NHS
Portsmouth
Clinical Commissioning Group

St James' Hospital
Locksway Road
Portsmouth PO4 8LD

Governing Board

A meeting will be held from 1.00pm – 3.00pm on Wednesday 18 September 2013 in the Entertainments Hall, St James' Hospital

This will be followed by a Question and Answer Session for the Public anticipated to commence at 3.15pm until 4.00pm

AGENDA

	Subject	Lead	Attachment
1.	**Apologies for Absence and Welcome**	Dr T Wilkinson	Verbal
	Apologies received from Dr Jim Hogan, Dr Elizabeth Fellows, Dr Dapo Alalade and Dr Andrew Mortimore. Welcome to Dr Matthew Smith and Suzannah Rosenberg.		
2.	**Declarations of Interest**	Dr T Wilkinson	Verbal
3.	**Minutes of Previous Meeting**	Dr T Wilkinson	White
	a. To agree the minutes of the Governing Board meeting held on Wednesday 24 July 2013. b. Matters Arising		
4.	**Chief Clinical Officer's Report**	Mr I Richens	Blue
5.	**Integrated Performance Report**	Mrs J Gooch	White
6.	**Register of Interests**	Dr T Wilkinson	Pink
7.	**Compliance with the Legal Equality Duties and CCG Equality Objective Setting**	Mr I Richens	Green
8.	**Governing Board Assurance Framework**	Mr T Morton	White
9.	**Briefing Paper: 'The NHS Belongs to the People: A Call to Action'**	Mr I Richens	Yellow
10.	**Older Persons Mental Health Services and Dementia**	Ms S Rosenberg	Lilac & Presentation
11.	**Minutes of Other Meetings**		
	• Clinical Commissioning Committee	Mr I Richens	Cream

	Subject	Lead	Attachment

12. **Date of Next Meeting in Public**

The Annual General Meeting of NHS Portsmouth Clinical Commissioning Group will take place on Wednesday 2 October 2013 at 6.00pm in the Entertainments Hall, St James' Hospital.

The next Governing Board meeting to be held in public will take place on Wednesday 27 November 2013 at 1.00pm in the Entertainments Hall, St James' Hospital.

13. **Meeting Close**

The Board meeting will be followed by a question and answer session open to members of the public and this is anticipated to commence at 3.15pm and close at 4.00pm.

Distribution:

Voting Members

Dr Dapo Alalade - Clinical Executive
Dr Linda Collie - Clinical Executive
Paul Cox - Practice Manager Representative
Dr Julie Cullen - Registered Nurse
Dr Elizabeth Fellows - Clinical Executive
Jo Gooch - Chief Finance Officer
Dr Jim Hogan - Clinical Leader and Chief Clinical Officer
Tom Morton - Lay Member
Jackie Powell - Lay Member
Innes Richens - Chief Operating Officer
Dr Tahwinder Upile - Secondary Care Specialist Doctor
Dr Tim Wilkinson - Chair of Governing Board/Clinical Executive

Non-Voting Members/In Attendance

Jayne Collis - Assistant Development Manager
Katie Hovenden - Director of Professional and Clinical Development
Dr Andrew Mortimore - Interim Director of Public Health
Ms Suzannah Rosenberg - Head of Integrated Commissioning
Dr Matthew Smith - Consultant, Public Health (for Dr Andrew Mortimore)
David Williams - Chief Executive, Portsmouth City Council

NHS
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GOVERNING BOARD

Date of Meeting	18 September 2013	Agenda Item No	3
Title	Minutes of Previous Meeting		
Purpose of Paper	To agree the minutes of the NHS Portsmouth Clinical Commissioning Group Governing Board meeting held on Wednesday 24 July 2013.		
Recommendations/ Actions requested	Approve		
Author	Jayne Collis		
Sponsoring member	Dr Tim Wilkinson		
Date of Paper	10 September 2013		

NHS
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Clinical Commissioning Group

DRAFT

Minutes of the NHS Portsmouth Clinical Commissioning Group Governing Board meeting held on Wednesday 24 July 2013 at 1.00pm – 3.00pm in the Entertainments Hall, St James' Hospital, Locksway Road, Milton, Portsmouth PO4 8LD

Present:

Dr Linda Collie	- Clinical Executive
Paul Cox	- Practice Manager Representative
Dr Julie Cullen	- Registered Nurse
Dr Elizabeth Fellows	- Clinical Executive
Jo Gooch	- Chief Financial Officer
Dr Jim Hogan	- Clinical Leader and Chief Clinical Officer
Jackie Powell	- Lay Member
Innes Richens	- Chief Operating Officer
Dr Tahwinder Upile	- Secondary Care Specialist Doctor
Dr Tim Wilkinson	- Chair of Governing Board/Clinical Executive

In Attendance

Mrs Alex Berry	- Chief Commissioning Officer, Portsmouth, Fareham & Gosport and South Eastern Clinical Commissioning Groups (Item 8)
Jayne Collis	- Assistant Development Manager
Katie Hovenden	- Director of Professional and Clinical Development
Dr Andrew Mortimore	- Interim Director of Public Health
Julian Wooster	- Strategic Director for Children's and Adult's Services, Portsmouth City Council (for David Williams)

Apologies

Dr Dapo Alalade	- Clinical Executive
Tom Morton	- Lay Member
David Williams	- Chief Executive, Portsmouth City Council

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1. Apologies and Welcome

Apologies were received from Dr Dapo Alalade, Tom Morton and David Williams. Dr Tim Wilkinson welcomed everyone to the NHS Portsmouth Clinical Commissioning Group (CCG) Governing Board meeting held in public. He reminded those present that although the meeting was being held in public it was not a public meeting and therefore during the CCGs formal business members of the audience would not be invited to participate. There would be, following the close of formal business, a question and answer session which he hoped members of the public would fully participate in.

2. Declarations of Interest

Paul Cox declared a possible conflict of interest relating to Item 6, IM&T Strategy. All GP Governing Board members present at the meeting declared a possible conflict of interest relating to Item 6, IM&T Strategy and Item 8, Emergency Department Front Door Review.

3. Minutes of Previous Meetings

The minutes of the Governing Board meeting held on Wednesday 15 May 2013 were approved as an accurate record.

An update on actions from the previous meeting was provided as follows:

Agenda Item	Action	Who	By	Progress
3 (17.4.13)	Ethical/Decision Making Framework to be uploaded to the CCG website.	IR	July 13	This is now available in the key documents section of the CCG website. Complete.
3 (17.4.13)	Updated Procurement Strategy to be presented.	IR	Future meeting	Once the national regulations are published the CCG Procurement Strategy will be updated and presented to the Governing Board.
5	Quality Report – Ensure future reports do not use unexplained acronyms/abbreviations.	DA/IR	July 13	Complete.
9	Governing Board Assurance Framework – COMPACT Joint IT Strategy to be presented to future Governing Board meeting.	JG	July 13	On agenda. Complete

4. Chief Clinical Officer's Report

Dr Jim Hogan presented a report which set out the key decisions and actions undertaken by the Clinical Executive under the leadership of the Chief Clinical Officer on behalf of the Governing Board. He highlighted the main points and drew attention to the key actions.

Primary Care CQUIN - We now have 100% sign up from practices for the Primary Care CQUIN.

Boards to Boards Meeting with Portsmouth Hospitals - The first meeting of representatives of the NHS Portsmouth CCG Governing Board and representatives from the Boards of NHS Fareham and Gosport CCG, Portsmouth Hospitals NHS Trust and NHS South Eastern Hampshire CCG took place on 12 June 2013. The focus was to build relationships and air any issues. Further meetings are planned in the future.

Integration Pioneer Bid - The CCG along with Portsmouth City Council have submitted a bid to become an Integration "pioneer" and we are waiting to hear if we have been successful.

Portsmouth Disability Forum Meeting - Jackie Powell has agreed to take on the role of "disability champion" as part of her "patient champion" portfolio.

Jackie Powell commented that the Patient Participation Group meeting held on 29 June 2013 had been well attended and there had been a lot of interest. The CCG wants to extend the work and get feedback and use this as part of the strategy.

Jackie Powell asked if Portsmouth Hospitals Trust had shared its business strategy with the CCG. Dr Jim Hogan explained that with all the changes happening within the Trust they are looking to refresh their long term business plans but it is not expected to be

complete until the end of the summer. Dr Julie Cullen commented that she was encouraged by Portsmouth Hospitals Trusts openness and honesty.

The Governing Board accepted the Chief Clinical Officer's Report.

5. Integrated Performance Report

Jo Gooch presented the Integrated Performance Report dated 24 July 2013. She explained that this is the first report to include Finance, Quality and Performance in one document. The report refers to April's data and where more up-to-date data is available it has been used.

Performance

Jo Gooch drew attention to the table on page 8 which shows mainly green rated indicators and explained that the contracted position and overall financial positions are on track.

There are a number of concerns/key risks as detailed below:

A&E 4 hour waits – Portsmouth Hospitals NHS Trust (PHT) are struggling to achieve this target however it has been an improved position and for the week ending 14 July 2013 they did achieve 95%, however the standard has not been maintained. There is an item on the agenda later which focusses more on this area.

Ambulance – Ambulance handover delays related to emergency care and attendances at PHT remains a challenge however they have reported an improving position in June.

Referral to treatment times (RTT) – RTT times have been a positive story for some time however the CCG is aware in some areas such as Trauma and Orthopaedics and Urology, PHT are struggling to sustain the position. The CCG are working closely with PHT to understand the emerging picture.

Cancer Targets – There has been variable performance and the 3 CCGs have asked as a compact if PHT can sustain the target. In May PHT failed the 62 day wait target and we have issued a formal contract notice and have been in discussions on how they will achieve it in future.

Quality

Hospital Standardised Mortality Ratio (HSMR) – There has been a deteriorating trend which is forecast to worsen and the CCG is seeking assurance from PHT on this and understand it may be related to coding issues.

NHS 111 – There are early signs of improvement however we are still monitoring the situation.

Out of Hours – Response times are not as expected and the CCG has written to the provider formally to seek assurance under the contract.

Solent NHS Trust – Leg Ulcer management work is still ongoing.

Dr Elizabeth Fellows commented on the out of hours and doctors rota and asked if we had an action plan and how it would be sustained. Jo Gooch explained that a response had not yet been received and we are still waiting for assurance. Innes Richens commented that if we are not happy with the service then there are levers and penalties within the contract that can be used if necessary.

Dr Elizabeth Fellows asked if the issues with RTT would have a knock-on effect. Jo Gooch said that there are interrelated issues.

Dr Jim Hogan commented on the out of hours rota and explained that it is monitored weekly which gives some reassurance, however issues around pay is one of the triggers and the number of doctors working within out of hours has also changed therefore there is an increase in competition for GPs. We are trying to get a standard rate for Out of Hours work and are closely monitoring the situation.

Dr Tim Wilkinson said that it was fair to say that the out of hours service is safe but some patients are waiting longer that we would want them to.

Dr Tim Wilkinson commented on the RTT issue and explained that the CCG are looking into the issues around Urology and Trauma & Orthopaedics.

Katie Hovenden asked about the Hospital Standardised Mortality Ratio (HSMR) which was discussed at the Clinical Quality Review Meeting (CQRM) and whether we could get an independent assessment as to whether it was an outlier or a coding issue. Jo Gooch explained that the CQRM are trying to triangulate with others and it is an ongoing piece of work subject to audit.

Contracts and Finance

Jo Gooch explained that it was early days in terms of reporting and that the major contracts are in line with the plan. There is a small pressure within University Hospitals Southampton contract but it is too early to indicate trends. There is also a small pressure within the Spire contract.

PHT - Elective is 1% above the planned activity and 2% above on costs. A&E attendances are below plan by 8% for the first two months of the year. Out-patients are on plan but there is a difference mix which we are looking at to see if this is correct or a coding issue.

Other areas such as Continuing Health Care (CHC) and prescribing are on plan. Running costs and QIPP plans are on track and the CCG is on plan to deliver its target surplus of £2.4m.

Risks - Changes to the CCGs allocation relating to specialised services has been identified as a risk and we are expecting to get some money back from the Area Team in this area. NHS Property Services property charges are coming in higher than anticipated and talks with them are ongoing. We do however hold a contingency of non-recurrent funds to help cover any issues.

Katie Hovenden commented on the accuracy of the GP practice prescribing performance report as it is saying that two months spend is higher than previous, when we are still spending at a lower rate than in previous months. With 1% growth we are still spending less than in previous years.

Jackie Powell asked about improving access to psychological therapies. Jo Gooch explained that one of the CCGs planned underspends were for psychological services. The CCG has been in discussions with Solent and are looking at the context of the wider contract and discussions are ongoing. Funding has been set aside to expand the service. Jackie Powell asked if there was funding for a full roll out of services. Jo Gooch said that it was her view that funding was available and the CCG has rebased activity for finance which corrects historical issues.

Jackie Powell asked about the QIPP schemes and asked for assurance that the CCG was confident they can be achieved. Jo Gooch explained that the schemes have detailed plans behind them but that they won't be without risk. We will closely manage and monitor the schemes and have weekly updates and if issues emerge they are tackled as soon as possible.

Dr Jim Hogan asked about blocks regarding data. Jo Gooch explained that it is a struggle for CCGs to access data because of the implications of the new health and social care act. We are not able to see data which supports the payment of invoices and we are no longer allowed to look at a certain level of patient data. The CCG is working with the Commissioning Support Unit (CSU) to try to resolve this. Dr Tim Wilkinson asked when it was likely to be resolved. Jo Gooch explained that the legal position is that we are not legally entitled to see the information and no one at a national level seems to appreciate the difficulty in terms of business. However we are not the only ones in this position.

Dr Tim Wilkinson said that we often ask member practices to use information for peer review and audit. Jo Gooch explained that it does effect risk stratification and how we can help practices with the work. Katie Hovenden commented that practices can still access their own information but we are unable to help and support practices by printing off reports at present because we cannot access the data. Dr Tim Wilkinson commented that it was about joint working. Julian Wooster commented that if the issues cannot be resolved perhaps it can be raised at the next Health and Wellbeing Board as we cannot plan for the population if we are unable to access data.

The Governing Board accepted the Integrated Performance Report and recognised the significant improvement of Quality reporting.

6. IM&T Strategy

Jo Gooch presented the Informatics Strategy 2013-2016 for NHS Portsmouth, Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups. She thanked Chris Day for producing the strategy and explained that we had worked with Fareham and Gosport and South Eastern Hampshire CCGs as part of the compact to underpin our strategic priorities as a CCG. The Strategy has been to a number of stakeholder groups such as PSEC and the IT Enabling Change Board. The document sets out strategic objectives for the three CCGs as it is intended to set direction and work programmes which align to our priorities as a CCG. The Strategy has been shared with the CSU who have reviewed it and have said they believe it is something they can work with us on.

