at ED or in Primary Care. • Stated that when looking at UHS current overspend and forecast it does not seem as if there will be any recovery and further assurance is required that work is being done to recover the position. It was responded that at present Southampton and South West system is not operating as a system to deliver a consistent control total. • UHS are still on full PBR with some limited mitigation. There is still a wish to work together to manage the pressures which we are seeing which is a formal part of the contract agreement with UHS. Escalation is in place and the next Performance Board is due to meet on the 13 September 2019 and will focus on where there are pressures and what our collective actions are to address this. There will be the opportunity for individual organisations to focus on their delivery and areas of negative impact on the wider system. It was reflected that at the moment UHS is significantly under plan on elective and the waiting list is going up; bringing this list down will impact on their spend and will only make our financial position worse. This is the same for Southampton. There is a need to take some substantial action to understand what is driving demand in order to put some system actions in place to address this. Currently UHS, SHFT and WHCCG have substantial financial risk. Solent and SCCCG face a lesser financial risk. • Commented that this is the first time in four years where in September the CCG has almost £9m QIPP not identified and it was questioned as to whether there should be more direct contact with the UHS Board regarding how we can work together, rather than just 'squeezing' the contract, recognising as already mentioned the chances of turning this around this late in the year is very slim. Maggie MacIsaac stated that there are questions around the whole system and there is clearly a dynamic in that the contract with UHS has more risks than in some other areas. If talking about winter pressures, one would think we are in that situation now that is UHS, PHT and IOW have had really low ED figures all this week. Rather than continue with the

approach adopted previously there is the opportunity for meaningful conversations about where we currently find ourselves and a joined up approach in what we are going to do to turn things around is required. The regulatory pressure on providers, particularly on urgent care is impacting on that dynamic. Need a system conversation, with representatives of Boards, recognising the huge pressure front line staff are experiencing, this is an area we need to develop to drive transformation. Simon Garlick suggested that he would like to take our Finance and Performance report to some of their NEDs to help them understand the position. It was reflected that there may now be an opportunity for lay members to apply pressure/start to support these types of conversations for executives.

- Stated that it is helpful to talk about the bigger picture, but it still feels that there is not any clarity regarding what is driving the increase in activity across the board. It was reported that the performance team have developed a report from previous year's data that indicates that the increase in activity is due to increasing ageing population. If this is the case it was questioned as to how do we work together to address this with providers and what are the required actions. It was reported that Adrian Higgins has established a clinical leads forum which includes leads from providers. The challenge therefore is not just about what Boards want to do but how it translates to clinical teams who meet demand on a day to day basis. It was reflected that the pressures everywhere are felt within general practice. When supportive discussions are taking place it was requested that people keep in mind the general practice perspective. Attention was drawn to a discussion at the preceding Primary Care Commissioning Committee and one thing that had stood out from the GP patient survey is the difficulties around access and it was suggested that perhaps this could be impacting on ED.
- Simon Garlick reported that he had a conversation with Simeon Baker where he shared an analysis of ED attendance stratified by why attending. On review the biggest number was those where nothing presented, that is, a high percentage where there was nothing to diagnose. It was reiterated that it is the admissions from ED which are paralysing hospitals. Rachael King added that a significant increase has been seen in minors, so we are working on this to understand why attending ED for minors when there are alternatives available such as hubs. This is about going to ED and talking to patients as to why they are there. It was agreed that majors and admissions is critical. It was reported that we benchmark well regarding elderly admissions, but feel that at least 30% could be turned round at the front door and cared for in the community, so it is about putting resource in place in the community for example the frailty service in New Forest. It was noted that issues are across the board, not just elderly or paediatrics, hence more detailed work is being done with trusts to understand some of the patterns.
- Queried whether the frailty team developments will have an impact on this winter. It was responded that expansion of the model will require finance so it is a balance of risk and investment. There is a need to look at a delivery model with a much more integrated model with UHS and working more closely with practices. Hope to get elements in place by this winter, although full implementation won't be until 2020.
- Commented that there is still a broader question around being asked to receive the report but the 'so what' question still needs addressing. It was responded that, as mentioned previously, it is that the discussion around the UHS system needs to be escalated and Maggie MacIsaac will be taking this forward with colleagues in CCGs and providers. An update will be brought back to this Committee following the meeting with Executive Team on the 13 September 2019.

ACTION: Mike Fulford

- Reported that in relation to Integrated Intermediate Care, the CCG is trying to put in a service specification which includes admission avoidance. Progress is challenging and slow and it was queried if there is more conversation that can be held with

	Hampshire County Council (HCC) and other colleagues as to how this can be escalated. It was responded that conversations are already underway with HCC and this has been escalated. • Reported that on a positive note the work undertaken with long stay patients and excess bed days has resulted in significant reductions in UHS which we want to build on regarding effective discharge for both complex patients as well as working with the trust on simple flow / discharge. On concluding the discussion Maggie MacIsaac expressed thanks to Rachael King who has been chairing some of the operational calls with partners.
4.1.4	**AGREED** **The West Hampshire Clinical Commissioning Group Finance and Performance Committee:** • **Received and reviewed the update on the risks in relation to the West Hampshire CCG financial position 2019/20 and the report on the Month 4 financial position.** • **Agreed the action outlined at paragraph 4.1.3**
4.2	**Update on 2019/20 Savings Programme – (FPC19/044)**
4.2.1	Mike Fulford introduced paper FPC19/044 and explained that West Hampshire CCG has recognised that it would be beneficial to improve the monitoring and management of the QIPP programme in 2019/20, in order to achieve 3 main objectives: • Ensure there is more focused oversight of the eight key QIPP programmes, with clearer management reporting of milestones delivered, and where milestones are missed to agree recovery actions • Ensure that the Board are clearly briefed on any key challenges in delivery of transformational QIPP programmes • Explain and understand clearly whether financial underperformance is due to non-delivery of agreed plans, or other factors linked to contract performance.
4.2.2	Attention was drawn to: • There are **unidentified savings** totalling **9.7 million** in the financial position at 31 July 2019. • The forecast outturn for each project has been agreed with the relevant director and takes into account estimated risk to delivery as at 31 July 2019. • The risk to the QIPP programme is assessed at **£11.2 million**, including **£9.7m** of unidentified QIPP. • Identified QIPP is forecast to deliver at **93%** of plan – however, the total CCG required QIPP including unidentified is only forecast to delivery at **62%.** • The CCG plans to offset this risk by the implementation of a future financial recovery action plan to equal or exceed this total. The priority is to agree actions to address financial over-performance on HHFT, UHS contracts.
4.2.3	It was highlighted that: • It is critical to note that identified QIPP is forecast to deliver at 93% of plan, however the total CCG required QIPP including unidentified is only forecast to deliver at 62%. • When looking at current risks regarding medicines management and CHC, the Committee were advised that further actions have been put in place for example signed off a little ‘expense to save’ in CHC and there is now more confidence that this will be brought back in line by year end.

	• There is still substantial pressures coming through that is we have got a targeted QIPP programme that is delivering substantial savings for example unscheduled care at UHS, but we are seeing a range of pressures coming out of other services which to date had not been identified as areas of opportunity. • The biggest area of opportunity that isn't being delivered at present is around outpatients. The team are struggling to get traction with these services, particularly when providers are challenged internally regarding their own processes / where they have substantial operational risks for example very substantial support is required to deliver the work programme around UHS. • For the next meeting a more slimmed down report focused on areas of slippage and identifying corrective actions being put in place is being prepared.
4.2.4	As a result of discussion: • Attention was drawn to the earlier discussion around the difficult position we find ourselves in at this point of the year with nearly £10m of unidentified QIPP. It was stated that we have had non-recurrent support for probably the last four years which is no longer available. In terms of opportunity to deliver efficiency savings, cash needs to come out of the acute sector. Therefore this comes down to bigger conversations regarding how we get to system discussion around how to move money out of acute services into other sectors. Even with putting in higher investment in Mental Health, Primary Care and Community Services, we have not seen the ability to shift the resourcing and so need to discuss how proactively as a system we move the money, which to date has been more difficult in the Southampton and South West System. • It was stated that CHC have identified further schemes and the Committee were reminded that this is in the context of improving performance for CHC; numbers of referrals have gone up, however time taken to deal with has gone down and the team is now achieving a number of national targets. • Reflected that WHCCG has always delivered financially and it does feel uncomfortable sitting here hearing these numbers and whilst similar stories are reflected elsewhere, the scale for WHCCG is particularly of concern. On concluding the discussion Caroline Ward asked Maggie MacIsaac if there are any areas the CCG has not already spotted that are working elsewhere. Maggie MacIsaac responded that the two key things are: • Making sure all transformation work and detailed activities is happening everywhere at the same pace. It was reflected that a lot of people in the team are focusing on a number of things and it was suggested that it might be worth undertaking a review of staff, where they are working and perhaps focussing on fewer workstreams which will provide the biggest impact. • The issue also around the dynamics with UHS and the way we work with them and the bigger picture work. Going back to the point made earlier in the meeting in that we are not very good across the whole system at having the primary care data. There is a need to get the system picture explained more explicitly with regard to data, with more focussed data required in order to generate the key things that we need to do, elevated to a strategic level to focus on things that will make a difference.
4.2.5	**AGREED** **The West Hampshire Clinical Commissioning Group Finance and Performance Committee:** • **Received and reviewed the update on the risks in relation to the implementation of the West Hampshire CCG Financial Plan 2019/20 as at Month 4.**

