Southwark Integrated Governance & Performance Committee
Minutes of the meeting held on 22 August 2013
160 Tooley Street

MINUTES

Present: Robert Park (RP) – Chair Lay Member, SCCG
Dr Simon Fradd (SF) Clinical Lead, SCCG
Malcolm Hines (MH) Chief Financial Officer, SCCG
Kieran Swann (KS) Head of CCG Performance & Planning, SCCG
Jean Young (JY) Head of Primary & Community Care Dev, SCCG
Dr. Jonty Heaversedge (JH) Clinical Lead, SCCG
Jacquie Foster (JF) Head of OD & Governance, SCCG
Alvin Kinch (AK) Southwark Healthwatch
Dr Amr Zeineldine (AZ) Chair, SCCG
Dr Richard Gibbs (RG) Lay Member, SCCG
Rob McCarthy (RMC) AD Acute Contracting Team, SLCSU
Dr Pat Holden (PH) Clinical Lead, SCCG
Dr Tushar Sharma (TS) Clinical Lead, SCCG
Dr Nancy Küchemann (NK) Clinical Lead, SCCG
Dr Ruth Wallis (RW) Director of Public Health for Lambeth & Southwark

In attendance: Omar Al-Ramadhani (OA) Planning & Performance Manager, SCCG

Apologies: Andrew Bland (AB) Chief Officer, SCCG
Tamsin Hooton (TH) Director of Service Redesign, SCCG
Gwen Kennedy (GK) Director of Client Group Commissioning, SCCG
Peter Underwood (PU) Head of Finance & Business, SCCG
Diane French (DF) Lay Member, SCCG
Prof. Ami David (AD) Nurse Member, SCCG
Dr. Alison Furey (AF) Consultant, Lambeth & Southwark Public Health
Harriet Agyepong (HA) Head of Acute Performance Management, SLCSU
Ali Young (AY) Head of Pathway Redesign, SCCG

1. **Introduction and Apologies**

   The Chair welcomed members and attendees to the meeting.

2. **Minutes of the Previous Meeting & Declarations of Interest**

   Members each declared no additional interests to those included on current Conflict of Interest Register. The register was signed.

   Minutes of the previous meeting dated 25 July 2013 were agreed as an accurate record.

   OA explained that the action on substance misuse indicators would be deferred until the following month.
JH updated the group on controlled medicines incidents and explained that he was assured that a system was in place to manage and monitor incidents and the Committee should continue to monitor through the Integrated Performance Report.

All other actions were noted to have been completed.

### Integrated Performance Report (M3)

KS presented the report and drew the Committee’s attention to common areas of performance variance which included; Referral To Treatment (RTT) performance at King’s College Hospital NHS Foundation Trust (KCH), sustained backlog of patients at KCH and the reduction in the number of patients waiting over 52 weeks at King’s. Improved Access to Psychological Therapy (IAPT) performance has remained under target and deteriorated further in M3. Previously the committee has been assured that investment has been made in IAPT to grow capacity which would result in an extra 2 practitioners and that performance would improve in Q2 and Q3 13/14.

RP suggested the Committee should be updated on forecasted IAPT performance – **Action GK**

RG queried why health visiting patient facing time performance was under performing against target. JY stated that there was a recording issue and that the performance position may not be accurate. The figures had been re-based in quarter 1 to address this. RW added that time spent by HV on safeguarding activities do not count towards face time. The Committee were also asked to note that there were significant issues in recruitment and retention of health visitors in London and nationally. The Committee noted that NHS England had taken on the responsibility on health visiting since April 2013.

RP highlighted the newly added text in section 7 of the report regarding CCG QIPP programmes. This section now includes summaries of the CCG-led QIPP programmes and would focus more on qualitative aspects of QIPP in future reports and track monthly performance against QIPP activity and financial plans. The Committee asked that a further presentation on the impact of CCG-led QIPP on patient outcomes and service quality be presented in October – **Action KS**.

### CCG Finance Report (M4)

MH explained that the CCG overall position is based on M3 figures. He highlighted a current £1.3m overspend against acute contracts. The predicted end of year position is an overspend of £8.3m with Guy’s and St Thomas’ NHS Foundation Trust (GSTT) one third and KCH two third of the predicted year end over performance.

All other areas are within budget and the CCG is confident of balanced year end position, assuming the outstanding specialised commissioning budget changes remain cost neutral as the CCG are advised. MH advised the Committee that at M4 sufficient reserves were available to manage in year risk. MH advised that by October the CCG is expecting a final agreement on transferred of funds for specialised commissioning.

MH further explained that there was still an outstanding issue over learning disabilities funds. The CCG is awaiting confirmation that the Department of Health will return this money, which should have been included in CCG allocations from 13/14. The forecasted worst case reflects the small chance that the CCG does not receive this funding (£2.3m).