Appendix A of the document details an action plan showing a timeline and is a live document and therefore will be constantly updated. Jo Gooch drew attention to the ten priority areas of work detailed within the strategy and provided details as follows:

Priority area 1 - System Integration – This is not an easy topic and is not about having just one system but having systems that can talk to each other.

Priority area 2 – Future IM&T Provision – We are currently receiving a service from PHT hosted IPHIS however a number of parties have pulled out and we need to consider if this is a risk to continue or whether we need to look at alternative providers.

Priority area 6 – Electronic Discharge Summaries (EDS) – This is key.

Priority area 9 – Telehealthcare and the AIM project – CCG is just embarking on a telehealthcare pilot project that has an interactive messaging service.

Innes Richens said that he commends the focus on integration as this has been one of the blocks in the past. He said we needed to ensure patient access to information and support the engagement of patients and carers in work and would be happy to help.

Paul Cox raised concern regarding the lack of clarity over the future hardware provision in GP surgeries. Jo Gooch explained that the strategies aim is to set the direction and we will need further work to understand GPs requirements. The responsibility for GP IT is with the Area Team which has been devolved to CCGs but we are beholden to the funding from the Area Team. We can work more closely on hardware requirements when we know how much funding will be received. This strategy is not intended to go into that level of detail.

Paul Cox asked about section 4.2.2.1 Patient on-line access to primary care services. Jo Gooch explained that any patient access would be done in accordance with guidelines.

Dr Jim Hogan commented on the decision made recently by the SHIP cluster concerning the adoption of Summary Care Records. Jo Gooch explained that Summary Care Records is a national initiative which relates to patient data being accessed by clinicians. We have previously not taken up this offer as we had Hampshire Health Records however CCGs have now decided to take on the initiative. This means that every patient in Portsmouth will be given the option to opt out. It would mean clinicians being able to access patient data with patient approval. Dr Tim Wilkinson commented that it would be limited information such as current medication, allergies and significant medical history.

Dr Elizabeth Fellows asked about integration as some CCGs have moved to one GP IT system and she was wondering where discussions had got to regarding moving to one system. Jo Gooch explained that work had been done however we cannot mandate to providers of GPs which system then use. We could however decide on what system the community used. We will never have one system that does everything but we need way for the systems to talk to one another.

Dr Andrew Mortimore commented that it was a great starting point to have agreement across the 3 CCGs but raised concerns regarding health records and resources such as non-recurrent head room.

Jo Gooch explained that in terms of CCGs it is part of planning that we will be proactive in setting aside resources for the IT plan and that we have annual planning rounds and the money changes year on year. There are many parties to this who would want to work together as a collaboration to make it happen. With regard to non-recurrent headroom, all CCGs put this aside.

Dr Jim Hogan said that with regard to summary care records, system providers are developing all the time and there are thing that can help us to move forward. Summary care records was a medium term solution without having to create a new IT system.

Jackie Powell commented that the action plan is not risk rated. Jo Gooch explained that specific issues are being picked up and we do need to have a view and assurance.

Julian Wooster commented on the hardware issue and said that the City had been successful in a bid for money from the government run super-connected cities programme. Jo Gooch said that the CCG would be working closely with the Council and hoped to discuss how this might work and will look into this further.

The Governing Board adopted and approved the Informatics Strategy 2013-2016 for NHS Portsmouth, Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups.

7. Whistleblowing and the CCG's Constitution

Dr Tim Wilkinson presented a paper which proposes a change in wording to the CCG Constitution with regards to whistleblowing as advised by NHS England. He drew attention to the recommendations detailed within the paper.

The Governing Board approved the proposed additional wording to be inserted into its Constitution when it is next updated. This will be subject to the agreement of member practices.

8. Emergency Department Front Door Review

Dr Jim Hogan introduced Alex Berry, Chief Commissioning Officer for Portsmouth & South East Hampshire Clinical Commissioning Groups, who gave a presentation on Urgent Care at Emergency Department (ED) Front Door.

Dr Tim Wilkinson thanked Alex Berry for her presentation.

Dr Elizabeth Fellows asked about signposting and who makes the decision. Dr Jim Hogan explained that the problem in the past is that the ED felt challenged in redirecting to primary care which is why the front door triage is going to be a primary care triage. GPs have asked for patients to be redirected back to them. If it is felt appropriate an appointment will be arranged for them to see their GP.

Paul Cox commented on the issue of referring back to GPs and raised concerns that GPs do not have extra capacity in the system for people to see GPs. Dr Tim Wilkinson said he noted Paul's comment.

Dr Linda Collie asked where the GPs who would be doing the work would come from. Dr Jim Hogan said that whatever is done needs to be sustainable and we cannot presume who will provide the service. It is hoped that primary care will seem themselves as a provider. Discussions have taken place about integration and barriers for integration and silos and one of the issues is the way we train the workforce regarding this in the future. It has been raised with the deanery that we need an increase in the number of GPs in training. The ED works to see 250 patients a day and at the moment they are getting 300-320. The service will not be 24 hours and will work during peak times and only a small number of patients will be referred back to primary care.

Paul Cox commented that when doing the pilot we need to ensure the impact on GP surgeries is monitored. Dr Jim Hogan commented that GPs are asking for patients to come back to them and a number of patients will be frequent attenders. A lot of analysis will be undertaken.

Dr Andrew Mortimore commented that it is a huge challenge and raised concerns that this may result in capacity elsewhere not being developed property because an alternative is there.

Dr Jim Hogan commented that this on its own will not solve the ED problem. If the flows in the department are not sorted it will not work. Some primary care colleagues are keen for this to be primary care work. Alex Berry said that if we see changes happen we can adapt the model accordingly and we will work during the year to model and shape it and we need stakeholders help to do this.

Dr Jim Hogan said that it is not being seen in isolation and is part of a review of services in the whole of the Portsmouth and South East Hampshire area.

Dr Julie Cullen said that she noted there was no extra finance and the aim to be cost neutral. Lots of problems such as this in ED fall down when winter pressures come in. Will there be something substantive about it even when other areas are under pressure. Dr Jim Hogan commented that this is why so much time and effort has been put into the pilot in order to get it right once and for all. There is no money in the system however there are other elements that may be procured differently.

Jo Gooch asked if the pilot had an exit strategy as we need to be clear up front. Alex Berry explained that she was confident we should see improvements from this however she recognised the point and there will be a break clause in the contract.

Dr Tim Wilkinson explained that as a Board we need to oversee this and have been asked to agree the following:

- The case for change
- The proposed model of delivery
- The outline commissioning arrangements including timescales
- The outline patient and public engagement
- The risk and issues

The Governing Board agreed the recommendations as detailed above.

9. City Wide Patient Participation Group

Katie Hovenden presented a paper which summaries the key issues and feedback received from the recent meeting of PPG representatives with the CCG and the proposed next steps by the CCG, in partnership with member practices.

A number of themes were raised as detailed within the paper including a desire to include more practices in the city wide forum.

Paul Cox commented that he had attended and thought it had been very useful. His only concern was that the group was largely of a certain age however one of the next steps is to try to address this issue and encourage more of the online groups to attend.

Jackie Powell said that she would like to reiterate the point that this is one way of tackling a particular group of people. We have made contact with the student union but we have not heard back from them. The engagement steering group will look at everything. Dr Elizabeth Fellows commented that people of a certain age are the heaviest users of the service.

Jackie Powell said that she was happy to continue to chair the forum.

The Governing Board discussed and accepted the report from the recent PPG event and approved the proposed next steps.

10. Reducing Health Inequalities – Men's Health

Dr Jim Hogan presented a paper which sets out the feedback from the recent stakeholders event themed around "reducing the impact on health inequalities in Portsmouth". The paper summarises the key issues and feedback received from the event and the proposed next steps by the CCG, in partnership with its public health colleagues in the Local Authority.

Dr Jim Hogan highlighted the proposed next steps as detailed within the paper and asked that the Board approve these.

Dr Andrew Mortimore thanked the CCG for an excellent event which provided a huge number of helpful observations.

Dr Tim Wilkinson drew attention to the presentation that was given by Dr Matthew Smith at the last Governing Board meeting on the same subject.

The Governing Board discussed and accepted the report from the recent stakeholder event and approved the proposed next steps.

11. Minutes of Other Meetings

The minutes of the following meetings were presented for acceptance by the Board:

- Clinical Commissioning Committee meetings held on 1 May 2013 and 5 June 2013.
- Audit Committee meeting held on 13 March 2013.
- Shadow Health and Wellbeing Board meeting held on 6 March 2013.

The Governing Board accepted the minutes.

12. Date of Next Meeting

The next Governing Board meeting will be held in public and will take place on Wednesday 18 September 2013 at 1.00pm in the Entertainments Hall, St James' Hospital.

13. Meeting Close

Dr Tim Wilkinson thanked everyone for attending the meeting and reminded members of the public that feedback and comments would be welcomed. He declared the formal part of the meeting closed and explained that the Board would now consider and respond to a number of questions from members of the public. The full list of all questions asked and a summary of the responses will be published on the CCG website in due course.

Jayne Collis
31 July 2013

NHS
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Clinical Commissioning Group

GOVERNING BOARD			
Date of Meeting	18 September 2013	**Agenda Item No**	4
Title	**Chief Clinical Officer's Report**		
Purpose of Paper	This paper sets out the key decisions and actions under taken by the Clinical Executive under the leadership of the Chief Clinical Officer on behalf of the Governing Board.		
Recommendations/ Actions requested	The Board is asked to accept the report.		
Author	Tracy Sanders		
Sponsoring member	Dr Jim Hogan, Clinical Leader & Chief Clinical Officer		
Date of Paper	2 September 2013		

NHS
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REPORT FROM THE CHIEF CLINICAL OFFICER

1 INTRODUCTION

This report summarises the key decisions and actions taken by the Clinical Executive under the leadership of the Chief Clinical Officer on behalf of the Governing Body since the previous Governing Board meeting in July 2013.

2 SUMMARY CARE RECORD

The CCG discussed the CCGs decision to participate in the national Summary Care Records initiative. This is an initiative to introduce an electronic record to give healthcare staff access to essential information to help provide safe treatment when a patient needs care in an emergency or when their GP practice is closed. The record will include important information about any medicines being taken as well as any allergies and bad reactions to medicines an individual may have; along with this will be details of an individual's name, address, date of birth and NHS number.

Further to the decision to partake in the initiative the Governing Board is informed that letters and an accompanying leaflet will be send to all adult patients explaining their rights together with an "opt out" form should they wish to decline. There will be 12 weeks from the date of the letter for patients to make this decision and if they choose to have a Summary Care Record then no action will be required. If a patient subsequently decides to opt out this can be undertaken at any time if they haven't received care using it with the created record overwritten.

3 CCG ASSURANCE AND BALANCED SCORECARD

The balanced scorecard is the tool by which NHS England seeks assurance on CCG performance. It is currently an interim scorecard following the publication of the interim CCG Assurance Framework in May 2013. This sets out a nationally consistent approach to the formal interactions between CCGs and the Area Teams on a quarterly and annual basis. There is an on-going process with CCG staff, patient groups and other key stakeholders to inform a final Framework due to be published in the autumn.

There are five domains to the scorecard:

- Domain one: Are local people getting good quality care?
- Domain two: Are patient's rights under the NHS Constitution being promoted?
- Domain three: Are health outcomes improving for local people?
- Domain four: Are CCGs delivering services within their financial plans?
- Domain five: Are conditions of CCG authorisation being addressed and removed (where relevant)?

For each domain a RAG rating is given. The CCG has recently completed its first assessment. It was green or amber/green in four of the domains. In domain 2 the CCG has an amber/red rating with three areas of failure:

- Emergency department waiting times
- Cancer waiting times
- Waiting times for diagnostic

More information about these are contained with the CCGs integrated performance report. The CCG will be submitting action plans to the Area Team setting out how it is addressing these areas with its healthcare providers and will meet the Area Team on the 12th September to discuss the assurance framework.

4 A&E FUNDING BID

In August the Prime Minister announced a £500m fund over the next two years to ensure A&E departments are fully prepared for winter. This is in response to the number of people using A&E departments increasing and harsher winters leading to exceptional pressure being put on urgent and emergency services. The aim is for patients to be treated promptly, with fewer delays in A&E and for other patients to get the care, prescriptions or advice they need without going to A&E. The funding includes an additional £15m cash injection to NHS 111 services.

The money is being targeted at local systems which will benefit most from the extra funding and Portsmouth and South East Hampshire has been invited to apply. The 3 CCGs in the COMPACT have worked together with local providers to submit a bid for additional staffing in A&E and community support. A decision is expected imminently as to whether the bid has been successful.

5 INTEGRATION PIONEER BID

Further to the update provided at the July Governing Board meeting the CCG has heard its bid has now reached the final shortlist of 20 bids. It awaits the final decision as to whether it has been successfully approved.

Governing Board members are reminded that integration ‘pioneers’ as a means of driving forward change at scale and pace from which the rest of the country can benefit, through the opportunity to share best practice and help address national challenges. The first wave of ‘pioneers’ will be announced in September.

Pioneer status will help us to further develop our model of locality community based integrated care teams, with primary and social care support at the heart of this. Pioneer status will provide us with the expertise to better understand and overcome the potential financial and organisational risks that maybe a barrier to integration. As well as an opportunity to share best practice with other areas to enable us to truly achieve a unified commissioning and delivery system of health and social care to support people in Portsmouth to live healthy and independent lives with care and support that is co-ordinated to meet their needs at the right time and in the right setting.

6 INTERGRATION TRANSFORMATION FUND

As part of the June 2013 Spending Round the Chancellor announced the establishment of a £3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements. This will be funded from existing NHS funding.

The fund is intended to focus on joining up services, so that health and care services work more closely together, keeping people healthier and treating them closer to home. The fund is believed to be an opportunity to transform care with the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community services. This will build upon existing work in CCGs and local authorities such as the integrated care “pioneers” initiative and Community Budgets.

Plans for use of the pooled monies will need to be developed locally on social care and health and will be subject to a number of national conditions. The CCG has recently met with Local Authority colleagues to consider the national requirements and to agree the way forward with regards this important fund. Final plans will need to be signed off by the CCG, Local Authority and the Health and Wellbeing Board.

7 COMMISSIONING SUPPORT ARRANGEMENTS

CCGs are required to review their commissioning support services (CSS) intentions by October 2013. The Clinical Executive is leading the review of all services and how well they meet the needs of the CCG, and this is being undertaken in partnership with our COMPACT CCGs. Following the conclusion of this review decisions will be made about when to extend current contracts or whether to bring some services in house.