5.	**PERFORMANCE REPORTING**
5.1	**Performance Report as at 8 August 2019 (FPC19/045)**
5.1.1	Mike Fulford introduced paper FPC19/045 which provided the overall performance for West Hampshire CCG and its main NHS providers.
5.1.2	Attention was drawn to the following key points: **Accident and Emergency 4 hour standard, and Urgent Care**: • Performance improved slightly in July, and there was a reduction in the very high volume of attendances we have seen, particularly at UHSFT. • UHSFT performance improved slightly from 78.08% in June to 81.74% in July. The SW AEDB has developed a further system wide delivery plan, following reviews by NHS E/I and a revised recovery plan, building on the 6 key elements requiring improvement. This plan has now been agreed with regulators, with a target to delivery 90% by September. • HHFT performance improved marginally from 83.77% in June to 84.71% in July. There has been a marked increase in short stay attendances at the Basingstoke site, which is under review as at the moment there is no one clear defining factor – there has been an increase across all age and activity types. The NHSE/I support provided to HHFT continues to help support the Trust, and in particular to extend the improvement work that started on the Basingstoke site to Winchester, as there continues to be variation in performance across sites on a daily basis. **Diagnostic performance, WHCCG wide** • Further to last month's update where there was a general, but notable, decline in the number of patients receiving their diagnostic test within six weeks in line with national standards, performance improved marginally but continues to be of concern. • 1.83% of WH patients (173 patients) missed the 6 week standard – nationally the average performance is 3.6%, and WHCCG are in the middle of the benchmarked position, but diagnostics performance is often an early warning indicator of pressures across RTT and cancer performance. • Recovery plans have been requested from all 4 major acute providers treating our patients. **Cancer standards, UHSFT and HHFT** • WHCCG met four of the nine cancer waiting time standards at CCG level in June 2019 – deterioration from 6 last month. • 2 week wait standards improved for the sixth consecutive month, and UHS significantly improved breast referral and TWW performance. Performance against the 31 and 62 day standard did not improve, but the remedial action plan that has been agreed for delivery of 31 day (surgery) and 62 day standards in December is on track and improvement is expected in the next month. **RTT delivery, and total waiting list size** • The CCG failed to achieve the 92% standard, with deterioration across providers, and an increase in the total waiting list to 40,232 against a plan of 37,735 – a verbal update will be provided at the meeting.
5.1.3	It was reported that: • All systems are under substantial performance pressure / financial pressure. Seen ongoing pressures that are variable in terms of performance which is why some are in national awareness.

	• There are pressures across both UHS and HHFT. HHFT have maintained a level positon but remain low against overall targets, pressures in surrounding systems such as PHT are having an impact. Diagnostics has not improved materially, in some services it is because of lack of capacity and the position is also compounded by the pension issue. Cancer performance improved for 2 ww and positive that although failing 31 and 62 days, trajectories are being met.
	• Unexpectedly a substantial rise has been seen in the waiting list particularly driven by UHS but seen across a number of providers so work is underway to understand this. It was noted that all have recovery plans in place.
	• UHS :
	  • July did see improving position 81.74%. August improving position 83.35% and last week 88.66%. Then hit the bank holiday and performance dipped to around 70%. Gradually through this week it is recovering and back up to 80%. Not high volumes in terms of activity; issues are regarding flow particularly simple flow which is within the trusts gift, but also complex flow. Work is being undertaken to review what action could be done by the system going into Bank Holiday weekends. It was highlighted that as of 1 July 2019 activity for Lymington New Forest Hospital (LNFH) transferred across to PHL and are no longer counted into these figures.
	  • Recovery plan to reach 90% by December for the trust, with a system recovery plan in place. System assurance calls with NHSE and through A&E Delivery Board regarding delivery as a system, so there are a lot of actions in place and we really need to work together as a system to improve areas identified. NHSE/I have said that they will review the level of performance and improvement at the end of September which may lead to further regulatory escalation. It was queried what is the sense of where they are at and the likelihood of meeting the 90% target. It was responded that the trust have focused on the internal actions agreed with Matthew Cook, national expert. The Trust has significantly improved minor performance and has met targets. Junior doctors started in August which has made a difference in terms of capacity. The CCG need to ensure UHS deliver internal actions, but also take account of what actions need to be undertaken as a system. It was stated that it is about sustaining performance and maintaining resilience and bringing forward all the usual winter actions to get that resilience in place.

5.1.4	As a result of discussion it was: • Queried if the issues with flu jabs will make an impact. It was responded, no as it is a phasing issue and it is only one strain that is delayed. If action is taken to target everyone that has respiratory disease this would make a huge difference in terms of admissions so this will be an area of a focused campaign. • Reflected on the issues around bank holiday performance and all of the discussions that lead up to these predictable events and it was questioned how are we learning from this to ensure that this does not continue. It was responded that a review of resilience is being undertaken. Some of this relates to internal processes within the trust, reviewing against Operational Delivery Group (ODG); there are issues regarding some of the community response that has been identified. • Reflected that a lot of conversations seem to be undertaken in isolation; trusts have plans as have GPs. All seem to try and put plans in place without working closely with other services such as PHL and Out of Hours to put resource together. It was recognised that this is a good point. It was stated that the ODG does have all partners represented, used for planning in terms of Bank Holidays and winter planning. However, these are system plans and a lot more work is needed in terms of integration. Attention was drawn to the fact that UHS were saying that frontline ED clinicians aren't aware of what else is available which in reality means there is limited

	connection at the point where people walk in. Therefore it is about getting front line people together more often to gain an understanding of what is available in the system. • Reference was made to the Frailty pathway, and there now being more understanding of availability of community resource and the way we want to work across the system will increase visibility of the service. It was stated that there are other pathways where this can be done. • Commented that there is discussion taking place regarding partners having no visibility of the pressure each of them has for example PHL have no idea of pressure in A&E, neither do 111 or 999 so presently there is no ability to act in a coordinated way when there is a surge in demand for example where there is capacity that can be accessed. • It was reflected that whilst systems have been put in place to publicise services that are available, lack of awareness in front line staff demonstrates that systems / contracts keep changing and therefore need to continue to publicise arrangements / services that are in place for example so a triage nurse could divert / refer elsewhere.
5.1.5	**AGREED** **The West Hampshire CCG Finance and Performance Committee:** • **Noted and provided comment on the performance report.**
5.2	**<u>NHS Improvement and Assessment Framework (IAF) 2018/19</u> (FPC19/046)**

5.2.1	Mike Fulford introduced paper FPC19/046 and explained that the purpose of the paper is to provide an update on the 2018/19 year end performance of West Hampshire CCG against the Integrated Assessment Framework (IAF), by NHS England. The IAF is a complex assessment process and an overall rating is received in July of each year for the previous year. The 56 clinical indicators that form part of the assessment are updated **quarterly**, as data becomes available. The data included in this year-end assessment is reported as relating to Quarter 4 performance – however, many of the metrics have a significant lag time and therefore, are reporting 6 months in arrears.
	
	Attention was drawn to the following key points:
	• The WHCCG 2018/19 overall rating was the same as last year – 'requires improvement.' However, there was an improvement in the financial rating for the CCG, which moved from red to amber.
	• The final overall rating received for 2018/19 was:
	    • Final CCG headline rating – Requires Improvement
	    • Quality of leadership rating – Amber
	    • Finance rating – Amber
	• There was no significant deterioration in any of the key clinical indicators, but 10 indicators remain in the bottom quartile, including one of the diabetes indicators, and dementia. Positively, however, there have been improvements in the majority of indicators.
	• The action plans for each indicator are included in the briefing pack.
	• The 'requires improvement' rating was predominantly driven by the CCGs amber financial rating – which accounts for 25% of the overall score.
	• The CCG met each of the financial requirements with the exception of Commissioner Support Fund allocations – for which the CCG was in receipt of £688k – and this meant that the CCG would not be able to be scored higher than 'requires improvement'
	• The detailed summary and methodology is set out in slides 2-5 of the attached pack.

5.2.2	Mike Fulford reminded the Committee that the CCG was rated as Requires Improvement in 2018/2019 which on initial viewing was queried as to whether this was in fact correct. The finance rating improved from Red to Amber but because we received some commissioning support funding (CSF) of just under £700k, this resulted in an Amber rating for that indicator. This was the only Amber in finance, which led to an overall finance rating of Amber, which due to the weighting took us to Requires Improvement. It was stated that this was an accurate reflection given the framework. However, Mike Fulford commented that if he had known that when the CCG agreed to CSF that it would have had that impact, this would have led to another discussion with NHSE.
5.2.3	Maggie MacIsaac reported that she has already commenced a review process with the Partnership with all CCG members looking at all 56 criteria of that framework, which has now been expanded to include WHCCG and SCCCG. Maggie MacIsaac added that we do need to look at this across the board as there are some inconsistencies which is not great for morale / standing with partners. A sensible approach seemed to be to have one conversation with NHSE with multiple hats on in order to hold them to earlier account as to what does good or outstanding look like so we have the best working knowledge of the ratings we can. A meeting will be held soon in order to endeavour to get everyone in the best position possible. It was commented that the quality of leadership has zero granularity and is pulled forward from last year and if we do not agree with a rating, then perhaps we should write back to NHSE to explain why and query what more can we do. It was responded that it is felt that the quality of leadership is the area that is less clear, this is all to do with CCGs and the ways they are working together and this is what prompted the conversation with NHSE about having greater transparency and to focus / do more on our outcomes, particularly in light of the variation that can be seen.
5.2.4	**AGREED** **The West Hampshire CCG Finance and Performance Committee:** • **Reviewed the briefing report**
6.	**ANY OTHER BUSINESS** – There were no items raised on this occasion.
7.	**RISKS ARISING FROM DISCUSSION OF AGENDA ITEMS TO BE INCLUDED ON THE CORPORATE RISK REGISTER** - There were no items identified on this occasion.
8.	**DATE OF NEXT MEETING** – The Finance and Performance Committee will next meet on Thursday 26 September 2019. Timing to be confirmed.

