NHS
Vale of York
Clinical Commissioning Group

Item 11.1

Minutes of the Quality and Finance Committee held on 22 October 2015 at West Offices, York

Present

Mr David Booker (DB) - Chair	Lay Member
Mr Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Mrs Michelle Carrington (MC)	Chief Nurse
Dr Mark Hayes (MH)	Chief Clinical Officer
Dr Tim Maycock (TM)	GP Governing Body Member, Lead for Primary Care
Dr Shaun O'Connell (SOC)	GP Governing Body Member, Lead for Planned Care and Prescribing
Mrs Rachel Potts (RP)	Chief Operating Officer
Mrs Tracey Preece (TP) - from item 5	Chief Finance Officer

In Attendance

Dr Emma Broughton (EB) - for item 9	GP, Governing Body Member, Clinical Lead for Women and Children's Health
Ms Natalie Fletcher (NF) – to item 8	Head of Finance
Mr Paul Howatson (PH)	Senior Innovation and Improvement Manager
Ms Helena Nowell (HN)	Strategy and Assurance Manager
Mr Shaun Macey (SM)	Senior Innovation and Improvement Manager
Ms Michèle Saidman (MS)	Executive Assistant
Mr Owen Southgate (OS)	Delivery Assurance Manager, NHS England
Mr Steve Wilcox (SW) – for item 8	Designated Professional for Adult Safeguarding, Partnership Commissioning Unit
Miss Helen Williams -for item 9	Innovation and Improvement Manager
Mrs Debbie Winder (DW)	Head of Quality Assurance

Apologies

Mrs Fiona Bell (FB)	Deputy Chief Operating Officer/Innovation Lead
Dr Andrew Phillips (AP)	GP Governing Body Member, Lead for Urgent Care/Interim Deputy Chief Clinical Officer

1. Apologies

As noted above.

2. Declarations of Interest in Relation to the Business of the Meeting

There were no declarations of interest in relation to the business of the meeting. All declarations were as per the Register of Interests

3. Minutes of the meetings held 17 September 2015

Quality and Finance Committee

The minutes of the meeting held on 17 September were agreed.

Primary Care Co-Commissioning Committee

The minutes of the meeting held on 17 September were noted; approval would be at the next meeting of the Primary Care Co-Commissioning Committee. The action from these minutes was at agenda item 11.

The Committee:

1. Approved the minutes of the meeting held on 17 September 2015.
2. Noted the minutes of the Primary Care Co-Commissioning Committee held on 17 September 2015.

4. Matters Arising

Matters were noted as agenda items or scheduled for a future meeting.

5. Quality and Performance Intelligence Report

MC presented the report which included validated data as at August and more recent unvalidated data where available.

In respect of Yorkshire Ambulance Service Red Combined the 8 minute response time had slightly decreased from July performance and was 73.1% against the 75% target which was achieved at 9 minutes. Red Combined 19 minute performance had also decreased from July at 92% against the 95% target which was achieved at 22 minutes. MC noted that during September Yorkshire Ambulance Service performance had been impacted by the need to train large numbers of staff on the Electronic Patient Report system. She also noted that NHS Vale of York CCG was the top performing CCG in the area for the Survival to Discharge Ambulance Quality Indicators.

In respect of the Yorkshire Ambulance Service first responder pilot being run with the Fire Service the potential of this approach had been recognised nationally and work was taking place to extend the opportunities provided to support people at home. DB commended this initiative.

MC reported that, despite additional investment and CCG schemes to help Yorkshire Ambulance Service achieve its targets, a cost pressure relating to patient transport was emerging.

Yorkshire Ambulance Service handover times performance was 73.2%, a decrease from July, against the 100% target. This was across both the York and Scarborough Hospital sites where performance was respectively 76.7% and 68.7%. There was a direct correlation with patient flow through the Emergency Department and work was taking place to address the issues.