As part of this review an early decision has been made by the Clinical Executive to give notice on Communications and Engagement, and Quality functions and will seek to be bringing these in house, possibly in partnership with neighbouring CCGs or the local authority, no later than April 2014. This decision was driven by a need to have a more locally proactive and responsive service in these areas aligned to the CCGs business needs. A transfer plan with clear timetable is being developed with the CSS.

8 OTHER KEY ACTIONS

Other key actions which the Clinical Executive would like to report to the Board include:

- Approved an updated Leave Policy and Flexible Working Guidance, new policies on Maternity, Paternity and Adoption Leave and Pay Guidance and Staff Learning Agreement
- Oversight of recruitment to vacant roles
- Review of relationships with the Wessex Academic Health Science Network and their business plan, Clinical Senates and Strategic networks
- Development of the CCGs website and in particular blog
- Review of draft Business Continuity Plans for presentation to Audit Committee
- Arrangements for GP leadership in a number of priority commissioning areas on a task and finish basis
- CCG response to the national 'Call to Action'

In addition the Clinical Executive has been maintaining oversight and driving from the commissioner perspective:

- Foundation Trust development progress by both Solent and Portsmouth Hospitals NHS Trusts
- In year QIPP and Contractual performance
- On-going review and horizon scanning of national publications, guidance and bulletins

9 SUMMARY AND CONCLUSION

The Board is asked to accept this report.

Dr Jim Hogan, Chief Clinical Officer

NHS
Portsmouth
Clinical Commissioning Group

<table>
<tr><td colspan="4">GOVERNING BOARD</td></tr>
<tr><td>Date of Meeting</td><td>18 September 2013</td><td>Agenda Item No</td><td>5</td></tr>
<tr><td>Title</td><td colspan="3">Integrated Performance Report</td></tr>
<tr><td>Purpose of Paper</td><td colspan="3">To inform the Governing Board of the position of the CCG with regard to progress against its financial, performance and quality requirements.</td></tr>
<tr><td>Recommendations/ Actions requested</td><td colspan="3">The Governing Board are asked to:
• Note the key achievements of the CCG for the reported period
• Note the financial position of the CCG
• Review areas of concern
• Note and approve the two self-certification elements of the Qtr1 balanced scorecard
• Note the current draft Qtr1 assessment of the CCG against the national assurance framework</td></tr>
<tr><td>Author</td><td colspan="3">Damien Ward / Michael Drake</td></tr>
<tr><td>Sponsoring member</td><td colspan="3">Jo Gooch - CFO</td></tr>
<tr><td>Date of Paper</td><td colspan="3">10th September 2013</td></tr>
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NHS Portsmouth CCG

Governing Board Meeting

Integrated Performance Report

18th September 2013

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NHS Portsmouth Clinical Commissioning Group

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Portsmouth CCG Assurance Framework (1/2)

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A Balanced Scorecard forms the focus of the CCG quarterly checkpoint meeting with the NHS England Area Team. The Scorecard is the primary tool underpinning the quarterly checkpoints, the first of which is on September 12th. The Balanced Scorecard contains a self-certification and it is a requirement this is approved by the CCG's Governing Board before submission to NHS England. Due to the tight timescale, NHS England agreed for the submission to be made and signed off by the Executive, with the provision that it will be formally approved at the next Governing Board meeting.

The Board is therefore asked to note and formally approve the submitted self-certification, the details of which are provided below. Following the checkpoint meeting, the Balanced Scorecard will be published and brought to the next Governing Board meeting.

Domain 1 - Portsmouth CCG

Providers	**Provider 1**	**Provider 2**	**Provider 3**
Provider Name	**PORTSMOUTH HOSPITALS NHS TRUST**	**SOLENT NHS TRUST**	**SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST**
Please identify the percentage of provider income for CCG:	**36**	**46**	**12**
Is this CCG the lead or associate commissioner?	**Lead**	**Lead**	**Associate**
Has local provider been subject to local enforcement action by the CQC?	No	No	No
Has local provider been flagged as a 'quality compliance risk' by Monitor and/or are requirements in place around breaches of provider licence conditions?	No	No	No
Has local provider been subject to enforcement action by the NHS TDA based on 'quality' risk?	No	No	No
Does feedback from the Friends and Family test (or any other patient feedback) indicate any causes for concern?	No	No	No
Has the provider been identified as a 'negative outlier' on SMHI or HSMR?	No	No	No
Do provider level indicators from the National Quality Dashboard show that MRSA cases are above zero?	No	No	No
Do provider level indicators from the National Quality Dashboard show that the provider has reported more C difficile cases than trajectory?	No	No	No
Do provider level indicators from the National Quality Dashboard show that MSA breaches are above zero?	No	No	No
Does provider currently have any unclosed Serious Untoward Incidents (SUIs)?	No	Yes – Action plan in place	Yes – Action plan in place
Has the provider experienced any 'Never Events' during the last quarter?	No	No	No
Is provider meeting the 15% response rates on FFT ? (Domain 3) - PHT	No	No	No

Portsmouth CCG Assurance Framework (2/2)

CCG:	
Clinical Governance -has the CCG self assessed and identified any risks associated with the following	
Concerns about quality issues being discussed regularly by the CCG governing body	No
Concerns about the arrangements in place to proactively identify early warnings of a failing service	No
Concerns around the arrangements in place to deal with and learn from serious untoward incidents and never events?	No
Concerns around being an active participant in its Quality Surveillance Group?	No
EPRR	
If there was an emergency event in the last quarter, has the CCG self assessed and identified any areas of concern on the arrangements in place for dealing with such an event?	No
Winterbourne View	
Has the CCG self assessed and identified any risk to progress against its Winterbourne View action plan?	No

Domain 3

Is the CCG progressing as expected in the IAPT trajectory submitted during the planning round?	Further development required
Local Priority 1	Yes
Local Priority 2	Yes
Local Priority 3	Yes

Domain 4

Assessment of internal and external audit opinions and on the timeliness and quality of returns	G

Portsmouth CCG Dashboard

The dashboard below provides the performance position in relation to quality, performance, contracts and finance. The body of the report provides further details. The report refers to June's data and where more up-to-date data is available it has been used.

Quality

	Target	Year to June		
MRSA	0	0	G	→
C.Difficile	10	8	G	↓
Venous Thrombo-embolus screening (PHT)	95.0%	95.2%	G	↑
Hospital Standardised Mortality Ratio (PHT)	100	100	G	→
Never events	0	0	G	→
Friends and Family Test (Year to July response rate, PHT)	15%	11.7%	R	↑

Commentary:
Friends and Family test improving. July (month) achieved target with a response rate of 17.7% (16.9% in June). Quarter one failed target due to underperformance in April (3.3%) and May (8.6%).
Risks (current and future):
Not achieving Friends and Family response rate for 2013/14.

Performance

Planned care	Target	Year to June		
RTT admitted patients <18weeks	90%	94.0%	G	↓
RTT non-admitted patients <18weeks	95%	98.2%	G	↑
RTT incomplete <18weeks	92%	95.8%	G	↓
Diagnostic test <6weeks	99%	98.9%	A	↓
Number of cancer measures achieving target	9	8		→
Unscheduled care				
A&E 4 hr waits	95%	89.5%	R	↑
Ambulance handover delays: >30 minutes (PHT)		1085	R	↑
Ambulance handover delays: > 60 minutes (PHT)		488	R	↑

Commentary:
A&E waits remains a concern. Remedial plans are in place and weekly performance being closely monitored.
Risks (current and future):
Maintaining the performance measures, eg Ambulance handover delays and Cancer patients treated after screening referral < 62 days.
Not achieving the Quality Premium in its entirety.

Contracts

	Year to August				Annual			
	Target £m	Actual £m	Var. £m		Target £m	Forecast £m	Var. £m	
Spend:								
Portsmouth Hospitals NHS Trust	42.9	42.4	-0.5	G	102.9	102.0	-0.9	G
Solent (Mental Health & Community)	20.5	20.5	0	G	49.2	49.2	0	G
South Central Ambulance Service	2.9	2.9	0	G	7.0	7.0	0	G
Care UK St Marys	2.0	2.0	0	G	4.7	4.7	0	G

Commentary:
PHT contract forecast to spend less than annual budget plan. Key areas lower than plan include nonelective activity and A&E attendances. The cost of elective activity is slightly above plan (before allowing additional activity to meet Referral to Treatment (RTT) targets).
PHT Q1 local Commissioning for Quality and Innovation (CQUIN) unpaid.
Ambulance handover delay penalties have significantly reduced in July.
Penalties have been applied to the PHT contract for underachieved targets in A&E 4 hour waits, RTT, Cancer waits and diagnostics.

Risks (current and future):
Costs of additional activity to achieve RTT standards is more than budgeted.
Winter may see an increase in patient activity levels beyond those planned.

Finance

	Year to August				Annual			
	Plan £m	Actual £m	Var. £m		Plan £m	Forecast £m	Var. £m	
Spend	97.6	96.6	-1.0	G	245.2	242.8	-2.4	G
	Year to July							
QIPP (gross)	1.8	1.8	0	G	6.7	6.7	0	G
Quality premium (estimate, June)					1.1	0.8		

Commentary:

Spend - The CCG is performing on plan and is predicted to achieve its targeted surplus.

Risks (current and future):
Costs of meeting NHS Constitution and growth is higher than estimated.
NHS Property Services Ltd (PropCo), allocation changes for property transfers and 'vacant' space. Current risk of £2.4m.
National changes to CCG allocation, eg specialised services adjustments related to providers outside Wessex.
Size of QIPP/Savings and pace of change.
Costs of meeting NHS Constitution and growth is higher than estimated.

Portsmouth CCG Key Achievements and Underperformance

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There are many areas of success which are worthy of note that occurred during the month of June. The headlines of these are detailed below:

- The CCG achieved all 3 national referral to treatment (RTT) targets at aggregate level
- The CCG is currently on plan to meet its target surplus of £2.4m with a year to date surplus of £1.0m
- All Ambulance response times targets were met
- There were not any reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Clostridium Difficile (C. Diff) was within threshold levels
- No patient was treated in mixed sex accommodation
- All programme areas and underpinning 2013/14 projects are on track
- The GP prescribing costs are within budget
- There were no patients waiting over 52 weeks for treatment

Key areas where the CCG is underperforming against national standards during the month of June are detailed below:

- Accident & Emergency (A&E) 4 hour waits were below target
- Ambulance handover delays continue for over 30 minutes and over 60 minutes
- Cancer patients treated after urgent referral <62 days
- Breast cancer referrals seen within 2 weeks
- Cancer patients treated after consultant upgrade <62 days
- Patients waiting less than 6 weeks for a diagnostic test

Key risks regarding performance at Portsmouth Hospitals Trust:

- Continued failure of A&E 4 hour wait target
- Cancer targets and breached remedial action plan (RAP)
- The referral to treatment (RTT) aggregate targets will not be achieved in September and October 2013

Portsmouth CCG Key Risks and Mitigating Actions

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Key Risks	Mitigating Actions
RTT: PHT have advised that they will fail September and October aggregate RTT standards. PHT has developed a plan to address performance which is still the subject of discussion with the CCG. Assurance is yet to be received that in year and sustainable RTT position can be achieved by PHT. Non achievement will reduce how much the CCG can earn from the Quality Premium in 2014/15.	High level plan received from PHT is being reviewed by Commissioners and detailed discussions taking place to understand assumptions, capacity constraints and proposed solutions.
A&E 4 hour waits: PHT's performance remains a challenge. Quarter one performance was 89.5% against the 95% target. The latest available performance for quarter two (to 8 September) is 90.5%. The redesign of the A&E front door will not come into effect until September 2013. The CCG has made a bid for additional funding to form part of the Winter Plan.	Development of Urgent Care Centre pilot to manage Primary Care attenders at A&E. Internal PHT actions to improve staffing levels including medical cover, particularly at weekends.
Ambulance Handover Delays: Ambulance handover delays continue to be a challenge but are showing improvement. The number of over 30 minutes handover delays in June was 250 (433 in May), of which 99 were over 60 minute delays (200 in May).	Penalties have been charged to Portsmouth Hospitals in relation to ambulance handover issues and 4 hour waits in the Emergency Department (ED). A recovery plan involving a setup of nurse led four bay clinical assessment areas which take patients direct from ambulance crews for clinical assessments and care until a bed becomes available in the major unit has been put in place.
Cancer: Concerns remain regarding PHT being able to consistently achieve the standards. Also, commissioners concerned that PHT missed the national reporting deadline for June data.	Elements of PHT's remedial action plan remain outstanding; the CCG continues to work with PHT to ensure all concerns have been addressed. In the meantime, a financial sum has been withheld from PHT until such time as commissioners have assurance that its concerns have been addressed. A formal contract notice has been issued in relation to the breach of the nationally mandated reporting requirement. The CCG has requested assurance that this will not reoccur.
Ambulance: Early indications show cost pressures within Ambulance Services due to both activity over-performance and fines as a result of handover delays.	Portsmouth Hospitals Trust and South Central Ambulance Trust have formed a working group to address the level of handover delays.

Portsmouth CCG Key Issues

Key issues	Potential consequence and action
Electronic Discharge Summary (EDS): EDS (PHT) issues remain and there is a delay in the full roll out of electronic discharge summaries.	An improvement plan has been received to ensure roll out of electronic discharge summary production and to address the interface with primary care. This includes interim assurances around the quality of discharge summaries until a full scale electronic system is in place.
Increased Access in Psychological Therapy (IAPT): Contract negotiations with Solent regarding IAPT cost and delivery are on-going.	The CCG has made an additional £500k investment for the delivery of the 2013/14 IAPT plan. Solent have stated that they will be able to meet the full IAPT roll out by 2014/15, however, the achievement of the 2013/14 plan will be a challenge. Commissioners are working with Solent on an 18 month strategy / improvement plan and it is anticipated that this will be completed by mid-September.
Quality Premium: Not all of the elements are being fully achieved.	This may lead to a reduction in premium received in 2014/15. A&E plans are in place to achieve the failing target.

Portsmouth CCG Quality (1/2)

The table below reflects the quality and safety performance in healthcare providers who hold a NHS Standard Contract with Portsmouth CCG, either directly or through a Host Commissioner.

Issues of Concern

NHS 111

- Full year compliance for 95% trajectory of calls answered in 60 seconds is at risk due to April and May underachievement. June achieved target with 95.7% compared to 90.2% in May and 84.6% in April.

Out of Hours GPs

- Eight Serious Incidents Requiring Investigations (SIRIs) reported for Quarter 1. The quality team will ensure any learning from the investigations is shared.
- Concern has been raised over telephone consultations, fluctuating levels of adequate weekend rota fill and a lack of compliance across all indicators. An updated rectification plan is being developed by Care UK.