NHS West Hampshire Clinical Commissioning Group

Minutes

Finance and Performance Committee

Minutes of the Finance and Performance Committee meeting held on Thursday 26 September 2019 from 9.30am to 11.00am at Lyndhurst Community Centre, Lyndhurst, Hampshire SO43 7NY

Present:	Alison Rogers	Lay Member Strategy and Finance, **CHAIR**
	Charlie Besley	Locality Clinical Director Totton and Waterside
	Mike Fulford	Managing Director and Chief Finance Officer
	Simon Garlick	Lay Member Governance/Audit
	Judy Gillow	Lay Member Quality
	Adrian Higgins	Medical Director
	Rachael King	Director of Commissioning – South West
	Johnny Lyon-Maris	Locality Clinical Director, West New Forest
	Lorne McEwan	Locality Clinical Director, Winchester
	Ellen McNicholas	Director of Quality and Board Nurse
	Sarah Schofield	Clinical Chairman
	Caroline Ward	Lay Member New Technologies and Digital
	Ali Young	Deputy Director Mid-Hampshire (Deputising for Jenny Erwin)
In Attendance:	Ian Corless	Board Secretary/Head of Business Services
	Mario Martin	Graduate Management Trainee, Finance
	Jackie Zabiela	Governance Manager (Minutes)
Apologies:	Jenny Erwin	Director of Commissioning – Mid Hampshire
	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes
	Rory Honney	Locality Clinical Director, Andover
	Maggie MacIsaac	Chief Executive: Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups; Southampton City Clinical Commissioning Group; West Hampshire Clinical Commissioning Group
	Jim Smallwood	Secondary Care Consultant
	Stuart Ward	Locality Clinical Director Eastleigh North and Test Valley South

Summary of Actions:

Minute Ref:	Action	Who	By
5.1.3	**Finance Report:** • Include in future papers additional narrative around SCCCG contractual position and provide same level of detail for PHT as highlighted for other providers. • To ask team to review graphs 9 and 10 and their match with percentages quoted, page 13 clarify how sub-total was reached and page 31 year end figure of 1883 was questioned as to whether there is a mis-match with the red and blue line of the graph.	(AS) (AS)	16.10.19 ASAP
5.2.3	**2019/20 Savings Programme:** • Mike Fulford to speak to Andrew Short about including additional narrative within the detailed QIPP pack. • Update on the actions being taken within the Mid Hampshire Transformation Plan including an update on. To be circulated through Jackie Zabiela/Terry Renshaw.	MF/(AS) AY/JE/JZ/TR	16.10.19 Immediate
6.1.4	**Performance Report –** To query with the team if there is any benchmarking of CAMHS performance in terms of benchmarking waiting times with other organisations.	(MD)	ASAP

1.	**WELCOME, APOLOGIES AND CONFIRMATION OF QUORACY**
1.1 1.2	Alison Rogers welcomed members present to the meeting of the NHS West Hampshire Clinical Commissioning Group (West Hampshire CCG) Finance and Performance Committee and noted apologies for absence. It was confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST (FPC19/050)**
2.1 2.2 **2.3**	Alison Rogers directed members to the Declaration of Interest Register. Attention was drawn to the fact that should a conflict arise at any point during the meeting members will need to declare this fact. **AGREED** **The West Hampshire CCG Finance and Performance Committee:** • **Received and noted the Register of Interests.**
3.	**MINUTES OF THE PREVIOUS MEETING (FPC19/051)**
3.1	The Finance and Performance Committee received the draft minutes of the meeting held on the 29 August 2019.

3.2	**AGREED** **The West Hampshire Finance and Performance Committee:** • **Approved the minutes of the meeting held on the 29 August 2019 with no matters arising.**
4.	**<u>ACTION TRACKER</u> (FPC19/052)**
4.1	Alison Rogers introduced paper FPC19/052. The following updates to the action tracker were noted:
	1. **<u>FPC19/006a) Savings Programme: More pro-active comms required around Orthopaedic Choice</u>** – It was reported that there will be no communications with regard to the Orthopaedic Choice service until around March next year once recruitment has embedded and the service established. It is intended that feedback on implementation will be programmed into a Board meeting/briefing session in the Spring. **Closed.**
	2. **<u>FPC19/006b) Savings Programme: Add resourcing the scale/challenge around the change programme and pressures driving the system onto the action tracker</u>** – It was reported that this has been added to the action tracker rather than the risk register. Alison Rogers commented that it is important not always to imply/reference that a system solution is the answer to everything and that we need to keep our eye on the ball locally. Alison Rogers reminded the Committee that this is not a true action, but an **AIDE MEMOIRE**.
	3. **<u>FPC19/007 Escalation around UHS System: Update to be provided at the next meeting following meeting with the Executive Team on 13 September 2019</u> –** It was reported that a meeting has taken place, about a week ago, with the UHSFT Director of Finance and Transformation and Chief Finance Officer along with both West Hampshire and Southampton City CCGs. Three key areas of over performance were raised as follows, in reverse order: • **High Cost Drugs:** There has been a spike which had not been anticipated. A review programme has been agreed with the pharmacist lead in the Medicines Optimisation team. A meeting has been scheduled in 2 weeks to review actions. There was some debate around internal meetings, with a revised working process put in place to ensure quicker escalation process. • **Out Patient Procedures**. There is a high overspend on outpatient procedures, with a review being undertaken on the key areas / services with increasing numbers. UHSFT are indicating that they are putting on more activity in order to meet targets for example cancer. This is being reviewed as some of the percentage changes are so substantial and to date the additional capacity had not been flagged. • **Non-Elective**. The biggest issue is non-elective related to both a bigger price change as well as a more modest activity change. Indications are that this is due to coding changes. CCGs will be working with UHSFT to rectify / look at this. There was discussion around unrelated co-morbidities, discharge summaries, PBR guidance, cultural change and medical training. Attention was drawn to: • A discussion earlier in the year regarding Red and Green Practice raising a challenge if a co-morbidity is received that is unrelated to the treatment provided. Adrian Higgins and Charlie Besley at the time agreed to look into this and it was noted that work is currently being undertaken to obtain specific examples from the data team in order to enable these to be followed up. • The need for an external review around co-morbidities and this will be taken

	formally through contract management processes/challenge until the matter is resolved. • Previous discussions around encouraging outpatient procedures rather than day cases and it was queried whether this has been seen in practice. It was reported that the more likely position is that there has been a shift from first to follow-up appointments into outpatient procedures; however it is too early to confirm this. A formal update on the UHSFT escalation position is to be presented at the next meeting.
4.2	**AGREED** **The West Hampshire Finance and Performance Committee:** • **Received the updates from the action tracker.** • **Agreed that one action is complete and can now be closed.**
5.	**FINANCE**
5.1	**2019/20 Finance Report for Period Ending 31 August 2019 (Month 5) (FPC19/053)**
5.1.1	Mike Fulford introduced paper FPC19/053 that provided an update to the Committee on the financial performance as at Month 5. It shows: • For the 2019/20 financial year we are planning on income of **£810,104m** and expenditure of **£810,058m**. This reflects the planning requirement to replicate in 2019/20 the small actual surplus of **£0.046m** that was the final position in the CCG Annual Accounts for 2018/19. • The financial performance position shown in the report at the end of August 2019 shows a **breakeven** position against plan in the year to date. This includes four months of data on acute contracts and three months of data available for medicines management. The overall forecast overspend on acute contracts is now **£7.9m** with overspends primarily driven by pressures in Non-Elective inpatient activity, Accident & Emergency, outpatient first attendance, outpatient procedures and critical care. • UHS, HHFT, PHT and SCAS have a combined forecast overspend of **£7.1m** within the **£7.9m** acute total above. • The month 5 position on CHC has moved to a year to date overspend of **£1.5m** that extrapolates to a forecast of **£2.3m**. Year to date and forecast outturn pressures in CHC Adult Learning Disabilities and CHC Adult Physical Disabilities care groups are primarily as a result of a small number of very high cost cases. In addition there has been an increase in the value of retrospective claims settled in the first part of the year which is forecast to continue for the remainder of the year. • The reported forecast underspend in Primary Care of **£0.9m** reflects the 1% contingency budget that sits within the Delegated Primary Care allocation of **£0.7m** less an expected overspend of **£0.4m** due to double running of existing QPS and new Primary Care Network funding. • The 2019/20 year-end forecast remains at plan at this stage in the financial year as work continues on financial recovery across all budget lines. • There remains a significant amount of risk to the CCG's year end forecast. At the end of August the CCG has identified £11.3m of QIPP risk, £3.2m of risk associated with in-year activity pressures and £0.6m of other risks. These risks are partially mitigated through plans totalling £1.2m. However, after mitigations the CCG has still identified a **net £14.0m risk** to the year-end breakeven forecast. This compares to a £14.6m net risk reported at the end of July.
5.1.2	Attention was drawn to the following highlights: • The CCG continues to see a continuation of our key pressures around acutes and CHC

	and in overall terms the risk has reduced to £14m; this is still substantial and is a real risk in terms of crystallisation of current pressures. • We are continuing to see pressure at UHS, although the majority is in the three areas already articulated, with 40% being in relation to non-elective cost pressures. • There has also been an increase with regard to the PHT contract for non-elective, which is still up. ED is also up. Non-elective has a bit of play off with regard to additional short stay admissions at HHFT. The issue being price rather than numbers. Recovery action plans are in place and a challenge is being made around the UHSFT contract. An update on performance to date of QIPP programmes is to be provided later in the meeting, with specific work underway with SCAS in relation to the current over performance position, which is currently 6% across the contract. • Both PHT and SFT have individual recovery action plans and challenge. • CHC still have some ongoing underlying pressures; the number of cases is flat, which is positive, and the cost of individual, normal cases is coming down, however there continues to be a spike in high cost packages of care. A couple of years ago it would be rare to have a case of more than £5k, however it is now not unusual to have packages which cost much more for example £14k - £15k for very complex patients, which are now more frequent. What is really driving performance is historic cases being finalised and these high cost packages. • We have seen an over performance on acute rehab beds at Snowden House as part of the Solent contract. Ellen McNicholas' team has been working really hard on this and the potential overspend has been turned around with forecast now broadly on plan. On concluding the highlight report it was summarised that the financial position is therefore still very pressurised, with no ability this year for non-recurrent financial support to close the financial gap.
5.1.3	As a result of discussion it was: • Questioned with regard to high cost CHC whether this is a trend or a spike and do our budgeting projections need to be changed. It was responded that there are some spikes; however this is now becoming a trend which the CCG is unable to predict/cannot map as well as other areas. It was highlighted that this is quite disease specific for example we know that more children require ventilation in the community and some of the spike this year is in relation to UHSFT patients with motor neurone disease. It is recognised that some of this is due to specialisation/impact of patient choice in that we have a very good teaching hospital which will attract the more complex patients. • Commented that it would be helpful to see SCCCG finance/performance data as well as our own to compare performance and also to see what actions we are taking both jointly and separately and if they are having an impact, so that we can start to see this as a system picture. Attention was also drawn to PHT performance and it was highlighted that it would be good to see them separated out as we do with other providers. It was agreed to include in future papers additional narrative around SCCCG contractual position and provide the same level of detail for the PHT contract as highlighted for other providers. **ACTION: (Andrew Short)** • Agreed to ask the team to review graphs 9 and 10 and their match with percentages quoted, page 13 clarify how sub-total was reached and page 31 year end figure of 1883 was questioned as to whether there is a mis-match with the red and blue line of the graph. **ACTION: (Andrew Short)** • Highlighted that in respect of the QIPP Performance Summary on page 23 it is indicating that forecast delivery is going to fall significantly from the current position and it was queried should we be worried about this given we are going into winter

