Working together for better health and care

NHS Thurrock Clinical Commissioning Group

QIPP Core Committee Meeting
11th August 2016
Thames Room, Civic Offices

Present:	Dr R Arhin (RA)	Chair of Committee
	Dr V.Raja (VR)	GP Board Member TCCG
	Ms L.Buckland (LB)	Deputy Chair & Lay Member
	Ms A.Springett (AS)	Senior Primary Care Manager
	Dr Nimal Raj (NR)	GP Board Member, Safeguarding Lead
	Mr A.Ahad (AA)	Head of Financial Strategy
	Ms I Lewsey	Head of Transformation
	Ms E Sanford (ES)	Strategic Lead, Health and Social Care, Public Health
	Dr A.Bose (AB)	GP Board Member TCCG
	Ms H Arnold (HA)	Business Support Team
	Mr B.Hughes (BH)	Business Intelligence Specialist NELCSU
	Ms S.Cleall	Quality & Patient Safety Manager
	Mr A.Olarinde	Chief Finance Officer
Apologies	Ms M Ansell (MA)	(Acting) Interim Accountable Officer
	Dr R.Mohile	GP Board Member, Mental Health Lead
	Mr J.Andrews (JA)	Implementation Lead Pharmacist
	Mr M Tebbs (MT)	Director of Commissioning

1.	**Welcome & Apologies**
	The Chair welcomed all to the meeting. The apologies were noted above. Chair asked if there were any declarations of interest that were not already on the register, none were noted.
2.	**Minutes of the meeting held on 9th June 2016 and Action Log**
	Minutes were agreed as a true account of the meeting. Action 12/05/16 Item 3 is on the agenda for today's meeting and can be closed.
3.	**QIPP 16/17 Update**
	AA presented QIPP update for July 2016. He provided the committee with 2 papers, The dashboard summary and the TNR Report. Regarding QIPP achievements in the current year to date, it is showing an achievement of 76%

against forecast for the year being 91%. The YTD position is slightly lower as there is QIPP to come out of contracts in year; currently being discussed. This cannot be shown in the YTD position but would be included in the forecast position. Another reason for this issue is regarding data lag which makes it difficult to verify savings early in the year. Data lag occurs due to flex and freeze data available and this is subject to national timetables. However this creates a natural delay in obtaining up to date data. The YTD position does not include any estimates for this as it is too early in the year to be able to do this. Although QIPP savings are forecast to be in line with achievement in 2015/2016, additional QIPP savings may have to be developed to mitigate the increase in the CCG's expenditure particularly if there is a risk to the CCG being able to the achieve its control total agreed within the NHSE.

MSK/Referral Management/Unplanned Care £693k
QIPP to come out in year was part of the 2016/16 contract agreement with Basildon Hospital although at that stage detail around the schemes had not been shared. Meetings are to be held at BTUH along with BB CCG to be evidenced they are having the impact in line with trajectories agreed within the Trust.

Referral Management scheme is a concern at this stage as there are early indications from NHS E data that GP referrals have actually increased in the first 2 months of 2016/17. It is in our best interest to deliver the scheme and keep hold of referrals.\

Ophthalmology £133k
This is similar to above in that these savings are expected to come out in year. This scheme is being led by Castlepoint CCG and there are concerns that this scheme will not deliver the expected savings; however there needs to be dialogue with Castlepoint CCG to better understand what the issues are and what can be done to mitigate them.

SEPT Rebasing £356k
Following NHSE decision, the CCG will not realise any savings in 2016/17

Thurrock Section 75
Significant savings have been achieved and the schemes are largely on track.

CHC Controls
CHC activity increased for the 3rd consecutive month impacting scheme savings

Mitigation Projects
No additional projects have been identified during this reporting period.

AO confirmed that next year's financial paper will be presented at August Board and Finance & Performance Committee next week. The block contract will need to be completed by December (it used to be March). AO stressed the importance of active monitoring as financial values will not change for this year.

VR asked if these figures also relate to cancer referrals and AA confirmed that it is all referrals. VR felt that cancer referrals should be taken out of it as this is something not in our control. AA said that a pack would be out together and sent out but it has been mentioned today so all are aware.

All agreed that patients should be seen in the most appropriate setting.

ACTION: AA to distribute Dashboard report before the next QIPP meeting.

AA confirmed that CHC is an area of concern and the Intermediate Care Review is again highlighted in 'red'. AO confirmed that, due to the Transformation programme, we should start to see contract action. Patients are to be discharged from the Mountnessing facility in Billericay and this will be used for dementia patients. There will be no savings from that this year but we

will see them next year.

AO explained that the SEPT rebasing is based on actual usage and should be cost neutral across all CCG's. He added that the decision made by NHS England is that Southend CCG will not take any financial heat this financial year. Thurrock and Castlepoint will receive no befit this year. When we are not hitting our QIPP target, this will be reflected.

