NHS
Thurrock
Clinical Commissioning Group

Core QIPP Meeting
6th March 2014
The Thames Room, Civic Office
14.00-16.00

Present:	Dr R Arhin	Chairman of QIPP / GP Thurrock CCG
	Dr A Bose	GP Thurrock CCG
	Dr A Deshpande	GP Thurrock CCG
	William Guy	Thurrock CCG
	Mandy Ansell	Thurrock CCG
	Alfred Bandakpara-Taylor	CSU
	Phillip Clark	Thurrock CCG
	Andrea Cronin	Thurrock CCG
	Siobhan Black	CSU
	Mary Tompkins	CSU
	Dan Stoten	CSU
	Ade Olarinde	Thurrock CCG
	Alana Stokes	Minutes
Apologies:	Dr H Okoi	GP Thurrock CCG
	Gavin Mackenzie	CSU
	Rahul Chaudhari	Thurrock CCG

1.	**Welcome & Apologies**
	RA welcomed everyone to the meeting and introductions were made. The group were asked if there were any conflicts of interest to declare. None were raised. Apologies were given as stated above.
2.	**Minutes of the meeting held on 23rd January 2014 and Action Log**
	The chair asked the Committee to point out any errors found in the minutes from the previous meeting. No comments were made and the minutes were agreed as a true record. *Action log:* 1. AB-T advised he would send the PBR breakdown via email to RC. 2. RC had shared spreadsheet template with DS. Complete
3.	**QEB Overview 13/14**

	SB presented the forecast for 2013/14 (subject to change) and advised that the PMO team were working with the Finance team for a clear position for the end of year. Key risks and issues had been identified, although some could not be captured. SB updated that the Dermatology Performance data was a struggle to quantify. The Medicines Management invoice issue had now been rectified. The group noted that the items were all mainly amber green from 81% of the target. Ade O noted that the task for the CCG would be to deliver the controlled total, 1% surplus target. Efforts would now be focused on next year and lessons learned from current successes and failures. Ade O also informed that the figures were on track to achieve the 1% surplus, although end of year deadlines for invoices are a risk but the Finance team are cautiously optimistic. Ade O set the scene for individual business cases to be presented. Two slides were shared in hard copy that detailed the future plans. Last year's plans and contract negotiation progress were discussed and contracts have now been agreed by all main providers, although the QIPP plans must now be revisited to adjust numbers. The five year summary was shared as the QIPP target required has now been reduced. Last year's surplus can be taken off the final total for this year. The actual QIPP plans were listed in the first column of the document as a basis of submission in February 2013. The second column was revised for values agreed in the actual contract, as the last column shows the achieved figures. Unplanned Care activity is all within the BTUH contract. Mental Health was noted to have changed significantly from the original assumptions. Medicines Management was updated as the original submission was increased but has now dropped back as it was against a South West Essex contract. The schemes that are currently being worked through were noted to include CAHMS. The schemes that do not have values that have been agreed for funding from NELFT include both Acute Spend and Wound Care Management. Next year the CCGs must plan to fund these schemes if they are successful this year. It is currently unclear how much will need to be invested. It was noted that Psychological therapies that can be scoped may help plug the financial gap. These will be continually scrutinised between now and April 2014. The group heard that both Unplanned Care and Planned Care outpatients had been poor performers during the last year for achieving savings, so the target was reduced for this year. Unplanned Care is now to be serviced in a block contract. The group discussed that the risk share for being under activity works both ways for the CCG and Providers.
4.	**Unplanned Care Business Case Overview**
	PC presented the Unplanned Care business case overview. Now that an Unplanned Care block contract has been negotiated, there is concern that no financial incentives will encourage the providers to take on any extra activity. The future plan will include

