JOINT QUALITY, PATIENT SAFETY AND RISK AND FINANCE AND PERFORMANCE COMMITTEE MEETING

Tuesday 23rd January 2018
St Paul's Church, Hammersmith, London W6 9PJ

Present

Name	Role and Organisation	Initials
Governing Body Members		
Trish Longdon	Lay member, H&F Clinical Commissioning Group (Chair)	TL
James Cavanagh	Vice Chair and GP member, H&F Clinical Commissioning Group	JCa
Janet Cree	Managing Director, H&F Clinical Commissioning Group	JC
Sena Shah	Practice Manager member, H&F Clinical Commissioning Group	SS
Jane Wilmot	Lay Member, H&F Clinical Commissioning Group	JaW
Nick Martin	Lay Member, H&F Clinical Commissioning Group	NM
Paul Skinner	GP member, H&F Clinical Commissioning Group	PS
Tony Willis	GP member, H&F Clinical Commissioning Group	TW
Andy Petros	Secondary Care Consultant	AP
Pritpal Ruprai	Co-opted GP member, H&F Clinical Commissioning Group	PR
Neil Ferrelly	Chief Financial Officer, NWL CCGs	NF

Name	Role and Organisation	Initials
Officers in attendance:		
Liam Edwards	Assistant Director for Quality Improvement and Clinical Assurance, H&F Clinical Commissioning Group	LE
David Hill	Senior Contract Manager, H&F Clinical Commissioning Group	DH
Sue Roostan	Deputy Managing Director, H&F Clinical Commissioning Group	SRo
Mark Jarvis	Head of Governance and Engagement, H&F Clinical Commissioning Group	MJ
Susan Brown	Clinical Quality, Assurance and Effectiveness Manager, CWHHE	SB
Margaret Kelly	Business Support Manager, H&F Clinical Commissioning Group (minutes)	MK

Apologies:	
Vanessa Andreae	Vice Chair and Practice Nurse member, H&F Clinical Commissioning Group
Amy Wilson	GP member, H&F Clinical Commissioning Group

Item	Agenda Item /Discussion	Action Owner
1.	**Welcome & Apologies**	
1.1	TL welcomed everyone to the meeting.	
2.	**Conflicts of Interest**	
2.1	The general conflict of GPs as commissioners and providers was noted. No additional conflicts were declared.	

3.	**Minutes of the last meeting**	
3.1	The committee approved the minutes of the last meeting. TL commented on the postscript note, and the decision taken for Central London CCG, the lead commissioner, to monitor the CIS risks and for this committee to be updated monthly on performance. LE explained that this came out of an action from the meeting; and whether the risk should be managed by Central London CCG as lead commissioner for CIS, and in the event that assurance was not forthcoming to escalate to the Governing body at that point. TL questioned what governance process was followed in taking this decision. MJ acknowledged that a discussion with the chair should have taken place initially given the decision to escalate in the first instance and would ensure this process was followed going forward.	
4.	**Matters Arising/Action Log**	
4.1	There were no matters arising. The outstanding actions were reviewed and discussed.	
5.	**Corporate Risk Register (CRR) – Joint F&P and Quality Risks**	
5.1	TL said it would be helpful for future cover sheets to include the headlines and any issues and work carried out since the last iteration of the register. The committee noted the CRR and further work required by MJ and MK to review the register for the next meeting.	**MJ/MK**
6.	**Month 8 Integrated Performance Report – 2017/18**	
6.1	<u>Imperial College Healthcare NHS Trust</u> DH provided a performance update on the M8 position and highlighted the following key points: **A&E:** DH advised that M8 performance should have read 87.4% an improvement from 86.9% reported in October. However, un-validated December figures show a big drop in performance to 84.2%, due to higher than expected pressure in trauma (22 patients daily) and mental health demand but performance was better than this time last year. DH emphasised that the Trust were doing everything possible to improve the position. TL queried whether the Trust was affected by the national statistics query in the media that A&E figures may need recalculation after the UK Statistics Authority said that the figures could lead to 'misleading conclusions', given that performance figures also included minor injuries or care centres, some of which were not on the same site as the hospital. DH said that Imperial should only count the urgent care centres that are part of their estates, but agreed to follow up and provide a response for the next meeting whether other providers were included. **Estates:** DH said that as a result of infection control issues, the majority of beds closed on the St. Mary's site were due to reopen in January 2018, which should assist with winter pressures. DH advised that it was a national directive to cancel elective work, with the Trust only cancelling elective procedures that did not affect beds days; however, confusion was caused amongst some patients. LE stated that the Trust had a prioritisation protocol to decide which procedures to cancel, but the protocol was not entirely followed, with procedures for some patients waiting over 52 weeks and some patients waiting almost 52 weeks cancelled. **RTT Incomplete pathway performance:** DH reported that performance plummeted in December and remained below the recovery trajectory with low level of activity affected by the number of patients coming off the list; however, the Trust were meeting the new agreed improvement trajectory (83.2%), achieving 83.3% in M8. DH said that performance was being measured against the draft aggregate recovery trajectory and speciality level recovery plans with the Trust expected to achieve 86% performance by year end, with all options for additional activity being maximised. DH advised that it hoped all specialities would achieve 92% performance in 18/19, with the exception of Trauma and Orthopaedics, which should take longer to achieve.	**DH**