	and providers will have pressures which will impact on us and our year end position. It was confirmed that we are concerned and this has been factored into all of the elements and is included in the forecast. Attention was drawn to a system meeting that is taking place in relation to system finance with an invitation on the 4 October 2019 to go to London to talk to Anne Eden with regard to the North and Mid-System. The Committee were reminded that as a Board a decision has been made to invest in CAMHS and the Primary Care Mental Health Strategy which will impact on the ability to support other community projects. As to the query as to whether the CCG is doing everything we possibly can it was responded that we are confident the CCG is doing everything we can to bring the position down/improve financial numbers by year end. • It was reflected that we as a Board need to work differently with our acute providers to enable the release of investment opportunities for other areas. It was responded that this is why the conversations we are having with the UHSFT Board in particular are critical and which is why we need a system conversation regarding how to redirect resources into the community. • It was questioned if SCCCG are experiencing the same pressures/issues as we are and if so are using the same model. It was confirmed that this is the case which is why we are working together in order to strengthen our position. At the moment Specialised Services are in line with their plan, which is a planned overspend. Attention was drawn to the fact that the two CCGs work together in terms of contract negotiations, and a lot of the transformation work that is being progressed is also being undertaken on a joint basis.
5.1.4	**AGREED** **The West Hampshire Clinical Commissioning Group Finance and Performance Committee:** • **Received and reviewed the update on the risks in relation to the West Hampshire CCG financial position 2019/20 and the report on the Month 5 financial position.** • **Agreed the actions outlined at paragraph 5.1.3.**
5.2	**Update on 2019/20 Savings Programme – (FPC19/054)**
5.2.1	Mike Fulford introduced paper FPC19/054 and explained that West Hampshire CCG has recognised that it would be beneficial to improve the monitoring and management of the QIPP programme in 2019/20, in order to achieve 3 main objectives: • Ensure there is more focused oversight of the eight key QIPP programmes, with clearer management reporting of milestones delivered, and where milestones are missed to agree recovery actions • Ensure that the Board are clearly briefed on any key challenges in delivery of transformational QIPP programmes • Explain and understand clearly whether financial underperformance is due to non-delivery of agreed plans, or other factors linked to contract performance.
5.2.2	Attention was drawn to: • There are **unidentified savings** totalling **9.7 million** in the financial position at 31 August 2019. • The forecast outturn for each project has been agreed with the relevant director and takes into account estimated risk to delivery as at 31 August 2019. • The risk to the QIPP is forecast to deliver at **92%** of plan, however, the total CCG required QIPP including unidentified is only forecast to deliver at **62%** • The CCG plans to offset this risk by the implementation of a future financial recovery

	action plan to equal or exceed this total. The priority is to agree actions to address financial over-performance on the HHFT, UHSFT contracts.

5.2.3	As a result of discussion it was:
	• Highlighted that page 32 of the preceding report on QIPP had a number of blank boxes in terms of actions/mitigations and it was noted there is enough space to be able to include more detail to avoid queries being raised. Mike Fulford agreed to speak to Andrew Short about including additional narrative within the detailed QIPP pack.
	ACTION: (Andrew Short)
	• Commented that one of our commitments to NHSE was to look at QIPP in a more granular way and the Chair asked the Committee if it would be beneficial to look at two or three schemes in more detail with director leads in order to provide more detail and to give an opportunity for members to raise any queries. There followed a focused discussion on the following schemes:
	  • **CHC** - It was stated that:
	    • As the Board will remember, the CHC had a fantastically good year last year in terms of QIPP delivery; all the quick wins were achieved last year and so now this will be more difficult. It was added that whilst this Committee is concerned with the WHCCG position, we also need to reflect that we do provide CHC to the wider Hampshire CCGs, so the overall target for the CHC team is £6.2m.
	    • For WHCCG we are forecasting a Year To Date overspend of £1.5m that extrapolates to a forecast of £2.3m but the current deficit is £0.8m, of this £0.5m was the stretch target given to the service in April after the team had agreed what the deliverable plans were. So effectively there is £0.3m slippage currently. This is because the team have focused on / prioritised the larger schemes that would make the highest impact to make the highest savings. £1.7m of this is secure and not at risk. From now on the team will be able to focus and gain traction on the slippage.
	    • With regard to the stretch target, the team are working up plans as to how this could be closed. They are working with Liaison who have proposed a retrospective check of payments made by CHC beyond the date of a person's death. They are estimating minimum savings of £100k but could be as high as £0.25m. Another potential scheme is to recharge items back to Hampshire County Council from the date of decision but this would have a massive impact on budgets for each CCG. This is against a background of an increasing number of assessments coming through which the team are managing to deal with, for example the team have achieved the target of 85% of assessments taking place outside of the acute setting for four months running now. Ellen McNicholas added that she is confident that everything that the team can possibly do to close the gap is being done.
	
	It was commented that, on the face of the report provided, one of the issues reported is that we fail to deliver projected savings due to prioritisation, which is a different message to the verbal update. It was responded that this is semantics; the team have focused on the priority schemes they knew they could develop. The £1.01m referred to in the report is for WHCCG data only; and it was reiterated that the team are working to deliver savings for other CCGs as well as us.
	
	  • **Outpatients: South West System –** It was reported that:
	    • There has been a great deal of discussion recently in the south west system. It was flagged that we are dependent on acute trusts to deliver outpatient transformation. Where the CCG is in complete control, for example the Referral Support Service where there is over delivery and where there is a particular interest for the trust for example excess bed days we are on target.

	• In terms of outpatients the issue is engagement, sign up and pace within the provider which is causing issues, with a forecast delivery of 25% of target. There is a robust programme in place focused on T&O, Ophthalmology, Dermatology and Gastro moving to non-face-to-face/virtual appointments and using My Medical Record. There has been slippage in delivery of that programme by the trust and the pace in identifying additional specialities is not at the pace we need either, which is causing a risk for QIPP. This is on the Transformation Meeting agenda this week (monthly meetings in place), however it was noted that Rachael King will be meeting with Jane Hayward and Tristan Chapman to discuss how we can improve pace. • With regard to the main risk being team resource, as this is the main risk for SW QIPP delivery some more senior resource has been put in as well as additional support to work with the acute trust and the specialities to get more pace. It was confirmed that there is a joint programme / transformation board with SCCCG in place. • **Outpatients: North & Mid** – It was: • Reported that the main focus is an oversight group reviewing where the high cost specialities are. The trust are seeing some significant productivity gains with a decrease in DNA and cancellations, however the difficulty is in how to translate this into cost savings. There is staff attrition within some services so some clinics can be closed down to reduce activity. Work is ongoing around cardiology and in terms of speciality work where we think there are some further gains to be achieved. • Noted that there are a number of milestones within the Mid Hampshire Transformation Plan which are overdue. It was agreed that an update on the actions being taken will be provided after the meeting, to be circulated through Jackie Zabiela / Terry Renshaw. **ACTION: Ali Young / Jenny Erwin** • **Emergency Departments: ED / Excess Bed Days** • **HHFT –** It was reported: • That in relation to HHFT both non-elective excess bed days and ED are closely aligned. Non-elective excess beds are being monitoring and there is a small proportion where we are starting to see gains, with a reduction in bed occupancy. Improvements are therefore now starting to be made, although there remains a risk regarding complex long stay patients over 21 days, where there has been a spike recently. A ‘grand ward round’ is being implemented so there is internal clinical challenge working on this cohort. In terms of ‘cost out’ and culture changes, there have been really valuable conversations with HHFT regarding how this can be translated into intermediate care beds and looking at shifting staff resource with the aim of getting cost down in the system. • In terms of ED / SDEC we are struggling to define the impact. A new unit is opening in Winchester so there is an increase in same day emergency care (SDEC) but we are trying to define if this is a real increase or if it relates to managing ED flow as we need to be sure of the impact on patients who previously were staying 2 or 3 days. Until we get the data to a recognisable point it is hard to determine the impact. Work is ongoing with NHSE to look at practical ways to move forward in terms of counting and coding. Mike Fulford added that this has been part of the external support by 2020 into both BNHH and RHCH sponsored by NHSE/I. It is early days in terms of the impact SDEC will have at Winchester. However, what is clear at the moment is that RHCH are the lowest in the close region in terms of occupancy level, down from 95% to the high 80’s% however this has not enabled release of any cost into the