MC advised that the biggest concern was the four hour target in A and E where August performance had been 91.8% against the 95% target; there had since been further deterioration. She also noted that 72 beds across York and Scarborough were currently closed due to diarrhoea and vomiting (one ward confirmed norovirus), there had been around 185 more admissions than normal, over the previous eight days bed capacity

was at 92% to 93%, and 39 more people had been admitted than discharged in the elderly wards. Although it was early in the year for this intervention, escalation beds had been opened. Step down and spot purchase beds in the community had been offered but these were not appropriate for many patients due to the need for home care packages.

TP joined the meeting

MC reported that a revised recovery plan was awaited but highlighted that workforce issues were the main concern. She noted that the nursing staff had increased by 72 and a further 60 planned to start in December. However, lack of medical staff, particularly in the Emergency Department, remained an issue.

The out of hours contract was performing well and the contracted response times were being achieved.

In respect of diagnostics the radiology performance target was being achieved; cystoscopy was the main concern due to staffing issues. There was a significant overtrade on endoscopies This would be a cost pressure for the CCG at month 12.

Maxillofacial and ophthalmology performance remained the most challenging specialties against the 92% target for 18 week referral to treatment and was contributing to the current overtrade in elective activity of £550k. Improvement was expected in maxillofacial performance through use of locums, Saturday lists and the use of Bridlington Hospital.

The cancer 14 day target of 93% had been impacted by patient choice with 91.7% performance for All Tumour Types and 91.5% for Breast Symptomatic. All 31 day treatments had been met for a fourth consecutive month and the 85% performance target for 62 day treatments following urgent GP referral had decreased to 80.2%. MC noted that the latter was impacted by the fact that it related to a small number of patients. She also highlighted that a new dermatology locum had taken up post and that the dermatology indicative budget project had started.

Progress with the new model for the stroke pathway was good.

In regard to clostridium difficile MC highlighted that as at 4 October the number of cases was 36 against a full year trajectory of no more than 43 for York Teaching Hospital NHS Foundation Trust. She advised that detailed consideration was given to each case and that penalties could be applied at the end of the year if there was agreement about a lapse of care. Discussion took place in the context of the national position relating to clostridium difficile due to failure of the flu vaccination and the fact that the nature of the infection was subject to change. MC advised that there was no evidence of case to case transmission and noted that when the external review of Healthcare Associated Infections was available she would present it to the Committee.

MC reported that, although there was increased assurance about serious incidents, concerns remained about the quality of investigations and learning from events. York Teaching Hospital NHS Foundation Trust had convened a small working group to review processes.

Improving Access to Psychological Therapies was showing variable performance for prevalence and recovery for all three providers, namely Leeds and York Partnership NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust and Humber NHS Foundation Trust. MC noted that the aim was to be able to provide GP level information but this may not be possible.

In respect of the York Teaching Hospital NHS Foundation Trust Care Quality Commission report MC noted that most of the work relating to the requirement for improvement had been completed. The main concern was the NHS Constitution targets. The report had also identified a number of areas as good or outstanding practice.

MC referred to the information relating to Bootham Park Hospital and confirmed that all patients had been moved by midnight on 30 September as per the Care Quality Commission's formal request. Of the eight patients placed out of area at that time half had now returned but a further 20 had subsequently been placed out of area. There had been no adverse incidents relating to patients discharged with increased support at home and staff morale at Tees, Esk and Wear Valleys NHS Foundation Trust was reported as good.

The Care Quality Commission had been back to Bootham Park Hospital with a view to returning outpatients and the Section 136 Suite and had requested an action plan. Their decision was currently awaited.

TP reported on the Mental Health Estates Programme Board meeting on 21 October. Tees, Esk and Wear Valleys NHS Foundation Trust and NHS Property Services were looking into the feasibility of partly opening Bootham Park Hospital for outpatients and the Section 136 Suite. However, this was complex for a number of reasons, including security. The potential and viability for an ECT suite in York in the short and long term was being considered. An options report would be presented to the November meeting of the Mental Health Estates Programme Board which would continue to meet for at least another two months for consideration of the interim arrangements prior to opening of a new hospital within a three year period.