6.2	The draft aggregate recovery trajectory indicates that year-end RTT performance may only reach 86% at year-end (March 2018) even with all possible options for additional activity being maximised. **52-weeks wait:** DH advised that the number of 52-week breaches had reduced over the past 6 months with 245 reported in M8, which had rapidly reduced from 440, the number reported in M6. DH said that M9 provisional data suggests a similar position to M8 of approx. 243. DH stated that it expected the number of 52 week waits to increase in January due to low activity levels in December and elective cancellations. DH added that the Trust expects to achieve zero breaches by the end of July 2018, and based on current speciality level performance, shows a vast improvement for gastroenterology due to a reduction in the endoscopy backlog. NM commented on the trajectory for the past few months, which was low, and asked on what basis were the commissioners optimistic that the trajectory was achievable. DH explained that the trajectory was revised in October and prior to this, the Trust had carried out a clean-up exercise and reduced the backlog of patients. LE said the Trust was open and transparent and were in a better position to understand all patients affected by the 18-week trajectory. TL mentioned that the Trust had a number of trajectories and sought assurance that the current trajectory was realistic and achievable. DH explained that Imperial were required to reach the constitutional standard in 18/19, but were confident that the Trust had a grip on waiting lists, due to the number of processes in place, and were in a strong position to improve. LE said that the Trust were looking at waiting lists from a root cause analysis (RCA) view, and were providing training for consultants and to data admin staff, reviewing the competence levels to ensure training was delivered appropriately and embedded from the start. DH said the Trust were managing the waiting lists and were doing work to consolidate all staff to the structure and were delivering accredited level training, not provided elsewhere. **Cancer:** DH advised the committee that in M8 Imperial achieved the 62-day GP referral to treatment standard, not met for the past year, and that all other national cancer standards continue to be met. DH said that provisional data for M9 suggests that the Trust should continue to achieve the 85% standard. TL commended the Trust on their performance and asked for this to be escalated to the March governing body as a good news story. **Diagnostics:** DH reported M9 performance was 98.6% against the 99% standard, and the Trust continued the recent improvements over the past four months with patients seen within the timeline, and performance ahead of the recovery trajectory. DH said as part of the Trust's solution for imaging that Imperial had outsourced imaging to be managed by an independent provider. DH noted that of the 152 breaches reported that the majority related to endoscopy, and the recovery trajectory had forecast breaches to be just under target in January 2018. DH noted that the Trust had reported at a prioritisation meeting, that achievement of this standard was more costly. <u>Imperial College Healthcare NHS Trust</u> LE provided a quality update and highlighted the following: **Hand Therapy:** The committee noted that the CCG had concerns with the proposed movement of hand therapy services from Charing Cross hospital to consolidate services onto the St Marys hospital site. LE said the Trust revised the impact assessment and Hammersmith and Fulham CCG would be formally responding to the Trust with comments regarding the mitigations relating to the equality impact assessment and simultaneously would provide patient communication as part of the response.	**MK**

Patients receiving incorrect patient details: LE mentioned the recent error in terms of patients receiving the wrong patient details in emails from the Trust, which was confirmed as an Information Governance breach and Serious Incident, with all appropriate parties informed. LE explained that this related to outpatients, patients checking in and a changeover of systems. LE noted that in total 230 people were affected. LE said that all affected patents were written to by Imperial with the email system stopped and weekly checks carried out of the system, until robust assurance and prevention of reoccurrence was confirmed.

NWL Oncology Services: LE said that concerning the NWL oncology services, that issues were highlighted at the last Associates Group meeting with the way test information was reported, at some of the Imperial sites. LE assured the committee that superior machines were being commissioned from April 2018, which should address this concern.

