West Hampshire
Clinical Commissioning Group

CCG Board

Date of meeting		**25 July 2019**	
Agenda Item	**12**	**Paper No**	**WHCCG19/082**

Minutes of West Hampshire CCG Committee Meetings

Key issues	To note the publication on our website of the approved minutes of the: • Clinical Governance Committee meeting held on 2 May 2019 • Clinical Cabinet meetings held on 9 May and 13 June 2019 • Primary Care Commissioning Committee meeting held on 25 April 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:** • **Clinical Governance Committee meeting held on 2 May 2019** • **Clinical Cabinet meetings held on 9 May and 13 June 2019** • **Primary Care Commissioning Committee meeting held on 25 April 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.	Clinical Governance Committee (supported by Clinical Quality Review Meetings), Clinical Cabinet 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	17 July 2019

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 2 May 2019 at 9.00am in the Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB

Present:	Judy Gillow	Lay Member: Quality & Patient Experience (Chair)
	Charles Besley	Board GP: Totton & Waterside
	Simon Garlick	Lay Member: Governance
	Karl Graham	Board GP: Eastleigh Southern Parishes
	Heather Hauschild	Chief Officer
	Adrian Higgins	Medical Director
	Rachael King	Director of Commissioning: South West
	James Lawrence-Parr	Deputy Director of Commissioning: Mid Hampshire
	Johnny Lyon-Maris	Board GP: West New Forest
	Ellen McNicholas	Director of Quality & Nursing (Board Nurse)
	Heather Mitchell	Director of Strategy & Partnerships
	Matthew Richardson	Deputy Director of Quality & Nursing
	Sarah Schofield	CCG Chairman
	Caroline Ward	Lay Member: New Technologies & Digital (part meeting)
	Stuart Ward	Board GP: Eastleigh North & Test Valley South
In attendance:	Carole Berryman	Senior Quality Manager: South West
	Kim Jones	Designated Nurse: Safeguarding Children
	Jaki Metcalfe	Consultant Nurse: Safeguarding Adults
	Jackie Zabiela	Governance Manager (minutes)
Apologies:	John Carr	Patient Representative
	Joanna Clifford	Senior Quality Manager: Mid Hampshire
	Jenny Erwin	Director of Commissioning: Mid Hampshire

Summary of Actions

Minute Ref.	Details	Who	By
5.4	**Primary Care Quality: Committee Framework.** To develop a framework for the discussion of Primary Care quality	Rachael King, Ellen McNicholas and Adrian Higgins	Progress Report July 2019 Final Report September 2019

Minute Ref.	Details	Who	By
6.4	**IFR Appeals Panel ToR.** To amend Terms of Reference as agreed, with amended ToR to be signed off via Chair's action.	Matthew Richardson	As soon as possible
9.12	**UHSFT Ophthalmology.** To feedback to the Executive meeting queries raised by GPs i.e. • If there is any rationalisation of the waiting list • The disconnect between what is being said to patients and the reality regarding follow-up appointments, including the impact on other parts of the system such as GPs and PALS	Matthew Richardson	As soon as possible
9.12	**Ophthalmology: Other Providers.** To determine the position in other providers with regard to ophthalmology follow-up appointments *(already underway)*.	Matthew Richardson	4 July 2019
10.3	**CHC Complaints: Benchmark.** To revisit how the CHC service benchmarks when compared with other services nationally.	Ellen McNicholas	4 July 2019
10.4	**CHC Team: Customer Support.** To include within the next report an update / assurance on what support the CHC team are getting in terms of customer support training.	Ellen McNicholas	4 July 2019

1. WELCOME AND INTRODUCTIONS

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

SECTION 1: BUSINESS

2. DECLARATIONS OF INTEREST (Paper CLIN19/045)

2.1 Judy Gillow 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 – 7 MARCH 2019 (Paper CLIN19/046)

3.1 The Committee received the draft minutes of the meeting held on 7 March 2019.

3.2 It was reported that the following topics were agreed for highlighting on 7 March to the Board of 28 March 2019 i.e.

- **Child & Adolescent Mental Health Services (CAMHS)**: Waiting times – regular update
- **Millbrook Hampshire Wheelchair Services (MHWS):** Increase in referrals and waiting times
- **Hampshire Hospitals NHS Foundation Trust (HHFT):** Progress being made on the Care Quality Commission action plan
- **Clinical Governance Committee Terms of Reference:** To inform the Board that they had been reviewed.

3.3 Please refer to Board report references WHCCG19/022 Integrated Performance Report and WHCCG19/032 Corporate Governance Update Report.

3.4 The Board was informed that Judy Gillow and Ellen McNicholas had written to Hampshire Hospitals NHS Foundation Trust (HHFT) and Southern Health NHS Foundation Trust (SHFT) to invite medical directors and directors of nursing to attend Clinical Governance Committee to provide updates on issues which had been discussed. It was also reported that Joanna Clifford, Senior Quality Manager is leading on work related to safety culture within HHFT, for which the Board formally expressed its thanks.

3.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee:

- **Approved the minutes of the meeting held on 7 March 2019 as being an accurate record of the meeting**
- **Noted that the items agreed for highlighting on 7 March were reported to the Board of 28 March 2019.**

4. ACTION TRACKER (Paper CLIN19/047)

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

4.2 **CLIN19/007 UHSFT Two Week Breast Symptoms Pathway: Feedback to GPs**. University Hospital Southampton NHS Foundation Trust (UHSFT) has confirmed that GP's would be notified within 24 hours of any diagnosis of cancer resulting from a referral in addition to the standard response to a referrer. There is, therefore, an opportunity for learning / follow-up. It was queried if there is evidence that this occurs. Karl Graham responded that UHSFT has a fairly robust system, with a form they send from the breast care nurse to advise when a patient has been diagnosed and that further details will follow. He added that he had not heard any feedback / intelligence that there have been any major problems with diagnosis recently. It was

therefore agreed that the action could be closed, as the issue would be raised again in the future if it is identified as a theme.

4.3 **CLIN19/008 UHSFT Glaucoma Trajectory / Assurance**. Matthew Richardson reported that the last Executive meeting at the trust had received a revised trajectory up to July 2019, which shows a peak followed by a recurrent decrease. Progress will continue to be monitored at the trust Executive meeting, at which the CCG are present. As updates will continue to be provided through regular reporting, it was agreed that this action was now closed.

4.4 **CLIN19/015 UHSFT VTE**. It was reported that there is currently no improvement trajectory for VTE (Venous Thrombo-Embolism) risk assessment, however an IT solution that is linked to e-prescribing has been piloted in the three clinical areas since 24 January 2019. At the last Clinical Quality Review Meeting (CQRM) in March 2019 early preliminary results were very positive. Once results have been ratified it is anticipated that the IT solution will be rolled out to all appropriate areas. The validation audit which will be conducted biannually is in the early stages with results still pending. It was clarified that this is a bespoke digital solution for UHSFT in terms of how their workflow goes through so it is easier to input the risk assessment information and harder to bypass. It would probably not apply to other trusts as this particular problem has been unique to UHSFT. As updates will continue to be provided through regular reporting, it was agreed that this action was now closed.

4.5 **CLIN19/017 Millbrook Wheelchair Service Progress**. Updates on waiting time initiatives were provided within the Mid Hampshire Directorate report reference CLIN19/052a. It was agreed that this action could now be closed.

4.6 **CLIN19/018a Community Ophthalmology**. Implementation plan for the development of the community ophthalmology service has been circulated. The business case for the service has been approved and is in the process of being implemented and progress reports will continue to be provided through the CCG's normal reporting routes. It was therefore agreed that this action was now closed.

4.7 The following actions remain open:

- **CLIN18/060 Medicines Optimisation Prescribing Comparison**. The issue of patients / parents attending Emergency Departments (EDs) and other Out of Hours services to obtain antibiotics (when the GP had declined to prescribe) was raised with Dr Keith Ridge, Chief Pharmaceutical Officer, Department of Health and Social Care / NHS England when he visited the CCG on 16 April 2019. Keith has raised the question of comparing antibiotic prescribing from EDs with Andrew Davies, Director of Hospital Pharmacy, NHS England / NHS Improvement (NHSE/I) and Elizabeth Beech, National Project Lead: Antimicrobial Resistance, and Andrew has provided an initial analysis of oral antibiotic liquids (as a proxy for prescribing for children) by NHS Region. The CCG is working with Andrew to obtain the data for UHSFT and HHFT (and possibly all Hampshire and Isle of Wight acute providers) to compare trends with primary care prescribing.
- **CLIN19/001 Supervision of medical professionals working in an isolated manner**. Work to obtain assurance / regular reporting remains ongoing.

- **CLIN19/005 CAMHS: GP Referrals**. Meeting taking place 3 May 2019 to discuss development of a GP survey to be undertaken as part of the Section 11 Safeguarding Children Audit.
- **CLIN19/016 Balanced Scorecard**. The balanced scorecard is still in development.
- **CLIN19/018b CAMHS**: **Transition**. Information on the transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services is being progressed through CQRMs with Carole Berryman and was covered by a CQUIN (Commissioning for Quality and Innovation) in 2018/19. An update will be included within the CAMHS report for the July 2019 meeting when the full year's data will be available.
- **CLIN19/021 Comparisons Report**: Coding**.** Discussion with regard to coding on discharge summaries not yet taken place as a number of Executive Team meetings have been cancelled.

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

- **CLIN19/018c CAMHS Tier 2 Pathway.** Update provided to the three way Board held on 30 April 2019.
- **CLIN19/019 CAMHS Procurement**. Report on the review of the CAMHS procurement process provided to Part 2 Confidential meeting.
- **CLIN19/020 SHFT**: **Care Programme Approach**. Meeting has taken place and an update provided within the Strategy & Partnerships Directorate report, reference CLIN19/052c.

4.9 **AGREED:**

The West Hampshire CCG Clinical Governance Committee:

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

5. CLINICAL GOVERNANCE COMMITTEE: ANNUAL REPORT SCHEDULE (Paper CLIN19/048)

5.1 Matthew Richardson reported that the annual report schedule for the Committee had been reviewed; there were no significant changes, apart from an addition to ensure that the Committee is informed regarding Integrated Care Partnerships (ICPs) and Sustainability and Transformation Partnership (STP) governance, and to ensure regular updates on Millbrook Hampshire Wheelchair Service (MHWS) and CAMHS.

5.2 Heather Hauschild questioned if there is enough focus on primary care; whilst the CCG has a number of community services, reporting is very focussed on acute providers. Care needs to be taken that there is no duplication with the Primary Care Commissioning Committee (PCCC), however she queried if the Clinical Governance Committee should have a more rounded view; this was supported by both Simon Garlick and Judy Gillow, who added that we need to ensure there is no silo reporting, with perhaps some of the same items needed at both Committees, but with a different focus. The following are the key points raised during discussion:

- PCCC would look at the detail, however it would be helpful for a framework regarding what will be discussed i.e. what is in place already and what will be developed.
- GP practices are entities in their own right so we need to determine what exactly is going to be reviewed; at GP practice level, or across the board.
- Most important to consider is how the CCG identifies a practice before it collapses, such as Brownhill; particularly as in hindsight there had been a number of indicators that should have been identified before this happened. The PCCC would have the remit to monitor this, with a dashboard in the process of being developed to provide an insight from a quantitative perspective, although it was suggested that what currently remains missing is the qualitative data.
- Johnny Lyon-Maris queried if the implication is that Primary Care Network (PCN) leaders have a role in ensuring the quality of services provided in their practices. It was suggested that they could potentially have some degree of responsibility to provide some evidence of reviewing practices in their network, supported by CCG colleagues. Johnny commented that PCN leads have a remit to provide a framework for the best quality, to be made available to their practices, but should not have a 'regulator' role; leads are not aware that there is the potential that this would be part their role and would not be comfortable with this.
- There is a need to consider how the work that the quality team does in terms of supportive quality visits and the intelligence they pick up is fed in.
- Further thought needs to be given to PCNs and how quality is monitored; it would be premature to propose a monitoring solution at this stage, however it is already within the remit of the PCCC to escalate to the Clinical Governance Committee when appropriate.
- Need to be clear that discussions are not duplicated. Heather Hauschild added she was not proposing that the same sets of papers are provided to both committees, but that the Clinical Governance Committee is utilised as a point of escalation given there are a number of GPs present at this Committee who are not in attendance at PCCC, which would allow a different conversation. There needs to be a clear framework of how the CCG assesses primary care quality in order to help practices to develop and share learning. She suggested that the framework is signed off by the Clinical Governance Committee and put through PCCC in order to ensure that random issues are not escalated.
- Simon Garlick suggested that the Clinical Governance Committee could perhaps have a role in shaping the CCG's version of the Long Term Plan as there was a great deal of clinical input that could be utilised to shape ideas.
- Sarah Schofield commented that there is a need to be clear on the difference between primary care and GP practices. With the development of networks between primary care and general practice, there will be a lot of overlap which needs to be resolved; there is a tendency to artificially separate general practice from the rest of primary care provision, so the right connections need to be made.

5.3 As a result of discussion, it was agreed that the main area of work is to develop a framework for what is discussed at each meeting, being clear what is escalated to the Clinical Governance Committee and to not duplicate discussions. The right connections need to be made so committees are not working in silos. Within this there is a need to identify which group is determining the strategic direction going forward, which may link to the STP Quality Assurance Framework. This piece of work is to be led by Rachael King, Ellen McNicholas and Adrian Higgins with involvement from GP locality directors and PCN leads, with a progress report to be provided at the July meeting and a final report by September.
ACTION: Rachael King, Ellen McNicholas and Adrian Higgins

5.4 **AGREED:**

The West Hampshire CCG Clinical Governance Committee agreed the Annual Report Schedule, to be further developed throughout the year.

6. INDIVIDUAL FUNDING REQUEST (IFR) APPEALS PANEL: TERMS OF REFERENCE (Paper CLIN19/049)

6.1 Matthew Richardson advised that the Terms of Reference for the CCG IFR Appeals Panel had been reviewed in accordance with annual review requirements with no amendments required. It was noted that the cover sheet states that only one IFR Appeals Panel has been held; it was clarified that this should read that whilst there was only one panel, two cases were reviewed.

6.2 It was pointed out that paragraph 6.3 was ambiguous and seemed to state that the IFR Appeal Panel could overturn a decision made by the main IFR Panel. It was clarified that the role is to determine if the IFR Panel has made an error in logic and assessment; a case could be referred back to the IFR Panel, proper process followed and still result in the same outcome / decision.