The issues experienced during the transfer of services from Leeds and York Partnership NHS Foundation Trust to Tees, Esk and Wear Valleys NHS Foundation Trust and the meeting of the Health and Adult Social Care Policy and Scrutiny Committee on 20 October were discussed.

In relation to the new hospital TP advised that NHS Property Services would submit a Project Initiation Document to NHS England by the end of November to signal it as a capital project for 2017/18. Consideration of funding options for building was required in addition to the options; the CCG would have a role in this. Tees, Esk and Wear Valleys NHS Foundation Trust would be invited to join the Mental Health Strategy Board. TP noted that sites which could be released on a health economy basis were being sought and an estates strategy was being developed to include all stakeholders.

MA-M advised that there was no expectation for revenue implications associated with the new hospital as the mental health and learning disability services bids had included a new build in the financial envelope. He also explained potential for void costs relating

to Bootham Park Hospital although the rules in this regard were changing from April 2016; the transition arrangements were not currently known. This was discussed in the context of the closure due to the building not being fit for purpose.

TP reported that work was taking place with Tees, Esk and Wear Valleys NHS Foundation Trust in respect of information flows and that the key metrics, which would be reported to the December Governing Body, were Improving Access to Psychological Therapies and serious incidents, including the context of progress; other metrics were expected by the end of December.

The Committee:

Noted the Quality and Performance Intelligence Report with additional reference to the number of listed potential cost pressures.

6. Financial Performance Report

In presenting the item which comprised the CCG's financial performance as at month 6 TP requested feedback on the new format of the report. She noted that, when appropriate, future reports would include specific detailed information and 'focus' reports advising that currently detailed work was being undertaken in respect of prescribing.

TP reported that for the first time in the year the forecast financial position was below the planned surplus. She noted that in reporting a forecast year end surplus of £0.35m, £3.6m below plan, there had been extensive discussion with NHS England. TP referred to previous discussion when she had emphasised that, although there was high risk due to all available mitigation having been incorporated, the financial recovery plan at month 5 would deliver the financial plan and forecast surplus. However, there had since been a c£1.4m swing in the York Teaching Hospital NHS Foundation Trust outturn, which together with four months' worth of prescribing data and estimates for months 5 and 6 resulting in a worsened forecast by £1m. Together these had resulted in the position now reported. TP assured members that potential further mitigation would continue to be sought but emphasised the continued commitment to report a realistic financial position.

TP reported further identified risk of £7.37m with mitigation of £4.35m leaving an unmitigated risk of £3.03m and noted that a Red Amber Green assessment would be used for financial measures.

In regard to key actions TP highlighted the detailed analysis being undertaken into the prescribing overspend and quarter 1 acute urgent care activity at York Teaching Hospital NHS Foundation Trust. She also noted that work was taking place to ensure clarity of reporting particularly in terms of percentages for metrics, joint working between the Finance and Contracting and Innovation and Improvement teams for monitoring of QIPP schemes, development of a first draft five year financial plan for 2016/17 onwards, and that the financial recovery plan would be updated to reflect the month 6 position including focusing on delivery of a recurrent, sustainable position and a system wide approach. TP also noted that the CCG was holding a staff workshop on planning and QIPP priorities, discussion with the Council of Representatives and ongoing meetings with City of York Council to review the Better Care Fund.

TP referred to the forecast outturn section highlighting the forecast overspend with York Teaching Hospital NHS Foundation Trust of £6.67m noting that discussion was taking place with them in respect of a potential risk share. However, she emphasised that the CCG was required to achieve its financial plan and noted discussion with the Area Team of a possible turnaround team approach.

In regard to mitigations and contingencies TP noted that the main area was the Better Care Fund, primarily with City of York Council, with the assumption remaining that the CCG would not invest the £3.3m in the current year. Discussions were continuing but the fundamental principle of the Better Care Fund, the requirement for an equivalent reduction in non elective and A and E activity, remained.