Community Independence Service (CIS)

TL mentioned the 74 incidents reported across CIS in November 2017 with 2 low/minimal harm incidents, and no harm associated with the remainder of incidents reported. LE explained that the high number of incident reported was good reporting by the provider with only 2 out of the 74 reported as low/minimal harm incidents. TL sought clarification around what was meant by "low/minimum" harm. JC advised that all incidents were investigated to prevent reoccurrence and the committee were not making a judgement on whether patient experience was acceptable. LE added that the provider was monitoring all incidents and were looking at the lessons learnt to ensure embedded throughout the organisation.

TL said as a user that 74 incidents reported per month (10% of people) seemed high, in particular given the low number of GP referrals. LE explained that safety was high given the high number of incidents being reported with low/minimal harm, and that the environment would be safer if all other providers reported likewise. LE stated that of the 3 Serious Incidents (SI's) reported in the last quarter, that the provider was keen to learn from what could go wrong. LE explained that the broad definition of incidents was more detailed and an incident could include ripped carpet in someone's home. JC highlighted that incidents were reported through the CIS contract monitoring process. LE said a CIS report could be produced for the committee quarterly; on progress with quality, also on the impact on learning, and could arrange for a deep dive to be conducted if deemed necessary.

PR mentioned that the CIS service had agreed to attend GP network meetings but had not attended a meeting for over a year. LE agreed to raise this issue with his counterpart at Central London CCG (CLCCG), the lead commissioner, and with the Primary Care Team to ensure future meeting attendance was scheduled. **LE**

TL requested that the committee receive a CIS report to include the governance process around how it was supported. LE agreed to discuss CIS with CLCCG and with Toby Hyde, the Hammersmith and Fulham CCG (HFCCG) CIS lead, and to ensure a report was produced. In the meantime, LE agreed to e-mail the committee to find out what particular information it wanted incorporated into the report. **LE**

Imperial Quality Account process

LE advised the committee that the quality account process would commence next month to include stakeholder engagement and planned to link in with the Trust around this.

The committee **noted and discussed** the M8 Integrated Performance Report

7.	**2017/18 QIPP M9 Performance plus 18/19 update**	
7.1	SRo introduced the report. She explained that the focus of today's QIPP Delivery Group (QDG) was on the financial position, QIPP M9 performance, planning for the 18/19 QIPP programme and the final Deloitte report. SRo agreed to circulate the Deloitte report to be discussed at a future Governing Body Seminar. SRo advised the committee that the CCG forecast was to deliver £12.6M QIPP savings against the plan of £19M. SRo reported no savings delivered against CIS to date and on a full year basis; with prescribing reporting a gap of £214k and further gaps reported against some of the other CCG local plans such as the planned care schemes and out of hospital services of £136k. SRo advised the committee that the CCG would be doing all possible in the final quarter of the year to deliver the QIPP savings required to support next year's position. SRo stated that the focus on the 18/19 QIPP programme would increase over the coming weeks to allow a complete plan to be produced by the 1st April 2018. SRo advised the committee that the CCG would be required to deliver approximately £18M QIPP savings in 18/19 (6.0% of the CCG allocation), but the figures could increase, and would depend on the outcome of the 17/18 QIPP plan. SRo reported that the current QIPP plan of £6.3m savings was prior to a risk adjustment for local schemes, therefore the impact of QIPP delivery following risk assessments shows that the total savings had reduced to £4m for the local schemes and NWL programmes, therefore a QIPP gap of £14M remained to deliver against. SRo reported that at a NWL level, the QIPP target was £152m, with a QIPP gap of approximately £62m for next year, but the CCGs await the NHSE planning guidance. She asked the committee to note that it excludes the provider risks. SRo said as part of the process to close the gap; and to provide a clearer understanding of the remaining gap to be managed; that this piece of work would take account of the following: ○ The outcomes from the NWL Steering Group 4 day PID/programme review sessions ○ outcomes following the GE Finnamore work ○ the existing benchmarking exercise ○ the internal cross comparison and review of current QIPP plans ○ existing CCG recovery/turnaround processes. SRo said that Shelley Martin, Bhav Patel and Jonathan Wise had a meeting to talk through the current schemes in place for 18/19 and to provide assurance to Neil Ferrelly, CFO NWL CCGs, of the plans in place locally. SRo reported a difference in the way the NWL CCGs and H&F were risk-rating schemes, but explained this was being looked into with the aim of establishing a consistent single process across NWL CCGs for reviewing PID plans and for assurance purposes. NM queried the H&F QIPP contribution for 18/19 of 6%, which he considered high compared with the other NWL CCGs. NF said this was calculated as part of the modelling process, with two of the eight CCGs required to make an 8% contribution, but NHSE were monitoring the mitigations and the CCGs still await the planning guidance to determine the final figures.	**SRo**