6.3 The following comments were also raised:

- Section 3.2 on membership should be amended to reflect that the Director of Quality & Nursing or a deputy could be in attendance.
- Ellen McNicholas clarified that whilst section 7.1 states that the Board Nurse in conjunction with the Head of IFRs is responsible for the organisation of the IFR Appeals Panel meetings, she has been involved in making arrangements, not leading.

6.4 Matthew Richardson agreed to coordinate changes to the Terms of Reference as discussed above, with the final version to be approved via Chair's Action.
ACTION: Matthew Richardson

6.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee approved the IFR Appeals Panel Terms of Reference, subject to revision of sections 3.2 and 6.3 as detailed above.

7. HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP QUALITY FRAMEWORK (DRAFT) (Paper CLIN19/050)

7.1 Matthew Richardson reported that the Hampshire and Isle of Wight (HIOW) Quality Board is a formal board of the Sustainability and Transformation Partnership (STP) made up of all CCGs, health providers, local authorities and regional organisations (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.

7.2 The Quality Framework has been developed to ensure a shared approach to quality governance and improvement and outlines the specific programmes which can be performed at scale across the STP.

7.3 Ellen McNicholas drew attention to the last slide of the document which details a list of organisations which are invited members of the HIOW Quality Board and have jointly developed the framework. She reported that the reason the document had been brought to the Committee was that unfortunately West Hampshire CCG were not actively involved in its development as neither she nor Matthew had been able to attend the meeting where this was discussed. The Committee therefore needs to take the opportunity to comment otherwise it will be assumed that the CCG is supportive of the document; for which feedback was required by that afternoon.

7.4 The following comments and queries were raised during a period of discussion:

- Slide 2 suggests that the STP plan is being delivered through four Integrated Care Partnerships (ICPs) across HIOW. This implies that these organisational structures have a delivery function, which is not the case; delivery is through CCGs and individual provider organisations. In addition there are five, not four ICPs.
- The voluntary sector is not mentioned but is an important part of delivery in the community.
- Would be good to include engagement with NHS Improvement (NHSI).
- Should ‘value for money’ be talked about in terms of quality, rather than just purely quality?
- Heather Hauschild reported that she and Matthew had been present at the Executive Delivery Group discussion where this was discussed; there are some statements which the CCG would not dispute, however the question is ‘so what’ i.e. how would the framework be applied. The framework talks about eliminating duplication, but does not describe which bits are going to be eliminated. It is therefore not clear what organisations are being asked to sign up to.
- Slide 7 on Quality Deliverables picks up some specific actions, such as implementation of RESTORE2 in nursing and care homes (although it was not clear why this particular action had been identified) and then refers to a new approach to quality surveillance, which is vague.
- When initially reviewing the document, Simon Garlick stated that he thought the framework was a prelude to a rationalisation of all the quality forums

across HIOW, however the document does not detail anything new but summarises what is currently in place.

- Slide 8 on the 'triangle' of how goals will be delivered implies that integrated service level is at the bottom, when it is actually at the top. There could be some benefit of coming together and having joint quality conversations; this is where duplication sits at the moment.
- The framework does not align with current arrangements, unless we are moving to a single organisational structure. The document also refers to 'clusters' not PCNs and ICPs around Southampton; whilst this is an ambition it is not the current position.
- The top domain on slide 4, shared definition of quality refers to safe care and avoiding harm, however there is only one statement which refers to safeguarding, with no mention of the changes in Local Safeguarding Children Boards and how CCGs are becoming partners in safeguarding.
- There is no reference to other quality frameworks, such as Care Quality Commission (CQC), CCG and provider internal metrics, so the STP needs to clarify which perspective the document is intended to address.
- There are too many shared values on slide 5 for them to be meaningful.

7.5 In terms of the feedback to be provided by the Committee, this was agreed as follows:

- The presentation / layout of the framework was clear.
- Who is it for, how will it be applied, and what are CCGs being asked to sign up to at this stage of the transformation journey.
- Inaccuracies, such as references to clusters and there being five rather than four ICPs.
- Fundamentals of how the system is working at the moment are not coming through, such as CCGs, networks and aligning in localities.
- Outcomes are not clear, including how these will be delivered.
- Does not reference the quality frameworks that are already in place; need to simplify the existing frameworks.
- Does not refer to other bodies such as NHSI who have an increasing role in monitoring delivery.
- Connections between the different groups.
- The document seems to be a set of principles and not a framework; perhaps the document should be reframed as a set of principles that could then be considered.
- There is a missed opportunity; if organisations are getting together at this stage, it would be possible to capitalise on properly developing and using data and sharing best practice. This should be given as positive feedback as there is a richness of information that can be shared across HIOW.

7.6 **AGREED:**

The West Hampshire CCG Clinical Governance Committee reviewed the draft Hampshire and Isle of Wight Sustainability and Transformation Partnership Quality Framework and agreed feedback as detailed above.

SECTION 2: KEY RISKS

8. RISKS REGARDING QUALITY ON THE CORPORATE AND QUALITY RISK REGISTERS (Paper CLIN19/051)

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 30 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.

Risk ID448 Sussex Partnership NHS Foundation Trust: Hampshire CAMHS

8.2 The risk around CAMHS waiting times remains the CCG's highest risk. A three way Board took place on 30 April 2019 between West Hampshire CCG, the Hampshire CCG Partnership and Sussex Partnership NHS Foundation Trust (SPT). The key message was that the CQC, the independent peer review and the CCG's own assurance processes point to the fact that children who are in the system are receiving good quality care, however there are concerns regarding equity and access to services. Further discussion on this is detailed in sections 9.19 to 9.22.

NEW Risk Learning Disabilities Mortality Review (LeDeR)

8.3 There is a new risk with regard to operational activity planning for 2019/20. NHSE have given CCGs four key actions i.e. 1) that CCGs are members of the LeDeR Steering Group (achieved), 2) that LeDeR reviews are achieved within six months (not achieving) and 3&4) that regular / annual reports are submitted. The CCG is currently receiving two to three new cases per month; each case takes an average of five complete working days (spread out over several weeks) in order to meet with family and write reports etc. Eleven cases are currently ongoing with seven to be allocated. This is a significant challenge to be able to turn around within people's existing job roles.

NEW Risk ID601 Southern Health NHS Foundation Trust (SHFT): Culture in Antelope House

8.4 The risk that the culture in Antelope House does not promote a therapeutic, safe or effective care environment has been added in light of recent incidents, with mitigation including changes to the medical and nursing leadership.

Risk ID447 SHFT: Personalised Care Plan (Mental Health)

8.5 Following discussion with Jenny Erwin and Beverley Meeson, Deputy Director of Service Development, it has been identified that the real risk is not around the Care Programme Approach (CPA) but about personalised care planning i.e. making sure that all patients have a personalised care plan.

NEW Risk SHFT: Assurance Processes

8.6 This risk has arisen since papers were published. SHFT are going through a major restructure. There have been a number of assurance and quality meetings that have not been attended by SHFT whilst they go through this process, which the quality team wanted to reflect on the risk register. Whilst the CCG has received the new operational structure, Ellen McNicholas will be formally writing to the trust regarding the need to ensure the right people are in attendance at meetings to be able to provide commissioners with assurance.

8.7 Ellen reported that there is an invite to a number of the CCG's executive team to attend a session in June with the trust's new senior team which will help to build relationships and get back to a good position in terms of assurance. Action is being taken in the meantime to ensure the right representation at meetings.

Closed Risks

8.8 It was highlighted that two risks have been closed since the March 2019 Clinical Governance Committee, as detailed in the report provided.

8.9 **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 CLIN19/052)

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.

9.2 Matthew Richardson reported that the following issue had arisen since the report was written:

Westbury House

9.3 Westbury House was a home that was decommissioned in 2016 as a result of significant safeguarding concerns. It has since been reported in the media that there were a number of clinical patient records which were not secured. The CCG has been working with the local authority (LA) to try and ensure records are secure. The CCG is not the data owner or controller and has no legal responsibility or accountability. The latest update is that the records have been destroyed by the data owner against CCG / LA advice which has been reported to the Information Commissioners Office as it is not known what the records relate to; they could have been medical records which should have been kept.

9.4 The CCG does not have responsibility in relation to Duty of Candour, but in conjunction with the LA it has been agreed that, as we were commissioning care, there is a need to write to patients in order to inform them there may have been a data breach. A joint letter will be sent from the LA and CCG; this action was supported by the Committee.

9.5 Key issues from the report highlighted to the Committee were as follows:

Millbrook Hampshire Wheelchair Service (MHWS) - Mid Hampshire Directorate

9.6 On 18 April 2019, two newspaper articles were published about MHWS. The articles highlighted the long waits experienced by MHWS service users with the Daily Echo focusing on a Southampton City CCG patient story and the News (Portsmouth) highlighting the experience of a service-user from Gosport. The articles also included quotes from the Kent Wheelchair Users' Group and research conducted by the Bureau of Investigative Journalism and cites specific patient pathways and concerns regarding the quality and commissioning of some of these elements. The CCG has responded and supported MHWS, however there has been no further press interest.

9.7 Performance has not improved with more referrals still being received than the service has capacity to manage, however there are a number of controls to ensure service users are triaged in a timely way. The CCG is working with community providers regarding a risk / harm assessment tool to ensure that where there are concerns these are flagged to MHWS in a timely manner.

9.8 It was confirmed that MHWS perform fairly well in comparison with other wheelchair services across the country which are also challenged, with local learning having been transferred to other areas of MHWS. It was suggested that a quality review / benchmark with other services is undertaken at intervals as time progresses as this might identify new initiatives that have been developed elsewhere in the country. Matthew added that MHWS work very hard with commissioners around quality and some of what is compromising this is capacity and performance, which is where complaints arise.

9.9 Ellen McNicholas reminded the Committee that MHWS, CCGs, other local organisations, patients and service user representatives have participated in a local quality improvement project which was well received. Steve Trembath, Commissioning Manager and Joanna Clifford, Senior Quality Manager have undertaken a great deal of work to take this forward.

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

<u>Ophthalmology: Capacity</u>

9.10 As previously reported, there have been three cohorts of ophthalmology patients who have been affected by a backlog in follow-up appointments:

- **Age-related Macular Degeneration**: this cohort has now been cleared
- **Diabetes**: the backlog as of March 2019 reduced to 69 proving continued reduction

- **Glaucoma**: the backlog in March 2019 rose to 3561. However, it was reported at the Executive Meeting of the week before that this had reduced to 3363. It was felt this is due to the impact of the 'Super Saturdays' and virtual review. Staffing challenges remain, with some staff leaving and vacancies that the trust cannot fill. Interviews for a consultant post are taking place during May; if successful an individual will start in post in August. An advert is out for a second consultant as well as a general advert for nursing staff. The CCG regularly attends the Ophthalmology Executive Meetings and from attending these is satisfied that UHSFT are doing all they can to manage and ensure the safety of people on the waiting list.

9.11 The following points were raised:

- Sarah Schofield expressed concern that a teaching hospital located in the South of England is struggling to recruit staff, querying if there is a sense of whether the culture in this department is of concern and if this is being reviewed. Matthew acknowledged that this is a good point, adding that he and Judy Gillow had recently attended a Never Event Panel which included two cases from Ophthalmology, where it was evident the trust were sighted on culture and human factors. He added that he did not believe there is a systemic problem regarding culture.
- Adrian Higgins reported that, from a discussion with Derek Sandeman, Medical Director, he has indicated that the challenge is that the post did not include operating sessions and so was not attractive for surgeons in a specialty that is challenged nationally. The job post has now been amended to include surgical sessions as a result of which there are now more applicants.
- UHSFT has undertaken a lot of work to risk stratify the waiting list, with a sub-set risk stratified for those that are overdue and further to those that are significantly overdue.
- Stuart Ward queried if any work has been undertaken in rationalising the follow-up pattern i.e. is there a logic behind the follow-up system.
- Johnny Lyon-Maris sought clarification as to whether the backlog is a historical figure for which a reduction is being seen. He gave an example where he had just seen a patient who had been told he would be reviewed in six weeks, who has an appointment in March 2020 and was told this was the first available appointment. It was clarified that the waiting list is both retrospective and prospective and is continually being updated.
- Rachael King pointed out that whilst there are concerns at UHSFT, there is good visibility of the issues, with recruitment being a national issue. However, there is a question as to whether there is the same visibility with other local acute providers. Matthew responded that the quality team has written to all of the CCGs key providers and is currently awaiting responses; HHFT is in the process of working through data. An offer was made by Sarah Schofield and Adrian Higgins to raise this when meeting with their clinical colleagues at trusts, which would support the work of the quality team.
- Stuart Ward commented that anecdotally there does not seem to be such a problem at HHFT, however the biggest issue is not so much the wait that patients are experiencing, but the disassociation with reality, i.e. being told they will be seen within a certain timescale and the appointment being

significantly later. There also needs to be recognition of the impact this has on other parts of the system, for example patients presenting at GP practices with concerns as they have not received an appointment and increased calls to Patient Advice & Liaison Services (PALS) within trusts.

9.12 The actions from discussions were summarised as follows:

- To feedback comments and queries raised by GPs to the Executive meeting i.e.
    - If there is any rationalisation of the waiting list
    - The disconnect between what is being said to patients and the reality regarding follow-up appointments, including the impact on other parts of the system such as GPs and PALS.
- To determine the position in other providers
  ACTION: Matthew Richardson / Quality Team

Southern Health NHS Foundation Trust (SHFT): Strategy and Partnerships Directorate

Care Programme Approach (CPA)

9.13 Carole Berryman reported that, as mentioned in paragraph 8.5, there have been concerns expressed around inconsistencies in the application of CPA for patients with severe mental health issues. Following discussion it was identified that this was not so much about CPA but patients having personalised care plans. The process in SHFT was reported to the Committee in March 2019 and is the way to ensure that patients will have a care plan for their own individual needs i.e. the clinical aspect based on NICE guidance, as well as the elements the patients themselves want to achieve which together will inform discussion and development of the care plan. This has been built into the quality contract for this year for which regular updates will continue to be reported back to the Committee. The quality team is also considering how something can be added to the dashboard to evidence that this is happening.

Antelope House

9.14 Carole reported that the CQC had visited Antelope House in February, for which the report had been received the week before. Nothing of concern was raised which the trust and commissioners had not already been aware of. This visit had been undertaken as a result of concerns raised by a patient, carers and staff on the unit, particularly in relation to a patient who is still there where there are concerns, which are being managed appropriately. The CQC had identified that the physical health needs of that individual were not being addressed properly; this has now been rectified.