	system. We have as yet not seen the shift in length of stay that we would expect to see from this in terms of 1 to 2 or 3 day length of stay coming down that is we have not seen the change we had been anticipating. This is still early days as to what we may see in RHCH. In financial terms the CCG is not at risk due to the contractual agreement we have with the trust, however the system has a £30m pressure when looking at all the providers so it is critical to now look at taking the cost out of the system and avoid more coming in. • Ongoing conversations are about the cost to the systems, whilst trying to balance with the requirements for the CCG. The contractual agreement means we have the trust's buy in to a number of these programmes, but in terms of pounds out of the system this is more problematic. As with SCCCG, all the work is aligned with North Hampshire CCG commissioners. On concluding the discussion it was observed that due to our improved relationship with HHFT we do not have a £2 to £3m cost pressure due to coding. SDEC and excess bed days has achieved getting people home quicker, which is positive. There is now some really good leadership at HHFT, investment in operational staff with a motivated workforce who are owning some of the improvements. Whilst the situation has improved since the poor CQC report of a while ago, this has come at a price, such as an increased staff pay bill, which has had quite a material impact on the trust.
5.2.4	**AGREED** **The West Hampshire Clinical Commissioning Group Finance and Performance Committee:** • **Received and reviewed the update on the risks in relation to the implementation of the West Hampshire CCG Financial Plan 2019/20 as at Month 5.** • **Agreed the actions outlined at paragraph 5.2.3.**
6.	**PERFORMANCE REPORTING**
6.1	**Performance Report as at 12 September 2019 (FPC19/055)**
6.1.1	Mike Fulford introduced paper FPC19/055 which provided the overall performance for West Hampshire CCG and its main NHS providers.
6.1.2	Attention was drawn to the following key points: **Accident and Emergency 4 hour standard, and Urgent Care**: • Performance improved slightly in August and there was a reduction in the very high volume of attendances seen. • UHSFT performance improved slightly from 81.74% in July to 82.16% in August. The further system wide improvement plan, agreed with all partners and NHSE/I, continues to work on the six key elements requiring improvement with a target to deliver 90% by September. Invalidated data shows this position is not currently being achieved. • HHFT performance deteriorated notably from 87.71% in July to 79.93% in August. This was predominantly due to staffing challenges during the month. • There has been a marked increase in short stay attendances at the Basingstoke site, which appears to relate to a change in the way in which patients are managed when they arrive, and is under discussion. • The NHSE/I support provided to HHFT continues to help support the Trust, and in particular to extend the improvement work that started on the Basingstoke site to Winchester, as there continues to be variation in performance across sites on a daily

	basis. **Diagnostic performance, WHCCG wide** • Further to last month's update where there was a general, but notable, decline in the number of patients receiving their diagnostic test within six weeks in line with national standards, performance has not yet improved, despite there being recovery plans in place with providers. • 1.83% of WHCCG patients (173 patients) missed at the six week standard in July and this increased to July's CCG performance was 2.91% in August. • Nationally the average performance is 3.6%, and WHCCG are in the middle of the benchmarked position, but diagnostics performance is often an early warning indicator of pressures across RTT and cancer performance. • Recovery plans have been requested from all four major acute providers treating our patients, and capacity constraints are mainly due to staff unplanned absence and equipment upgrade. **Cancer standards, UHSFT and HHFT** • WHCCG met four of the nine cancer waiting time standards at CCG level in July 2019. • Two week wait (TWW) standards improved for the sixth consecutive month, and UHS significantly improved breast referral and TWW performance. Performance against the 31 and 62 day standard did not improve, but the remedial action plan that has been agreed for delivery of the 31 day (surgery) and 62 day standards in December is on track and an improvement is expected in the next month. **CAMHS standards** • The CCG continues not to achieve any of the performance standards with four out of the five standards declining in month. A detailed update is provided as part of the Board Integrated Performance Report.
6.1.3	Particular attention was drawn to: • Performance in relation to ED 4 hour standard is still variable but in general a slight improvement has been seen around UHSFT over the month and further work is ongoing with Rachael King coordinating a system plan which is delivering significantly on actions. The impact is still coming through onto performance data. There is significant variation across all providers. HHFT performance has deteriorated over the same period and seeing a great deal of volatility; we are also seeing this at RBCHFT with numbers in 60-70s (%) and SFT, who are doing well at the moment but has dipped into the 70s (%). Trusts are in a lower position going into winter this year than in previous years. • There is significant pressure around diagnostics; a number of areas are struggling with a lot of activity coming through, particularly cancer with referrals up around 10% at both UHSFT and HHFT leading to an increase in diagnostic waits; action plans are in place. • Whilst UHSFT have only achieved four out of nine cancer standards, improvement is being seen and the trust is on track with their performance trajectory. • CAMHS standards have been of concern for some time with a further deterioration being seen in performance. There had been some discussion with regard to reducing the frequency of contract meetings, however we have been firm with the lead commissioners that we do not want a decrease and have raised concerns and requested further assurance as to how these further deterioration issues are being mitigated as a matter of urgency.
6.1.4	As a result of discussion it was: • Highlighted in terms of diagnostic waits; conscious that a 10 year cancer plan has been published that is driving a need for earlier diagnosis. If we are unable to achieve diagnostic targets now is there any assurance that anything is in place that will ensure

	we are able to deliver when predominantly the issue is staffing and are we realistically expecting change or do we need to do something completely different to what has been done to date. It was responded that there is no doubt that it will be more challenging to deliver the long term plan, however there are other things that are coming through which could provide other opportunities to manage demand in different ways. In conjunction with providers we need to look at developing a proper plan going forward. This year's contract includes provision for a 6 to 7% increase in activity, although providers are seeing increases in demand over and above this. We will need to continue to work together with all parts of the systems to come up with a plan moving forward that will enable us to meet targets. • Queried if the CCG can contract for innovation, it was stated that all providers will take any opportunity that will help them manage the tide of demand as they do not want to miss any of these targets. We do not need to push them to innovate; we need to find a way of identifying innovations and putting them into plans and actioning as rapidly as possible. • Questioned if there is any benchmarking of CAMHS performance, noting that the report states that it is 'not applicable' in terms of benchmarking waiting times with other organisations. It was responded that we do not think there is as if so these would have been included within the report, however Mike Fulford agreed to take the query back to the performance team. **ACTION: (Michaela Dyer)** • Commented that we only measure what we can measure and metrics are nearly all around secondary care. It was noted that SHFT performance is predominantly green, however the impact of actions taken by the trust on GPs is enormous for example taking decisions to stop services which they have historically been providing in a unilateral way, which impacts on services and is not measured. The question is how do we therefore capture this. It was acknowledged that it is difficult to capture data regarding some of the decisions that have been made. Any measures that we can collectively measure for example through integration work would therefore be helpful. It was also queried if there is any way to measure the impact on stakeholders, acknowledging that this is tough to do. In response it was advised that with the establishment of Primary Care Networks we really need to look at integration as if primary care and community are working as one team these issues will not arise. • Concern was expressed that, if we are looking at bringing community and primary care together, it is likely that they will be benchmarked against current results that is if they are currently all showing as green, it could be said that performance has deteriorated as a result as we would be looking at different numbers in a different way. A lot of these indicators are focused on the acute section of the trust, not community, which is why we need to develop measures for integrated services. In addition increased pressure being experienced by primary care is a result of more and more patients coming out of acute hospitals with more complex needs, so costs are translating to community services. • Community health was raised and in particular family health flagging that there remains concern with regard to wheelchair waiting times which continues to be reviewed at a number of committees within the CCG. It was queried where can we therefore make an impact and to whether we need to have a different approach. It was responded that we will be entering a programme of review and procurement around wheelchairs. We will be doing this as a collective with SCCCG and Isle of Wight which will be starting soon. Within this will be a focus on how we get the right information to be able to monitor improvement in terms of outcomes, rather than delivery which has previously been based on inputs. An item for the next Board seminar agenda will be to provide a brief on the Wheelchair and Posture Service. It was stated that Steve Trembath, Commissioning Manager within Jenny Erwin's team and Joanna Clifford from the quality team have done a really valuable amount of work, working with service users to understand the issues as far as they see them and the impact this has on service users

	and their families and all of this is being used to inform the new procurement. The pilot which is underway to reduce the waiting list is on track to reduce by the end of the year.
6.1.5	**AGREED** **The West Hampshire CCG Finance and Performance Committee:** • **Noted and provided comment on the performance report.** • **Agreed the action outlined at 6.1.4.**
7.	**ANY OTHER BUSINESS** – There were no items raised on this occasion.
8.	**RISKS ARISING FROM DISCUSSION OF AGENDA ITEMS TO BE INCLUDED ON THE CORPORATE RISK REGISTER** - There were no items identified on this occasion.
9.	**DATE OF NEXT MEETING** – The Finance and Performance Committee will next meet on Thursday 28 October 2019. Timing to be confirmed.

NHS
West Hampshire
Clinical Commissioning Group

Primary Care Commissioning Committee

Minutes of the West Hampshire CCG Primary Care Commissioning Committee Meeting held on Thursday 29 August 2019 at 9.30am in the Boardroom, Omega House, 112 Southampton Road, Eastleigh, SO50 5PB

Present:	Caroline Ward	Lay Member, New Technologies and Digital **(Chair)**
	Liz Angier	Clinical Director Primary Care
	Ian Corless	Head of Business Services/Board Secretary
	Mike Fulford	Chief Finance Officer and Deputy Chief Officer
	Simon Garlick	Lay Member, Governance
	Judy Gillow	Lay Member, Quality
	Adrian Higgins	Medical Director
	Rachael King	Director of Commissioning: South West
	James Lawrence-Parr	Deputy Director of Commissioning: Mid Hampshire (Deputising for Jenny Erwin)
	Maggie MacIsaac	Chief Executive: Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups; Southampton City Clinical Commissioning Group; West Hampshire Clinical Commissioning Group
	Ellen McNicholas	Director of Quality, Board Nurse
	Alison Rogers	Lay Member Strategy and Finance
	Sarah Schofield	Clinical Chairman
	Jim Smallwood	Secondary Care Board Member
In attendance:	Jackie Zabiela	Governance Manager
Apologies:	Jenny Erwin	Director of Commissioning Mid-Hampshire
	Local Medical Committee Representative	

Summary of Actions

Minute Ref:	Action	Who	By
4.2.3	**Communications / Briefings** - To arrange to add lay members / Jim Smallwood to distribution lists for all communications, e.g. In Practice / PCN communications / comms updates (media releases) etc, with specific request for Alison Rogers to be added to list for communications to PPGs (reference discussion in Part 2).	EM	Immediate
5.3	**Primary Care Strategy** - To clarify when the final version of the Primary Care Strategy will be signed off.	RK	ASAP
6.2	**General Practice Forward View** - To provide an update to the next meeting on the headlines regarding how PCNs are shaping up and what intelligence is telling us of how things	RK	ASAP