The QIPP 'Red Amber Green' programme progress in terms of year to date performance and forecast outturn was supplemented by a detailed appendix. PH noted that this provided a narrative of all the programmes highlighting the recent decision not to award contract for the MSK service and the associated ongoing work. He also referred to the Provider Alliance Board update and noted that the prioritisation workshop to align programmes of work with the CCG's strategic objectives had been deferred to November.

TP noted the secondary care information which reported year to date activity variance and year to date cost variance by point of delivery. The main areas that were over contract were non elective admissions and A and E. Activity with Leeds Teaching Hospitals NHS Trust was also over contract but the data was subject to challenge by NHS Vale of York CCG and also a number of other local CCGs. The Finance Dashboard at Appendix 1 provided the overall financial position.

Members welcomed the new format of the report noting that it would be further developed. RP added that it would be helpful to have more detail of emergency activity including patient group such as children or elderly. This would inform planning.

DB sought clarification on a number of aspects of the financial position: NHS England's view, the need for the longer term to be considered, implications of not investing in the Better Care Fund, and a business model of investment for benefit in later years. In response TP reported that the Area Team, whilst recognising that the CCG was taking all possible measures and was in fact one of the first to consider the Better Care Fund investment in this regard, had also requested further potential actions be pursued. She noted that there had been an underlying gap of £19m in the original plan for the current year which had been closed through a number of planned measures leaving £1.2m planned unmitigated risk from a number of cost pressures carried forward from 2014/15 and arising during planning. Work was taking place in respect of integrated budgets and potential efficiencies in reablement and integrated care but these would not be achieved in 2015/16. Consideration was also being given to expediting delegated indicative budgets to primary care and to extend the work of the integration pilots. A line by line review was being undertaken in respect of prescribing budgets, Local Enhanced Services and voluntary sector contracts. The Innovation and Improvement Team had compiled a list of around 50 projects for consideration and had looked at all potential opportunities. These would be prioritised as part of recurrently addressing the gap.

In respect of NHS England TP reported that the Area Team had escalated the CCG's forecast. She was awaiting feedback which was expected on 26 October.

With regard to the business model MH highlighted the need to take a longer term view and consider investment in the current year to avoid a similar financial position in 2016/17 and beyond. Opportunities to transform the system should be taken even if the return was longer term.

SOC questioned whether the work on the Deep Vein Thrombosis (DVT) pathway, which had potential to achieve savings, could be expedited. Discussion included the requirement for engagement with primary care prior to implementation and for the business case approval process to be completed.

SOC noted that detailed analysis and comparison of Practice level prescribing data was being impeded by the level of available Business Intelligence support.

OS observed that York Teaching Hospital NHS Foundation Trust was an outlier across the patch in terms of non elective admissions and A and E activity. He agreed to seek examples of schemes that had had an impact with a view to learning from their implementation.

The Committee:

1. Welcomed the new format of the report noting that further development was taking place.
2. Noted the Financial Performance Report.
3. Noted that OS would seek examples of schemes that had had an impact on non elective admissions and A and E activity.

7. Corporate Risk Update Report

RP referred to the report which presented the corporate risk registers as at 16 October produced from the Covalent system. These identified risk trends and highlighted the most significant risks to the delivery of programmes of work and organisational objectives. RP noted that the issues relating to provision of ambulatory care, previously reported as a risk, had been resolved but that risks had materialised in respect of Bootham Park Hospital facilities and the MSK contract. There was also the continuing risk relating to NHS Constitution targets, as discussed at item 5, particularly four hour waits in A and E. RP also referred to the discussion at the previous item about the Better Care Fund.

The procurement process for the Commissioning Support service was presenting risk, particularly in respect of Business Intelligence. This was being escalated through the Transition Board and was a concern across the Yorkshire and Humber CCGs.

RP reported that, due to the non delivery of the four hour waits in A and E and the early winter pressures being experienced across York and Scarborough, NHS England had sought system support from the Emergency Care Improvement Programme. Implementation of their recommendations was mandatory.