9.15 Staffing on the unit has been problematic, a lot of which is around morale; there have also been a number of incidents on this unit so morale is not good. As a result a number of changes have been made and morale is now starting to improve. An independent review of the culture has been commissioned; terms of reference have been agreed with some further information awaited.

9.16 Clarification was sought on the number of deaths reported as there seemed to be a low number on the dashboard. It was clarified that the data reported is in relation to

deaths that have been reported as serious incidents (SIs). All deaths of patients who had been in receipt of care by the trust within the last 12 months are investigated.

9.17 In light of previous comments with regard to engagement of the trust at key meetings whilst going through a restructure, the compliance in meeting CQC deadlines starting to tail off and the percentage of SIs being closed at first presentation, it was queried if this was evidence that there is a deterioration in oversight across the trust. Carole clarified that, in terms of SIs closed at first presentation, this was something that CCGs started monitoring two years ago as it was felt that if reports had gone through the trust's internal governance processes and CCGs were not then able to close at panel, this was an indication that the organisation's corporate processes were not as robust as they could be. The numbers shown are very small so if three Root Cause Analysis (RCA) reports are reviewed but one is not passed this drops to 66% compliance, so percentages are difficult to get a real feel for the situation. The reports being received are actually of really good quality and the SI panel are very strict as to whether incidents will be closed straight away. The SI framework is followed to the letter. Action plans generally reflect the actions from the report, however there are often issues with the way they are written, which often are not actions and could be something like reminding staff to read policies. These are therefore rejected and have to be re-written. The trust have undertaken to look at all their action plans across the trust to determine where there are teams that are really good at writing action plans and others where this is not the case, so training can be provided. Carole added that she is getting no sense that the trust had taken their eye off the ball. The new risk that has been added to the risk register is with regard to senior representation at corporate panels during this particular period of transition / organisational restructure. This is being escalated, with Ellen raising with Paula Hull, Director of Nursing.

9.18 With regard to workforce, Sarah Schofield mentioned that she was part of the monthly workforce review process for SHFT, which has now reduced to biannual meetings with the last meeting having taken place in February. Concern had been expressed at that meeting with regard to some of the actions being taken forward around how the trust will recruit and drive to do things differently, with issues including consultant behavior and there being no culture of a consultant team. She therefore requested assurance that this conversation around workforce had been taken forward, together with if there is a sense that the drive to look at workforce is continuing apace. Ellen reported that she meets regularly with Paul Draycott, Director of Workforce and Organisational Development for updates. Some of the behavior of consultants was recognised, with a number of individuals who had driven that behavior having since moved on. She added that she has met with a couple of the senior appointments and been impressed regarding their style and approach and how they want to take their teams with them. This will continue to be monitored and should there be concern that there was not the movement the CCG would want to see, the monthly workforce meetings will be reinstated.

Child & Adolescent Mental Health Services (CAMHS): Sussex Partnership NHS Foundation Trust (SPT) – Strategy & Partnerships Directorate

9.19 The waiting times for young people waiting for initial assessment and for treatment continue to be concerning. The single point of access (SPA) continues to have challenges in processing all referrals in a timely manner.

9.20 All referrals are currently being screened for risk either on the day of receipt, or next working day. Historically the SPA has found it difficult to triage all referrals. This has in the past been mitigated through overtime and some changes in the SPA. Where there is staff sickness, maternity leave, annual leave or vacancies the service has struggled. In addition, the number of referrals received by the SPA has been higher than anticipated since the start of the contract.

9.21 The following actions are being undertaken:

- The SPA phone line will be closed for three hours per day to enable staff to concentrate on triaging referrals without interruption. In order to ensure that there is a safety net to enable urgent calls to be responded to it has been negotiated that the telephone message can direct callers to NHS111.
- A review of the SPA is being undertaken by an experienced clinician.
- A survey of GPs is being developed by the CCG to identify if there are any concerns regarding referrals into the service and failure to respond to urgent cases.
- A small (0.5WTE) resource has been allocated to the Winchester and Test Valley team to help reduce waiting times. In addition, the trust has piloted closer working with GP colleagues to offer assessments within GP surgeries.
- A Quality Impact Assessment has been undertaken jointly with CAMHS and CCGs to determine whether reducing the average number of clinical sessions from 12 to 10 would be a viable option.

9.22 An update on discussions from the three way Board meeting (reference 8.2) was provided to the Part 2 Confidential meeting.

(Caroline Ward joined the meeting)

9.23 **AGREED:**

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

SECTION 4: IMPROVEMENT

10. NHS CONTINUING HEALTHCARE: COMPLAINTS THEMATIC REVIEW (Paper CLIN19/053)

10.1 Ellen McNicholas introduced a report on a thematic review of all complaints within a seven month period received by the Patient Experience and Complaints Team (PECT) regarding the NHS Continuing Healthcare (CHC) service hosted by West Hampshire CCG. During the period of 1 September 2018 to 31 March 2019 there were a total of 40 complaints relating to 40 patients (in comparison there were 48 complaints in the previous six month period). The results from the review present CHC with learning opportunities and the chance to focus on areas to assist in meaningful change.

10.2 Ellen highlighted that whilst there might seem to be a lot of complaints, this is only 1.5% of the activity that CHC are dealing with. Complaints tend to be around process,

length of time or eligibility decisions. The team have undertaken some great work, having gone from 46 decisions per month in April last year to 183 decisions in February this year, so speeding up the process will reduce complaints. In addition a number which come through as complaints are actually concerns regarding eligibility decisions, so a process is being developed to take these out of the complaints process to put them into the appeals process.

10.3 Caroline Ward commented that it was good to see that the number of complaints is reducing and the process is speeding up, querying how the CCG benchmarks and whether there is any more best practice that can be taken from elsewhere in the country to support the team i.e. is 1.5% good or not. Ellen responded that when previously reviewed the CCG had benchmarked fairly favourably with other areas, however this could be revisited.
ACTION: Ellen McNicholas

10.4 Heather Hauschild commented that she has personal experience of the CHC process; the key issue is to have proper sight of communications and discipline within the team to understand that they really need to go back to people and let them know what is going on. There is repeated feedback that service users / families did not know what was going on. The CCG has invested fairly heavily in new data systems however we are still seeing some of the same concerns. Assurance is therefore needed within the next report on what support the team are getting in terms of customer support training.
ACTION: Ellen McNicholas

10.5 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the CHC complaints thematic review report.

SECTION 5: ITEMS FOR INFORMATION

11. HAMPSHIRE AND ISLE OF WIGHT QUALITY GOVERNANCE TOOLKIT (Paper CLIN19/054)

11.1 It was reported that the HIOW Quality Board has developed a quality governance toolkit to support the implementation of new integrated health and care services at service level. The toolkit is designed for any group of clinical staff developing new ways of working and joining up services to transform health and care for patients. The main aim is to deliver safe and effective care, whilst ensuring partners in the service adhere to national contractual regulations and professional standards.

11.2 The toolkit follows CQC key lines of enquiry. This will enable any integrated service team to demonstrate they are meeting the fundamental standards set out in the Health and Social Care Act (2012). It is designed to meet the needs of a range of stakeholders, including voluntary sector, patients, experts, consultants and all types of clinicians who may be wishing to work together in new ways.

11.3 No comments or queries were raised in respect of this report.

11.4 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the Quality Governance toolkit.

12. WHCCG SUMMARY OF THE CLOSTRIDIUM DIFFICILE INFECTION OBJECTIVES FOR NHS ORGANISATIONS IN 2019/20 AND GUIDANCE ON THE INTENTION TO REVIEW FINANCIAL SANCTIONS AND SAMPLING RATES FROM 2020/21 (Paper CLIN19/055)

12.1 The Committee received a paper which outlined key changes in the way in which cases of Clostridium difficile Infection (CDI) will be calculated and allocated in 2019/20:

- There has been a change in the way CDI cases are allocated to bring the NHSE system in line with the Centres for Disease Control and Prevention (CDC) and the European Centre for Disease Prevention and Control (ECDC) allocation system – an additional category for Community Onset Healthcare Associated (COHA) cases has been added.
- Acute providers and CCGs have seen a change in their objectives in line with the changes in allocation: West Hampshire CCG's allocation will now be 160 cases.
- CCGs and providers have been given notice of potential changes in financial sanctions and sampling rates in 2020/21.

12.2 No comments or queries were raised in respect of this report.

12.3 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted the report.

13. EXCEPTION REPORT: NATIONAL INSTITUTE FOR HEALTH CARE EXCELLENCE (NICE) REVIEW (Paper CLIN19/056)

13.1 The Committee received a paper which raised issues and risks highlighted by review of NICE Guidance to date. Quality Standards from long term conditions, maternity and child health, and mental health have been prioritised and reviewed. Action plans have been monitored. The medicines management review of technology appraisal guidance is noted.

13.2 No comments or queries were raised in respect of this report.

13.3 **AGREED:**

The West Hampshire CCG Clinical Governance Committee noted:

- **The exceptions, particularly where the CCG has decided not to pursue an action plan even though compliance cannot be evidenced**
- **The correspondence with local providers.**

14. MINUTES FOR INFORMATION (Paper CLIN19/057)

14.1 **AGREED:**

The West Hampshire CCG Clinical Governance Committee received the minutes of the following meetings which had been provided for information:

- **Clinical Cabinet of 14 February (redacted) and 14 March 2019**
- **Medicines Optimisation Clinical Steering Group of 5 March 2019.**

SECTION 6: ESCALATION & CLOSE OF MEETING

15. RISKS / ISSUES

15.1 It was agreed that no new risks were identified through discussion for adding to the Risk Register.

16. BOARD

16.1 The Clinical Governance Committee agreed that the following topics should be highlighted to the Board of 23 May 2019:

- To inform the Board that the draft HIOW STP Quality Framework had been reviewed and feedback provided
- MHWS: update regarding the negative press
- UHSFT Ophthalmology: remains an issue of concern, with an update to be provided on what is being done about this
- CAMHS: regular update
- CHC complaints thematic review: to highlight the improvements that have been made and the ongoing actions given that this had been an area of concern.

17. ANY OTHER BUSINESS

Southern Health NHS Foundation Trust: Table Top Review

17.1 Simon Garlick commented that he has no real feel for whether SHFT are improving and questioned whether a date should be identified for another table top review as had been undertaken in August 2017 to review all the issues to determine if things had improved. Heather Mitchell responded that significant progress is being made, although the ongoing restructure is having a slight impact.

17.2 Heather Hauschild noted that objectively, if looking at all the measures in place and feedback from regulators, there has been quite a lot of substantial assurance to the point that commissioners in Hampshire have moved away from commissioning community services elsewhere, with SHFT now carrying no more risk than many of the CCG's other providers. She suggested that it may however be advantageous to have a rolling programme of table top reviews. Ellen McNicholas added that it is important to recognise that SHFT are undertaking the restructure of the senior team as a result of issues that have been identified; this would probably not have been raised at the Committee if it hadn't been for the significant amount of oversight the trust has received recently.

18. DATES OF FUTURE MEETINGS

18.1 The next meeting of the West Hampshire CCG Clinical Governance Committee will be held from 9.00m to 12.00pm on Thursday 4 July 2019 in the Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB.

Dates of future meetings:

5 September 2019	7 November 2019	9 January 2020
5 March 2020		

NHS
West Hampshire
Clinical Commissioning Group

Minutes

Clinical Cabinet Meeting

Minutes of the West Hampshire Clinical Commissioning Group Clinical Cabinet meeting held on Thursday 9 May 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
	Jenny Erwin	Director of Commissioning, Mid-Hampshire (from 10.25am)
	Roland Fowler	Clinical Director Children and Families
	Mike Fulford	Chief Finance Officer and Deputy Chief Officer
	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes and Clinical Director, ICT
	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
	Lorne McEwan	Locality Clinical Director, Winchester (from 10.25am)
	Ellen McNicholas	Director of Quality and Safety (Board Nurse)
	Heather Mitchell	Director of Strategy and Service Development (from 10.30am)
	Sarah Schofield	Clinical Chairman
	Stuart Ward	Locality Clinical Director, Eastleigh North and Test Valley South
	Katrina Webster	Clinical Director, Mental Health
In Attendance:	Lara Alloway	Divisional Medical Director, Medical Services, HHFT (Item 3)
	Simeon Baker	Interim Associate Director Transformation Communication and Engagement
	Christine Blanshard	Medical Director, Salisbury NHSFT (Item 2)
	Sophie Douglas	ST3 Trainee GP
	Cheryl Harding-Trestrail	Senior Commissioning Manager, Acute Transformation (South West) (Items 2, 3, 4, 9.3)
	Jason Hope	Senior Commissioning Manager , Mental Health and Learning Disability (Items 9.1 and 9.2)

In Attendance Cont.	Caroline Marshall	Chief Operating Officer, UHS (Item 4)
	Naomi Ratcliffe	Programme Lead, TECC HHFT (Item 3)
	Katie Smith	Haematologist HHFT (Hampshire 20-20 programme) shadowing Sarah Schofield
	Caroline Ward	Lay Member New Technologies and Digital
	Terry Renshaw	Governance Manager
Apologies:	Simon Bryant	Associate Director of Public Health HCC
	Judy Gillow	Lay Member Quality and Patient Engagement
	Heather Hauschild	Chief Officer
	Beverley Meeson	Deputy Director Service Development

Summary of Actions:

Minute Reference:	Action	Who	By
2.3	**Salisbury Clinical Strategy**: • Provide Christine Blanshard with PCN links (Avon Valley, Test Valley and Andover) • Further discussion required around digital requirements and mechanism for sharing learning from digital exemplar sites.	**RK/JE** **HM/RK**	ASAP ASAP
3.3	**Transforming Emergency Care across Winchester and Mid-Hampshire:** • Provide Naomi Ratcliffe with points of contact at Barton Peveril. • IT future digital solutions – Caroline Ward and Karl Graham to be included in discussions in moving forward.	**SPS/NR** **NR/CW/KG**	ASAP On-going
4.3	**Managing Cancer Pathway Changes** – Adrian Higgins to email Matt Hayes a summary/outcomes of Cabinet discussion.	**AH**	ASAP
9.1.3	**Primary Care Mental Health Service** – Take proposal for criteria to select networks entering the first wave of implementation through the May Locality Leads meeting.	**KW/JH/KG**	16.05.19
9.2.3	**Mental Health IFR Report** – Explore with Karen Gregory the potential to blend the two panels together.	**AH**	ASAP

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	Adrian Higgins welcomed members present to the Clinical Cabinet meeting and apologies for absence were noted. It was confirmed that the meeting was quorate.