Minute Ref:	Action	Who	By
	are embedding in practice, to include an update on PCN organisational development /Clinical Director development.		
6.2	**General Practice Forward View: Risk Register – Engagement / Communications with key stakeholders** - To discuss with Simeon Baker how might frame potential risk for the risk register in relation to PCNs being in their infancy, are critical to ICS development, to include how might share communications with stakeholders given issues are wider than just comms.	EM/RK	ASAP
9.4	**Risk Register: GP IT Support Out of Hours (Risk ID 484)** - To confirm if there is now extended GP IT support 24/7 (Out of Hours).	MF	ASAP
10.2.2	**Antimicrobial Prescribing:**		
	• **Link between secondary and primary care** - To contact HHFT and UHSFT again to obtain data on antimicrobial prescribing in ED / to compare with primary care prescribing (to support / ensure same messages in secondary care).	NH	ASAP
	• **Delayed prescriptions** - To consider if it would be possible to determine how many delayed scripts are being issued and why this is being done e.g. when patients are being seen on a Friday in case they should deteriorate over the weekend.	NH	ASAP

1.	**Chairman's Welcome**
1.1	Caroline Ward welcomed all present to the twenty-first meeting in public of the Primary Care Commissioning Committee since responsibility was delegated to the CCG in April 2015. She noted the apologies for absence and highlighted that this was a meeting being held in public, rather than a public meeting.
1.2	It was confirmed that the meeting was quorate.
2.	**Declaration of Interests** ***(Paper PCCC19/055)***
2.1	Caroline Ward reminded Committee members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of NHS West Hampshire Clinical Commissioning Group.
2.2	Sarah Schofield drew attention to the fact that she is not included on the register of interests for this meeting; this will be addressed for the next meeting. Sarah declared that she is a GP Associate at St Francis and Park Surgery (not a partner).
2.3	No additional conflicts of interest were identified as a result of these declarations and the business of the meeting commenced with no requirement for Committee members to absent themselves from proceedings. Attention was drawn to the fact that should a conflict arise at any point during the meeting members will need to declare this fact.

2.4	**AGREED** **The Primary Care Commissioning Committee:** • **Agreed to note the updated Register of Interests for Committee members.**
3.	**Minutes of the Last Meeting** ***(Paper PCCC19/056)***
3.1	Caroline Ward asked Committee Members to confirm the minutes of the meeting held on the 27 June 2019 as a correct record of proceedings. She explained that she had received no amendments in advance of the meeting.
3.2 3.3	**AGREED** **The Primary Care Commissioning Committee:** • **Approved the Minutes of the meeting held on 27 June 2019 as being a correct record and commended them for signature by the Chairman.** **Matters Arising** There were no matters arising from the minutes that are not covered by the action tracker.
4.	**Action Tracker** ***(Paper PCCC19/057)***
4.1	Caroline Ward referred the Committee to the action tracker.
4.2	The following updates were provided: 1. **Ref No 39) 2019-20 General Practice Work Plan: Cyber Security: Undertake a review on CCGs compliance with New Cyber Security standards and report back to the Committee** – It was reported that the deadline for cyber security standards is June 2021 so there is still time to review full compliance. A full review will be undertaken with our IT provider (SCWCSU) in due course, however, currently other items are taking priority such as the GPIT Capital Programme and some of the earlier targets as detailed in that same presentation. Assurance can be provided as the CSU has achieved Cyber Essentials Plus accreditation – which is the highest status currently achievable which gives assurance and confidence in current position. New requirements in force by 2021 which will be factored into ongoing review of capital programme to be undertaken in the New Year given quite a significant pressure area for GPIT Programme. Quarterly updates on the GPIT programme will come to Committee, starting from next meeting.
	2. **Ref No 40a Operational Report Primary Care Networks (PCNS): Share copy of updating boundary map, to include population numbers, with the Committee** – It was reported that this action is complete. **Complete**.
	3. **Ref No 40b Operational Report Primary Care Networks: Communications team to promote establishment and development of PCNs** – It was noted that the Communications team have promoted the establishment of the 13

	PCNs and the role and purpose of PCNS. Ongoing communications to be undertaken as PCNs continue to develop. **Complete.** Simon Garlick raised PCN communications and advised that he had met with Simeon Baker and it was identified that lay members and Jim Smallwood are not being copied into what has been communicated. It was requested that the lay members/all Board members be included within portal/package system. It was agreed that Ellen McNicholas is to arrange for lay members/Jim Smallwood to be added to the distribution lists for all communications for example In-Practice/PCN communications/comms updates(media releases) etc. There was a specific request to add Alison Rogers to the list for communications to PPGs (reference discussion in Part 2). A new action is to be opened. **ACTION: Ellen McNicholas**
	4. **Ref 41 Risk ID 329 Andover ETTF: Change manager to read Jenny Erwin**. **Complete.**
	On concluding the update the Chair extended the Committee's thanks to those individuals who progress actions between meetings and for closing them so promptly.
4.3	Following general discussion linked with PCNs, Clusters and Localities it was stated that feedback has been received that people working in health services genuinely don't know how to access/signpost to all these things for example minor injuries. So there is a big generic issue around signposting people regarding their points of need. It was responded that this is part of the urgent care recovery plan where resource has been put in for wider Choose Well comms campaigns to raise awareness of the various different services they can access. It is also about ensuring that professionals in the system also know who to contact when 'in the moment'. It was reported that the CCG has just recruited a new member of staff to look at all these issues.
4.4	**AGREED** **The Primary Care Commissioning Committee:** • **Reviewed the Action Tracker and received the updates.** • **Agreed that the three actions are complete and can be closed.**
5.	**<u>Hampshire and Isle of Wight Primary Care Strategy</u> (*Paper PCCC19/058)***
5.1	Rachael King introduced paper PCCC19/058 and explained that this document sets out a vision and ambition for primary care services in Hampshire and Isle of Wight. Primary care services include general practice, community dentistry, optometry and community dental services.
5.2	Rachael King provided an overview of the plan and explained that the strategy is written within the context and framework of the emerging Hampshire and Isle of Wight (HIOW) Long Term Strategic Delivery Plan and describes the future of primary care services, how they will work with partners and the contribution they will make to the following system-wide objectives and goals: • **Supporting people to stay well.** Will work together to prevent ill-health and promote self-care. Citizens, patients, service users and communities will be better empowered and technology will be harnessed more effectively to support

	wellbeing. • **Joining up care locally.** Will strengthen and join up care in local neighbourhoods. This will be done by integrating health and social care teams to better support the needs of the local communities they serve, use technology to revolutionise people's experiences and outcomes, ensure we have a sustainable primary care workforce, and deliver care in the right place at the right time to reduce reliance on hospitals and care homes. • **Specialised care when needed.** Will improve services for people who need specialist care by identifying, understanding and reducing unwarranted variation in outcomes, clinical quality and efficiency and through the consolidation of more specialised care on fewer sites. The HIOW Long Term Strategic Delivery Plan (SDP) will set the vision and strategic direction for our health and care system over the next five years. This is currently in development and due to be published in autumn 2019. For this reason the strategy is iterative. It will both inform the development of, and evolve in response to, the ambition, objectives and plans that will be described for the whole system over the coming months.
5.3	As a result of discussion it was: • Commented that the pace seems really slow as is deployment of funding and investment and it was questioned as to what will be the impact on secondary care and what does the bigger picture look like in terms of the Long Term Plan and the balance between secondary and primary care services. It was responded that we are planning to fully utilise the uplifts for primary care and there will be elements which evolve as the framework develops and more intelligence becomes available around the full elements which will form part of the ongoing review. The plan is to uplift by 4 or 5% on annual plan. Clinical Cabinet has also queried what we can do over and above the allocation and shift from acute. This is in line with the Strategy. • Commented that whilst volunteers are mentioned it was questioned if the Strategy could be more overt regarding the role of volunteers and how they complement existing teams particularly within the headline summary. • Stated that workforce is a challenge in going forward and it was suggested that it might be helpful to give examples or case histories so people can understand the innovative models that could be developed in going forward. • Queried as to how do you measure GP workload, page 11 of the Strategy says GP workload 2.5% increase; it was questioned as to an increase in what. It was responded that a frustration exists nationally down to coalface GPs in that there is very limited visibility of what actual workload is. It does not mean caseload it means contacts and this has been raised nationally. It was reported that SHREWD is a system which is used across the acute system and one of the innovation fellows working on the national programme is looking at the potential of using SHREWD across the whole system for example for GPs regarding how many appointments, how many home visits, ambulance usage. However, there is not quite functionality yet and it is proposed that three pilot sites are identified and WHCCG has expressed an interest in being one of them. • Questioned if there is an intention from HIOW to develop other strategies for example community, which fit alongside the Primary Care Strategy as we need to see the totality. It was reported that there is a requirement to develop a