	SRo advised the committee that assurance on the NWL schemes and the time gap was provided to the CCG and was one of the areas that the QGD focused on as part of their discussions. Furthermore, Kingsgate did a piece of work looking at non-electives (NEL) activity with the integrated partnership and GP networks, but would need to progress the review to allow the CCG to see the impact in 18/19. NM raised concern about the lack of visibility around the NWL collaborative QIPP schemes. SRo explained that feedback was provided through the QIPP Delivery Group (QDG) on the programme of work, in particular around outpatients, and agreed to include further detail and slides in the M10 QIPP pack. JCa mentioned the QIPP engagement provided at the GP members meeting; and the difficult choices to be made, and the importance of engagement with GP members and patients around the level of QIPP savings to be delivered. JC emphasised the importance of having an engagement plan from a member's perspective through the members meetings; network meetings and at the Patient Reference Group (PRG), to relay key pertinent messages, in order to achieve the overall impact, but would require a formal request to do so. JaW asked when would the CCG alert patients and the public about the CCG commissioning intentions, in particular any proposed decommissioning decisions and emphasised the importance of allowing sufficient time to engage. JC reiterated that a CCG engagement plan would be required to relay key messages, but the other elements would require specific engagement plans around this. TL said that the NWL collaborative was clear about the work that must happen to obtain a balanced view, and to gain an understanding around how it arrived at this position. TL added that a plan and 1-2 page document was being looked at around the current position and the need to prioritise all areas in 18/19 given the level of QIPP required. NF mentioned his involvement with this piece of work, with a summary document to be shared with this committee and locally through the PRG. SS mentioned the local council elections in H&F; scheduled for Thursday 3rd May, and the need to cease decision making from the 27th March until the elections conclude. NF mentioned the low level of growth and underline deficit position in H&F and the need for this level of QIPP to be delivered to manage the position, and to support the work happening across all of our providers. JC mentioned the further work required especially around system changes at Trust level, and to focus on maximising the opportunities to be achieved through the new network configuration. JC mentioned the work required at local level and the integrated patient care arrangements, utilising some of the provider driven solutions already prepared, in order to make the difficult decisions and to ensure that processes was managed appropriately. JC emphasised the importance of having as much information as possible especially on the CCG portfolio of contracts, in order to make informed decisions, and to use this committee and the governing body to make these decisions. JC highlighted the challenging decisions ahead that need to be taken; and emphasised the importance of having correct information and robust processes in place this year, and the planned review of contracts should provide greater oversight and indicate the opportunities. SRo reiterated the importance of preparation work in 17/18 to allow the CCG to be ready for the full year affect in 18/19, and not to rely on back ended QIPP where possible. JC said the CCG was working with the NWL programmes to deliver the QIPP savings; support local QIPP and the local delivery elements around prescribing wisely and the requirements and ownership at local level, and the importance of patients and GP networks to recognise this work, so the CCG was fully supported.	**SRo** **SRo**