	SEMINAR SESSIONS 1 TO 3
2.	**SALISBURY NHSFT CLINICAL STRATEGY 2019-22 (Presentation)**
2.1	Christine Blanshard explained that the Salisbury NHSFT Clinical Strategy is being developed and is a live document and subject to continuous reiteration. The presentation today is a part of the engagement process with stakeholders.

2.2	The presentation covered:
	• Clinical Strategy Development
	• Context Affecting Clinical Strategy
	• Clinical Strategy Themes
	• Local Services – Outstanding DGH Care
	• Next steps:
	  • Priority areas : frail elders; long term conditions; high throughput elective surgery
	  • Ensuring the strategy is for the whole patient pathway: how do we work with primary care networks and community services?
	  • How do we link with three regional STP plans and NHSE/I perspective?
	  • What does this mean for demand and capacity?
	  • Implementation plan.

2.3	Cabinet reflected on the presentation and the following topics were debated: • Mental health and proposals on how to improve quality of care for vulnerable groups for example the military. • Self-management for patients - How to give them more ownership and management strategies for dealing with self empowered care. • Emergency pathway and use of OOHs and Primary Care Hubs. • Public health agenda, prevention and health promotion. • Spinal Services including, spinal surgical pathway, patient expectations, spinal clinical network. • Estates • Digital and IT Solutions. It was agreed: • To provide Christine Blanshard with Primary Care Network links, Avon Valley, Test Valley and Andover. **Action: Rachael King/Jenny Erwin** • Further discussion is required around digital requirements and mechanisms for sharing learning from digital exemplar sites. **Action: Heather Mitchell/Rachael King** The Chair on closing the discussion thanked Christine Blanshard for sharing the Salisbury NHSFT Clinical Strategy 2019-22.
	Lorne McEwan and Heather Mitchell joined the meeting.

3.	**<u>TRANSFORMING EMERGENCY CARE ACROSS WINCHESTER AND MID-HAMPSHIRE AND HHFT CLINICAL STRATEGY</u> (Presentation and Paper CC19/036)**
3.1	Lara Alloway and Naomi Ratcliffe undertook a presentation on Transforming Emergency and Urgent Care for Winchester that covered: • Drivers for change • RHCH Emergency Department (ED) data • Average day in RHCH ED • Achievements to date • TECC objectives • A new model of care – Ideas generation • Improved patient outcomes as a result of timely provision of care by the right person in the optimal place • Recommendations • Summary Attention was also drawn to the October 2018 Nuffield Trust publication – Rethinking acute medical care in smaller hospitals.
3.2	It was highlighted that: • The opening of the Emergency Department at RHCH will take place on 9 May 2019 following the recent upgrade. • Funding has been identified for a Primary Care Clinical Director, 2 sessions per week, to focus specifically on primary care developments, this is a separate role to that of a PCN Director. Currently out to recruitment.

3.3	Cabinet reflected on the presentation and the following topics were debated:
	• Membership of the project board and patient engagement. It was stated that:
	  • The project board has a wide and diverse membership.
	  • The Trust are keen to ensure that patients, relatives and carers have a voice at the 'right time'. It was recognised that this is an evolving process and the Trust is keen to engage with healthcare staff also. In order to facilitate the engagement of the voice of young people Sarah Schofield agreed to provide Naomi Ratcliffe with points of contact at Barton Peveril College.
	Action: Sarah Schofield/Naomi Ratcliffe
	• Recruitment and retention and innovative ways of involving clinical staff in different roles.
	• Digital and IT Solutions. It was agreed that Caroline Ward and Karl Graham are to be included in discussions in moving forward.
	Action: Naomi Ratcliffe/Caroline Ward/Karl Graham
	• Co-location of services
	• Mental health
	• Cultural change.
	
	The Chair on closing the discussion thanked Lara Alloway and Naomi Ratcliffe for taking the time to come and speak to Cabinet today and reiterated that

	WHCCG is happy to provide support/contribute to help drive this programme forward.
	<u>HHFT Clinical Strategy 2019-2022</u> (CC19/036)
3.4	Adrian Higgins introduced paper CC19/036 and explained: • Hampshire Hospital FT has previously made proposals for development of a Critical Treatment Hospital. Following a McKinsey review through 2017, the CCG and partners agreed this was not a viable option and recommendations were made for alternative options, specifically suggesting centralisation of some services, but for retention of emergency department at both its principal sites at Basingstoke and Winchester. • During 2018/19 HHFT experienced a number of challenges in which their Emergency Departments performance as a Trust declined, there were significant staffing issues and an inadequate CQC report specifically relating to the ED and urgent care facilities. • Whilst the Trust has worked hard to rectify its 4 hour ED performance and implemented a Rapid Improvement Plan, it has recognised that, for the sustainability of its Winchester site and in order to move to the provision of innovative and exemplar urgent and emergency care services for Winchester and mid-Hampshire, this will benefit from a collaborative approach with partners in WHCCG, Primary Care, Southern Health Foundation Trust and Hampshire County Council. • Dr Andrew Bishop previously attended Cabinet in March 2019 to outline the Trust Clinical Strategy, which has included the resulting Transforming Emergency Care (TEC) Programme.
3.5	Areas for discussion were considered as part of the earlier presentation on the TECC programme, that described the vision, background, progress to date, aspirations and anticipated outcomes.
3.6	**AGREED:** **Clinical Cabinet:** • **Supported and endorsed the programme which will include contribution of the CCG to the leadership programme development and in the expected benefits of the programme.** • **Noted receipt of the Trust Strategy in line with the previous presentation by Dr Bishop.**
4.	**<u>MANAGING PATHWAY CHANGES</u>**
4.1	Caroline Marshall joined the Cabinet for a discussion around the process of reforming the 2 week wait referral forms and the pathway changes which these presage.
4.2	It was: • Recognised that in moving forward the debate there is a need for closer working when introducing new pathways and the forms that go with this. • Highlighted that cancer targets are changing from April 2021 when 10 targets will reduce to 3.

4.3	The following areas were discussed: • Mandatory and essential tests. Clarity required around unintended consequences. • Mixed messaging and the need for clear communication and consistency of approach. • Data tracking, interoperability of computer systems and automated solutions. • National drivers. • Roles and responsibilities and levels of consent. • Consultant to consultant onward referral. The Chair summarised the discussion and outlined the following conclusions: • The Trust is open to the possibility of changing the wording on the form by agreement with Southampton City CCG. • The need to capture learning from before to ensure information can be available to support the learning process. Important not to learn in isolation and there needs to be a mechanism to share feedback with other Trusts and the Cancer Alliance Group. • A firm commitment that admin staff is informed of script in order to minimise returned/rejected forms. • There needs to be a consistent language with clear meaning for all. • Pathway and form changes are likely to land better if they are discussed first and WHCCG Cabinet has recently agreed to establish a Clinical Reference Group which will be an ideal vehicle for considering/supporting change. It was agreed that Adrian Higgins is to email Matt Hayes, Clinical Lead, Wessex Cancer Alliance, NHS E (South, Wessex) a summary/outcomes following today's discussion. **ACTION: Adrian Higgins**
4.4	The Chair on closing the discussion thanked Caroline Marshall for taking the time to come and speak to Cabinet today.
5.	**<u>DECLARATIONS OF INTEREST</u> (Paper CC19/037)**
5.1	Adrian Higgins directed members to the Declarations of Interest Register.
5.2	Adrian 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. Adrian declared that from May 2019 he will be undertaking locum work in Bournemouth, Southbourne Surgery. Katrina Webster reported that she is no longer a Salaried GP at St Mary's Surgery, Andover and asked that this reference be removed. The report will be updated for the next meeting. (Action complete: 10 May 2019).

5.3	No further specific interests were declared relating to items to be discussed at the meeting.
6.	**<u>MINUTES OF LAST MEETING</u> (Paper CC19/038)**
6.1	Clinical Cabinet reviewed the minutes of the last meeting, held on the 11 April 2019.
6.2	**AGREED:** **Clinical Cabinet:** • **Agreed the minutes of the Clinical Cabinet meeting held on the 11 April 2019 and commended them for signature by the Chair of the meeting.**
7.	**<u>ACTION TRACKER</u> (Paper CC19/039)**
7.1	Adrian Higgins introduced paper CC19/039 and the items on the action tracker were reviewed. An update was provided on:
	1. **CC18/024a) Stakeholder Engagement Plan: Communication to go out to the membership to promote achievements and to thank membership for what it does** – Scheduled for 13 June 2019 meeting.
	2. **CC18/024b) Stakeholder Engagement Plan: September update to Cabinet deferred to October 2018** – Scheduled for 13 June 2019 meeting.
	3. **CC18/026a) Children and Young Peoples Services: Prepare paper for Executive Team on due diligence and contracting check points in terms of an integrated service** – It was reported that discussion is ongoing around the paediatric therapy contract. Re-thinking the procurement process. Public Health has re-tendered Health Visiting and School Nursing. It is not proposed to bring anything back to Cabinet until we are at a point to discuss the Service Specification. Agreed to close action and note as a future item on the forward view agenda planning list. **Closed**. (Action complete 10 May 2019)
	4. **CC18/026b) Children and Young Peoples Services: Service Specifications/implementation/governance plan update to be presented at 8 November 2018 Clinical Cabinet** – It was reported that discussion is ongoing around the paediatric therapy contract. Re-thinking the procurement process. Public Health has re-tendered Health Visiting and School Nursing. It is not proposed to bring anything back to Cabinet until we are at a point to discuss the Service Specification. Agreed to close action and note as a future item on the forward view agenda planning list. **Closed**. (Action complete 10 May 2019)
	5. **CC18/036b) Matters Arising 2ww Lower GI Pathway minute reference 9.1 – Karl Graham to work with Adrian Higgins on amending the referral form –** Agenda item 4. Caroline Marshall attended Cabinet and discussed the issues/concerns that have been raised. Refer to minute reference 4. **Closed**.

	6. **CC19/039 Chief Officer Report: Consider if Keeping Well Collaborative is to be asked to present at a future Cabinet meeting –** Adrian Higgins has emailed the Wellbeing Collaborative and extended an invitation but has not received a reply to date. Response was progress chased on the 23 April 2019 and the offer of a 'slot' on either June or July's agenda was offered. It was agreed to close the open action and if a response is received then a presentation date will agreed and agenda item scheduled. **Closed**.
	7. **CC19/044 AOB Clinical Reference Group: Draft Clinical Reference Group proposal for Cabinet consideration –** It was reported that: • Secondary Care membership has now been included within the Terms of reference. **Closed**. • A plan in respect of admin support has been agreed. • Information regarding the platform is awaited. Karl Graham is looking at options for both this and the PCNs in conjunction with Claire Parker. Potential cost implications were flagged.
	8. **CC109/045c) PCMH Service Specification –** Agenda item 9.1. Service Specification agreed. **Closed**.
7.2	**AGREED:** **Clinical Cabinet:** • **Received updates on the actions arising.** • **Agreed that five actions are now complete and can be closed.**
8.	**<u>CHIEF OFFICERS REPORT</u>**
8.1	Mike Fulford introduced the Chief Officers Report covering the following matters:
	1. **System Reform** It was reported that discussions are ongoing. Sarah Schofield reported that she has met with David Radbourne NHS I & E and other commissioning groups within the patch and it is proposed that an update will be presented to Board on 23 May 2019.
	2. **WHCCG Chief Officer** It was reported that Heather Hauschild has resigned as Chief Officer following her successful appointment to the post of Chief Operating Officer for the Roman Catholic Diocese of Portsmouth, which includes the counties of Hampshire, Berkshire and the Chanel Islands. Heather's last working day will be 28 July 2019. Heather will be working with the Board and STP colleagues to agree the ongoing leadership arrangements following her departure.
	3. **Glenside Manor Neuro-Rehabilitation Hospital, Wiltshire** Ellen McNicholas briefed Cabinet on the on-going issues and the action taken by the CQC in respect of three units at Glenside Manor, whose residents include patients with extremely complex needs some of whom are detained under the Mental Health Act or under Dols. An outline of the action being undertaken by the CCG was outlined.

	4. **Mental Health Investment** Attention was drawn to a joint bid around community mental health services and transformation that is due to be submitted on 10 May 2019. There is also an opportunity for a joint commissioning bid around a Community Forensic Service.
	5. **Coaching Conversations Masterclass** Attention was drawn to the information/application form included within the agenda papers. Cabinet members were asked to apply direct should they wish to be considered for a place. It was noted that Kate Hardy is currently in the process of identifying what coaching and mentoring skills we have within the CCG.
	6. **CAMHS Partnership Improvement Board** Attention was drawn to the 8 May 2019 briefing to CCG governing bodies, included within agenda papers, on behalf of Ros Harley (Hampshire and IOW CCG Partnership) and Heather Mitchell (West Hampshire CCG) following the 30 April 2019, three way Board meeting between the Hampshire and Isle of Wight CCG Partnership, West Hampshire CCG and Sussex Partnership NHS Foundation Trust to discuss the work of the CAMHs Partnership Improvement Board.
8.2	**AGREED:** **Clinical Cabinet:** • **Noted the Chief Officers Report (May 2019)**
9.	**<u>ITEMS FOR NOTING/APPROVAL</u>**
9.1	**<u>Primary Care Mental Health Service</u> (Paper CC19/040)**
9.1.1	Katrina Webster introduced paper CC19/040 and explained a primary level mental health service has been under development for West Hampshire CCG member practices for over two years. After extensive co-production and approval of the model of service at Clinical Cabinet, a Service Specification has been produced for approval. The service will be implemented in waves over three years. The criteria for selecting which networks are to be in the first wave is included within the paper for approval and discussion.
9.1.2	Cabinet were reminded that the Service Specification had been presented at the March meeting and it was agreed that it would go back to all Localities in order to obtain further feedback/comment. The Service Specification received full support and questions were related to implementation and timing. Additional conversations have been held with Winchester practices, which are now supportive of this service.
9.1.3	As a result of discussion it was: • Highlighted that a phased implementation is proposed and that the service will start in Q3/4 with four networks going forward this financial year. The proposal for criteria to select networks entering the first wave for implementation was considered and it was agreed that the criteria

	should be considered/agreed at the May Locality Leads meeting. Criteria will not need to return to Cabinet. **ACTION: Katrina Webster/Jason Hope/Karl Graham** • Noted that investment is subject to approval by the Finance Committee. • Reported that the CCG has been invited to submit an expression of interest by Friday 10 May 2019 for transformation money to support development of mental health linked to Primary Care Networks. Should bid be successful it is possible that this service could move forward further/faster. • Noted that Cabinet will be advised, in due course, as to who has been supported to go forward in phase 1.
9.1.4	**AGREED:** **Clinical Cabinet:** • **Approved the Service Specification for the Primary Care Mental Health Service** • **Delegated to Locality Leads the approval of the criteria for choosing primary care networks implementation order. See action at paragraph 9.1.3.**
9.2	**<u>Mental Health IFR Update</u> (Paper CC19/041)**
9.2.1	Jason Hope introduced paper CC19/41 and explained that this paper gives an overview of activity from the Independent Funding Panel for the financial year ending March 2019. It also raises a few issues for discussion and reflection.