	Primary Care Strategy as part of the Long Term Plan (LTP). It was highlighted that this focuses on GPs and community sits alongside this, and there is also an acute strategy at Sustainability and Transformation Partnership (STP) level. The Primary Care Strategy is part of a wider LTP strategy which will be pulled together by the STP. • Clarification was sought as to what is the status of this report. It was responded that this is a final draft for comment prior to the final version being signed off by the STP and then an STP wide group being established to ensure delivery, alongside local plans to deliver. Rachael King agreed to check the sign off process and timescale. **ACTION: Rachael King**
5.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted and provided comment on the draft Hampshire and Isle of Wight Primary Care Strategy prior to approval by the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP)** • **Agreed the action outlined at paragraph 5.3**
6.	**<u>West Hampshire CCG General Practice Forward View 2019-20 Work Programme</u>** ***(Paper PCCC19/059)***
6.1	Rachael King introduced paper PCCC19/059 that provides details on progress to date against the agreed key priorities for delivery in 2019-20 in line with the five key components of the integrated care model and key enablers and the Primary Care Investment and Evolution Plan. The plan has been developed in line with the requirements of the National Primary Care Network Directed Enhanced Service (DES) and the West Hampshire CCG 2019-20 Operating Plan, building on the National GP Forward View Plan. The key priorities have been identified and agreed with Localities and Clinical Cabinet. Delivery will make a difference, both in terms of improved patient care, as well as supporting the sustainability of general practice. Changes will include; a focus on population health and prevention, more convenient access to care, general practice working together to meet local need, a focus on proactive joined up care for vulnerable people and those with complex need, a shift to community based care, care delivered by a wider range of professionals and new models of care.
6.2	As a result of discussion it was: • Highlighted that the CCG continues to support the development of Primary Care Networks (PCN). Network Plans are under development and work is taking place to agree the funding of network plans and priorities are being considered in line with local need. STP funding has been received to support development and is in the region of around £30k for each PCN. The 30k for organisational development was questioned around how PCNs will assess their needs and if there is a formal self-assessment process and how this relates to the development of Clinical Network Directors. It was reported that this needs to be formally submitted which will help identify what can be done at scale as well as locally. Discussions are ongoing through the Network Forum regarding

	providing more facilitated sessions. It was reported that there have been discussions about the need to look at the individual needs of Clinical Directors and then at Network and cross-network needs. Will need to arrange workforce regarding what to do locally, as well as looking at population health. Account will be taken of quality improvement and the need for coaching to achieve transformation programmes. The CCG will provide ongoing support, creating a platform via kahootz that other PCNs can go to. It was stated that the £30k is proposed to be managed via a nominal split of 90% organisational development and 10% personal development for Clinical Directors. Attention was drawn to the fact that Clinical Directors are feeling overwhelmed by the scale of work and it has been agreed to hold a facilitated workshop. There was discussion around the fact that PCNs are at different stages and the balance facing Clinical Directors of setting-up PCNs versus their 'day job', it was agreed to provide an update to the next meeting on the headlines regarding how PCNs are shaping up and what intelligence is telling us of how things are embedding in practice, to include an update on PCN organisational development /Clinical Director development. **ACTION: Rachael King** • Reported that opportunites are to be explored with neighbouring CCGs to share some of the development across geography in order to break down/mix and match across the STP. Attention was drawn to the fact that WHCCG has held one joint Network Forum with Southampton City CCG and will continue discussion as to how we can work more closely together. • Questioned if there is a toolkit and a comms structure in terms of sharing best practice regarding early adopters and how much can be facilitated to avoid reinventing the wheel/ensure continuous improvement. It was reponded that the STP has a New Models of Care (NMOC) programme with primary care leads from all CCGs that HIOW use for shared learning and is also trying to do the same with Network Directors to ensure a shared learning approach is adopted. In addition the STP is also looking at establishing a wider forum across HIOW. It was questioned if there is anything nationally regarding sharing not so good practice. It was reponded that at each network meeting there is discussion around what is not going so well. It was suggested that it is important for PCN Clinical Directors to link with reasearch institutes to ensure that research is built into the PCN agenda at an early stage. • Questioned if there should be a risk articulated on the Risk Register around communications and making sure that communities and key stakeholders are well briefed on PCNs, on phases of change, and when will enagage as feedback received from GPs is that they are inundated with concerns. It was agreed that this will be given further thought and discussed with Simeon Baker around how we might frame a potential risk for the risk register in relation to PCNs being in their infancy, are critical to ICS development, also to include how we might share communications with stakeholders given that issues are wider than just comms. **ACTION: Ellen McNicholas/Rachael King**
6.3	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the progress in delivery against the West Hampshire CCG GP Forward View Work Programme 2019-20.** • **Agreed the actions outlined at paragraph 6.2.**

7.	<u>**Operational Report**</u> ***(Paper PCCC19/060)***
7.1	Rachael King introduced paper PCCC19/060 and explained that West Hampshire CCG received approval by NHS England for delegated primary care commissioning arrangements from 1 April 2015.
7.2	The Primary Care Commissioning Committee were asked to note the following: **CCG Wide:** • The national General Practice Access Review • The update on national flu planning 2019-20 • The planned work to increase the uptake of immunisations and screening programmes • The GP Premises Policy review and data collection • The Primary Care Premises Minor Improvement Grants 2019-20 • The Primary Care Resilience Scheme 2019-20
7.3	Particular attention was drawn to: 1. **National Review of Access to General Practice** The national Review of Access to General Practice Services in England announced in 'Investment and Evolution – A Five Year Framework for General Practice Reform' (January 2019) is currently taking place. The review will look at ways to enable the development and implementation of a coherent access offer to patients accessing general practice appointments. The initial focus will be on in-hours and extended access with a view to understanding capacity, demand and improving productivity. Data gathering has commenced to inform the review. National data sets and practice visits are being used for in-hours access. CCGs have been requested to submit data on extended access services by 29 August 2019.
	2. **National Flu Immunisation Programme 2019-20** The national flu immunisation programme aims to provide direct protection to those who are at higher risk of flu associated morbidity and mortality. Groups eligible for flu vaccination are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) and include older people, pregnant women, and those with certain underlying medical conditions. In 2019-20, the following are eligible for flu vaccination: • all children aged two to ten (but not eleven years or older) on 31 August 2019 • those aged six months to under 65 years in clinical risk groups • pregnant women • those aged 65 years and over • those in long-stay residential care homes • carers • close contacts of immunocompromised individuals The only change to the eligibility criteria is the planned extension of the programme to school year 6 children. This means that all primary school aged

	children will now be offered the vaccine for the first time in England. West Hampshire CCG's Immunisation, Vaccination and Screening Group in conjunction with local practices, has undertaken a review of the 2018-19 local flu immunisation programme. Learning from the review has been incorporated in a tips and hints briefing for increasing uptake rates across all at risk groups which will be circulated to West Hampshire GP Practices in August. A specific targeted local focus will be on increasing flu immunisation uptake amongst patients with Chronic Respiratory Disease. This is a key component of the South West Hampshire Urgent and Emergency Care Plan and joint work has commenced with the West Hampshire CCG Clinical Lead for Respiratory and Public Health England to inform the development of a local action plan. West Hampshire CCG has supported the NHS England audit of flu vaccination orders by primary care. Whilst practices have guaranteed delivery dates, one pharmaceutical company (Sanofi UK) have confirmed phased deliveries of vaccines for the under 65's to be scheduled from October to November 2019. West Hampshire CCG is working with NHS England Wessex to support practices to ensure vaccines are available for all at risk groups. As a result of discussion it was questioned if there are any implications from Brexit given timeframe as October/November is key to provision of vaccinations. It was advised that it is public knowledge that medicines are at a higher priority at government level than food, so there is a massive work stream regarding this. This is an area of focus for the National Pharmacy Group and whilst it cannot be said that there won't be an issue, there is a huge amount of work to try and ensure there is a supply chain. Planning for flu vaccines started a while ago and there is a slight delay in delivery of flu vaccinations, not related to Brexit but a manufacturing delay. The impact this will have on uptake rates is not known however there are plans in place to take account of this for example for WHCCG staff the dates have been pushed back for staff vaccinations.
	3. **GP Premises Policy Review** The GP Premises Policy Review was published in June 2019 following engagement with key stakeholders to understand the issues currently impacting general practice premises and to explore potential solutions. The areas considered by the review were: • De-risking leases in strategically important estate • Central estate ownership and state backed loans • Property ownership as part of the partnership model • Professionalism of property ownership and management • New models and the premise cost directions • Developing greater support for community and primary medical care in local estate planning and in developing strong and future facing Integrated Community Services (ICS) capital funding The outcome is a series of policy responses to the issues which were explored, which are set out in this report. The report can be found via: https://www.england.nhs.uk/publication/general-practice-premises-policy-review/

	The outcomes of the review will now be taken forward to implementation stage. The outcomes will help ensure that future investment is made in a more coherent and strategic way into a professionally managed estate. However, it is recognised that capital is required both to bring up the standard of current estate and to transform primary care estates across England, to deliver what is required for the clinical and service vision of the Long Term Plan in purpose-built premises. The work that follows this Review will therefore create an implementation framework, informed by the government's future spending review timetable and outcome, to start the delivery of that transformation.
7.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the updates in the Primary Care Operational Report.**
8.	**National GP Patient Survey Results** ***(Paper PCCC19/061)***

8.1	Rachael King introduced paper PCCC19/061 National GP Patient Survey Results and explained the background that:
	• The GP Patient Survey is an England wide survey providing practice level data about patients' experience of their GP Practices. Ipsos MORI administers the survey on behalf of NHS England. The slides presented showed the key results for NHS West Hampshire CCG for the July 2019 survey publication conducted January to March 2019.
	• In West Hampshire CCG, 12,904 questionnaires were sent out and 5,948 were returned completed. This represents a response rate of 46%. This is above the overall national response rate to the survey of 33.1%, based on 770,512 completed surveys.
	• The GP Patient Survey measures patients experiences across a range of topics including:
	    • Your local GP Service
	    • Making an appointment
	    • Your last appointment
	    • Overall experience
	    • Your health
	    • When your GP Practice is closed
	    • NHS Dentistry
	• The limitations of the survey should be noted but the survey data can be triangulated with other sources of feedback, such as Patient Participation Groups and the Friends and Family Test to develop a fuller picture of patients' experience, enabling the identification of best practice and areas for potential improvement.

8.2	A summary of the survey results for NHS West Hampshire CCG showed: **Overall Experience of GP Practice** • 87% of patients described their experience of their GP Practice as good

compared to 83% nationally. The CCG also compares favourably to neighbouring CCGs. Satisfaction by practice ranged from 39% to 99%, with the majority of Practices above the national average.

Local GP Services

- 79% of patients said that it was easy to get through to someone at their GP practice on the phone, compared to 68% nationally. 92% of patients said that they feel that receptionists are helpful when coming into contact with their Practice compared to 89% nationally.

Access to online services

- 48% of patients are aware that they are able to book appointments online, compared to 44% nationally. 47% of patients are aware that they are able to order repeat prescriptions online, compared to 41% nationally. 18% of patients are aware that they can access their medical records online, compared to 15% nationally.
- Although the use of online services was either the same or higher than the national average (at CCG level), overall utilisation remains relatively low, with an average of 73% of patients using none of the online services listed in the last 12 months.