	more utilisation of the available community pathways. Drafts were shared of the Unplanned Care leads and what they can currently deliver including identifying pathways and navigating patients to the solution. BTUH will be restricted from DVT follow-ups and instead deliver this service within the community. BTUH are currently reviewing where this service should be cited in the contract negotiations. A trajectory for where patients currently are in the system now and where they are expected to be will be shared. A transactional business case is being drafted on the CCG's behalf by BTUH. PC noted that the first comprehensive Discharge Planning meeting had gone ahead with no Thurrock GP input, but if the GPs have an opportunity, they are able to input for the follow-on Care Management plan. Concern was raised for patients being discharged (who are over the age of 75) into the appropriate community services. The TPP had offered System-One to all Nursing and Care homes for free. This would aid in structuring their ward rounds to monitor what they aim to identify and include a remote monitoring arrangement. A matrix grid with community services was suggested, as well as listing all Care home services in Thurrock i.e. SSKIN bundles and Community Geriatrician etc. AB questioned what the pathway for patients under 75 would be. PC explained that over 75s had been cited because of the access to Community Geriatricians. A link back to primary care MDTs and the rate of re-admission for the group is high. AB noted that the shared care protocol is already happening. PC advised that the Continence workstream is on-going. AD queried where DVT services will sit with the BTUH contract for Unplanned Care. PC explained there will be an extension of the first point of call. MT noted that the contract for next year will include KPIs for discharge and GP engagement will need to be provided for quality assurance. AB asked MT about medications from Family Care. MT advised that the Prescribing team are continually working with BTUH and NELFT to have a commissioning based formularise as there has not been GP involvement throughout the process. If problems occur after discharge, information must be shared of what has gone wrong to so that pharmacies can track the issues. The Medeanalytics Champion has been asked to look into this. A facilitator will be going into each practice to assist with this workstream. It was noted that a reason System-one has been suggested for use in care homes is because Thurrock Social Services are reviewing whether they should employ System One within their teams.
5.	**MSK Business Case Overview**
	The MSK business case overview was presented by WG and he explained that the

	MSK project had been pulled out of consultation last year and is now planned for inclusion at BTUH. Key issues identified in the workstream include variation in systems between IT and patients being referred from different points of entry. Patients are often not placed with the right clinician first time. Another issue was raised regarding the 18 week target, WG advised that it is being addressed. Contract negotiations this year have been focused and phased savings are expected. Thurrock will be receiving £30k this year as there is a redesign. WG advised that quality impact assessment needs further work within the business case paper. Risks have been identified as the proposed triage hub model is pivotal. NELFT and BTUH are the main providers and concerns concern has been raised over ideas submitted that are not best practice. This has been addressed with an offer to bring in outside expertise. The second key risk identified was the Community Physiotherapist being outside of current activity. A decision will need to be made for the workstream after recommendations from the Clinical group. AD commented on the Community Physiotherapist and questioned the referral pathway as to if every referral goes to the Physiotherapist then is moved on to the MSK hub. AD also queried if MSK referrals go through the hub, can the hub refer to the Community Physiotherapist. It was noted that there are still high levels of referrals to Tier 2 from MSK. AB suggests a tighter pathway be brought in a commended the description of MSK within the business case document. He suggested the use of a clause for the definition of physiotherapy and this would need to be discussed with NELFT. RA queried if more physiotherapist services would be brought into the community. It was suggested that more pathways and services were needed in the community through a combination of BTUH and NELFT physiotherapists. A discussion of Ambulatory Pathways was opened by RA as there should be GP input over which patients can come out of these pathways. PC noted that there should be aligned clinical GPs and appropriate clinical forums for these decisions. MA advised the group that Walk-in Centres are now up for tender. It was discussed that there will be alternate month Board sessions and forums for different groups to be discussed.
6.	**Paediatric Business Case Overview**
	DS presented the Paediatric business case and informed the group of the contractual changes and decommissioning of the Parents First initiative. DS also updated the group on the position for up to 13 different children that are naturally transitioning to 18years old that are currently being provided for and savings will be made as a result of this transition.