Issues to Note

NHS 111

- Recruitment to clinical vacancies continues which should impact on the performance of 'transfers to clinician call rate'.
- All relevant calls are audited and feedback given to individual staff involved where appropriate.
- Discussions are on-going with Commissioners to increase the number of calls received.

Out of Hours GPs

- The quality lead is to liaise with Care UK to ensure appropriate clinical environment of Out of Hours delivery.
- A review will be undertaken to re-assess the quality indicators included in the contract.

Achievements

NHS 111

- SCAS confirm that call answering within 60 seconds was achieved for Hampshire in the month of June.
- Revised professional feedback forms to improve the quality of information received have been disseminated with a one-page guidance.

Out of Hours GPs

- Performance for face to face consultations has shown an improvement in June.
- Call answering times have been met for Hampshire in June.

Portsmouth CCG Quality (2/2)

Issues of Concern

South Central Ambulance Service

- Four SIRIs reported in Quarter 1.
- The subject of most complaints remains staff attitude, Clinical Support Desks (CSD) triage/non attendance of a vehicle and delays. The Patient Experience Review Group is monitoring these trends and actions taken to reduce attitude related complaints.

Portsmouth Hospitals NHS Trust

- Pressure Ulcer trajectory over internal target by 5 (12 cases against 7). PHT confirm they have introduced an urgent launch of the Surface, Keep moving, Incontinence and Nutrition (SKIN) bundle and weekly audits as a result.
- 24 SIRIs reported for Quarter 1.

Solent NHS Trust

- There has been a slight increase in the percentage of patients with harm resulting from falls. The June figure is reported as 1.3%, compared to 0.9% in May. A training programme is being delivered to all clinical staff to support the reduction of harms.

Issues to Note

South Central Ambulance Service

- Root cause analysis of long waits is underway.
- Further investigation is underway in relation to handover delays and clear up rates. The number of over 30 minutes handover delays in June was 250 (433 in May) of which 99 were over 60 minute delays (200 in May).

Portsmouth Hospitals NHS Trust

- Improvements in performance were made to the 4 A&E hour target in month 3. The June figure is reported as 92.4% compared to 86.6% in May. The urgent care model continues to be implemented and rapid access & triage commenced in June. This has positively impacted on time to first assessment.

Solent NHS Trust

- In June there continues to be a positive decline in the percentage of patients with harm resulting from pressure ulcers, catheters and Urinary Tract Infections (UTIs), and Venous Thromboembolism (VTE). This is particularly encouraging as the actual sample size has significantly increased.

Achievements

South Central Ambulance Service

- Achievements in meeting Red 1 (critical conditions; patient transportation within eight minutes), Red 2 (serious conditions; patient transportation within eight minutes) and Red 19 (immediately life-threatening conditions; patient transportation within 19 minutes) organisational targets.

Portsmouth Hospitals NHS Trust

- Zero cases of MRSA and four cases of C.Difficile in Quarter 1 (against the trajectory of 11).
- The VTE risk assessment compliance for Quarter 1 is 95.2%, achieving the 95% target.

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Portsmouth CCG Rights & Pledges and Other Key Priorities

Indicator	Target	2012-13 Cum.	Period	Prev	Curr	Perf Dir	YTD 2013/14
Referral To Treatment waiting times for non-urgent consultant-led treatment							
RTT:% of admitted patients who waited 18 weeks or less	90%	94.4%	Jun-13	94.2%	93.8%	↓	94.0%
RTT:% of non-admitted patients who waited 18 weeks or less	95%	97.7%	Jun-13	98.2%	98.5%	↑	98.2%
RTT:% of incomplete patients waiting 18 weeks or less	92%	95.8%	Jun-13	96.4%	95.8%	↓	95.8%
RTT: Number of admitted patients who waited >52 weeks	0		Jun-13	0	0	→	0
RTT: Number of non-admitted patients who waited >52 weeks	0		Jun-13	0	0	→	0
RTT: Number of incomplete patients waiting >52 weeks	0		Jun-13	0	0	→	0
Diagnostic test waiting times							
% Patients waiting <6 weeks for a diagnostic test	99%	99.5%	Jun-13	98.6%	98.5%	↓	98.9%
A&E waits							
A&E <=4hrs (QTD)	95%	92.6%	Jun-13	89.3%	90.3%	↑	89.5%
Cancer waits – 2 week wait							
Cancer patients seen <14 days after urgent GP referral	93%	96.9%	Jun-13	94.3%	97.0%	↑	95.7%
Breast Cancer Referrals Seen <2 weeks	93%	98.0%	Jun-13	94.6%	92.9%	↓	94.8%
Cancer waits – 31 days							
Cancer diagnosis to treatment <31 days	96%	97.7%	Jun-13	96.5%	96.1%	↓	96.6%
Cancer Patients receiving subsequent surgery <31 days	94%	95.9%	Jun-13	100.0%	100.0%	→	100.0%
Cancer Patients receiving subsequent Chemo/Drug <31 days	98%	100.0%	Jun-13	100.0%	100.0%	→	100.0%
Cancer Patients receiving subsequent radiotherapy <31 days	94%	98.8%	Jun-13	94.7%	100.0%	↑	96.4%
Cancer waits – 62 days							
Cancer urgent referral to treatment <62 days	85%	88.3%	Jun-13	82.9%	79.3%	↓	83.9%
Cancer Patients treated after screening referral <62 days	90%	95.7%	Jun-13	83.3%	92.9%	↑	90.0%
Cancer Patients treated after consultant upgrade <62 days (local threshold)	86%	95.7%	Jun-13	100.0%	85.7%	↓	95.2%
Category A ambulance calls							
Cat A calls within 8 minutes - Red 1	75%		Jun-13	85.9%	81.1%	↓	85.9%
Cat A calls within 8 minutes - Red 2	75%		Jun-13	81.8%	84.9%	↑	82.3%
Cat A calls within 19 minutes	95%		Jun-13	98.4%	98.3%	↓	97.8%
Mixed Sex Accommodation Breaches							
Mixed Sex Accommodation Breaches	0	0	Jun-13	0	0	→	0
Healthcare Associated Infections							
HCAI: Clostridium Difficile (C. Diff.) Infection rates	37	44	Jun-13	2	3	↓	8
HCAI: Incidence of MRSA	0	3	Jun-13	0	0	→	0
Mental health							
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%		Q1	-	96.03%		96.03%

G On target A <5% below target R >5% below target

RTT
All RTT targets were achieved in June and no patient waited more than 52 weeks.

Diagnostics
Diagnostic tests within 6 weeks did not achieve the target in June. This has been attributed to an increase in the number of diagnostic referrals and a recent departure of a Nurse Endoscopist. There were 20 breaches at St Mary's Treatment Centre during the month of June, which have been attributed to patient choice and a reporting error.

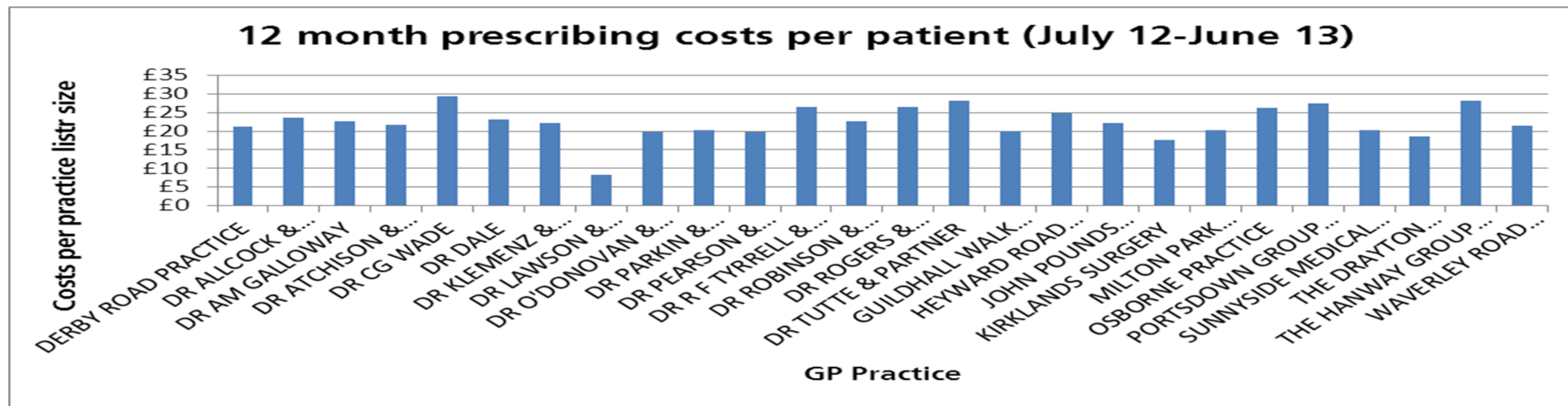
Cancer Waits
The CCG is extremely concerned that patients are experiencing waits for cancer treatment. It is anticipated that achievement of targets will remain challenging until capacity and demand within diagnostics are aligned. PHT has breached an agreed Remedial Action Plan for Cancer and the CCG is withholding monies until PHT has achieved the agreed plan.

Ambulance Response Times
The ambulance response time is measured on the overall performance of SCAS and on this basis all of the standards were met for the reported period *(see page 21)*.

GP Practice Prescribing Performance

The current 12 month prescribing spend to June is 0.7% lower than the previous 12 month spend. This is comfortably below the QIPP target for growth of less than 2.4%.

For June the practice spend per list size weighted for age and sex is charted below:



Dr Lawson & Partners costs per patient are low due to a large student population. The high growth rate for Dr Tutte and partners is due to practice merge with Dr Bennett, hence the overall list size has increased. The growth rate for Guildhall Walk is high because a significant proportion of spend is due to walk in activity and not registered patients.

Portsmouth Hospitals Trust

Summary Overview

The year to date contract position shows as an underspend of £0.5m. The annual forecast is now £102.0m against the £102.9m plan.

Solent NHS Trust

Summary Overview

The contract position is on plan with no significant issues to report at this time.

University Hospital of Southampton Foundation Trust

Summary Overview

The contract position is on plan with no significant issues to report at this time.

Portsmouth CCG Finance (1/3)

NHS Portsmouth Clinical Commissioning Group

Summary Financial Performance

•Year to date spend against budgets is on plan, with a year to date surplus of £1.0m

•Other Commissioning is over plan due to higher than anticipated charges from NHS Property Services. Talks are on-going to resolve the issue with credits expected during Q3 at the latest.

		Month 05 - August 2013					Best Case		Worst Case	
	Annual Budget	Budget to Date	Actual to Date	Variance to Date	Forecast Outturn	Forecast Variance	Forecast Outturn	Forecast Variance	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Acute Commissioning:	123.1	51.3	50.9	(0.4)	122.5	(0.6)	121.3	(1.8)	126.9	3.8
Mental Health Commissioning	29.7	12.4	12.5	0.1	30.1	0.4	29.7	0.0	30.0	0.3
Community Services Commissioning	25.0	10.3	10.3	0.0	24.8	(0.2)	24.9	(0.1)	27.1	2.1
Primary Care Commissioning	31.7	13.1	13.1	0.1	31.9	0.2	31.8	0.1	32.4	0.8
Continuing Care	13.8	5.8	5.8	0.0	13.3	(0.5)	12.3	(1.5)	13.8	0.0
Other Commissioning	3.5	1.4	2.2	0.8	3.2	(0.3)	3.2	(0.3)	5.5	2.0
Running Costs	5.3	2.0	1.8	(0.2)	5.3	(0.0)	5.3	0.0	5.3	0.0
Reserves & Contingencies	10.6	0.4	0.0	(0.4)	11.6	1.0	11.6	1.0	4.2	(6.5)
Surplus Reserve	2.4	1.0	0.0	(1.0)	0.0	(2.4)	0.0	(2.4)	0.0	(2.4)
Total NHS Portsmouth CCG	**245.2**	**97.6**	**96.6**	**(1.0)**	**242.8**	**(2.4)**	**240.1**	**(5.0)**	**245.2**	**0.0**

Forecast Outturn:

•The CCG is expecting to meet its target surplus of £2.4m at the year end.

•Running Costs are expected to remain within the target of £25 per head of population

Portsmouth CCG Finance (2/3)

NHS
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Clinical Commissioning Group