AZ queried the accuracy of the acute predicted year end performance best case scenario and also asked if the CCG was reconciling due to the risk associated with CCG funds being allocated to acute trusts due to the acute specialist commissioning allocation. MH responded by saying that the CCG was challenging the Specialist Commissioning Group (SCG).
AZ asked for clarity on process for receiving the £2.3m learning disabilities funds. MH explained that the issue was to do with the funds being a non-recurrent allocation to the PCT in the previous year and because of complications during the transition, these funds had not be included in the CCG’s baseline.

RG asked what is included in ‘other contracts and non-contracted activity’ in the CCG financial summary. MH explained that this included small contracts, specialised treatment and individual funding requests. It would also include activity from other out-of-area providers used by Southwark patients. MH stated that he was confident that this would flatten off over the year.

The Committee highlighted that the predicted end of year figure was lower than the current performance variance, MH said figures will be checked and clarified if need be – **Action PU.**
Acute Integrated Performance Report

RMc took the Committee through the highlights of the report. RMc highlighted that there is a large variance between acute Year To Date (YTD) and Forecast Outturn (FOT) positions and that this is due to anticipated phasing of elective care and that there was currently under performance against plan due to both KCH and GSTTs rate of emergency admissions which were impacting on elective capacity. KCH is predominantly driving the CCGs acute over-performance.

RMc explained that main drivers of the YTD over-performance at KCH were maternity pathways activity, outpatient new activity and direct access diagnostics. For maternity, the over performance position is being driven by a significant change in case mix for antenatal and birth activity. M3 actuals are of a more complex case mix than assumed in the contract plan as well as a higher level of activity than planned. RMc assured the committee that discussions will take place with KCH and that the trust would be challenged on this variance in planned versus actual activity. RMc noted that KCH is expecting a challenge meeting in next couple of weeks and that he would report back to the Committee – Action RMc.

RMc also highlighted that direct access diagnostics was significantly over performing due to a potential issue associated with the assignment of activity between Lambeth and Southwark CCGs. This will also be queried with KCH – Action RMc.

JH queried why there is a significant difference in KCH and GST maternity performance variance. RMc clarified that GST case mix is even more complex but that activity had dropped at GST which has resulted in the difference in performance.

SF queried why there was over performance in new outpatients. RMc explained that the figures quoted were post-QIPP figures and that figures also included Consultant to Consultant and A&E referrals, and not just GP referrals.

RMc highlighted that the over spend in KCH ‘all other expenditure’ was shown to be driven by hyper-acute and palliative bed days but that this was a data error in M3. Over-performance in those areas should be reduced by around £100k.

RMc gave an update on acute performance and highlighted that KCH should clear 52 weeks waiters by the end of September. Only benign HPB patients will remain and that backlog of patients should be cleared by end of November. He also clarified that the Trust is incurring contractual penalties for each 52 weeks breach. He noted that the opening of Infill Block 4 has been delayed to October. KCH are confident that they will still meet the agreed Mixed Sex Accommodation (MSA) trajectory.

RMc also updated the Committee that good progress had been made on moving patients waiting over 18 weeks for orthopaedic elective admissions from KCH to GSTT. The transfer was of a wider scope of patients than expected and a good level of activity was taking place.

Regarding diagnostic waits at KCH, RMc stated that he was confident that performance would hit the 1% target by the end of August.
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<th><strong>CCG Governance Update and Risk Register</strong></th>
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<td>MH highlighted that limited access to patient confidential data has been an on-going issue for some months but that the issue is being closely managed and the CCG is operating in line with the guidance provided.</td>
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<td>MH explained that the CCG was collecting changes of Committee terms of reference in order to provide a list of proposed Constitution changes for NHS England to sign-off in November.</td>
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<td>On internal audit, MH noted that the CCG is in discussions with the CSU on forming a procurement group and going through a process across all 6 CCGs. Five firms are on the framework, which is expected to be setup over next few weeks.</td>
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<td><strong>Board Assurance Framework (BAF)</strong></td>
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<td>JF introduced the BAF by reminding the Committee that a request had been made at the last meeting to provide action plans for 3 extreme risks. These are: achievement of financial targets for 2013-14; TSA impact on provider landscape; and achievement of RTT performance targets. JF asked the Committee to focus on the actions plans for critique and assurance, as they would be presented to the Southwark Governing Body meeting in September.</td>
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<td>RG offered his view that the document is an effective assurance mechanism. RG also wanted to recognise that two of the extreme risks were associated with external matters that are difficult to control.</td>
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<td>RG asked why IAPT was not a red rated risk as performance is red rated in the Integrated Performance Report and that investment into the service was yet to yield improvement. JF explained that the BAF captures risks to achieving strategic objectives and not just about achieving a particular performance target within that objective.</td>
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<td>AK highlighted that an addition could be made to the risk controls for FB -15 - Engagement (add: “Healthwatch sit on Governing Body and other committees”) and for SR9 - Quality and Safety (add: “Healthwatch attend Quality Surveillance group meetings”). – Action JF.</td>
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Follow-Up of Pressure Ulcers & Falls Review