9.2.2	It was reported that:
	• Individual Funding Requests are managed by the NHS South Central and Commissioning Support Unit Team on behalf of the Hampshire 5 CCGs. The panel that makes decisions relating to IFRs does not currently include any mental health clinicians. The Vulnerable Adults (VA) Team was asked to support the decision making process and provide recommendations for IFRs relating to mental health.
	• Cases:
	  • Total cases considered by the Panel 100
	  • Total cases going on to treatment 73
	  • WHCCG 39
	• The VA Team currently consider IFRs at their fortnightly individual placements panel:
	  • Requests for ADHD have reduced significantly with the commissioning of service, but make up a significant proportion.
	  • Requests for post diagnostic support for people with Autism remain high
	  • Requests for British sign language psychological therapy are high, although costs have been reduced through market development.
	  • The proportion of applications that do not provide sufficient or specific enough information for the panel to make a recommendation has reduced.
	  • Significant liaison is required in specialist clinical areas where expertise is not available to the CCG.

9.2.3	Attention was drawn to the pressure facing the VA Team in supporting the clinical review of IFRs as an additional requirement over and above their main portfolio. It was noted that discussions are taking place around how to support the clinical decision making process in moving forward. In view of parity of esteem it was questioned as to why there are two separate panels in place. It was agreed that Adrian Higgins is to explore with Karen Gregory the potential to blend the two panels together. **ACTION: Adrian Higgins**
9.2.4	**AGREED:** **Clinical Cabinet:** • **Reviewed the report, which gives an overview of activity from the Independent Funding Panel in the financial year ending March 2019.** • **Agreed the action outlined at paragraph 9.2.3.**
9.3	**<u>Hampshire Priorities Committee Recommendations</u> (Paper CC19/042)**
9.3.1	Cheryl Harding-Trestrail introduced paper CC19/042 and drew attention to: 1. **Policy Statement 49: Dilation and curettage in heavy menstrual bleeding** There is no current formal position within Hampshire related to this treatment in the indication of heavy menstrual bleeding. This procedure is almost obsolete within Hampshire CCGs but to bring us in line with the National Evidence Base Intervention Programme (EBIP) guidance, it is recommended that the EBIP criteria is adopted in full as set out in the paper. Medication and intrauterine systems (IUS) are the first line treatments to be used to treat heavy periods.
	2. **Policy Statement 50: Primary joint replacement for hip and knee osteoarthritis** The committee have considered the current thresholds for operative interventions for primary joint replacement of hips and knees and makes the following recommendations that: • Weight management has an important role throughout the patient's life, and this should be reflected in prevention strategies. • Primary replacement should be reserved for patients with a BMI below 35. Feedback received from Public Health is that language needs to be aligned with the Smoking Cessation Policy. This has been fed back to the Committee and will be added to the guidance. • Stopping smoking should be encouraged for at least 8 weeks prior to operation. • Shared decision making should be routinely used using resources such as the 'Joint Replacement Decision Aid' as a recommended tool and there should be a period of 3 months for patients to consider the risk and benefits to them of surgery and to address issues such as weight loss or smoking cessation if required. This statement complements and supports the West Hampshire Policy statement on 'Optimising Health before of Elective Surgery: 'Fit for Surgery'.

	3. **Policy Statement 51: Treatment of Bunions** Management of patients with bunions and peripheral neuropathy or diabetes is outside of the scope of this recommendation. The trial evidence for benefit from interventions is lacking, therefore it is recommended that this intervention should remain a low priority, requiring prior approval, following assessment through an MSK triage service to ascertain if they are likely to benefit from intervention. This is no change to current practice.
9.3.2	A contractual 30 day notice period to providers to be issued together with a refreshed version of the overarching IFR and RTAP Policy for 2019/20.
9.3.3	**AGREED:** **Clinical Cabinet:** • **Reviewed, approved and adopted Policy Statements 49 to 51.**
10.	**RISKS AND ISSUES IDENTIFIED AS A RESULT OF ITEMS DISCUSSED AT THE MEETING** : No new risks identified.
11.	**ANY OTHER BUSINESS** - There were no items identified.
12.	**DATE OF NEXT MEETING**
12.1	The next meeting of the Clinical Cabinet will take place on Thursday 13 June 2019 from 09.30am in the Boardroom, Omega House, Eastleigh.

NHS
West Hampshire
Clinical Commissioning Group

Minutes

Clinical Cabinet Meeting

Minutes of the West Hampshire Clinical Commissioning Group Clinical Cabinet meeting held on Thursday 13 June 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
	Simon Bryant	Associate Director of Public Health HCC
	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	Chief Finance Officer and Deputy Chief Officer
	Karl Graham	Locality Clinical Director Eastleigh Southern Parishes and Clinical Director, ICT
	Emma Harris	Clinical Director, Medicines Management
	Heather Hauschild	Chief Officer
	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
	Ellen McNicholas	Director of Quality and Safety (Board Nurse)
	Beverley Meeson	Deputy Director Service Development deputising for Heather Mitchell
	Stuart Ward	Locality Clinical Director, Eastleigh North and Test Valley South
	Katrina Webster	Clinical Director, Mental Health
In Attendance:	James Adams	Medical Director, Division B, UHSFT
	Sophie Douglas	ST3 Trainee GP
	Theresa Lawrence	Governance Officer
	Caroline Ward	Lay Member New Technologies and Digital
Apologies:	Judy Gillow	Lay Member Quality and Patient Engagement
	Heather Mitchell	Director of Strategy and Service Development
	Terry Renshaw	Governance Manager
	Sarah Schofield	Clinical Chairman

Summary of Actions:

Minute Reference:	Action	Who	By
	Action Tracker:		
4.1.3	• **CC18/036b) Matters Arising 2ww Lower GI Pathway –** Liz Angier to draft a response to Matt Hayes for signature by Adrian Higgins.	**LA/AH**	ASAP
4.1.10	• **CC19/049 Mental Health IFR Report: Explore with Karen Gregory the potential to blend the two panels together** – Use complex metal health case as an example to support a review of the potential merger of the panel processes.	**AH**	ASAP
6.2	**Collaborative Commissioning Report Transforming Care Programme:**		
	• Access to training/ LD Health Facilitators. Details to be provided for inclusion in In-Practice. Ellen McNicholas agreed to work with team to contact other groups.	**KW/LA/EM**	ASAP
	• Review recent coding issue and the number of templates in use.	**KW**	ASAP
6.4	**GPFV Work Plan 2019-21**		
	• Strengthen healthy lifestyles section and rename Weight Watchers as WW. Rachael King to liaise with Simon Bryant.	**RK/SB**	ASAP
	• Include reference to Children. Rachael King to liaise with Roland Fowler.	**RK/RF**	ASAP

1.	**<u>WELCOME, APOLOGIES AND CONFIRMATION OF QUORACY</u>**
1.1	Adrian Higgins welcomed members present to the Clinical Cabinet meeting and apologies for absence were noted. It was confirmed that the meeting was quorate.
2.	**<u>DECLARATIONS OF INTEREST</u> (Paper CC19/043)**
2.1	Adrian Higgins directed members to the Declarations of Interest Register.
2.2	Adrian 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	Katrina Webster reported that she has a new clinical role at Acorn Health Partnership. Sophie Douglas reported that she is now in a partnership at New Horizons in Totton.

	The report will be updated for the next meeting. (Action complete: 17 June 2019)
2.4	No further specific interests were declared relating to items to be discussed at the meeting.
3.	**<u>MINUTES OF LAST MEETING</u> (Paper CC19/044)**
3.1	Clinical Cabinet reviewed the minutes of the last meeting, held on the 9 May 2019.
3.2	**AGREED:** **Clinical Cabinet:** • **Agreed the minutes of the Clinical Cabinet meeting held on the 9 May 2019 and commended them for signature by the Chair of the meeting.**
4.	**<u>ACTION TRACKER</u> (Paper CC19/045)**
4.1	Adrian Higgins introduced paper CC19/045 and the items on the action tracker were reviewed. An update was provided on:
	1. **CC18/024a) (See also CC18/009) Stakeholder Engagement Plan: Communication to go out to the membership to promote achievements and to thank membership for what it does** – It was reported that the new Communication and Engagement Strategy, which will include the Stakeholder Engagement Plan, is due to be presented to Board in July. **CLOSED**.
	2. **CC18/024b) Stakeholder Engagement Plan: September update to Cabinet deferred to October 2018 -** It was reported that the new Communication and Engagement Strategy, which will include the Stakeholder Engagement Plan, is due to be presented to Board in July. **CLOSED**.
	3. **CC18/036b) Matters Arising 2ww Lower GI Pathway minute reference 9.1 – Karl Graham to work with Adrian Higgins on amending the referral form –** It was reported that Liz Angier has altered all forms and collated feedback and forms have been returned and the other new forms have been circulated. Attention was drawn to the fact that not everyone can access DCX and the website is being re-designed for forms to be entered in line with NHSE 28 day strategy. It was questioned if we are liaising with Southampton City CCG as UHSFT were less certain regarding having different versions of the paperwork in circulation in different areas. It was responded that there is the intention to liaise regarding the 2 week wait pathway and forms will be forwarded again today for discussion at meeting. In summary the current position is: • Changes have been agreed. • A mechanism for sharing with Practices has been agreed. • At a point of agreeing processes with UHSFT It was agreed that Liz Angier is to draft a response to Matt Hayes for Adrian Higgins to sign. **ACTION: Liz Angier/Adrian Higgins**

	4. **CC19/039 Chief Officer Report: Consider if Keeping Well Collaborative is to be asked to present at a future Cabinet meeting –** Adrian Higgins has emailed the Wellbeing Collaborative and extended an invitation but has not received a reply to date. Response was progress chased on the 23 April 2019 and the offer of a 'slot' on either June or July's agenda was offered. It was agreed to close the open action and if a response is received then a presentation date will agreed and agenda item scheduled. **CLOSED**.
	5. **CC19/044 AOB Clinical Reference Group: Draft Clinical Reference Group proposal for Cabinet consideration –** It was agreed that an invitation should be circulated via In-Practice for people to join and it is important for Primary Care Network Leads to be part of the Group. Platform will be via https:www.Kahootz.com/ and Claire Parker is preparing for this to be ready by the end of the month. It was reported that CCG is the organisational owner of the Reference Group, Liz Angier is clinical owner and Trudie Higby will organise the administrative support. It has been underestimated how much time that might be required so will streamline with the referral strategy process of how forms come in. Suggested that there is a need to put some comms out to Providers and Trusts to filter down to say if there are any new forms they should go directly through the CCG as there is the potential opportunity for things to be bypassed. Agreed also to take a step backwards and write referral strategy and send to providers and arrangements to meet with Directors is to be put in place to raise awareness. It was questioned as to whether the LMC has been consulted. Liz Angier reported that she has met with Andy Purbrick from the LMC and will send the referral strategy to him in order to secure LMC support.
	6. **CC19/047a) Salisbury Clinical Strategy –** Jenny Erwin confirmed that she has provided contact details to Christine Blanshard of the Mid-Hampshire Practices. **CLOSED**
	7. **CC19/047b) Salisbury Clinical Strategy : Further discussion required around digital requirements and mechanism for sharing learning from digital exemplar sites** – It was noted that Heather Mitchell has asked Andy Eyles as part of STP to scope all the work going on including exemplar sites and will share this information with Salisbury. Mike Fulford drew attention to the first draft of the document that was presented at the HIOW Digital Commissioners Forum on 12 June 2019 and reported that the final document will be available soon. Attention also drawn to the Digital exemplar seminar session scheduled for the July Cabinet meeting.
	8. **CC19/048a) Transforming Emergency Care across Winchester and Mid-Hampshire : Provide Naomi Ratcliffe with points of contact at Barton Peveril** – It was noted that Sarah Schofield forwarded the information as requested. **CLOSED**.
	9. **CC19/048b) Transforming Emergency Care across Winchester and Mid-Hampshire : IT future digital solutions – Caroline Ward and Karl Graham to be included in discussions in moving forward** – It was noted that Naomi Ratcliffe has made contact with Karl Graham and Caroline Ward. A meeting has been arranged for Naomi Ratcliffe and Karl Graham. Caroline Ward is to discuss with Naomi Ratcliffe how she would like to be involved going forwards. **CLOSED.**

	10. **CC19/049 Mental Health IFR Report : Explore with Karen Gregory the potential to blend the two panels together** – Adrian Higgins reported that he has not yet made contact with Karen Gregory but will do so shortly. Attention was drawn to a particularly complex mental health case that is going to the next IFR panel and the need to have a process in place that is auditable. It was agreed that Adrian Higgins will use this as an example to support a review into the potential merger of the panel processes. **ACTION: Adrian Higgins**
4.2	**AGREED:** **Clinical Cabinet:** • **Received updates on the actions arising.** • **Agreed that six actions are now complete and can be closed.**
5.	**<u>CHIEF OFFICERS REPORT</u>**
5.1	Heather Hauschild introduced the Chief Officers Report covering the following matters:
	1. **System Reform** Discussions continue with various interested parties regarding the arrangements to be put in place following her departure and a further meeting is scheduled between Sarah Schofield, NHS E and others. It is hoped that a proposal can be shared shortly. It was stated that a key theme is that Primary Care Networks and Locality work are definitely the building blocks to support/shape work moving forward.
	2. **Continuing Healthcare** Attention was drawn to the BBC Victoria Derbyshire current affairs programme that was broadcast on the 10 June 2019 on Continuing Healthcare provision across England. One of the families featured was from within the WHCCG patch and Ellen McNicholas has contacted family to offer support and has provided a written notice for this and to date there has not been any further media interest.
	3. **ED Performance** UHS ED performance against the 4 hour standard continues to be exceptionally poor at the moment and they are at the bottom of table. Portsmouth are off table as they have a different reporting structure. Regional requirements are for a recovery plan to be delivered. At the recent A and E Delivery Board UHS were asked to provide more detail in order to provide clarity of the hospital system and their plan. The expectation is for UHS to return to trajectory of 90% by September 2019 and there is absolute focus around impact of external factors, internal issues and issue with demand and capacity. Action plan to be resubmitted by Friday 14 June 2019 and the CCG will continue to work closely with the Trust. There has also been a significant increase in activity going into ED at HHFT and work is taking place to understand the composition of that activity.