Detailed Finance Performance

			Month 05 - August 2013					Best Case		Worst Case	
		Annual Budget	Budget tn Date	Actual to Date	Variance to Date	Forecast Outturn	Forecast Variance	Forecast Outturn	Forecast Variance	Forecast Outturn	Forecast Variance
		£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Acute Commissioning	Portsmouth Hospitals	102.9	42.9	42.4	(0.5)	102.0	(0.9)	101.8	(1.1)	105.9	3.0
	University Hospital Southampton FT	1.9	0.8	0.8	0.0	2.0	0.1	1.9	0.0	2.0	0.1
	Western Sussex Hospitals	0.8	0.3	0.3	(0.0)	0.8	0.0	0.8	0.0	0.8	0.0
	Hampshire Hospitals FT	0.2	0.1	0.1	(0.0)	0.2	(0.0)	0.2	0.0	0.3	0.1
	Salisbury Healthcare	0.3	0.1	0.1	(0.0)	0.3	(0.0)	0.2	(0.1)	0.3	0.0
	Royal Surrey County Hospital	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0
	London Providers	1.2	0.5	0.5	(0.0)	1.2	0.0	1.2	0.0	1.2	0.0
	Spire Healthcare	0.4	0.2	0.3	0.2	0.8	0.4	0.4	0.0	0.7	0.3
	South Central Ambulance	7.0	2.9	2.9	(0.0)	7.0	0.0	7.0	0.0	7.2	0.2
	Clinical Assessment and Treatment Centres	5.7	2.4	2.5	0.1	6.0	0.2	5.5	(0.2)	5.9	0.2
	NCAs / OATs	2.6	1.0	0.9	(0.2)	2.2	(0.4)	2.2	(0.4)	2.6	0.0
Mental Health Commissioning	Solent NHS Trust (MH)	25.2	10.5	10.5	0.0	25.2	(0.0)	25.2	0.0	25.2	0.0
	Other Mental Health Commissioning	4.6	1.9	2.0	0.1	5.0	0.4	4.6	0.0	4.9	0.3
								0.0			
Community Health Commissioning	Solent NHS Trust (Community)	24.0	10.0	10.0	(0.0)	24.0	0.0	24.0	(0.1)	25.0	1.0
	Southern Healthcare FT	0.3	0.1	0.1	0.0	0.3	(0.0)	0.2	(0.1)	1.3	1.0
	AQP Providers	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.1
	Carers & Hospices	0.6	0.1	0.1	(0.0)	0.3	(0.3)	0.6	0.0	0.6	0.0
Primary Care Commissioning	Practice Primary Care Prescribing	27.3	11.3	11.3	(0.0)	27.3	(0.1)	27.3	0.0	27.5	0.1
	Central Primary Care Prescribing Costs	1.6	0.7	0.7	0.0	1.7	0.1	1.6	0.0	1.9	0.2
	Local Enhanced Services	1.0	0.4	0.3	(0.0)	0.9	(0.1)	0.9	(0.1)	1.0	0.0
	111 Service	0.4	0.2	0.2	0.0	0.5	0.1	0.4	0.0	0.5	0.1
	OOH (Care UK)	1.3	0.6	0.6	0.1	1.6	0.2	1.5	0.2	1.6	0.3
Continuing Care	Adult Continuing Care	11.9	5.0	5.0	0.0	11.4	(0.5)	10.4	(1.5)	11.9	0.0
	CHC Children	0.3	0.1	0.1	(0.0)	0.3	0.0	0.3	0.0	0.3	0.0
	Funded Nursing Care	1.5	0.6	0.6	(0.0)	1.5	0.0	1.5	0.0	1.5	0.0
Other Commissioning	Reablement	1.2	0.5	0.5	0.0	1.2	0.0	1.2	0.0	1.2	0.0
	Recharges NHS Property Services Ltd	1.5	0.6	1.4	0.8	1.5	0.0	1.5	0.0	3.4	2.0
	Programme Projects	0.7	0.3	0.2	(0.1)	0.4	(0.3)	0.4	(0.3)	0.7	0.0
	Other Commissioning	0.2	0.0	0.1	0.1	0.2	0.0	0.2	0.0	0.2	0.0
Running Costs	Headquarters/ Directorates, Agency and Assurance Services	3.0	1.2	1.1	(0.2)	3.0	(0.0)	3.0	0.0	3.0	0.0
	CSU Charges	1.9	0.6	0.6	0.0	1.9	0.0	1.9	0.0	1.9	0.0
	Estate Management	0.4	0.2	0.2	0.0	0.4	0.0	0.4	0.0	0.4	0.0
Centrally Managed Programmes	General Reserve	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Commissioning Reserve	10.6	0.4	0.0	(0.4)	7.4	(3.3)	7.4	(3.3)	4.2	(6.5)
	Surplus Reserve	2.4	1.0	0.0	(1.0)	0.0	(2.4)	0.0	(2.4)	0.0	(2.4)
	Mitigation Available/ (Outstanding)					4.2	4.2	4.2	4.2	0.0	
	Total NHS Portsmouth CCG	**245.2**	**97.6**	**96.6**	**(1.0)**	**242.7**	**(2.4)**	**240.1**	**(5.1)**	**245.2**	**0.0**

Portsmouth CCG Finance (3/3)

NHS Portsmouth Clinical Commissioning Group

Financial Risk Rating

Risk	Mitigation	RAG rating
CCG Allocations have been published however risk remains around: Potential further anomalies from original expenditure mapping exercise; NHS Property Services Ltd (PropCo), allocation changes for property transfers and 'vacant' space. Current risk of £2.4m	CCG is working closely with: Wessex Area Team to ensure potential anomalies from the original mapping exercise are understood NHS Property Services to understand the allocation changes and confirm transactions required Regular updates will be reported to the CCG, should the risk materialise financially for any of the above the CCG can review expenditure programmes and adjust accordingly	Red
Specialised Services 'maximum take' allocation deduction	Wessex Area Team to ensure Specialised Services allocation deduction remains cost neutral to the CCG with the expectation of £3m to be returned to the CCG. Wessex provider numbers have now been agreed materially reducing the risk to Portsmouth CCG. Work is currently on-going to finalise adjustments for providers outside of Wessex	Amber
Size of QIPP/Savings and pace of change	Robust in year monitoring to ensure schemes are on target to deliver expected savings. Use of 2% non recurring fund to support system reconfiguration. Contingency will provide further risk mitigation as necessary.	Amber
Foundation Trust applications for Portsmouth Hospitals and Solent	Regular communication on progress and monitoring of QIPP and contract performance	Amber
Legacy financial position of the South East Hampshire system remains challenging	The CCG will continue to work with neighbouring CCG's and local providers to ensure the health system continues to recover any underlying issues.	Amber
Newly implemented Information Governance rules restrict the ability to verify the authenticity of Non-Contracted Activity and Individual Funding Request charges.	National Guidance has been issued, the CCG is working with the CSU to look for possible solutions	Amber
Quality Premium milestones not being met throughout 2013/14, potential loss of 2014/15 income to the CCG of £1m	Milestones continue to be monitored in year to understand current performance	Amber
The CCG has now finalised all major Contract Agreements. Changes in nationally set prices and move towards additional mandatory tariffs (e.g. Maternity pathway; Mental Health and Paediatric diabetes) mean that activity levels above plan will carry financial implications	On going regular contact with providers to monitor contractual performance against plan.	Green
Costs of meeting NHS Constitution and growth is higher than estimated	Review through planning governance framework and consider use of contingency and other non recurrent resources, as well as robust monitoring of contracts throughout the year	Green

Portsmouth CCG QIPP

Total CCG year-to-date (July) planned savings is £1.815m, this was achieved. The Forecast Outturn is also on track at £6.689m.

However, before the use of contingency the YTD savings are for Portsmouth £1.762m (which is 97% of the YTD target). Therefore 3% of the overall achievement is made up of contingency.

The phasing of planned savings means that the majority of savings are expected to be realised during the later months of the year, which may be a risk.

The table below provides the programme level reporting for Portsmouth CCG.

Programme	£'000s				Variance	
	13/14 Total	YTD Planned	YTD Actual	FOT	YTD	FOT
	Project Plans, FYE & Budget Adjustments					
Enabling Programmes	586	195	195	586	0	0
Integrated Commissioning	2,117	651	651	2,117	0	0
Maternity and Child Health	286	64	64	286	0	0
Medicines Management	1,523	508	508	1,523	0	0
Planned Care and Long Term Conditions	785	130	130	785	0	0
Urgent and Integrated Care	1,233	215	215	1,233	0	0
Total	6,530	1,762	1,762	6,530	0	0
Developmental QIPP	159	53	0	116	-53	-53
Contingency	0	0	53	53	53	53
Total:	6,689	1,815	1,815	6,689	0	0

Portsmouth Hospitals Trust System Summary

NHS
Portsmouth
Clinical Commissioning Group

This dashboard provides an overview of Portsmouth Hospitals Trust (PHT) performance from the quality, performance, contracts and finance perspectives. The data is sourced from PHT's Integrated Performance Report (with the exception of contracts).

Quality

	Target	Year to June		
HCAI - MRSA	0	0	G	→
HCAI - C.Diff.	11	4	G	↑
Venous Thrombo-embolus screening	95%	95.2%	G	↑
Pressure Ulcer Prevalence (grade 2, 3,4)	1.06%	1.6%	R	↓
Hospital Standardised Mortality Ratio	100	100	G	→
Never events	0	0	G	→
Friends and Family Test (Yr to July response rate)	15%	11.7%	R	↑
Number of SIRIs	n/a	24		
Number of complaints received	n/a	152		

Commentary:

Urgent launch of the SKIN bundle and weekly ward based audits actioned as a result of increased pressure ulcer prevalence.

Friends and Family test improving. July (month) achieved target with a response rate of 17.7% (16.9% in June). Quarter one failed target due to underperformance in April (3.3%) and May (8.6%).

Risks (current and future):

Risk of not achieving pressure ulcer target.

Performance

	Target	Year to June		
RTT admitted patients <18weeks	90%	91.4%	G	↓
RTT non-admitted patients <18weeks	95%	97.2%	G	↑
RTT incomplete <18weeks	92%	94.7%	G	↓
Admission directly to stroke unit	90%	89.3%	A	↓
Number of cancer measures achieving target	9	8		→
A&E 4 hr waits	95%	88.9%	R	↑
Ambulance handover delays: >30 minutes (PHT)		1085	R	↑
A&E unplanned re-attendance rates < 7 days	5%	5.5%	R	↓

Commentary:

A&E waits continue to remain a concern. Remedial plans are in place and weekly performance being closely monitored.

10 patients were not admitted directly to stroke unit bringing the overall performance against the 90% standard to 86% in the month of June.

There is an action plan currently under consideration for all cancer pathways.

Risks (current and future):

Not meeting RTT standards if backlog is not reduced; a planned fail has been proposed for September and October.

Contracts

	Year to August				Annual			
	Target £m	Actual £m	Var. £m		Target £m	Forecast £m	Var. £m	
Fareham & Gosport	38.0	38.5	0.5	R	91.3	92.7	1.4	R
South Eastern Hampshire	33.6	34.1	0.5	R	80.7	82.0	1.3	R
Portsmouth	42.9	42.4	-0.5	G	102.9	102.0	-0.9	G

Commentary:

Non-elective activity: activity below plan but costs are above plan demonstrating a more complex case mix than in contract, predominantly in pneumonia,fractured neck of femur and digestive disorders.

A&E attendances: activity 3% below plan in activity and financial value.

Elective activity: activity higher than contract plan for both activity and cost.

Outpatients: above plan

Critical care: above plan but at reduced rate this month

Risks (current and future):

Activity above plan presents financial risks to CCGs.

PHT's ability to flex capacity to meet activity levels.

Financial risk to PHT on some elements of non-elective activity that is only paid at a marginal rate.

Finance & Workforce

	Year to July				Annual			
	Plan £m	Actual £m	Var. £m		Plan £m	Forecast £m	Var. £m	
Finance:								
Surplus / -deficit	-2.0	-4.2	2.2	R	-5.0	-5.0	0	G
Workforce:								
Staff turnover	12.0%	8.8%	-3.2%					
Sickness absence (June)	3.0%	3.4%	0.4%					

Commentary:

Finance: This variance is primarily driven by the phasing of unallocated or unidentified Cost Improvement (CIP) requirements (in equal 12ths), which accounts for £1.8m of the YTD variance.

Workforce: Staff turnover for July decreased to 8.8% (NHS average 9.5%), whilst sickness absence remained at 3.4% in June (NHS regional average 3.9%).

Risks (current and future):

The A&E 4-hour wait target performance and ambulance handover times penalties.

The Trust has breached a Remedial Action Plan in Cancer, money is being temporarily withheld until the breach is resolved or a new plan agreed.

Solent Trust System

NHS Portsmouth Clinical Commissioning Group

This dashboard provides an overview of Solent's performance from the quality, performance, contracts and finance perspectives.

Quality

	Target	Year to June	
HCAI - MRSA	0	0	G
HCAI - C.Diff.	2	1	G
Venous Thrombo-embolus screening	95%	100%	G
Pressure Ulcer Incidents		59	
Friends and Family Test (response rate)			
Friends and Family Test	80%	84.0%	G
Number of SIRIs		13	
Number of complaints received		99	
Number of local CQUIN indicators (to be agreed)			
Number of national CQUIN indicators (milestones on track)		n/a	

Commentary:

There continues to be a general trend of reduction in grade 2 and grade 3 pressure ulcers, however the number of grade 3 and 4 remain stable.
There have been six SIRIs identified and logged in June, which are under formal investigation.
There were 26 complaints received in June which relate to three services: Adult Services, Children and Family Services and Mental Health Services.

Risks:

The proportion of higher severity pressure ulcers increasing.

Performance

	Target	Year to June	
CPA follow up < 7 days	95%	98%	G
IAPT (number receiving therapy)	2.7%	2.4%	A
RTT admitted patients <18weeks	90%	99.4%	G
RTT non-admitted patients <18weeks	95%	99.7%	G
RTT incomplete <18weeks	92%	99.9%	G
Diagnostic test < 6 weeks	99%	100%	G
A&E waits	95%	99.9%	G

Commentary:

Discussions are in place with commissioners to invest in the IAPT service to ensure targets can be met in 2013/14.

Risks:

IAPT not achieving target.

Contracts

	Year to August				Annual			
	Target	Actual	Var.		Target	Forecast	Var.	
	£m	£m	£m		£m	£m	£m	
Spend:								
Fareham & Gosport	1.8	1.9	0.1	A	4.5	4.5	0	G
South Eastern Hampshire	1.8	1.9	0.1	A	4.5	4.5	0	G
Portsmouth	20.5	20.5	0	G	49.2	49.2	0	G

Commentary:

Target represents the block contract value. All contracts currently on track.

Risks:

No major risks so far identified

Finance & Workforce

	Year to June				Annual			
	Plan	Actual	Var.		Plan	Forecast	Var.	
Finance:	£m	£m	£m		£m	£m	£m	
Surplus / -deficit	0.5	0.5	0	G	1.9	1.9	0	G
Workforce:								
Staff turnover (12m)	12.0%	12.2%	0.2%	R				
Staff sickness	3.4%	4.2%	0.8%	R				

Commentary:

The workforce turnover variance is primarily due to more dental and estates staff transferring into the organisation than planned in April.
Targeted support is in place to help effective management of absence and an increase in referrals to Occupational Health will facilitate a further reduction.
Long term sickness cases are being proactively managed on a case by case basis.

Risks:

No major risks so far identified

University Hospitals Southampton and Western Sussex Hospitals

NHS Portsmouth Clinical Commissioning Group

This dashboard provides an overview of University Hospitals Southampton Foundation Trust (UHSFT) and Western Sussex Hospitals Foundation Trust (WSHFT) performance from the quality, performance, contracts and finance perspectives. The data is sourced from Integrated Performance Reports (with the exception of contracts).

Quality

	Target	Year to June UHSFT		Target	Year to June WSHFT	
HCAI - MRSA	0	2	A	0	0	G
HCAI - C.Diff.	11	8	G	12	25	R
Venous Thrombo-embolus screening		n/a		95%	#####	G
Pressure Ulcer Prevalence (grade 2, 3,4)		n/a		32	28	G
Never events					0	G
Friends and Family Test (response rate)	15%	11.3%	R	15%	6.4%	R
Number of SIRIs		41			3	
Number of complaints received				141	139	G

Commentary:

UHSFT: (MRSA) 2 post 48 hr bacteraemias at end of Q1; 1 case agreed as unavoidable.

UHSFT: It was agreed urgent need to gain Friends & Family responses via a non-electronic method had been addressed in May/June.

WSHFT: Trust C.diff remedial actions have been endorsed by the TDA and regional microbiologist. There have been no reported cases relating to Portsmouth CCG.

WSHFT: Plan in place to learn from best performing Trusts to improve Friends and Family response rate.