RP also reported on identification at the System Resilience Group on 15 October of work in addition to that of the Unplanned Care Working Group. There were five areas - Delayed Transfers of Care, Early Supported Discharge, Discharge to Assess, NHS 111 Directory of Services and Intermediate Care – each with a named lead. This work, which would include learning from systems in other areas, would be reported to the Committee.

DB noted that the Audit Committee also considered aspects of risk.

The Committee:

Noted the corporate risks and events identified that may impact delivery of the corporate objectives.

NF left the meeting

SW joined the meeting; EB and HW joined the meeting during item 8

8. Safeguarding Adults Report

In presenting this report SW highlighted the NHS England Pledge to Urgent Action, emanating from three separate reports, in respect of rapid action to address the over-prescribing of psychotropic drugs to people with learning disabilities; national guidance on an action plan was awaited. SOC noted that the potential for savings if treatment was improved.

SW noted the Law Commission Mental Capacity Act and Deprivation of Liberty Safeguards consultation paper, which aimed to reduce bureaucracy, and the newly established Care Quality Commission Engagement Meeting hosted by North Yorkshire County Council which he would attend.

SW additionally reported renewed focus on the Prevent counter terrorism strategy - pursue, prevent, protect, prepare – noting the statutory responsibility of the health and education sectors to intervene if radicalisation was suspected. SW advised that North Yorkshire was not designated a high priority area for Prevent due to the demographics but there was the requirement for trained trainers and for reporting of Prevent alerts. He also noted that a greater level of assurance was required from providers in this regard.

SW advised that City of York Council Safeguarding Adults Board was working with the North Yorkshire County Council Prevent Board on a Prevent Strategy. He highlighted that to date most Prevent referrals had been under 18 years of age and noted the need to identify vulnerable families. Access to training was being sought with the intention of having a trained trainer for the CCG. However, there was a broad requirement for knowledge of Prevent.

In respect of current safeguarding activity SW reported that the CCG was not an outlier and assured members that there were no notable concerns. Safeguarding alerts had risen in some areas due to greater public awareness but the number converted to cases had not increased.

MC additionally reported on the potential impact from an unannounced visit by the Care Quality Commission to a care home following a whistleblower report. SW noted that the biggest increase of alerts across the county were from care home staff.

MC reported on her attendance at an NHS England Transforming Care meeting as part of the assurance process relating to the Winterbourne requirements. The CCG appeared to be an outlier in terms of the number of admissions in comparison with similar areas. She was working with SW in this regard.

SW requested that members inform him of any safeguarding concerns and, when asked by DB, confirmed that in his view he received full support for his work from the CCG and related agencies.

The Committee:

Noted the Safeguarding Adults Report and additional information pertaining to *Prevent*.

SW left the meeting

9. General Commissioning Policies and Referral Support Service Guidelines

SOC noted that the policies and guidelines presented for approval had been considered by the Clinical Research and Effectiveness Committee. The former were among a large number of policies being reviewed and were updated from previous versions inherited from the former Primary Care Trust.

SOC noted in respect of the Cholecystectomy Policy the addition of requirements relating to smoking and BMI which required the Committee's consideration.

Detailed discussion ensued as to the consultation and engagement that had taken place in development of the policies. Whilst recognising that the Committee was not part of the clinical decision and that the policies were in line with those implemented nationally, assurance was required as to the involvement of General Practice to ensure clinical support for implementation. Members further noted that a consistent approach across all policies was required in regard to smoking and BMI. SOC highlighted the complexity of the policy review process and the fact that all policies had an expiry date.

It was agreed to defer a decision on the two policies in light of the current work on engagement with the Council of Representatives and that these policies be utilised as part of this process.

EB reported that engagement with GP colleagues had informed development of the Referral Support Service guidelines. She noted in respect of the clinical assessment tool for babies/children under two years with suspected bronchiolitis that the equipment for monitoring saturation in air was not routinely used in General Practice; work was taking place to identify associated costs to remedy this.