LB noted, on page 7 of the QIPP Core Update, it states that "…we are not attaching financial savings of even close to the magnitude of £133k to Ophthalmology schemes. She asked whether this is not compromised rather than risk?
AO confirmed that the Ophthalmology scheme was agreed with Southend under re-organisation of the block contract. There is a clear plan of action as to what needs to happen.

ACTION: AO to take understanding from Southend's Lead Commissioner of Ophthalmology and update on progress for the next QIPP meeting.

4. Hypertension Pilot

ES presented a paper to the committee for which she sought approval; the main purpose is to pilot the use of self-testing machines in primary care and other settings to help identify patients with this condition. It was felt that this could be done at a cost of approximately £25,000.

She explained that, over the next 3 years, it is hoped that 1104 patients can be identified with hypertension; with more diagnoses this could result in a system saving of £1,47,254.76
A Health Equity Audit was recently carried out and it was felt that this would be the best way to identify potential patients. At present, it is not certain the type of machines to acquire. There are a variety of different ones which test BMI and pulse. ES confirmed that Section 106 money could be used if it turns out to be a feasible option – Section 106 funds are only for localities. She was open to suggestions as to the best place to put the machines, they cannot constantly be moved as they will need to be recalibrated and they would take up quite a lot of space. Suggestions included pharmacies and GP practises.

There was a discussion about using HUB's for blood pressure checks; it was felt this may be a good place to pilot the scheme. Often patients attend surgery and are diagnosed with high blood pressure. They show a high reading but are not referred elsewhere. They are meant to return to the surgery but often don't come back. Like this, if they are due to go back for monitoring they can access the HUB and therefore be monitored.

Admin Costs; RC felt that the only issue with this is that HUB's cannot refer people anyway but AB said this is not correct and that there is an option as to where to send the patient.

RA said that it would definitely need a pathway so, if a clinic was set up, they would know where they are going.

AB said that they already do similar projects like this in Sainsburys where there are resident pharmacies; Tescos mainly only use locums but it definitely may be worth having a conversation with them.

LB noted that the reported system savings of £1,407,254 and asked whether we mitigate against additional costs; are the figures net or gross? Surely once patients have been identified then there would be drug costs to take into account. ES said that the cost of these would be still be less than if we were treating people with strokes. LB questioned whether we could honestly say that we will be saving £1million.

LB thought that it is a good idea but thinks we should have a public engagement and ask patients where they feel the best place for the machines would be so that they are easily

accessible for members of the public and suggested ES speak to Liv Corbishley.

ACTION: LB to speak to LC about contacting ES

It was also suggested to speak to volunteers as they visit homes and go into patient's houses; it may be good to get a social care angle on this.

AS stated that the Afro-Carribean are at a much higher risk therefore it may be best to approach Afro-Carribean hairdressers or churches. ES confirmed that they have found a link between dental health and coronary problems so it may be a good idea to raise awareness about this too. VR stated that hypertension drugs are actually quite cheap although it costs about £20k to treat each stroke patient.

AO asked if the approval is for two separate projects and ES confirmed that it is just one. The investment is for £100,800 but was under the impression this would be over 3 years but felt we need clarity as to whether this would be per year. For this reason, committee members felt that a clear pathway but would be better for clarity.

ACTION: AB and ES to develop a pathway.

All were happy to proceed; the project should start approximately October time and feedback will be given back to this committee in 6 months' time.

ACTION: Liv Corbishley and Richard Stone to be informed of the scheme.

5.	**Service Restriction Policy**

Nyssa Paige provided the committee with a copy of the Service Restriction Policy.

She explained that this is the proposal from BB CCG. It would be useful if this document could be shared with GP's. All CCG's have a Service Restriction Policy (SRP) which sets out the clinical criteria for a large range of medical treatments and procedures; designed to only be carried out where there is clinical evidence that they are both beneficial and effective to patients and affordable with funding available. We are looking for QIPP Committee to decide what they would be happy with.

AO felt that this would need consultation and approval by the Governing Body. It was meant to come to QIPP last month but there was an issue with the providers. If this document does get agreed, this would mean that Basildon would have to do the same.
RV said that this would have been better to have had before the meeting so that members could fully understand the document. It was suggested that GP's and Clinical Leads take the document away and it be brought to Board on the 24th August for Part 2. We need a proper understanding of what this would mean for providers.

NP confirmed that since the document has come out; there have been several public meetings that have not been too positive.

ACTION: Document to be shared with all Board GP members.

LB confirmed that the IFR Panel is currently renewing its policy. For this document, we would need clinical input into any decision making; not just at the IFR panel but before that. AO confirmed that CCG's are the decision makers.