Risks:

Risk of not achieving Friends and Family response rate. Risk of WSHFT above threshold for C. Diff.

Performance

	Target	Year to June UHSFT		Year to June WSHFT	
Planned care					
RTT admitted patients <18weeks	90%	91.4%	G	90.2%	G
RTT non-admitted patients <18weeks	95%	90.5%	R	96.6%	G
RTT incomplete <18weeks	92%	89.4%	R	94.2%	G
Diagnostic test < 6 weeks	99%	99.9%	G	99.5%	G
Cancer measures achieving target	9	9		9	
Unscheduled care					
A&E 4 hr waits (PHT)	95%	92.9%	R	97.0%	G

Commentary:

UHSFT: A detailed RTT recovery plan has been prepared by each division and has been agreed with the Interim Chief Executive Officer and Chief Operating Officer.

UHSFT: The strong A&E 4 hr waits performance seen at the end of Q1 (97.4% in June) is expected to continue into Q2.

Risks:

UHSFT: Not meeting RTT incomplete standard in Q2 if backlog is not reduced.

Contracts

	Year to August Target £m	Year to August Actual £m	Var. £m		Annual Target £m	Annual Forecast £m	Var. £m	
UHSFT								
Fareham & Gosport	3.3	3.2	-0.1	G	7.9	7.7	-0.2	G
South Eastern Hampshire	0.7	0.8	0.1	A	1.8	1.8	0	G
Portsmouth	0.8	0.8	0	G	1.9	2.0	0.1	A
Western Sussex								
Fareham & Gosport	0.1	0.1	0	G	0.3	0.3	0	G
South Eastern Hampshire	3.0	3.1	0.1	A	7.2	7.2	0	G
Portsmouth	0.3	0.3	0	G	0.8	0.8	0	G

Commentary:

Over-performance in Spinal Surgery and Digestive System Procedures.

Risks:

No major risks so far identified.

Finance & Workforce

	Year to June Plan £m	Year to June Actual £m	Var. £m		Annual Plan £m	Annual Forecast £m	Var. £m	
Finance:								
UHSFT	2.6	2.6	0	G	5.2	5.2	0	G
WSHFT	5.3	3.8	-1.5	G	32.2	32.7	0.5	R
Sickness								
UHSFT	3.0%	3.6%	0.6%	R				
WSHFT	3.3%	3.6%	0.3%	R				

Commentary:

UHSFT: Continued delivery of absence management training to over 100 managers.

Risks:

Risk of not achieving annual plan.

Other Providers

The **South Central Ambulance Service** (SCAS) performance for the month of June for the whole of the SCAS:

	Target	Actual	
Red 1 incidents within 8 minutes	**75%**	79.9%	G
Red 1 incidents within 19 minutes	**95%**	96.6%	G
Red 2 incidents within 8 minutes	**75%**	77.6%	G
Red 2 incidents within 19 minutes	**95%**	96.2%	G
Non-conveyance to A&E	**41.5%**	40.2%	R

Response time performance has remained strong and above national targets. However, long delays remain a concern and plans have not been met for reducing conveyance to hospital. This is due to the increasing severity of the conditions that patients are presenting with. Non-conveyance to A&E performance to be improved through wider spread usage of GP triage.

Overall, **NHS 111** performance (Hampshire 111) for June is good:

- A further fall in 111 demand to 34,999 calls offered to the service in the month (37,942 in May).
- The proportion of calls transferred to 999 and the Emergency Department increased to 6.1% (5.5% in May).
- The number of calls answered in 60 seconds rose to 95.7% against the 95% target (91.2% in May).
- The trajectory to achieve <5% abandonment rate is on target, with 1.2% of calls abandoned (2.1% in May).
- Joint working through the Clinical Governance Group and with communications colleagues is improving the quality of feedback received to inform service development.
- Recruitment to clinical vacancies continues which should impact on the performance of 'transfers to clinician call rate'. This includes recruitment to clinical vacancies.

Out of Hours total provider service: Performance for the month remains similar to May's. The response rate to urgent calls (re-based to within 15 minutes from 20 minutes) was 93.5% (target of 100%). The response rate to routine calls within 60 minutes was 88.3% (target of 100%).

St Mary's NHS Treatment Centre: Diagnostics – The June figure for patients receiving a diagnostic test within 6 weeks was 94.6% (unconfirmed data) against a 99% target (94.5% in May). The breaches have been attributed to patient choice for echocardiograms and a reporting error for ultrasounds which has now been addressed.

Recommendations

The Governing Board are asked to:

1. **Note the key achievements of the CCG**
2. **Note the financial position of the CCG**
3. **Review areas of concern**
4. **Note and approve the two self-certification elements of the quarter 1 balanced scorecard**
5. **Note the current draft quarter 1 assessment of the CCG against the national assurance framework**

NHS
Portsmouth
Clinical Commissioning Group

GOVERNING BOARD

Date of Meeting	18 September 2013	Agenda Item No	6
Title	Register of Interests		
Purpose of Paper	The CCG is committed to the principles of transparent and open decision making. As part of this, and underpinning the CCGs Constitution, the CCG has a Standards of Business Conduct policy to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without any possibility of the influence of external or private interests. The CCG keeps a register of interests which is reviewed regularly and updated as necessary. The attached Register of Interests covers members of the CCGs Governing Board and its formal sub-committees as declared at 5 September 2013.		
Recommendations/ Actions requested	To accept the Register of Interests.		
Author	Jayne Collis, Assistant Development Manager		
Sponsoring member	Dr Tim Wilkinson		
Date of Paper	5 September 2013		

NHS
Portsmouth
Clinical Commissioning Group

REGISTER OF INTERESTS 2013

NAME	INTERESTS DECLARED:
DR JIM HOGAN **CLINICAL LEADER/CHIEF CLINICAL OFFICER** **GP practising from Lake Road Practice, Portsmouth** **Member of Governing Board** **Member of Clinical Commissioning Committee**	• Foundation School Governor at Oaklands Catholic School • General Practitioner practising from Lake Road Practice, Portsmouth
DR DAPO ALALADE **CLINICAL EXECUTIVE** **GP practising from University Surgery, Portsmouth** **Member of Governing Board** **Member of Clinical Commissioning Committee**	• Sexual Health Clinic at University Surgery – PBC • Minor Shareholder with Circle
DR LINDA COLLIE **CLINICAL EXECUTIVE** **GP practising from Baffins Surgery, Portsmouth** **Member of Governing Board** **Member of Clinical Commissioning Committee**	• Partner at Baffins Road Surgery • Regular locum (bank staff) at Guildhall Walk Healthcare • Chair of Governors, St John the Baptist CE Primary School, Waltham Chase • Member of the MU
PAUL COX **PRACTICE MANAGER REPRESENTATIVE** **Member of Governing Board**	• Business Manager at Sunnyside Medical Centre

NAME	INTERESTS DECLARED:
DR JULIE CULLEN **REGISTERED NURSE REPRESENTATIVE** **Member of Governing Board** **Member of Audit Committee**	• Corporation Board Member (Governor), Portsmouth College • Chair of Audit Committee, Portsmouth College • Employed by University of Southampton
DR ELIZABETH FELLOWS **CLINICAL EXECUTIVE** **GP practising from Milton Park Practice, Portsmouth** **Member of Governing Board** **Member of Clinical Commissioning Committee** **Member of Audit Committee**	• Shareholder of Circle Health • GP Partner Milton Road Practice, Portsmouth
MRS JO GOOCH **CHIEF FINANCE OFFICER** **Member of Governing Board** **Member of Clinical Commissioning Committee**	• Husband is Head of Finance, Wessex Area Team
KATIE HOVENDEN **DIRECTOR OF PROFESSIONAL AND CLINICAL DEVELOPMENT** **Non-Voting Member of Governing Board** **Member of Clinical Commissioning Committee**	• NONE
JAN MATTHEWS **PRACTICE MANAGER REPRESENTATIVE** **Member of Clinical Commissioning Committee**	• Practice Manager at Salisbury Road Surgery

NAME	INTERESTS DECLARED:
DR ANDREW MORTIMORE **INTERIM DIRECTOR OF PUBLIC HEALTH** **Non-Voting Member of Governing Board** **Member of Clinical Commissioning Committee**	• Interim Director of Public Health, Portsmouth City Council • Director of Public Health, Southampton City Council • Member of Governing Body, Southampton City Clinical Commissioning Group • Member of Association of Directors of Public Health
TOM MORTON **LAY MEMBER** **Deputy Chair and Member of Governing Board** **Member of Clinical Commissioning Committee** **Chair of Remuneration Committee** **Chair of Audit Committee**	• Member of the Board of the Royal Naval Museum • Trustee of the Portsmouth Cathedral Development Trust • Chairman of the Agamemnon Housing Association • Chairman of the Portsmouth Voluntary Community Network • President of the Royal Naval Association (Waterlooville Branch) • Associate Hospital Manager for Solent Healthcare
JULIA O'MARA **PRACTICE NURSE REPRESENTATIVE** **Member of Clinical Commissioning Committee**	• Working as a Nurse Practitioner at Heyward Road Surgery • Director of J25 Training Ltd (training company for health professionals)
JACQUELINE POWELL **LAY MEMBER** **Member of Governing Board** **Member of Clinical Commissioning Committee** **Member of Remuneration Committee** **Member of Audit Committee**	• Associate Hospital Manager Solent NHS Trust • Mental Health Act Review Manager Southern Health NHS Foundation Trust • Young Persons Counsellor for Third Sector Organisation (Off The Record) and Member of its Advisory Committee
DR JONATHAN PRICE **CLINICAL COMMISSIONING LEAD** **GP practising from The Osborne Practice, Southsea, Portsmouth** **Member of Clinical Commissioning Committee**	• Partner of Osborne Practice • Part-owner of Surgery premises • Occasional work for EADS Astrium, ANA (drug & alcohol rehab), Research • Shares in Circle Health • Involved in work to develop primary care provision to support integrated care (currently in partnership with Solent)

NAME	INTERESTS DECLARED:
MR INNES RICHENS **CHIEF OPERATING OFFICER** **Member of Governing Board** **Member of Clinical Commissioning Committee**	• NONE
DR TAHWINDER UPILE **SECONDARY CARE SPECIALIST DOCTOR REPRESENTATIVE** **Member of Governing Board** **Member of Remuneration Committee**	• Director of ENT and Thyroid Surgery Ltd • Secondary Care Consultant Surgeon • Primary Care Physician
DR KEVIN VERNON **CLINICAL COMMISSIONING LEAD** **GP practising from Lake Road Health Centre, Portsmouth** **Member of Clinical Commissioning Committee**	• GP Partner at Lake Road Practice Portsmouth
DR TIMOTHY WILKINSON **CLINICAL EXECUTIVE** **GP practising from Derby Road Practice, Portsmouth** **Chair of Governing Board** **Member of Clinical Commissioning Committee** **Member of Remuneration Committee**	• General Practitioner - Co-owner surgery premises at 27-29 Derby Road, North End and 358 Copnor Road, Copnor, Portsmouth
DAVID WILLIAMS **CHIEF EXECUTIVE** **PORTSMOUTH CITY COUNCIL** **Member of Governing Board**	• Details Awaited

5 September 2013

NHS
Portsmouth
Clinical Commissioning Group

GOVERNING BOARD			
Date of Meeting	18 September 2013	**Agenda Item No**	7
Title	**COMPLIANCE WITH THE LEGAL EQUALITY DUTIES & CCG EQUALITY OBJECTIVE SETTING**		
Purpose of Paper	This paper sets out the requirements of the CCG to ensure it is compliant with its legal equality duties and makes recommendations with regards the requirement for the CCG to have one or more approved Equality Objective published on its website no later than 13 October 2013.		
Recommendations/ Actions requested	The Board is asked to: • Note the requirements on the CCG in respect of legal Equality Duties • Approve the proposed Equality Objective set out in section 5 for publication on the CCGs website • Note information demonstrating the CCGs compliance with the public sector equality duty will be published no later than 31 January 2014		
Author	Tracy Sanders		
Sponsoring member	Innes Richens, Chief Operating Officer		
Date of Paper	6 September 2013		

COMPLIANCE WITH THE LEGAL EQUALITY DUTIES & CCG EQUALITY OBJECTIVE SETTING

1 INTRODUCTION

As part of the Clinical Commissioning Group Authorisation process, the CCG declared that at the point of authorisation that it would be compliant with the Public Sector Equality Duty and that it would demonstrate the use of the Equality Delivery System (EDS) to help attain compliance and ensure good equality performance. As part of this the CCG's Board approved its own 'Equality and Diversity Strategy' in June 2012 which set out what it already had in place and what it planned to do to ensure that it fulfilled its statutory requirements.

2 PUBLIC SECTOR EQUALITY DUTY

The public sector Equality Duty, part of the Equality Act 2010, is made up of a 'general duty which is the overarching requirement and the 'specific duties' which are intended to help performance of the general duty.

The general duty has three aims and it applies to most public authorities including NHS England and CCGs, who must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristics and persons who do not share it

Under the Equality Act 2010 there are nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. There are some exceptions for some protected characteristics under the public sector Equality Duty.

3 CCG SPECIFIC REQUIREMENTS

Under the specific duties of the public sector Equality Duty, the CCG is required to publish in a manner that is accessible to the public:

- Information to demonstrate its compliance with the public sector Equality Duty at least annually, starting **by 31 January 2014**. This information must include, in particular, information relating to people who share a protected characteristic who are:

- Its employees – (public authorities with fewer than 150 employees are exempt – NHS Portsmouth would therefore currently be exempt from this requirement although commits to the principles of it)
  - People affected by its policies and practices

- Equality objectives at least every four years starting **by 13 October 2013**. All such objectives must be specific and measurable.

The timeframes for CCGs to meet the specific duties of the public sector Equality Duty are outlined in the Health and Social Care Act 2012 (Consequential, Transitional and Savings Provisions) Order 2013.

4 EQUALITY DELIVERY SYSTEM

The CCG has committed to use the Equality Delivery System (EDS) which is a tool-kit that can help NHS organisations improve the services they provide for their local communities. Consider health inequality in their locality and provide better working environments, free of discrimination, for those who work in the NHS. Used effectively its support NHS organisations to:

- Meet the public sector Equality Duty of the Equality Act 2010
- Deliver on the NHS Outcomes Framework and the NHS Constitution
- And, if they are providers, meet the Care Quality Commission's 'essential standards of quality and safety'

The EDS has four goals, with 18 specific outcomes. NHS organisations need to listen to and engage with patients. Carers, voluntary organisations and people who work in the NHS in order to grade their equality performance, identify where improvements can be made an act on their findings. The EDS goals are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels

5 CCG EQUALITY OBJECTIVES

In partnership with the SHIP Cluster PCTs, the EDS was used to develop a long list of Equality Objectives in partnership with local diverse communities, based upon quantitative and qualitative evidence. These were informed by the evidence gathered for the NHS Equality Delivery System baseline assessment (published in January 2012), the findings of 'everyone counts survey', the views and ideas of community representatives from the nine protected characteristic who attended the 'everyone counts workshops', and other relevant national research including studies of health inequalities.