OA introduced the review by explaining that it was a follow-up to an initial deep-dive review which was presented to the Committee in April 2013. This review provides an update on the progress made by providers for whom the CCG is a lead commissioner (KCH & South London and the Maudsley (SLaM)) on improvement plans presented in the initial review. OA summarised that the Committee should be assured that KCH and SLaM are implementing their improvement plans and that progress for the majority are green RAG rated.

RP asked if the findings from the review had been shared with other CCGs. KS clarified that now that the review had been completed the findings could be shared more widely. MH agreed that findings of the review could be shared.

RG asked if the CCG is presented with findings from Root Cause Analysis (RCA) reports and if improvement plans detailed in those reports are monitored and followed-up?

SF clarified that they are reviewed at Serious Incident meetings but that it was sometimes difficult to gauge if improvements are getting rolled out throughout the organisations. SF added that findings and learning from RCAs could be rolled out system wide.

JF explained that shared learning was one of the reasons Quality Surveillance Groups had been introduced, though it is too early to say if this is being achieved. In the interim Southwark had introduced Clinical Governance network meetings for SE London which do share learning. JF also clarified that there is a sign-off process for the implementation of improvement plans from Serious Incident RCAs and that this occurs 3 months after the presentation of a RCA.

CCG Quality Report – Q1 2013/14

KS presented the report and reminded the Committee that the report has been developed in response to recommendations made in the Francis Report. The aim of the Quality Report was to present a regular update about the quality of care at providers using local intelligence reports including from external organisations (like the CQC and Healthwatch) in order to gather a broad view about some of the key quality issues in the local health economy.

The draft Quality Report had been presented to Engagement and Patient Experience Committee (EPEC) and a previous IG&P. KS noted that the recommendation from EPEC was to avoid pulling out themes or rating quality issues as all are important and should be made available for discussion. KS suggested that at present there is still a focus on performance measures as quality indicators but that in future the plan was for the report to focus more on qualitative information.

KS noted that there is a lack of patient led data on services and that more patient experience data is required. KS asked the Committee to provide further feedback on the structure and content of the report.

JH suggested that about the CCG could consider how we adapt the report so it better triangulates information received about services from different parts of the system. KS noted that the report is very much officer/portfolio holder driven and not really clinically led. It was agreed that clinical leads should be further involved in the sharing of quality issues ahead of the Q2 report.

PH asked that the number of Quality Alerts be included in future versions of the report. – Action KG. JY noted that a large number of QA coming from practices were around problems in
communications with other services.

JY highlighted the proposed visit to the community diabetes service and noted that this was a commissioned service that that clinical commissioners have developed and implemented in full.

RP highlighted that the report covers areas the Committee does not usually consider such as continuing care but requested a review of this at a future IG&P – Action KS.

The Committee raised the high number reported serious incident at SLaM. JF recognised there is a slight peak at the moment and that this will be closely monitored.

The Committee discussed the issue of communication between primary care and district nursing services. This was identified as a quality issue, which the CCG and provider would need to work to resolve. NK suggested it may be useful to focus Quality Alerts on particular issues during particular time-periods.

### TSA Implementation

MH gave a brief update on the Trust Special Administrator (TSA) implementation including the process for the next stage of the TSA programme, including the review of trusts’ business cases.

AZ advised the Committee that the South East London Clinical Strategy Committee would be meeting on 28 August and that NHS Southwark CCG would run a Part II Governing Body on 29 August.

### Any Other Business

#### Home Oxygen Service:

JY presented a proposal relating to contract management of the London Home Oxygen Service (HOS). JY asked the Committee approve a request to delegate authority for the management of this contract to the South London CSU.

The Committee agreed to delegate this responsibility on the following conditions:

1. The CSU representative responsible for the management of the contract engages with the CCG to understand our position prior to attending contract discussions.

2. This CCG is kept updated with any decisions made and with progress made including receiving monthly activity and the financial summary report.

The Committee approved the request.

NK requested a glossary of acronyms. KS suggested she contact Rosemary Watts to obtain the one developed with EPEC.

### Next meeting

1500-1730 Thursday 26 September at Goldsmith Room, **Dulwich Hospital**.