Making an appointment

- 64% of patients said that they were offered the choice of an appointment when they last contacted their Practice compared to 62% nationally. 77% of patients said that they were satisfied with the type of appointment they were offered, compared to 74% nationally. 72% of patients said that their overall experience of making and appointment was good, compared to 67% nationally. Only 12% of patients said their overall experience of making an appointment was poor, compared to 16% nationally.

Perceptions of care at patients last appointment

- At their last appointment 89% of patients said that they were given enough time, 91% said the healthcare professional listened to them and 90% felt they were treated with care and concern. 96% of patients felt involved in the decisions about care and treatment, 96% had confidence and trust in the healthcare professional and 95% felt that their needs were met. 90% of patients felt that the healthcare professional recognised and/or understood any mental health needs that they may have had, compared to 86% nationally.

Managing health conditions

- 84% of patients said that they felt they had enough support from local services or organisations to help them to manage their condition/s. This compares to 74% nationally. 16% of patients said no to the above, compared to 22% nationally.

Satisfaction with general practice appointment times

- 67% of patients said that they are satisfied with the general practice appointment times that are available to them, compared to 65% nationally. 15% of patients said that they were dissatisfied with the above compared to 18% nationally.

	Services when the GP Practice is closed • 73% of patients responded positively when asked 'how do they feel about how quickly they received care or advice on that occasion', compared to 66% nationally. 93% said that they had confidence and trust in the person they saw or spoke to compared to 91% nationally. 74% said that their overall experience of their last contact with NHS services was good when they wanted to see a GP but their GP Practice was closed. This compared to 69% nationally.
8.3	It was reported that: • The CCG benchmarks well against both local and national comparators with every patient satisfaction question scoring above the national and local average. • There has been a small reduction (1-4%) in the CCG average for a number of questions when compared to the 2018 survey. • There is variation across Practices, with an opportunity for sharing of best practice and shared learning. This will be facilitated through Primary Care Networks. • St Luke's and Botley remains the most challenged provider in the survey results, with overall patient satisfaction deteriorating since 2018. The Living Well Partnership has taken action to address this. • Although the use of online services was either the same or higher than the national average (at CCG level), overall utilisation remains relatively low. The CCG will take continued action to promote the availability and use of online services, as well as actively working with local Practices to increase uptake rates. • Although below the national average, patient experience of Out of Hours Services compared with a couple of years ago has dramatically improved, however 27% of patients felt that it took too long to receive care or advice when their practice was closed. The CCG will correlate this with patient experience satisfaction of its out of hours providers and continue to work with them to identify actions to improve responsiveness.
8.4	As a result of discussion it was: • Questioned as to whether there is anything further we need to do at St Lukes given that they are such an outlier. It was advised that this correlates with other information and feedback that is more complaints and concerns regarding access than others. The Living Well Partnership has taken action to improve patient experience and processes and support better access. It was stated that it will be interesting to see the result of the next survey but the CCG is concerned as it correlates with wider information. The CCG Quality Team continues to work with St Lukes. It was queried if there are any early indicators regarding the impact of the Living Well actions rather than waiting for the next GP Survey, for example Friends and Family Test (FFT) results. It was responded that this point can be picked up under the part 2 agenda item. It was therefore agreed to discuss this further in Part 2. (See minute reference 6)
8.5	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the results of the GP Patient Survey, the key messages and the actions to be taken.**

9.	**Primary Care Risk Register** ***(Paper PCCC19/062)***
9.1	Rachael King introduced paper PCCC19/062 and explained that the Primary Care Risk Register has been updated to include identified risks and mitigating actions. Attention was drawn to the following high risks: • Risk ID 329 - Estates & Technology Transformation Fund (ETTP) due diligence timescales mitigated by locality working groups and Primary Care Steering Group oversight, detailed timelines with milestones and regular reviews. • Risk ID 210 - Delivery of the Primary Care Strategy mitigated by locality and Network plans. • Risk ID 484 - Out of Hours IT issues, mitigated by contract variation and further negotiation. • Risk ID 495 - GP remote connection, mitigated by existing security solutions and investigation regarding alternative connection.
9.2	The Committee reviewed the Risk Register and an update was provided on each of the high level risks.
9.3	It was reported that: • The risk has decreased for Risk ID 329 Andover ETTF. • The risk remains very high for Risk ID 411 Eastleigh ETTF. Noted that Project manager is working closely with Eastleigh Borough Council and the CCG continues to hold briefing discussions with NHSE for support and guidance. • In terms of GPIT the position has changed significantly from where we were this time last year. Now as a result of how we are managing the programme and issues it feels as though the risks have substantially reduced. Not to say that GPIT because of scale and pace of delivery required is not without risk, but the way that services are being overseen, led and delivered means that the risk is much more reduced.
9.4	As a result of discussion attention was drawn to Risk ID 484 Out of Hours and cyber-attack and the statement that we 'Have a quote to extend to 24/7' and it was questioned as to whether we have actually got the extended support. It was stated that it is believed that it is in place and this will be confirmed outside of the meeting. **ACTION: Mike Fulford**
9.5	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the report of the Primary Care Commissioning risk register, the identified high risks and mitigating actions.**
10.	**Primary Care Prescribing Report – August 2019** ***(Paper PCCC19/063)***
10.1	Neil Hardy introduced paper PCCC19/063 and explained that the paper provided a summary of CCG and individual practice performance for total prescribing and for a number of key interventions contained within the QIPP (Quality, Innovation, Productivity and Prevention) plan and Medicines Optimisation Incentive Scheme (MOIS) for 2019/20.

	Particular reference was drawn to the following CCG strategic objectives: • Ensure system financial sustainability (reducing unnecessary medicines and dressings spend) • Ensure safe and sustainable high quality services - improved medication review and de-prescribing of problematic medicines and antimicrobial stewardship. • Establish local delivery systems (the integrated pharmacy service is a high priority within the LDS) • Develop the CCG workforce (the development of a more clinical role for pharmacists is in line with the national direction of travel and supports the sustainability of primary care).
10.2	Attention was drawn to the following highlights: 1. **Primary Care Dashboard** Jon Rumsey, CCG Analytics Manager, has developed a Medicines Optimisation QIPP Dashboard that contains data for all the *items less suitable for prescribing in primary care* at CCG and individual practice level. The Team are continuing to work with Jon to enable a dashboard that can be used with GPs in practice and at locality meetings to demonstrate performance against our key interventions. There is also a national system but is not that user friendly at GP practice level.
	2. **Antimicrobial Stewardship** The use of antimicrobials is an important issue globally. Whilst the total prescribing of antibiotics within the CCG, using weighted population, remains significantly lower 10% than the national average, the proportion of broad spectrum antibiotics prescribed continues to be higher. June data shows a continuing downward trend. This good news is to be shared with GPs and wider. As a result of discussion it was: • Stated that it is good to see some of the non GP prescribing data and it was reflected that it is often found that when GPs advise patients that they can't have antibiotics they will often present elsewhere for example ED and more widely across secondary care and it was questioned if there is any opportunity to look at if patients have been to GPs, and are ED staff well supported in saying 'no'. It was responded that secondary care are starting to share their prescribing data. Neil Hardy agreed to email HHFT and UHSF to obtain data on antimicrobial prescribing in ED in order to compare with primary care prescribing in order to support and ensure consistency of messages in secondary care. **ACTION: Neil Hardy** • Commented that there is some data regarding local prescribing, but it would be helpful to ask how many delayed scripts are being issued (for example being seen in surgery on a Friday and issued with a prescription just in case they deteriorate over the weekend) and why this is being done as this will help regarding the wider part of the picture. Neil Hardy agreed to give this further consideration. **ACTION: Neil Hardy**
	3. **Patient Engagement** The medicines optimisation team continues to engage with patient

	participation groups and other public and patient forums to encourage patients and their carers to take greater responsibility for their medicines and seek advice and medication reviews if they are concerned. The CCG easy-read version of the medication review prompt is now hosted on the WidgitHealth website which means it is now available for any organisation to use: https//widget-health.com/easy-read-sheets/index.htm The idea is that GPs will use this as part of an annual health check with people with a learning disability and their carers/relatives.
10.3	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the Primary Care Prescribing report (August 2019)**
11.	**Primary Care Finance Report – Month Three** ***(Paper PCCC19/064)***
11.1	Mike Fulford introduced paper PCCC19/064 and explained that at Month 3: • Across all funding streams Primary Care is, as at 30 June 2019, underspent by 156k. • The position excluding the Primary Care Delegated 1% reserve is an overspend of £26k. • The forecast outturn is an underspend of £289k Alignment with strategic objective 1.9: • We will promote a sustainable model for primary care with improved access and choice with an increased focus on people with complex and multiple conditions through the provision of integrated care.
11.2	Mike Fulford reported that we are on plan for a small surplus; however there are some risks which will be reported within the part 2 meeting. We have resolved outstanding issues from last year so what is reflected is the current position. There are a number of small pressures compensated by some small underspends, resulting in a relatively small forecast underspend. It was reflected that this is the tightest the CCG has been since we have had delegated budgets; this is due to the challenges in implementing the new GP Framework which has caused more cost pressures than anticipated due to publication of late guidance.
11.3	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the Month 3 finance report 2019-20**
12.	**Any Other Business** – There were no items raised on this occasion.

13.	**Risks Arising From Discussion of Agenda Items To Be Included on The Primary Care Risk Register :** To consider adding the potential risk raised in Item 6 General Practice Forward View: with regard to engagement with key stakeholders. The Committee were reminded that an update on PCN Clinical Director workload / pressures would be provided to the next meeting, and that an action would be added to the Action Tracker regarding the link between antimicrobial prescribing in secondary and primary care.
14.	**Date of Next Meeting**
14.1	The next meeting of the Primary Care Commissioning Committee is scheduled for: • Thursday 24 October 2019, 9.00am to 11.00am, Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB.
15.	**The Committee approved a resolution that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *[In accordance with section 1 (2) Public Bodies (Admission to Meetings) Act 1960].***