Following a short listing process, in April 2012, together with the SHIP PCT cluster, we agreed to work towards the following Equality Objectives:

- Increase awareness and utilisation of psychological therapy programmes among protected groups
- Increase completion of ‘say it once’ profiles by protected groups alongside increased use of patient completed profiles by clinicians using Hampshire Health Records (HHR)
- Increase access to high quality interpretation and translation services for people with little or no English and the deaf community
- Improve staff awareness and responsiveness to needs of protected groups
- Improving the patient journey for protected groups, including appropriate choice of service, access and discharge
- Making the 111 service an effective point of access which meets the needs of protected groups

Measurements for each of these were agreed as part of the SHIP Cluster PCTs Board approval.

As these objectives were built from the EDS for the area (with the demographic/protected groups profile not being significantly different from the predecessor PCTs) with engagement from local diverse communities it is proposed that the CCG continues to support these as it moves forward.

The CCG is required to have one or more equality objective and in reflection of its developing status proposes to focus its attention on a single but important objective of:

- Improving staff awareness and responsiveness to needs of protected groups

6 DEMONSTRATING COMPLIANCE

Under the leadership of the Chief Operating Officer, the Director of Quality and Commissioning will work with NHS South Commissioning Support Unit, who are the CCGs provider of its equality and diversity functions to ensure that information to demonstrate the CCGs compliance with the public sector equality duty is published no later than 31 January 2014.

7 SUMMARY

The Governing Board are requested to:

- Note the requirements on the CCG in respect of legal Equality Duties
- Approve the proposed Equality Objective set out in section 5 for publication on the CCGs website and the development of measurements to support this by the CSU
- Note information demonstrating the CCGs compliance with the public sector equality duty will be published no later than 31 January 2014

TS.6.9.13

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<table>
<tr><td colspan="4">GOVERNING BOARD</td></tr>
<tr><td>Date of Meeting</td><td>18 September 2013</td><td>Agenda Item No</td><td>8</td></tr>
<tr><td>Title</td><td colspan="3">Risk Management including the Governing Board Assurance Framework</td></tr>
<tr><td>Purpose of Paper</td><td colspan="3">In line with the CCGs Risk Management Framework the Audit Committee has reviewed the Governing Board Assurance Framework, taking into account recommendations for changes and updates proposed by the Clinical Executive and this is presented to the Governing Board for their ratification.

Proposed additions and amendments are highlighted in red. Deletions are underlined and highlighted in purple. The Governing Board should note the following key changes:

• A new strategic risk related to estate is incorporated (GB09).
• A new strategic risk related to delivery of NHS Constitution rights and pledges is incorporated (GB10)
• In addition existing risks GB05, GB07 and GB08 have revised residual risks scores recommended.
• the GBAF is re-presented ordered by residual risk score

In addition other activities led by the Audit Committee with regards risk management include:

• approval of an updated Risk Management Framework to accurately reflect current processes and terminology
• oversight of the development of team level operational risk registers
• approval of an updated Standards of Business Conduct Policy
• approval of CCG Business Continuity Plans</td></tr>
<tr><td>Recommendations/ Actions requested</td><td colspan="3">The Governing Board is asked to review and ratify the Governing Board Assurance Framework and to note the other risk management activities led by the Audit Committee.</td></tr>
<tr><td>Author</td><td colspan="3">Tracy Sanders</td></tr>
<tr><td>Sponsoring member</td><td colspan="3">Tom Morton, Chair of Audit Committee</td></tr>
<tr><td>Date of Paper</td><td colspan="3">11 September 2013</td></tr>
</table>

Governing Board Assurance Framework

Last updated: 11.09.13

Ref	Area	Strategic Objective	Description of risk (CCG Risk Register Ref if applicable)	Responsible officer	Risk score L	Risk score I	Risk score S	Description of Actions (Key Controls/Processes)	Sources of Assurance (Data Inputs)	Further action needed for Improvement (stuff to be done)	Residual Score L	Residual Score I	Residual Score S	Movement	Status
GB07	Resources	D/E/F	Financial sustainability of key partners impacts on service delivery and outcomes for patients	Jo Gooch	4	4	16	- COMPACT - Sustainability programme - Board to Boards - Health & Well Being Boards - NHSE Wessex Commissioning Assembly	- CCG Finance reports - provider finance reports - alignment of financial plans and strategies - contract monitoring	- refresh LTF plans and quantify impact - collaboration with TDA	4	4	16	↑	open
GB10	NHS Constitution	F/D/E	Failure to meet the rights and pledges under the NHS Constitution results in a detrimental impact on patient services and experience	Innes Richens	5	4	20	- Contract monitoring, levers and penalties - Remedial Action Plans with Portsmouth Hospitals NHS Trust (PHT) - Commissioner work programmes with PHT and other providers to redesign and review services to improve delivery	- Contract monitoring groups including CQRM and ECRM - Performance Assurance Committee & PIAG - Governing Board and CCC integrated performance reporting - Remedial Action Plan performance reporting	- Develop system wide performance monitoring (kit bag) - board to board programme with CCGs and PHT - Escalation of concerns regarding performance to PHT Chief Executive from Clinical Leaders - Collaborative working arrangements with the Trust Development Agency - service redesign and attraction of additional resources e.g. national A&E monies	4	4	16	New	open
GB01	Quality	F/D	Failure of system-wide quality supervision and oversight, with resultant poor outcomes for patients	Dapo Alalade	4	5	20	-Interpretation of secondary care, community, mental health and other sources of care data to ensure appropriate priority of investment in care and compassion -Strategic relationships across local commissioners re quality- -feedback from patients across the system -intelligence from bodies and group such as Healthwatch - monitor relevant CQC activity in the area	- Soft intelligence via GP practices / patient complaints - cluster/trend analysis - work with patient and public involvement groups - systematic review of complaints and other patient experience data - provider quality reports - feedback from patient and public engagement lay member and registered nurse Governing Board member - oversight of friends and families feedback - Integrated performance reports	- systematic programme of service visits for all GB Members - systematic reporting of range of patient experience data - oversight of friends and families implementation (delete)	3	5	15	↔	open
GB04	Provider Relationships	C/D/G	Failure to achieve cultural change in providers necessary to achieve CCG commissioning intentions.	Jim Hogan	4	4	16	- Engagement with staff at all levels, from ward to board - quarterly strategic reviews - contracts and robust performance management, clinically led with clinical outcomes and focus on expenditure	- performance reports from Providers - provider staff attitude survey results - progress against commissioning intentions - sustainability programme performance - integrated performance reports	- Board to Board programmes - review of sustainability programme arrangements	3	4	12	↔	open
GB09	Estates	C/D/E/F	Lack of coherent and aligned plans for utilisation of estates across commissioners and providers in the System impacts on quality of service, patient experience and use of resources	Jo Gooch	5	4	20	- Sustainability Estates work programme - COMPACT - Wessex Commissioning Assembly - Provider Board to Boards - NHS Property Services liaison meetings	- Sustainability programme reports	- Commissioners workshop to review intentions - GB development session - CCG has clear estates intentions to support its commissioning and service strategies	4	3	12	New	open
GB03	Local Health Economy	C/D/E/F/G	Failure of Portsmouth / South East Hants Integrated Care Agenda	Innes Richens	4	4	16	- agreed commissioning intentions with local providers - understanding of the market - adequate access to primary care services - integrated commissioning board/health and social care - single commissioning team and approaches - health and well being board/sustainability board	- comprehensive and up to date understanding of the market evidence in GB and CCC discussions (delete) - urgent care delivery board - provider 18 point system plan - Delivery of integrated care projects and shift in provider approach	- system OD programme - finalise feedback from commissioning assurance programme - complete redesign of ED Front door	3	3	9	↔	open
GB08	Information Technology	E/D	Lack of coherent IT solutions that support the integrated care agenda.	Jo Gooch	5	4	20	- Directing IT strategy to support Integrated Care agenda - securing expert advice & leadership to the CCG - PSECC	- IT enabled change board - Urgent Integrated care delivery board - performance of CSU SLA/work programme - CCG IT strategy	- implementation of first stage of CCG IT strategy - Commissioners workshop to clarify requirements and expectations	3	3	9	↓	open

GB02	Engagement	A/B	Failure of member practices to engage across the full spectrum of the local health agenda	Jim Hogan	3	4	12	- Wider engagement with member practices - mechanisms for communications to practices about service transformation e.g. PIP and specific engagement events - primary care engagement team - primary care CQUIN (amended from commissioning incentive scheme) - practice visits	- Feedback from membership meetings - patient and public feedback on GP comprehension of local health economy key issues - intelligence from practice visits & other contact - primary care CQUIN monitoring	- mechanisms to enable all practices to contribute to commissioning plans - commissioning incentive scheme refresh (delete)	2	4	8	↔	open
GB05	Collaborative Working	C/D/F/G	Non-alignment of NHS England (Wessex)(amended from WAT) and CCG commissioning strategies lead to fragmentation of services	Innes Richens	4	4	16	- Agreed approach with local Area Teams - impact of commissioning decisions described effectively - analysis of commissioning intentions	- audit of commissioning intentions to check for gaps and overlaps - integrated single care pathways in place - LAT/CCG operating plans - NHSE (Wessex) two way assurance process	- alignment of NHSE(Wx) and CCG commissioning intentions and operating plans - collaborative contract monitoring - NHSE (Wx) participation in Sustainability Programme Board	2	3	6	↓	open
GB06	Collaborative Working	C/D/F/G	Failure of CCG Collaborative or failure of CCG to exercise sufficient influence in Compact affecting services provided to the population	Jim Hogan	3	4	12	- COMPACT infrastructure - effectiveness of Memorandum of Understanding/method of sharing delegations - considered approach as to decisions which are delegated to the collaborative - operational interdependence	- Reports from COMPACT - integrated single care pathways - regular monitoring arrangements for shared services	- detailed SLAs for hosted services signed off (hosted services regular monitoring arrangements in place - delete and move to data inputs)	2	2	4	↔	open

Strategic Objectives:

A	enable our GP surgeries as members to engage and drive commissioning	D	invest in improving and better health services
B	engage with our patients and public in our commissioning and decision making	E	manage our resources effectively
C	work with our partners to collaborate to deliver health improvements	F	ensure that our services are safe and focused on maintaining and improving quality
		G	develop the CCG as a mature organisation considered as credible and competent with the appropriate capacities and capabilities

Document Control:

Date	Version Number/Reason
6.2.13	First draft of GBAF by Beachcrofts following GB development session to develop
12.2.13	v1.1 for consideration by FCE for review and completion of responsible officer, risk and residual risk columns
01.3.13	v1.2 reflecting FCE review for consideration at Audit Committee 13.3.13
14.03.13	v1.3 reflecting Audit Committee 13.3.13 amendments for presentation to Governing Body May 2013 Approved by GB May 2013
16.07.13	v1.4 proposed updates to GBAF from JG/IR/TS review for consideration by FCE for review by Audit Committee in Sept 13
14.08.13	v1.5 FCE proposed amended GBAF for review by Audit Committee in Sept 13 - reordered by score
06.09.13	v1.6 Development of proposed new risk GB10 for consideration by Audit Committee 11th Sept 13
11.09.13	v2.0 Approved GBAF by Audit Committee 11 September 2013 for presentation to Governing Board 18th September 2013

NHS
Portsmouth
Clinical Commissioning Group

GOVERNING BOARD			
Date of Meeting	18 September 2013	**Agenda Item No**	9
Title	**Briefing Paper: 'The NHS Belongs to the People: A Call to Action'**		
Purpose of Paper	'The NHS Belongs to the People: a Call to Action', produced by NHS England in July 2013, recognises the successes of the NHS but also the current and future challenges facing it. It sets out the case for change for the NHS, suggesting the types of developments required and commits to a national programme of engagement with both NHS users and staff in order to generate further proposals. This briefing paper summarises the key messages from that paper and sets out NHS Portsmouth Clinical Commissioning Group's response.		
Recommendations/ Actions requested	NHS Portsmouth Governing Board is asked to note the national 'A Call to Action' paper and the alignment of current CCG work to the recommendations of that paper.		
Author	Innes Richens, Chief Operating Officer		
Sponsoring member	Innes Richens, Chief Operating Officer		
Date of Paper	29 August 2013		

NHS
Portsmouth
Clinical Commissioning Group

Briefing Paper: 'The NHS Belongs to the People: A Call to Action' - NHS England, July 2013

1 Introduction

'The NHS Belongs to the People: a Call to Action', produced by NHS England in July 2013, recognises the successes of the NHS but also the current and future challenges facing it. It sets out the case for change for the NHS, suggesting the types of developments required and commits to a national programme of engagement with both NHS users and staff in order to generate further proposals.

The full paper can be downloaded via the NHS England website here:
http://www.england.nhs.uk/2013/07/11/call-to-action/

This briefing paper summarises the key messages from that paper and sets out NHS Portsmouth Clinical Commissioning Group's response.

2 The Challenges to the NHS

'A Call to Action' identifies the following national challenges to the NHS:

Increasing life expectancy: Between 1990 and 2010 life expectancy in England increased by 4.2 years. Whilst premature deaths from heart and circulatory disease have reduced in the UK, we are not performing as well as other countries on some conditions (such as cancers).

High resource use for long term conditions: one quarter of the population have a long term condition and use a high proportion of health care services:

- 50% of GP appointments
- 70% of hospital beds
- 70% of total healthcare spend

People with more than one condition and, particularly, people living with higher levels of deprivation use higher levels of NHS resource.

Changing Burden of Disease: the 30% of people with one or more long term conditions account for £7 out of every £10 spent on healthcare in England. A model of hospital-based delivery of care no longer makes sense for managing this pattern of ill health, which requires a range of inputs and a good degree of co-ordination in the community.

Increasing emergency and hospital care demand: in England, over the past 10 years there has been a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75yrs. There has been a rise of 2.6% per year of hospital re-admissions.

Patient Experience: whilst a 2011 Commonwealth Fund Study of eleven national health services reported that 88% of patient in the UK described the quality of care they received from the NHS as excellent or very good, there are clearly areas requiring significant improvement. In particular, the frail older population, black and ethnic communities, younger people and vulnerable children traditionally report poorer experiences of our NHS services.