	JC underlined the importance of the F&P committee in challenging QIPP delivery to maximise the benefits of the existing programmes. TL suggested future investment proposals brought to the F&P committee for consideration to include as one of the options "do not commission" and list the advantages and disadvantages to assist the committee in making the decision. JaW acknowledged the hard work currently underway by the CCG on the project plans for 18/19; and the difficult decisions being taken by the CCG four months into the new year, in order to maintain a balanced position. JC said the CCG should ideally be making decisions now to achieve the full year affect next year, but it was not always possible to align services at the beginning of the year. JC said the CCG would maximise the planning stage of the QIPP plans for each project area; and would include clear deliverables, milestones and the mitigating actions if the scheme were off plan. Additionally, it would review the plans four weekly to ensure targets were achieved. JC emphasised that this was an on-going process to ensure the right decisions were being taken to ensure the CCG delivers its plans and to deliver effective patient care. NM mentioned having a strategic overview of services to decide whether to commission or de-commission schemes and to review the portfolio of contracts in advance with sufficient clinical oversight. SRo said that the CCG would be looking at this in its entirety at a future governing body seminar. SRo mentioned a prior governing body seminar discussion around the mental health portfolio of services, assessed against the CCG investment prioritisation. SRo advised the committee of the strategic difficulties in making decisions; specifically taking into account the 5-year forward view and statutory requirements, the block contractual arrangements and services commissioned by other CCGs on our behalf. SRo said as part of the decision-making process that the CCG would look at acute and community provision, to decide what could be delivered differently and more effectively. AP asked if the PRG was a listening group, and what their involvement was with local services. JC said that the PRG was a forum to provide early warning about difficult decisions being made by the CCG and members of the group would be involved as part of the process. MJ explained that there are different elements of consultation and engagement; and the CCG had a clear comms and engagement strategy, with the principles developed alongside patients, and had a clear process in place to fulfil its commitments to the local population. TL questioned if any of the procurements involved service users; and if patients were being asked for their opinions, as to whether the CCG should not commission a service, given the level of savings that the CCG had to deliver. TL acknowledged that the difficult conversations required with service users would need to be managed appropriately. JC advised that locally and from a NWL perspective, there was a rationale for doing this. JC mentioned that other QIPP savings could be achieved; in addition to prescribing wisely, and to build on this work across NWL and deliver consistent messaging to patients. TL asked whether it was worthwhile holding discussions on services such as CIS; where no savings were delivered, or are the advantages great elsewhere in the service. SRo said that conversations would need to be had around community services in its entirety. The committee **noted and discussed** the QIPP M9 Performance plus 18/19 update	**All** **SRo**

8.	**Falls Prevention Service update**	
8.1	CL presented the report. CL explained that CLCCG, the lead commissioner of the service, led a piece of work across the 3 CCGs to transform the service to meet the needs of patients in a more effective way. CL explained that a clinical review of the service specification was undertaken, with the specification revised in accordance with NICE clinical guidance and the fall prevention programme. CL highlighted that the review involved patient engagement around the impact of the service changes, how it links to the Steady and Stable service (run by Open Age) and the promotion work led by the Local Authority to educate patients. CL noted a QIPP saving of £86k (25% of the overall cost) to be delivered as part of the 18/19 QIPP programme. PR queried how the Falls Prevention Service sits with the Reablement Service and Charing Cross Falls Clinic. CL explained that links were established with the falls clinic and some of the referrals in come from the falls clinic. CL said work was going on round fracture liaison in the wider context across NWL; and the service supports those with the highest risk of falls and incurring fractures, by carrying out assessments and treatments and in providing advice to improve bone health. CL stated that CIS were involved to support the housebound and to provide rehabilitation and reablement for the best outcomes. PR asked how the service was funded. CL clarified that the service was funded through the Central London Community Healthcare NHS Trust (CLCH) block contract, and the alternative would be for patients to go to acute. PR sought clarification around how to differentiate where to refer patients. CL explained that the service had referral criteria for each element, which was included as part of the information pack. The committee requested that the criteria around how to refer to the Falls Prevention Service, including the criteria and information about how to refer to acute and the differential with the CLCH service, be shared with GP practices through the GP newsletter. JaW suggested that the information be co-produced with GP practices. CL explained that GPs across the 3 CCGs has input into devising the criteria and would need to ensure no duplication of the process across the 3 CCGs, making sure that patients received the right service at the right time. JaW said that people would need to understand the language and have the opportunity for testing to make sure it was clear. CL reiterated that the acute criteria would need to be clear; and specify how it differs from the Falls Prevention Service, and what the service offers. JC said that the GP newsletter was the principal way of alerting GP practices about the service to be included on SystmOne with clear pathways to refer. SS mentioned the criteria and exclusion of under 16's. CL said it was paramount that the right group of people were targeted; with the criteria based around referrals for older people, who are considered more prone to falls. SS asked if the service was available to people not living in the borough. CL explained that the service was specifically for the registered population of Hammersmith and Fulham and for West London CCG, who are part of the service. TL mentioned the additional care home costs for West London CCG and asked what care homes in H&F were utilising the Falls Prevention service. CL explained that many patients were using the CIS service with work underway with care homes led by the GP Federation, to review the work-streams, and to ensure residents were being looked after appropriately and to maximise admission avoidance. The committee **noted and discussed** the Falls Prevention Service update	**CL**
9.	**Any Other Business**	
9.1	No other business was discussed.	
Date of next meeting: Tuesday 13th March, 1.30 - 3.00 pm, St Paul's Church, Hammersmith		