VR said that he strongly disagrees with 'rationing' health services in order to save money; in the long term, this would be a waste of money. He felt that, if the Essex Success Regime are imposing this policy on us, then it is a waste of time. He said he will not agree with something

	just because Basildon is happy for it to happen. All agreed that we need both clinical and public input for this document. NP said she is not sure how much scope we have on this document to do something different. AB felt that we should speak to the Darent Valley, Dartford and BHRUT. It was agreed that this be sent to August Board for discussion only on the principal and process.
6.	**MH Older People Decommissioning Business Case**
	The Mayfield Mental Health Inpatient Decommissioning Business Case was included within the binder for information. The idea is that Mayfield, which is an older person mental health unit, is decommissioned. The ward has 24 beds and cost £2,835,079 for 15/16. There are currently 5 patients in the unit. IL confirmed that there have been discussions with the CCG and they are on board. She explained that a fully costed business case will be presented at September Board. Once Mayflower closes, the money should come back to us. IL stressed the urgency that the finance for this needs to be resolved quickly; the patients cannot be moved until this is done. We are still employing 8 members of staff to care for 5 patients. AO confirmed that this specific case is not in the QIPP plan. As it is a provider facility, it would be SEPT who is dealing with this. We need to be mindful of the money that is put into NELFT and not just SEPT. The paper has come to this committee meeting for noting only, the work is still on-going.
7.	**Personalisation**
	JI gave a presentation to the Committee about the Personalisation and Personal Health Budgets. She explained that the Personalisation in Health offers the opportunity for an individual to work in equal partnership with the NHS and its partners on how to best meet their health and wellbeing needs. Promoting recovery and independence whilst working towards defined outcomes. The main aim is to give people with people with long-term conditions and disabilities greater choice over their healthcare and support they receive. HF explained that the protocol needs to be developed; concerning factors are who will be liable for criticism. Would it be the CCG or the person for wasting tax payer's money? Committee members felt it would be both. LB confirmed that she had once been involved in a pilot and it was a minefield. She therefore requested that 'the i's are dotted and t's are crossed' she said that patients actually suffered. We should learn from the pilots and individuals involved in them. We need to be cautious and ensure good safeguarding. HF stated that they aim to start small and build gradually. VR asked what will happen when the budget runs out and we need a 'top up'. IL confirmed that it is based on outcome. JI confirmed that it is about assessed need not money and will need to go through the assessment process.
8.	**Referral Management**
	AS confirmed that the end of year data has now been made available and this was shared with the Committee members, for month 2. She explained that the data shows that a third of patients had been discharged. She explained that there will be a Peer to Peer Review at the September CEG; although there is little evidence that there a Peer to Peer Review will bring the numbers down. She confirmed that letters have been sent and an audit undertaken of the all referrals that have been discharged in April. During the period 2015/16; 3383 patients were discharged. Of that number, 1100 were paediatric patients; some of which are on the 'Penguin/Puffin Pathway'. 514 of these patients

	were for DEXA scans. It was felt that the issues which were highlighted last time have actually hindered the clinical data. NELCSU can actually alter their search criteria on NELI (?) but there may be a cost for this. It was also suggested that paediatric patients who have been referred on the same day as their consultation. GP's are not happy with the proposed scheme so it was suggested to come back to QIPP; there are no savings for the CCG. QP+ Scheme will pay GP's should they meet their targets. AO stated that if you are asking today if the scheme can go ahead, it simply cannot be agreed at the moment. The figures relate to inappropriate referrals only; the referral activity will be high at secondary care if nothing can be done. IL confirmed that for this to happen we need to ensure that we have the correct data and it may be worth considering paying someone to ensure that data is correct. AO agreed saying that with realistic numbers, we could make better decision making. AS confirmed that the main issue with the accuracy was due to the data being incorrect as to where the patient was referred. She added that the Audit had been extremely thorough and detailed. AO felt that this particular QIPP scheme could not go forward and should be discussed further outside of the meeting. RM confirmed that, being a former fund holder, he would support any investment made for correct data. If you have good data, you can save thousands. AS said that she will discuss this with Bill Wood tomorrow.
9.	**Specialist Developmental Playgroups**
	HF explained that Specialist Developmental groups were commissioned to provide a service for children aged 18 months to 4 years old with complex needs. Basildon & Brentwood CCG and Thurrock CCG wrote to NELFT in September 2015 informing them that they intended to decommission the service from September 2016. The SDG's underwent a review in previous years and as a consequence of this decided to continue to commission the service but to reduce the number of groups in Thurrock from 2 to 1. NELFT provided data for the period of April 2015 – March 2016 regarding the SDG activity. This indicated that the groups were not fully utilised and therefore ceased to be offered for a significant period over this time. There is also a high level of non-attendees. Therefore, it has been agreed that they are to be decommissioned. HF confirmed that she has informed the Director of Children's Services at Thurrock Council.
10.	**AOB**
	• **NHS Procurement Update** AO provided an update on the NHS Procurement. This was passed through at the recent Finance and Performance Committee and is due to expire at the end of the year. All 7 CCG's are in agreement for scoping; two of which are considering the STP footprint as part of the procurement process. It has been agreed that the business case will go to each CCG for joint procurement. This will come back in September although final decision may not be until October. • It was agreed that *AF (?)* be put on the agenda and VR will bring his proposal.
Date of Next Meeting	
8th September 2016, 2PM, Thames Room, Civic Offices	