	4. **Sallie Bacon Director of Public Health, Hampshire** Sallie Bacon is leaving her role of Director of Public Health, Hampshire today and Heather formally extended thanks to Sallie for all her hard work over the last few years and stated that the CCG is looking forward to working with Simon Bryant in the future.
	5. **John Richards Chief Officer Southampton City CCG** John Richards retired on the 7 June 2019 and good wishes for the future were extended.
5.2	**AGREED:** **Clinical Cabinet:** • **Noted the Chief Officers Report (June 2019)**
6.	**<u>ITEMS FOR NOTING/APPROVAL</u>**
6.1	**<u>South West and North and Mid Hampshire Local Delivery System Report (May 2019)</u> (Paper CC19/047)**

6.1.1	Rachael King introduced paper CC19/047 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:
	• The work within Local Delivery Systems within West Hampshire
	• 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.

6.1.2	As a result of discussion it was recognised that reference to public health needs strengthening and there is also a lot of work being undertaken around family based approaches. Heather confirmed that she has a meeting booked with Simon Bryant to discuss closer working with Public Health and the need to ensure there is proper visibility around Public Health performance information.
6.1.3	**AGREED:** **Clinical Cabinet:** • **Reviewed the Local Delivery Systems report (May 2019) including**

	the associated work programmes in relation to commissioning new care models, primary care transformation and quality initiatives in West Hampshire's localities.
6.2	**<u>Collaborative Commissioning Report</u> (Paper CC19/048)**
6.2.1	Beverley Meeson introduced paper CC19/048 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 WHCCG. The report provides a reminder of the 2019/20 work programmes and an update on activities in April and May. Actions for the next two months and risks are also summarised within the report.
6.2.2	Particular attention was drawn to: • Maternity and Child Health, there has been a significant rearrangement of the team. A redraft of the 3 year action plan and reconfiguration of team so resources are focused. STP areas of work are noted in the report. • Over the next couple of years there will be four areas of work and projects will be aligned with the following: 1. Maternity and Child Health 2. Mental Health and Learning Disability 3. Continuing Health Care 4. CAMHS • Mental health out of area placements there is a significant amount of progress on work being undertaken and there are robust processes in place. Thought is being given to investing in a single point of access, step up/down and a change in culture will be required to facilitate this • In relation to the transforming care programme the following highlights/achievements were provided: • WHCCG have 69% of Practices signed up to be a Learning Disability Friendly Practice, aim is to achieve 100%. • Annual health checks achieved 59% against a target of 64%. The Committee were reminded that the target is higher this year at 75% so Cabinet were asked to consult with Practices to see how WHCCG can help achieve this figure. Katrina Webster reported that she is meeting with the Learning Disability Health Facilitator who supports Practices to make sure that annual health checks get done, and questioned whether this could be looked at by Primary Care Network (PCN) level. It was responded that in a PCN they might have a perfect Learning Disability Friendly Practice but think it would be difficult to take at Practice level with 49 Practices to prioritise this over QOF, so wonder if PCNS will want to look at it in terms of population as a whole to outshare. There was discussion around: • Requirements of the DES and consistency of services • The fact that PCNs are just forming • Availability of a Primary Care Dashboard that incorporates a lot of information all in one place for PCNs and shows variations for Practices. • How Practices can access Learning Disability Health Facilitators. It was agreed that Katrina Webster is to send the details and link to Liz Angier to include within a future edition of In-Practice. Ellen McNicholas agreed to work with team to contact other groups. **ACTION:Katrina Webster/Liz Angier/Ellen McNicholas**

	• It was questioned if the Learning Disability Health assessment performance was as a result of the integration of the Learning Disability health check QOF or EMIS and by amalgamating the two the codes did not match with the QOF. It was stated that this is currently being investigated by Jason Hope. • Attention was drawn to the problem that there a too many templates. Katrina Webster agreed to look into this. **ACTION: Katrina Webster**
6.2.3	**AGREED:** **Clinical Cabinet:** • **Reviewed the collaborative commissioning report and considered the associated risks and mitigating actions.**
6.3	**Any Other Business**
6.3.1	**Cabinet and Locality Clinical Directors** Adrian Higgins drew attention to the suggestion that with the emerging PCNs and changes to roles that Locality Clinical Directors might like to attend meetings of the Clinical Cabinet. It was noted that this will be included on the Locality Clinical Leads agenda for feedback to be obtained.
6.3.2	**Prioritisation of Children's Hubs and Roll Out Programme** Attention was drawn to a question that has been raised from one of the Networks that a more broad discussion is required on how to rollout pilot schemes across networks and how to decide where need is. It was reflected that: • There is the potential to broaden clear inequity with urban/rural networks and it was outlined which Localities are feeling disenfranchised. • Most of the pilots undertaken are under the umbrella of wider part of geography so there is a need to be clear, in the future, when clinical cases are coming through for approval that there are discussions had around rollout and procedures. It was stated that good engagement is key. • It is different working at scale in a condensed geography rather than a rural geography. Meeting has been held with Southern Health FT about how to work at scale in rural geography's and what does shared learning look like to enable the building of services around rural geography's. Shared learning about rollout delivery plan when operating at scale needs to be understood as does arrangements for linking with partners and capacity to enable implementation.
6.3.3	**Concordia** Attention was drawn to service issues. It was noted that an intelligence gathering exercise is currently being undertaken and a meeting has been scheduled.
6.4	**General Practice Forward View Work Plan 2019-21 (Presentation)**
6.4.1	Rachael King presented the GPFV Work Plan 2019-21 and highlighted that

	Cabinet will recognise all the key work areas as this plan builds on the work undertaken to date.

6.4.2	Attention was drawn to:
	• There are 49 GP Practices across West Hampshire and from 1 July 2019 there will be 48. The number of General Practices in West Hampshire will decrease as a result of mergers supporting Practices to work at scale.
	• The plan sets out the priorities for delivery against the five components of the Integrated Care Model and the difference they will make both to the health and wellbeing of local people and in supporting the future sustainability of general practice.
	• The priorities have been informed by General Practice as to what will make the biggest difference in supporting future sustainability these include:
	  • Referral Support
	  • Primary Care Mental Health
	  • Musculoskeletal Services
	  • Frailty Support Team
	  • Pharmacy
	• Key priorities in going forward :
	  • **Primary Care Networks** (PCNs) will be the key focus and absolutely critical going forward over the next five years and the way forward is set out in the GP contract framework.
	  • **Supporting People to Stay Well** – There has been a huge advancement around improving the health of our local population in terms of smoking, obesity and healthy lifestyles and programmes will continue over the next two years.
	  • **Proactive Joined Up Care** – Focus on Integrated Care Teams and Multi-disciplinary Teams around complex patients. Integrated Intermediate Care including agreement of single model for same day emergency care unit at UHS, WHCCG and SCCCG, development and implementation of Integrated Intermediate Care, core offer programme plan with three core components:
	  • Local Access Point
	  • Reablement and rehabilitation at home
	  • Reablement and rehabilitation inpatient care.
	  Clinical Pharmacy support to facilitate the employment of Pharmacists within PCNs, as part of the DES contract from 1 July 2019 and explore the expansion of the Integrated Clinical Pharmacy Service Model across WHCCG.
	  • **Better Access to Care** – Will build on greater use of digital technology for example 100% of Practices using eConsult by March 2020 and the continued use and promotion of Connect to Support Hampshire.
	  • **Primary Care Mental Health Service Model** – Is to be rolled out from Quarter 4, this year. It is known that 30% of GP appointments are related to mental and wellbeing issues.
	  • **Musculoskeletal Services** – Including improving self-care via MSK App and implementation of MSK First Contact Practitioners. It is known that 30% of GP appointments are related to musculoskeletal problems.
	  • **Referral Support Service** – Received positive feedback regarding benefits for patients and practices as well as supporting the delivery of QIPP plan.

	• **Extended Access to Primary Care** – Continued focus regarding workload/workforce. • **Infrastructure : Technology** – To give people control of their information and how it is used, with more flexible access to information and advice at a time and in a way that suits them. • **Infrastructure : Primary Care Estate** – To ensure modern, fit for purpose estate which supports the provision of joined-up care in line with the CCGs Integrated Care Model and Strategic Estates Plan. On concluding the presentation it was stated that the work plan really does build on the good work undertaken to date and key achievements and the focus will be on the development of PCNs and Locality work going forward.

6.4.3	As a result of discussion:
	• Attention was drawn to General Practice Workforce and wider specialties beyond that for example Paramedics. It was responded that this reflects discussions that are taking place around the wider workforce but this plan is very much General Practice focused but does link. It was highlighted that there was discussion at local AC Board and a Task and Finish Group is being set up to look at needs associated with that. Ellen McNicholas is to be involved and has asked for LMC to be involved in order to help, shape, direct and hear back what thoughts are. Johnny Lyon-Maris is also to be linked into this work.
	• Attention was drawn to the fact that previously LWAB dates have clashed with Board/Sub-Committee meetings. Now prioritising attendance and ensuring that there are others engaged who can attend.
	• It was highlighted that UHS when they have a pre-registration year have now accepted link with CCG to have a three month attachment in Primary Care so pre-registration Pharmacists can be exposed to what Pharmacists can do within Primary Care. It was stated that Pharmacy is one of the very few health professions at the moment that doesn't have a significant shortage of people training and coming through, there are other issues however such as attracting people to our area in terms of the high cost of living, but training is not as seriously impacted.
	• Liz Angier shared the outcome of her discussion with the LMC regarding workforce and :
	  • Drew attention to the good survey the LMC has undertaken on nurses. Link https://www.wessexlmcs.com/nursingsurveyresultsandpossiblesolutions
	  • The fact that there are lots of fantastic qualified people who want to do more for example home visits/triage.
	  • Potential for passport type work where an individual can work in Hospital/Community/General Practice, so maybe this is an opportunity for different professions. It was stated that the Workforce Group have this on the radar including shared competencies through professions.
	• It was reflected that NHS App training has been undertaken and looks to be quite good regarding functionality and ease of use. It was questioned as to whether there are plans to add other things onto that platform such as e-consult. It was responded that it is believed there is work in place to generate a link to put e-consult to NHS App. The e-consult platform was designed to not have an account so you don't have to go through registration process

	each time. Integration and any other work developing the App will be an NHS Digital decision and may be restricted due to availability of funding. Also looking to bring together 111 triage and Pathways Tool. Attention drawn to how smooth the system is, instant with great user-ability. It was noted that GPs are encouraging people to sign up and have access to their own record. On concluding the discussion it was agreed: • That the healthy lifestyles section needs to be strengthened and that Weight Watchers needs to be renamed WW. Rachael King is to liaise with Simon Bryant. **ACTION: Rachael King/Simon Bryant** • A reference to Children needs to be included. Rachael King is to liaise with Roland Fowler. **ACTION: Rachael King/Roland Fowler**
6.4.4	**AGREED:** **Clinical Cabinet:** • **Received the presentation and provided comment.** • **Agreed the actions outlined at paragraph 6.4.3.**
7.	**<u>UHS Divisional B Strategy Overview</u> (Presentation)**
7.1	The Chair welcomed James Adams, Medical Director for Division B at UHSFT and explained that James has been invited to talk to Cabinet about Division B and its role and plans for moving forward over the next year, recognising that the Trust in entirety is refreshing its Clinical Strategy.

7.2	James on opening his presentation explained that towards the end of last year internal work was undertaken in the division with the various specialties and contributors to Division B around what was important to them in order to bring together key themes to focus on for next year.
	
	The presentation covered:
	• Outline of Division B specialities and it was reported that in addition to those listed it also manages HIOW Air Ambulance, which is an offsite service in partnership with them.
	• Key metrics
	• Four further primary drivers for change
	• Six generic strategic priorities
	• Emergency department/Acute Medical Unit
	• Medicine for Older People
	• GIM
	• Ophthalmology
	• Pathology
	• Infectious Diseases
	• Specialist Services
	• Direction of travel as an organisation. Three categories of work:
	  • District general functions for Southampton
	  • Highly specialised/tertiary centre/regional work
	  • Specialised care regional review.

7.3	Cabinet reflected on the presentation and the following topics were discussed: • Financial balance and moving to blended payment models • Increasing demands on ED • Growth in the frail/elderly population • Challenges locally regarding emergency services around mental health and increase in ED attendances and admissions to Medical Unit • Vacancy levels and recruitment issues • Out-patient major review • Estates and Capital Programme • Increased use of digital technology • DTOC, delayed length of stay • Public health agenda, prevention and health promotion • Cultural change The Chair on closing the discussion thanked James Adams for taking the time to come and speak to Cabinet today.
8.	**RISKS AND ISSUES IDENTIFIED AS A RESULT OF ITEMS DISCUSSED AT THE MEETING** : No new risks identified.
9.	**DATE OF NEXT MEETING**
9.1	The next meeting of the Clinical Cabinet will take place on Thursday 11 July 2019 from 09.30am in the Boardroom, Omega House, Eastleigh.