The Committee:

1. Deferred a decision on the Cholecystectomy and Cosmetic Breast Surgery policies.

2. Approved the Referral Support Service guidelines in respect of:
    a. Bronchiolitis Healthcare Professional Guidelines and Bronchiolitis Patient Information with notification that work was taking place to address the position relating to saturation in air monitoring.
    b. Gastroenteritis Healthcare Professionals Guidelines and Gastroenteritis Patient Information
    c. Recurrent Urinary Tract Infection (UTI) in women

EB and HW left the meeting

10. NICE Summary Guidance Follow Up Process

MC referred to the fact that summary NICE guidance was presented at the Clinical Research and Effectiveness Committee where it was allocated for review. A tracker system was in place to monitor reviewing. However, consideration was now required as to GPs' involvement in the review process. In this regard SOC reported that to date one tranche had been sent out for consultation and no feedback had been received. This was being followed up and would be reported to the Committee. SOC commented on the volume of work associated with this process.

The Committee:

1. Noted that a tracker system had been established to monitor the review of NICE summary guidance.
2. Noted that consideration was required in respect of GP involvement in the review process.

11. Primary Care Co-Commissioning Committee Meetings – Process

RP noted that the report presented was in the context of the first meeting of the Primary Care Co-Commissioning Committee and the September and October meetings of the Council of Representatives. She described the offer made to the 15 October meeting which had included: review of the role and membership of the Primary Care Strategy Group to ensure there was a clear process for consideration of primary care provider issues; the Council of Representatives being a commissioner forum; and the establishment of a reference group for matters that required consideration within a short timescale.

SM presented the report which described the requirements of primary care co-commissioning, proposed an approach for implementation, and summarised co-commissioning requests received to date in terms of administrative/transactional and infrastructure/planning/finance. He proposed establishment of a task and finish group to agree systems and processes highlighting the opportunities for engagement with Practices to develop strategy and the need to engage effectively with the Council of Representatives in management of the £40m primary care co-commissioning budget.

Members discussed the issues emanating from the first meeting of the Primary Care Co-Commissioning Committee noting the complexity and transition from NHS England to the CCG. SM noted the need to establish criteria to assess whether matters submitted by Practices comprised "business as usual" or required consideration by the

Primary Care Co-Commissioning Committee. In this regard RP referred to her offer to the Council of Representatives which would ensure that the Primary Care Co-Commissioning Committee considered appropriate business. She also noted that HN was currently looking into learning from other CCGs in regard to primary care co-commissioning.

It was agreed that a task and finish group be established comprising DB, MA-M, SM, TM and RP be established to develop proposals for discussion with the Council of Representatives as a matter of urgency.

The Committee:

Agreed that a task and finish group be established comprising DB, MA-M, SM, TM and RP to develop proposals for discussion with the Council of Representatives.

12. Key Message for the Governing Body

- Best practice to be sought in respect of management of reduction of A and E admissions both from within the CCG and nationally
- An urgent task and finish group to be established to consider issues relating to the Primary Care Co-commissioning Committee, including a process for approval of clinical policies and guidelines and a commissioner/provider strategy.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

13. Next meeting

9.30am on 19 November 2015

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP QUALITY AND FINANCE COMMITTEE

SCHEDULE OF MATTERS ARISING/DECISIONS TAKEN ON 22 OCTOBER 2015 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
QF33	21 May 2015	Strategy for Use of Patient Related Outcome Measures and Shared Decision Making Tool in NHS Vale of York CCG	• Progress report on embedding of PROMS	SOC	19 November 2015 meeting
QF42	22 October 2015	Financial Performance Report	• Examples to be sought of schemes that had had an impact on non elective admissions and A and E activity.	OS	
QF43	22 October 2015	NICE Summary Guidance Follow Up Process	• Consideration was required in respect of GP involvement in the review process.	MC/SOC	
QF44	22 October 2015	Primary Care Co-Commissioning Committee Meetings – Process	• Task and finish group to be set up	RP	