	DS explained the community and acute side of the high impact pathways. Asthma, febrile illness and head injury will be the pathways to be work towards for next year. Learning would be taken from audits of the two high impact pathways currently in place to inform the workstreams for the next three. Repatriation is on-going for children attending services in London for Sickle Cell disorders. Best practice will be employed and a plan put in place to settle on a pathway along with community providers. There must be re-scope of Sickle Cell services regarding all age ranges. All other CCGs are accessing that part of the service. Both Community and Acute Sickle Cell pathways are being worked on. MA suggested the review of funding of children by the Local Authority must be completed as soon as possible as the group are keen to see a date for the phasing of payments to be stopped. Ade O advised that the CCG had been cited on the invoices for this year but who would be invoiced next year. AD noted that clinically the NICE guidelines will be followed as BTUH and NELFT must follow the same guidelines. DS clarified that there is not currently a complete pathway in South West Essex. Ade O explained that the high impact pathway savings identified as £15k were for the five pathways since September 2013. In 2015/16 there will be a full year value impact to access.
7.	**Mental Health Business Case Overview**
	AB-T presented the Mental Health business case overview to the group. It was noted that Mental Health savings come directly from the SEPT contract. Mental Health contract savings will be derived from the closure of a Dementia ward and closure of LD beds because of underutilisation of the beds. There will instead be a community focus rather than inpatients. Decommissioning of five beds will occur for savings and the workstream is currently on track for this to go ahead. This option is not unique to Thurrock and in accordance with Winterbourne guidance. As the beds have not been used to full capacity, they will be marketed to recoup the funds. AB-T also outlined plans for out of area charging to which SEPT are to provide examples of basis. Individual placement 117 was discussed and the CSU are funding an individual placement team. There are expectations for the team to robustly review the individuals from 117 as a default of 117 individuals are sectioned out of the area. These individuals are taken off the list if they are settled after moving out of the area. AB-T addressed the position for Rehab beds and advised that ten beds could be decommissioned for community rehab services. The workstream will look at trends and utilisations of the beds and focus on the community needs. WG queried if there is a single project plan for decommissioning and what the risk would be to the CCG if the targets for next year are not achieved. AB-T advised that the risk and problems with reductions in beds include fear of cost shunting when brought to the attention of the Local Area Authority. Other areas have done it with successful management of the patients in the community. Current utilisation of the beds allows for a reduction in the need for these beds which will lead to future

	investment of funds into patient community services. The trend reviewed is from two months this year and there has not been any resistance from SEPT as national guidance suggests moving away from large patient cohorts in inpatient facilities. **The group agree with the process and would support it going forward including the formal presenting of the QIPP programme to Board. (*Group not quorate*).** PC noted that Public Health were listed on the business case template and this should be removed as it is not applicable.
8.	**Prescribing Business Case Overview**
	A brief summary was presented by MT of 2013/14 saving as they were not fully delivered. An issue of clarity over what exactly can be prescribed is being addressed. Formulary management was provided in the hand-out supplied during the meeting. Challenges must be made by the end of this month and some will be accepted even if formulary has not been agreed. MT advised that treatment at the appropriate stage will reduce admissions and cost. The COPD pathway has been agreed with all parties including BTUH and NELFT. Home oxygen service assessment is on-going within the services. Dietetics and nutritional supplements have been linked to home enteral feeds and this workstream was noted to be complicated. MT advised that both Script Switch and generics need templates included on System one. Prescribing issues in Care homes have been challenging and scoping what can be done and by whom is now needed to be completed. Mental health was identified as a key area for large savings within Care homes in the reduction of use of antipsychotics. SEPT are yet to quote what they can provide in this workstream. Clinical and financial control of drugs excluded from tariff is difficult to process and changes are to go live from 1st April 2014. Wastage is hard to quantify and electronic prescribing is a positive move, whilst becoming more widely available. Ophthalmology produces a wide range of interventions that are available and are not included in the drug tariff. NHS England and CCG commissioning have differences and teams should be challenging providers that should be charging to NHS England in some cases. The direction of challenges and savings are realistic to achieve. The group were advised that the business cases were to be submitted tomorrow and formally adopted in the next QIPP Core meeting. AB queried the connection with pharmacies for savings. MT advised that the pharmacy is in contract with the Local Area team. It was suggested that an up to date

	list of pharmacies to be circulated on a monthly basis and shared with CCG for information. MT noted the Local Pharmacy network is being developed to make change happen. RA discussed Polypharmacy and the options for taking patients off of medications. MT advised it is within the contract to look review the stopping of medications when necessary and observed the benefits of electronic prescriptions within this workstream.
	AOB
	AB shared a fax regarding Alcohol services and MA agreed to chase up more information for the joint commissioning forum. The group were advised that the Respiratory Network is currently going on. WG gave the group an update on Fortis as it is in best financial interest to serve notice on Fortis, as RMC is costing rather than saving after this time. The notice period must be completed and communication to general practice of when Fortis will stop accepting referrals must be shared. If referrals climb, there will be plans in place to halt this. SB advised that PMO are reviewing the business cases within the upcoming week and once feedback has been passed on to the Commissioners and they have made any amendments, PMO will then supply the draft business cases for circulation to the GPs by five days before the next QIPP Core meeting.
	Date of the next meeting
	Next QIPP Core Meeting to be held on 27th March 2014 at 14.00 at The Civic Offices, Grays.