NHS
West Hampshire
Clinical Commissioning Group

Primary Care Commissioning Committee

Minutes of the West Hampshire CCG Primary Care Commissioning Committee Meeting held on Thursday 25 April 2019 at 10.00am in the Boardroom, Omega House, and 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
	Jenny Erwin	Director of Commissioning Mid-Hampshire
	Mike Fulford	Chief Finance Officer and Deputy Chief Officer
	Judy Gillow	Lay Member, Quality
	Heather Hauschild	Chief Officer
	Rachael King	Director of Commissioning: South West
	Heather Mitchell	Director of Strategy and Service Development
	Jim Smallwood	Secondary Care Board Member
In attendance:	Neil Hardy	Associate Director Medicines Optimisation (Item 9.2)
	Terry Renshaw	Governance Manager
Apologies:	Sallie Bacon	Director, Public Health
	Simon Garlick	Lay Member, Governance
	Adrian Higgins	Medical Director
	Ellen McNicholas	Director of Quality, Board Nurse
	Alison Rogers	Lay Member Strategy and Finance
	Sarah Schofield	Clinical Chairman
	Local Medical Committee Representative	

Summary of Actions

Minute Ref:	Action	Who	By
8.3	**Risk Register** – Review following low risks to identify if the risks are fully mitigated and can be closed: • Risk ID 132 Winchester Practice Development • Risk ID 534 Paper Referrals	RK/(SM)	31.05.19
12.2	**Primary Care Finance Report** – Circulate copy of M12 report to Committee.	MF/(TR)	03.05.19 Action Complete

1.	**Chairman's Welcome**
1.1	Caroline Ward welcomed all present to the nineteenth 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.	**<u>Declaration of Interests</u> *(Paper PCCC19/019)***
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	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.
2.3	**AGREED** **The Primary Care Commissioning Committee:** • **Agreed to note the updated Register of Interests for Committee members.**
3.	**<u>Minutes of the Last Meeting</u> *(Paper PCCC19/020)***
3.1	Caroline Ward asked Committee Members to confirm the minutes of the meeting held on the 28 February 2019 as a correct record of proceedings. She explained that she had received no amendments in advance of the meeting.
3.2	**AGREED** **The Primary Care Commissioning Committee:** • **Approved the Minutes of the meeting held on 28 February 2019 as being a correct record and commended them for signature by the Chairman.**
3.3	**Matters Arising** There were no matters arising from the minutes that are not covered by the action tracker.
4.	**<u>Action Tracker</u> *(Paper PCCC19/021)***
4.1	Caroline Ward referred the Committee to the action tracker.
4.2	The following update was provided: 1. **Ref No 32a) GPFV Work Programme: Include specific reference to the governance reporting routes in terms of monitoring, delivery and outcomes** – It was reported that the new DES includes requirement for governance arrangements to be detailed in Network Agreements. Further assurance is to be provided through scheduled Board briefing.

	2. **Ref No 32c) GPFV Work Programme: For Q3 report identify measurables and how trajectories are achieving in order to provide assurance** – Further development is being undertaken with the Performance Team and a summary dashboard, linked to the Primary Care Dashboard, is included as part of the Q4 report. **Closed**.
	3. **Ref No 34 Primary Care Finance Report: Include in next report detail around cluster resourcing** – It was reported that financial schedules are under development and are to be brought to the June 2019 meeting.
	4. **Ref No 35a) GPFV 2018/19: Heather Mitchell to provide post meeting note by 8 March 2019 to Committee around deadline for achievement of, 100% practices live with E-prescribing, 100% referrals sent electronically via ERS** – It was reported that Digital progress reports will now be presented at Board to avoid having the discussions in several places. **Closed**.
	5. **Ref No 35b) GPFV 2018/19: Report for next meeting to include an update on the status of the key digital work streams** – It was reported that Digital progress reports will now be presented at Board to avoid duplication. **Closed**.
	6. **Ref No 36 GP Contract Reform: Chairs action delegated for sign-off of mini QPS April – June 2019** – Final paper included at agenda item 9.1 paper PCCC19/026. **Closed.**
4.3	**AGREED** **The Primary Care Commissioning Committee:** • **Reviewed the Action Tracker and received the updates.** • **Agreed that four actions are complete and can be closed.**
5.	**<u>WHCCG General Practice Forward View 2018-19 Work Programme Key Achievements</u> (*Paper PCCC19/022)***
5.1	Rachael King introduced paper PCCC19/022 and explained that the report provides a summary of the key achievements in 2018-19 delivered through the West Hampshire General Practice Forward View Plan and provides assurance regarding the effective discharge of the CCG's responsibilities under delegated commissioning. It was reported that: • The plan was developed in line with the requirements of the national GP Forward View and the 2017-19 Operational Planning and Contracting Guidance. • The four key **care design** work streams are: 1. Health Promoting Care 2. Improving Access to Care 3. Holistic, person centred co-ordinated care 4. Consistently High Quality Care • The four key **enablers** are: 1. Workload 2. Workforce 3. Infrastructure – Estates and Technology 4. Transformation Support

5.2	Rachael King drew to the attention of the Committee the following key highlights:
	• This report provides a summary of key achievements in 2018-19 delivered against the five components of our Integrated Care Model and the difference made both to local people and in supporting the future sustainability of our general practices. It provides assurance regarding the effective discharge of the CCG's responsibilities under delegated commissioning and in line with the national framework for GP contract reform, sets out emerging priorities for delivery over the next five years.
	• Clusters of GP Practices covering populations of 30,000 to 70,000 choosing to work together alongside acute and community services and the voluntary sector to deliver better joined up care for local people. There are 13 Clusters in West Hampshire and these will become known as Primary Care Networks from 1 July 2019. GP Cluster Clinical Leads appointed and in post, Cluster Plans are being developed that will be focused on local need.
	• Supporting people to stay well:
	  • Influenza and pneumococcal vaccinations – Significant work has been undertaken to promote the uptake of flu vaccination, particularly for people aged over 65 and children aged 2-3 years. West Hampshire CCG flu vaccination uptake 2018-19 for those aged 65+ years was 75.6% against a national target of 75%. National achievement was 71.3%. It was reflected that this achievement is due to the hard work of GP Practices despite the difficulties encountered in sourcing vaccinations this year.
	  • Weight Watchers – West Hampshire Practices have worked with Weight Watchers to invite eligible patients to join a 12 week programme. Twenty – two Practices have invited over twenty thousand patients to join the weight management services and of those accessing this service 91% saw a loss in weight.
	• Proactive Joined-up Care – The Frailty Support Team has been established across seventeen Practices across the New Forest to provide rapid assessment, diagnosis and care to reduce unnecessary hospital admissions and support people to remain at home. From April 2018 to February 2019:
	  • 1,293 patients supported to remain at home avoiding an admission to hospital
	  • 1,135 General Practice visits avoided, 1,135 hours of GP time saved.
	  • 232 patients accepted directly from the ambulance service rather than transferring patient to A&E.
	  • Admissions to Care Homes where the Team have supported are down by 43.5%.
	• Primary Care Mental Health Service Model – A co-produced model has been developed to strengthen the support available and the benefits will include:
	  • Reducing demand in secondary care mental health for assessment
	  • Reducing referral to crisis services for short term social crisis.
	  • Helping to deliver prevention and early intervention in social care.
	  • Helping to maintain independent living, particularly around housing support.
	  • Creating opportunities to bring other disciplines into closer delivery in primary care.

	• Better Access to Care – People encouraged to make the right choices at the right time. Easier access to self-help information and advice and guidance to make informed decisions. This includes: • Practice Reception staff trained in Active signposting, Benefit: Right care at

	right time, reduces 5% GP consultations. (Practices trained in 2018-19 and 25 practices in 2017-18, equating to a total of 34 (70%). • 36 Practices (76%) using eConsult, with 38,863 eConsults submitted in 2018-19, saving an estimated 23,318 GP appointments. An average of 3,329 eConsults are submitted per month, an increase from 1,710 in 2017-18. Initiatives of this type should reduce demand on general practice and help practices to manage their workload in different ways. • Referral Support Service – Phased implementation of the Referral Support Service from October 2018. Ensures that patients are referred to the right place, first time for routine (planned) care. There has been a 7% reduction in referrals and the use of advice and guidance has increased. There will be full roll-out across West Hampshire by March 2020. • Medicines Management Optimisation – Over 4,000 pharmacist-led medication reviews were carried out in the period November 2018 to March 2019 with over 2,000 medicines de-prescribed, either stopped or those reduced, for clinical reasons.
5.3	As a result of discussion: • The Committee reflected on the thorough report and thanks were extended to all who have contributed to the impressive set of achievements realised over the last year and it was asked how it is planned to communicate to patients the achievements made. It was reported that a communication plan is in development that will provide a platform for sharing this head-line information with our local population. It was reflected that there is also a need to promote achievements wider for example with NHS England and local stakeholders • Attention was drawn to the fact that we benchmark well against our peers. • It was highlighted that 77% of all GP Practices in West Hampshire are Dementia Friendly accredited but there are still 23% of Practices who to date are not and it was questioned as to what is the plan to improve the figure this year. It was responded that the CCG continues to encourage more practices to come on board and we are building on this year on year and the ultimate aim is to have 100% of Practices accredited. • The wording in respect of the Frailty Support Team supported 1,293 patients to remain at home avoiding an admission to hospital was questioned and clarification was sought as to whether this includes figures relating to alternative point of care such as a care home or other supported service. It was responded that the figures are subjective and based on information from assessment teams and GPs on what would have happened. • Attention was drawn to a recent Health Select Committee discussion on the overall plan for the NHS which implied it was not obtainable due to workforce issues and concern was expressed that there is not enough base-line detail in the report around GP issues for example vacancy rates. It was responded that this is one of the biggest challenges and a separate more detailed report is available developed via a tool that provides a rich data source. It was stated that this information will be updated each year and forms the basis for the Primary Care Networks (PCN) to develop their plans. It was observed that PCNs moving forward the reality is that they will not get the required GP numbers and therefore will need to consider putting in other health care professionals. Work is being undertaken locally around identifying competencies for some roles that will work alongside GPs.

	The Chair on concluding the discussion reflected on the impressive set off results that are moving forward in line with the CCG Strategy.
5.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the key achievements in 2018-19 for West Hampshire CCGs General Practice Forward View.**
6.	**<u>A Framework for GP Contract Reform to Implement the NHS Long Term Plan</u>** ***(Paper PCCC19/023)***
6.1	Rachael King introduced paper PCCC19/023 which provided a summary of the five-year framework for GP Contract reform to implement the NHS Long Term Plan. The key elements of the contract reform are: • Addressing the workforce shortfall • Quality and Outcomes Framework • Network Contract Directed Enhanced Services • Digital Programmes – Improving access.
6.2	It was reported that General Practice is the bedrock of the NHS, and the NHS relies on it to survive and thrive. Attention was drawn to the following key areas: • New centrally funded clinical negligence scheme for General Practice commences in April 2019 operated by NHS Resolution. All General Practices are to be covered including out of hours and all staff groups working in the delivery of primary care services. To be funded through a one-off permanent adjustment to global sum. • Changes to the Quality and Outcomes Framework stepping down a number of indicators and associated points. 101/175 points to move into 15 more clinically appropriate indicators covering 5 areas: 1. Reducing iatrogenic harm and improving outcomes in diabetic care (43) 2. Aligning blood pressure control targets with NICE guidance (41) 3. Supporting an age appropriate cervical screening offer (11) 4. Offer pulmonary rehabilitation for patients with COPD (2) 5. Improving focus on weight management for patients with schizophrenia, bipolar, psychoses (40) Remaining 74/175 points for two Quality improvement modules within a new quality improvement domain. Each module to be supported through QOF for one year. For 2019-20, modules to cover include prescribing safety and end of life care. • Network Direct Enhanced Service: • PCNs are the essential building block of every Integrated Care System and under the Network DES, general practice takes the leading role in every PCN. This ensures integration of primary and community health services. PCNs are about provision not commissioning and are not new organisations. The Network Contract DES has 3 main parts: 1. National service specifications setting out what networks have to deliver 2. National schedule of Financial Settlements 3. Supplementary Network Services which can include local schemes

	developed by CCGs and PCNs and added as supplements to the contract. • All PCNs must appoint a Clinical Director as its accountable leader. • New additional roles reimbursement scheme to fund 5 reimbursable roles. Model role specifications published March 2019 as a guide. Networks will decide the job descriptions of their own staff but in doing so, will need to consider the new service requirements in the DES. There will be phased implementation. 2019-20 will focus on clinical pharmacists and link workers. • Existing Extended hours access DES to transfer to Network Contract DES from July 2019. • Delivering new network services. Seven specific national service specification under the DES. To be focused on areas where PCNS can have significant impact. To be developed in 2019-20 covering: 1. Structured medications review and optimisation (from 2020/21) 2. Enhanced Health in Care Homes (from 2020/21) 3. Anticipatory care requirements (from 2020/21) 4. Personalised care (from 2020/21) 5. Supporting early cancer diagnosis (from 2020/21) 6. CVD prevention and diagnosis (from 2021/22) 7. Tackling neighbourhood inequalities (from 2021/22) • Network governance arrangements: • The requirements for all Networks to deliver are set out in the Network Contract DES Contract specification. All Practices signing up to the DES accept that funding is dependent on the Network delivering these requirements. • The Network Agreement is required to be completed and signed by all Network Practices. This consists of 7 schedules that set out the Network specifics, the way in which the relevant members will deliver the requirements of the DES, financial arrangements, how the workforce will be employed and utilised and the governance arrangements, including meetings and decision making. • This includes any details of sub-contracting arrangements. All sub-contracting arrangements must be approved by WHCCG. • With agreement between the CCG and PCN, the CCG may commission local supplementary services as an agreed supplement to the Network DES, supported by additional local resources. This would be commissioned via a separate local incentive scheme in discussion with the LMC. • Monitoring of the DES: • CCGs to calculate payments based on delivery • Member practices to use SNOMED codes to record link worker and pharmacist activity. • Indicates that national PCN dashboard will also be developed.
6.3	As a result of discussion it was: • Stated that it is important to reflect on the changing boundaries and mergers of Practices and the report was commended for describing the changes in an easily understandable format. It was responded that this framework enables the CCG to build on the work that we have already undertaken to date. Thanks were extended to Rachael King and her team.

	• Questioned how these messages are taken out to Practices. It was stated that to date this has been via :
	  • Cluster Clinical Leads
	  • Network Forum
	  • Briefing at Locality meetings
	  • LMC have provided detailed briefings.
	This has increased knowledge and dialogue has commenced as understanding has grown.
	• Highlighted that it would be helpful to have on reports, in the future, an understanding of how communication is being executed and whether plan is on/off target. It was responded that the current focus is on increasing the understanding of our Practices and our wider partners and how we involve and support them as we move forward. Consideration is to be given to communication aspects.
	• Stated that for our local population we need to communicate messages that cover off the question 'so what does this mean for me'. It was responded that it is still early days and Locality Clinical Directors have been very supportive and helpful in respect of messaging within Localities and in moving forward a consistent messaging approach is to be adopted.

6.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the five year framework for GP contract reform to implement the NHS Long Term Plan**
7.	**<u>Operational Report</u>** ***(Paper PCCC19/024)***
7.1	Rachael King introduced paper PCCC19/024.
7.2	**<u>Hedge End Boundary Change</u>** It was reported that: • Hedge End Medical Centre (list size 15,008 at 1 January 2019) has submitted a boundary change request to reduce their Inner Boundary. The practice has had a steady increase in their patient list size over the last 10 years (2,000 patients in the last 6 years) and significant housing development is planned in the area which will put additional pressure on the practice. The boundary reduction request is to support them in managing the increased popultation in their boundary area. • The practice has communicated with their patients and out of 216 responses 96% supported the change. They have also communicated with local practices in WHCCG who also support the change. • The request was reviewed by the Primary Care Steering Group, and following discussion, the Steering Group approved the reduction in practice boundary area shown in the striped yellow section on the map within paper PCCC19/024 . This area is covered by another local practice, Bursledon Surgery who supported the change. The proposal was also supported by Wessex LMC and NHS England (Wessex). • Approval was not given to reduce the practice boundary area shown in the yellow dotted area on the map within paper PCCC19/024 as this area is not covered by any other practice within West Hampshire CCG. • The Practice will retain all patients currently registered within the change of boundary area. The change will only apply to new patient registrations.

7.3	As a result of discussion : • Clarification was sought in respect of people in the hatched area which are to be excluded and the fact that people who are within area are to stay in area and new people moving into the area are to be advised to register with another Practice and how Practices are to be supported in managing expectations of their local population and in view of the numerous developments in place/planned what is being considered in terms of strategic comment for all Practices in the future. It was responded that in terms of patients within the striped area they will remain and new patients are to be advised to register at an alternative Practice. However, individual circumstances will be taken account of on a case by case basis. • Attention was drawn to the wider estate provision implications for Primary Care and it was reported that work has commenced with Practices and wider Partners around strategic planning and requirements for the future.
7.4	**AGREED** **The Primary Care Commissioning Committee:** • **Ratified the decision to reduce the Hedge End Medical boundary (striped area only) subject to the requirement that patients from this area currently registered with the Practice are retained on the registered list.**
8.	**<u>Primary Care Risk Register</u>** ***(Paper PCCC19/025)***
8.1	Rachael King introduced paper PCCC19/025 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 re- alternative connection.
8.2	The Committee reviewed the Risk Register and an update was provided on each of the high level risks.
8.3	As a result of discussion it was: • Questioned as to whether a risk needs to be included that encompasses the overarching change agenda. It was responded that this is more a mitigating action as it relates to reputation and there are clear arrangements in place in respect of communication plans around specific areas of focus. It was recognised there is a need to identify a better way to celebrate the wider success of Primary Care. • Agreed to review the following low risks to identify if the risks are fully mitigated and can be closed: • Risk ID 132 Winchester Practice Development

	• Risk ID 534 Paper Referrals **Action: Rachael King/(Sylvia Macey)**
8.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the report of the Primary Care Commissioning risk register, the identified high risks and mitigating actions.** • **Agreed the action outlined at paragraph 8.3**
9.	**<u>GP Incentive Schemes</u>** ***(Paper PCCC19/026)***

9.1	**<u>Quality Progression Scheme (QPS) Quarter 1 2019-20</u>**
	
	Rachael King introduced paper PCCC19/026 which set out the proposed Quality Progression Scheme for Quarter 1 2019-20 (April – June 2019). It was explained that:
	• The aim of the Quality Progression Scheme is to:
	  • Support practices to be active participants in their Locality and Clusters/Networks to progress improvements in the quality of care available to the locality population.
	  • Support practices, working together as a Locality and Clusters/Networks to review and better understand the health needs of the locality population.
	  • Provide the opportunities to improve the design and quality of care provision necessary to meet the needs of the Locality and Cluster/Network populations.
	  • Enable locality practices to co-design and participate in education programmes delivered at TARGET meetings to improve the quality of care delivered to the locality population.
	  • Support development of shared learning and cooperative working between all partners in the Network and the locality practices.
	• The Quality Progression Scheme has the following components: Component A: Locality and Cluster Plans to action
	  • Part 1: Developing and implementing Locality and Cluster Plans
	  • Part 2: Workforce mapping
	• Component B: Improving Quality in Primary Care
	  • Part 1: Patient Safety – Learning from significant events
	  • Part 2: Education for improving quality and health.
	• In light of the recent publication of the GP Contract Framework and the Network Contract Directed Enhanced Service (DES), it is proposed to initially fund the scheme for Quarter 1 (April – June 2019). This will ensure that plans are progressed and momentum maintained, building on all the work undertaken to date. Practices will therefore receive funding for participating in the QPS, as well as the financial entitlements outlined in the DES, placing Networks in a strong position going forward. The QPS will then be reviewed in collaboration with the Local Medical Committee, taking into account the requirements of the DES and QOF Quality Improvement modules to inform any requirements for the scheme from 1 July 2019.
	• This proposal was approved by the Primary Care Steering Group.

9.2	It was reported that: • At the point a decision needed to be made in terms of the Quarter 1 QPS national guidance was not available and there was a need to support the locality structure and good work undertaken to date in terms of Cluster and Network Plans, which is why this approach has been adopted. • There is a potential cost pressure as the £1.50 previously used to fund will go into network funding agreement. The team are currently working through financial allocations and the potential implications.
9.3	**AGREED** **The Primary Care Commissioning Committee:** • **Ratified the decision made by the Primary Care Steering Group to approve the Quarter 1 2019-20 Quality Progression Scheme and the associated budget of £226,139.**
	<u>Medicines Optimisation Scheme Quarter 1 2019-20</u> (PCCC19/026)

9.4	Neil Hardy introduced Paper PCCC19/026 and explained:
	• The paper sets out the proposed Medicines Optimisation Incentive Scheme for Quarter 1 2019-20. This scheme has been evaluated quarterly with reports to the Primary Care Steering Group and has resulted in significant quality improvements and associated savings in line with the 2018-19 QIPP plan.
	• The aim of this incentive scheme is to:
	  • Incentivise practices to engage with the CCG Medicines Optimisation Team and other practices within the Locality and Network through active participation at Locality Medicines Optimisation Groups.
	  • Agree and implement a practice specific annual medicines optimisation action plan which is based on the CCG medicines optimisation QIPP plan, national priorities and takes account of the individual practice's priorities and opportunities for quality improvement and savings. The medicines optimisation team will support practices in developing and implementing their plans.
	• In light of the recent publication of the GP Contract Framework and the Network Contract Directed Enhanced Service (DES), it is proposed to initially fund the scheme for Quarter 1 (April – June 2019). This will support the delivery of the 2019-20 QIPP and ensure that Practices continue to be actively engaged in the scheme. The scheme will then be reviewed in collaboration with the Local Medical Committee, taking into account the requirements of the DES and QOF Quality Improvement modules to inform requirements for the scheme from 1 July 2019.
	• This proposal was supported by the Primary Care Steering Group.

9.5	As a result of discussion it was reflected that in taking stock of the changes to the GP contract it is encouraging to see that a lot of the quality and safety work WHCCG has been doing is embedded within the contract and the team are working through the finer detail of what is in/is out of contract.

9.6	**AGREED** **The Primary Care Commissioning Committee:** • **Ratified the decision of the Primary Care Steering Group to support the Quarter 1 2019-20 Medicine Optimisation Incentive Scheme and the associated budget of £70,866.**
10.	**<u>Quarter 1 PMS Premium Reinvestment 2019/20</u> *(Paper PCCC19/027)***

10.1	Rachael King introduced paper PCCC19/027 and explained that:
	• Following a review undertaken in 2016 of services offered under the premium funding of PMS contracts held with eight Practices, core and non-core services under the GMS contract were identified. Non-core GMS services were prioritised for commissioning across West Hampshire through the reinvestment of the PMS premium in line with national guidance.
	• The PMS Premium funding is £183,644 per annum, equating to a total of £918,220 over five years.
	• The prioritised areas for reinvestment of the PMS Premium 2016-17 to 2018-19 were the provision of:
	  • An equitable Minor Injuries Service for all WHCCG patients.
	  • A 'basket' of nursing services.
	  • A complex wound and leg ulcer service and
	  • A monitoring and prescribing service with additional medicines.

10.2	Following consideration by the Primary Care Steering Group of the proposals for the reinvestment of the PMS premium in 2019-20, the following was approved: • Continue to commission an equitable minor injuries service across WHCCG at a total cost of £174,403. • Continue to commission the basket of services at a total cost of £184,368. • Continue to commission the monitoring and prescribing of the thirteen shared care drugs at a total cost of £756,998 (which includes £200,788 funding from the PMS Premium), plus additional funding of £45,394 for the full year cost of Amiodarone and a fourteenth drug, Mycophenolate. This additional funding will be met through the primary care budget. • Invest year four of the PMS Premium of £183,644 in the Complex Wound and Leg Ulcer Service. This increases the total funding of the service to £472,144. • Commission a template with Snomed coding to ensure the accurate recording of complex wound and leg ulcer activity in 2019-20. This will enable a review of actual activity against plan (as at Month 9) to inform commissioning intentions in 2020-21.
10.3	Particular attention was drawn to: • The analysis of Read code data shows significant variation across practices. Work has been undertaken with Practices to understand the reasons for the variation. Despite the removal of post-operative wounds, which had been included in the data by some Practices, significant variation remains which cannot be explained by the size of the Practice or demographic need The variation ranges from 0 to 653 initial appointments and 0 to 1,407 follow-up appointments, as at Month 9. It is therefore not possible to use the data to accurately calculate the level of activity undertaken by general practices and the associated required investment.

	• It is therefore proposed that the year 4 PMS Premium investment of £183,644 is divided by weighted population across all Practices and commissioned through a block contract as the only equitable way of increasing the funding allocation for the Locally Commissioned Service. The block contract means that, as now, Practices will be paid monthly one twelfth of an annual agreed budget. • It is also proposed to include new Snomed codes and a specially written template for quarterly reporting in 2019-10 to ensure accurate data capture.
10.4	As a result of discussion it was: • Questioned as to how it is proposed to evaluate quality outcomes. It was responded that in respect of acute activity positive benefits have been seen for example a reduction in complex wound cases but cellulitis has increased and work is being undertaken with the quality team to undertake a detailed audit with our Practices. • Highlighted that some Primary Care Networks are keen to provide services across Practices in moving forward.
10.5	**AGREED** **The Primary Care Commissioning Committee:** • **Ratified the additional (recurrent) funding of £183,644 PMS premium reinvestment in the complex wound and leg ulcer service, equating to a total investment of £472,144 in 2019/20.**
11.	**<u>Business Case for Merger of Totton Health Centre and Forest Gate Surgery</u>** ***(Paper PCCC19/028)***
11.1	Rachael King introduced paper PCCC19/028 and explained that: • Totton Health Centre and Forest Gate Surgery merged Partnership contracts on 1 October 2018 following approval of the addition of partners to the two PMS contracts in August 2018. The partnership is now known as the New Horizons Medical Partnership. The practices have now submitted a Business case requesting a formal merger of their contracts. The potential benefits of the merger are detailed in the business case. • The practices have undertaken comprehensive public engagement, this included; a survey that was sent to all registered patients at the practices and three drop-in sessions and a Q&A sheet on their website. A summary of the patient feedback from the engagement was submitted as part of the paper. • Feedback showed that practice patients were generally supportive of the proposed merger and recognised that it supports sustainability of providing General Practice services and continuity of care in the local area. Some concerns were raised regarding travel to another site. • The Primary Care Steering Group at its meeting in February 2019 supported in principle the merger, subject to the practices undertaking patient and local stakeholder engagement regarding the proposed changes. • Following completion of the engagement period the final approval of the merger was now sought.

11.2	As a result of discussion it was: • Highlighted that the CCG has supported the Practices with their communications and engagement activities. • Reflected that there is a third Practice, Test Vale, who for them at this time a formal merger with Forest Gate and Totton Health Centre is not the right time, however they will act as a single network and the three Practices will be working together to provide services for patients. • Questioned whether any premises changes are proposed as a result of this merger. It was responded that the Practices are aware that no premises changes can take place without agreement via a Business Case and the agreement of the CCG. • Questioned if lessons learnt as a result of mergers are being captured. It was reported that the benefits of mergers are being clearly documented so that learning can be shared.
11.3	**AGREED** **The Primary Care Commissioning Committee:** • **Approved the formal merger of Totton Health Centre and Forest Gate Surgery subject to the Caveat outlined above around changes to premises.**
12.	**<u>Primary Care Finance Report – Month 11</u> *(Paper PCCC19/029)***
12.1	Mike Fulford introduced paper PCCC19/029 and explained that at Month 11: • The budget for Delegated Primary Care for 2018-19 is £70,559k. • Across all Primary Care funding streams the budget is, at 28 February 2019, underspent by £989k. • The Forecast Out Turn is an underspend of £1,232k. • The forecast excluding the Primary Care Delegated 1% surplus is an underspend of £522k.
12.2	Mike Fulford reported that the M12 position has just been finalised and provided the following headlines: • Primary Care Delegated budget at M12 is showing a £435k underspend and the Locally Commissioned Services year end position is an underspend of £412k. This is broadly in line with the 1% contingency included in the plan. • There is an underspend on rent and other premises costs of £612k • There is an underspend on business rates of £101k • There is an overspend of £256k on prescribing and dispensing fees. • Due to the pricing concessions and supply issues around the availability of some drugs it was reported that the CCG has recently received £0.5m in support of prescribing 'price concessions' this is against a £1.6m cost pressure. It was agreed that a copy of the finalised Month 12 report will be circulated to the Committee. (**Post meeting note**: reported circulated 1 May 2019) **Action: Mike Fulford/(Terry Renshaw)**
12.3	It was reflected that in 2018-19 there has been a good overall performance and that there will be variances to play into the 2019-20 budget. Work is currently being

	undertaken to understand the complexity in respect of the money that is being moved around various parts of the contract. The general message is that the budget will be challenged for example aspects of Medicines Optimisation Incentive Scheme and the Quality Progression Scheme as to what is in/out of the core framework. Conscious that there will be changes/surprises in year as more detail becomes available.
12.4	**AGREED** **The Primary Care Commissioning Committee:** • **Noted the month 11 Finance Report 2018-19.** • **Received a highlight report on the M12 position** • **Agreed the action outlined at paragraph 12.2.**
13.	**Any Other Business** - There were no new items identified on this occasion.
14.	**Risks Arising From Discussion of Agenda Items To Be Included on The Primary Care Risk Register** - There were no new items identified on this occasion.
15.	**Date of Next Meeting**
15.1	The next meeting of the Primary Care Commissioning Committee is scheduled for: • Thursday 27 June 2019, 9.00am to 11.00am, Boardroom, Omega House, 112 Southampton Road, Eastleigh SO50 5PB.
16.	**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].***

BLANK PAGE