Patient Safety: high-profile cases such as Mid-Staffordshire Hospital and Winterbourne View demonstrate what happens if safety is not core to our business. Continuous attention to safety is required.

Health Inequalities: differences in health, illness and life expectancy are experienced by people from different groups in society. Health inequalities are generated by multiple influences - such as education, gender, geography, and economics. Only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risks.

Ageing Society: The proportion and absolute numbers of older people are predicted to grow, in particular in the over 85s. Two thirds of people admitted to hospital are over 65 years old and 70% of hospital emergency bed days are for the same age group. Health care expenditure on over 75s is, perhaps unsurprisingly, 13-times greater than the rest of the adult population.

Dementia: the number of people with dementia is predicted to rise from 800,000 currently to over 1 million by 2021, though more recent evidence suggests these predicted levels may be too high.

Lifestyle Risk Factors in the Young: the risk of developing debilitating illness is increased by personal and lifestyle circumstances. Drinking, smoking, poor diet and lack of exercise contribute to premature mortality. Evidence to support effective interventions is still patchy. There is not yet enough evidence to be confident about what will ensure, for example, sustainable weight loss for individuals.

Rising Expectation: patients and the public are increasingly expecting access to the latest therapies, more online information and also greater involvement in their care. The NHS needs to keep pace with other sectors in providing easier access to information and services. Increasingly people want seven-day per week access to primary care that is near their home, work or local shops and pharmacies.

Increasing Costs: the NHS provides a more extensive range of treatments, drugs and services each year. Many of these innovative therapies are at an increased cost and the range of services adds to NHS costs placing pressure on the affordability of a public NHS.

Limited Financial Resources: there is consensus at a national level that the NHS can expect its budget to remain flat in real terms or to increase with overall GDP growth at best over the coming years. This represents a slow-down in spending growth for the NHS. The gap between projected spending requirements and resources available is approximately £30billion between 2013/14 and 2020/21 (assuming no changes are made).

Pressures on Social Care: spending settlements for social care services have not kept pace with demand for social care, adding to the increased demand for NHS services.

Limited Productivity Improvement Opportunities: NHS productivity between 1995 and 2010 grew by 0.4% (Office of National Statistics, 2010) whilst in the economy as a whole it grew by 2%. The application of productivity measures and comparisons to a health service is still vigorously contested. However, NHS England's analysis suggests the NHS efficiency challenge could be 5-6% by 2015/16 (currently it is 4%). Measures already being implemented to meet the current productivity challenge (£20billion) will not be enough - a fundamentally more productive service is needed.

3 Future Opportunities

Throughout 'A Call to Action' a number of opportunities to address these challenges are highlighted. The table below summarises these. Many of these are already within the CCG's commissioning plan and being implemented locally; the table that follows gives a brief update on local delivery.

Theme	'A Call to Action' Recommendations	CCG Response
Better Prevention of Disease	Working more closely with partners such as Public Health, Local Authorities and Health & Wellbeing Boards to find ways to influence people's behaviors, encouraging healthier lifestyles Develop similar methods of assisting people adapt their diet, take more exercise or drink less alcohol as currently used to stop smoking. Review of health spending and how investment in prevention may be scaled up over time. Refocus the NHS workforce on prevention in order to better support individuals in community & primary care settings	The CCG has routinely made a commitment to public health work despite it not being a statutory CCG function. For example, the CCG's 2013 stakeholder event had a focus on inequalities in men's health, with a set of recommendations adopted at the August CCG Governing Board meeting. The CCG has strongly supported the need for a Director of Public Health for Portsmouth within Portsmouth City Council The CCG actively supports Public Health membership of key business groups The CCG is an active member of the Portsmouth Health & Well Being Board CCG sign-up to the Joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment incorporated into the CCGs Commissioning Strategy
Give people with long term conditions better control of their health	Support self-management, personalised care planning and shared decision making Implement Personal Health Budgets Manage patients and help them manage themselves, by understanding their individual risks (also known as 'risk stratification'). Ensure patients are supported by a range of professionals - ensuring there is close co-ordination amongst these different professionals. Facilitate this model by use of technology Work with Local Authorities and Health & Wellbeing Board to deliver more community-based care, including care delivered in people's homes.	Personalised care planning and shared decision-making is being adopted in Long Term Conditions care; for example it is in place for End Of Life care Personal Health Budget pilot is currently in place for NHS Continuing HealthCare Risk stratification: we are currently trialing different approaches in GP practices Integrated community teams - with primary care, health and social care are being trialed by clusters of GP practices in the City Technology: currently 2 projects underway (Florence and Portsdown Practice) Integrated commissioning with Portsmouth City Council is in place and being expanded

Theme	'A Call to Action' Recommendations	CCG Response
Integrated, 7-day week services (including urgent care services)	New thinking on how to provide joined up services across health and social care is needed, including at weekends. Develop 7-day per week access to primary care provided near people's homes, work or local pharmacies. Autumn 2013: expect first report of the National Medical Director on how to improve access to more services seven days a week. NHS England are currently conducting a review of urgent & emergency services (including addressing 7-day week services).	We have supported a primary care development programme, run by local GP practices working in clusters; this includes social care services and aims to join up services We currently transfer £3.2m of its allocation to Portsmouth City Adult Social Care per year to support integrated out-of-hospital care, including urgent care. This will rise over the next 3 years as part of the national Integration Transformation Fund delivery. We have delivered a review of urgent care - starting with the front-door of the Emergency Dept. The CCG will be commissioning a revised model of service for ED from October. We will next review minor injuries and walk-in provision in the City. We have made the national short-list to become an 'integration pioneer' – which will bring additional support to the City to join up services.
Maintain a focus on safety	Make it easier for staff and patients to report incidents and near misses.	We monitor the quality and safety of all NHS funded services through monthly quality reviews with each provider. Outcomes from these reviews are reported to the CCG Governing Board. We conduct service visits to talk to patients and staff and assess quality of services. We conduct clinical review of specific services with clinicians from that service (eg Solent Adult Mental Health Services) We have a dedicated, Portsmouth-specific Quality Team We review provider productivity plans to assess impact on quality of services. We have established feedback forms for GPs to raise any issues about services directly to the CCG as well as a feedback form on our CCG website for members of the public.

Theme	'A Call to Action' Recommendations	CCG Response
Tackle health inequalities with partners	Work closely with Local Authorities, Public Health and others to ensure co-ordination of healthcare, social care and public health services.	We are an active member of the Portsmouth Health and Well Being Board We have an established Integrated Commissioning Unit with Portsmouth City Council that includes elements of Public Health commissioning (eg services for children). The Integrated Commissioning Board oversees this arrangement and aligns priorities and plans.
Support older people to stay independent	Develop solutions such as Extra-care housing (very sheltered housing with care) for older people and people with long term conditions.	We continue to be a partner in the City's joint accommodation strategy that delivers extra-care.
Harness Transformational Technologies	Patients should have the same level of access, information and control over their healthcare as they do in other sectors (eg banking). Offer online access to individual medical records, test results and appointment bookings. Facilitate email consultations with individual clinicians. Develop at-home monitoring for long term conditions. From April 2013, 50 existing UK online centres in local settings (eg libraries, cafes) to receive funding to develop as digital health hubs for people to access online health information (eg from NHS Choices)	Currently 2 tele-health projects underway (Florence and Portsdown Practice) supporting people with long term conditions. We are working with GP practices to develop online booking, access to medical records and test results. We are a member of the Portsmouth & SE Hampshire IT Enablement programme – which aims to join up IT across different services to support better patient care We would acknowledge the need for broader regional and national support and approaches to improving access to technologies that assist staff and patients to deliver better care.
Transparent Data	Dramatic improvements need to be made in the supply of timely and accurate data - for people, clinicians and commissioners. From July 2013, publication of the results of the Friends and Family Test.	We agree and acknowledge that, whilst our local approaches to improving data continue, these must be supported by ongoing improvements at a regional and national level.

Theme	'A Call to Action' Recommendations	CCG Response
Move away from 'one-size-fits-all' models of care	Consider how the health service can invest in work to understand the biological basis of common diseases.	The CCG would be supportive of national moves to develop this area of work.
Seeing healthcare as a source of economic growth	Investment in individual's health delivers wider benefits to society and the economy (eg by reducing illness costs to the taxpayer, by improving the health of the workforce). NHS is the largest customer for the UK health and life sciences industries and Britain is a leader in biomedical research.	We recognise the wider benefits to society and the economy of supporting individuals to maintain or improve their health and wellbeing.
Invest in best-value services	Be rigorous about applying best-value considerations not just to drugs and technology but also throughout the healthcare system - including different models of delivering health and care services.	We are constantly improving our planning and procurement processes to assess for best-value for the Portsmouth pound.

4 The National Engagement Programme

NHS England intend to analyse in more detail the trends its highlights in its "Call to Action' paper and publish their findings. Consideration will be given to the recommendations from ongoing reviews (eg the Urgent and Emergency Care Review, the Berwick Review on safety)

There will also be a nationwide campaign called 'The NHS Belongs to the People: a Call for Action'. This will be a programme of engagement to seek contributions to the debate about the future of health and care provision in England.

CCGs will be expected to use the outputs of this engagement programme to develop a 3-5 year commissioning plan.

The engagement programme will involve:

- an online platform hosted by NHS Choices for staff, patients and the public to contribute their views
- 'Future of the NHS' surgeries with staff, patients and public at a local level and led by CCGs, Health & Wellbeing Boards and Local Authorities
- specific events designed to engage with NHS staff
- 'Town Hall' meetings at a regional level to engage local government and regional businesses
- National engagement events focusing on national organisations including the Royal Colleges, charities and the private sector.

Six CCGs: Dorset, North East Lincolnshire, Harrogate and Rural District, Hull, Birmingham South and Central and Enfield have expressed an interest to work with NHS England's Call to Action team on the development and content of the local and national engagement events, which will take place from September 2013.

A range of stakeholders, including members of the public, third sector, Healthwatch and health and wellbeing boards will be involved in the co-design phase and the overall shape of the campaign. The outcome will give the engagement exercise a structure, but not mandate it too much so that it can still fit with CCGs existing priorities.

NHS England are also working through other key elements of the 'Call to Action' campaign which includes producing dedicated resources for CCGs to use in their own campaigns, web and digital plans.

NHS England have also launched a specific consultation on primary care services. 'Improving General Practice – a Call to Action' was launched in August and is seeking views to help shape the future of general practice services in England. The consultation is being conducted primarily through an online survey on the NHS England website and will close by 10th November 2013.

The survey can be found here: http://www.england.nhs.uk/ourwork/com-dev/igp-cta/

5 What will not be considered as part of the solution?

NHS England sets out 3 options it will not consider as part of addressing the challenges set out in its 'A Call to Action':

i. Do nothing: the NHS cannot meet these future challenges without changing
ii. Assume increased NHS funding: NHS England do not believe it is either realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years

iii. Cut or charge for fundamental service or ‘privatise’ the NHS: reducing the scope of services the NHS offers would contravene the principles of the NHS and its Constitution. Charges for users or co-payments are also inconsistent with these principles.

6 Next Steps and Recommendation

In addition to the integrated of the principles and themes of ‘A Call to Action’ in the CCGs work programmes the CCG is also taking the following next steps specifically regarding the national initiative:

- Working with member practices specifically on the ‘Improving General Practice – a Call to Action’. This will be undertaken through the CCGs newsletter, PIP and its forthcoming member practices commissioning event where specific discussions will be facilitated.

- Jointly discussing this with the Health and Wellbeing Board

- Incorporating stakeholder and public participation in the national programme as part of the CCGs forthcoming Annual General Meeting – specifically seeking ideas and solutions from those attending on what should be considered nationally and locally for the future plans for the NHS

NHS Portsmouth Clinical Commissioning Group Governing Board is asked to note the national ‘A Call to Action’ paper and the alignment of current CCG work to the recommendations of that paper.

Innes Richens
Chief Operating Officer

August 2013

NHS
Portsmouth
Clinical Commissioning Group

<table>
<tr><td colspan="4">GOVERNING BOARD</td></tr>
<tr><td>Date of Meeting</td><td>18 September 2013</td><td>Agenda Item No</td><td>10</td></tr>
<tr><td>Title</td><td colspan="3">Older Persons Mental Health Services and Dementia</td></tr>
<tr><td>Purpose of Paper</td><td colspan="3">To brief the Governing Board on the current position, achievements to date and challenges ahead for Older Persons Mental Health and Dementia services</td></tr>
<tr><td>Recommendations/ Actions requested</td><td colspan="3">The Governing Board is asked to:
(i) note the progress of these developments and
(ii) receive an update early in 2014 on further progress</td></tr>
<tr><td>Author</td><td colspan="3">Suzannah Rosenberg</td></tr>
<tr><td>Sponsoring member</td><td colspan="3">Dr Tim Wilkinson</td></tr>
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NHS Portsmouth Clinical Commissioning Group Governing Board

Older Persons Mental Health & Dementia

1. CONTEXT

1.1 Dementia is a key priority for the CCG and the Health & Wellbeing Board

1.2 Prevalence forecasts for Portsmouth in 13/14, taken from the DPC[1] show -

- 2142 Portsmouth residents will have some form of dementia
- 55% (1178) will be mild, 32%(685) will be moderate, 13% (279) will be severe
- About a third (750) will be male and two thirds (1392) will be female
- 50 will be early onset (<65 years old) and 2092 will be late onset (>65 years old)
- 1669 will be living in the community and 473 will be living in residential care

1.3 In 2011/12 65.7% (1345 people) of the local predicted prevalence had a diagnosis, ranking Portsmouth 4th out of 211 CCGs in England for diagnosis to prevalence rate. Portsmouth CCG's target is for this to increase to an ambitious 80% (1753 people) by the end of March 2015 which could result in 400 more people accessing services.

1.4 The CCG and LA have been working together to implement Portsmouth's Dementia Action Plan in response to the Government's national strategy, "Living Well with Dementia" (DH 2009). NHS, LA and third sector organisations are committed to a vision for the city:

1.5 *Portsmouth aspires to be a dementia friendly city where people with dementia will be treated with respect and feel included in our local communities. We want everyone to be able to find information and advice about memory problems and dementia quickly and easily and for people with dementia to receive a diagnosis at the right time.*

In the future we want to see dementia services offering people greater choice and control over their care, enabling individuals to remain independent in their own home for longer and minimising the crises that have previously resulted in lengthy acute hospital stays or admission to long term care.

We aim to have advisory services and peer support networks available to support people with dementia and help their carers and families to access support throughout their lives as and when required. There will need to be a shift away

[1] Dementia prevalence calculator (By clinical commissioning group), adjusted for care homes in the area.

from acute care towards primary and community based service provision, including rehabilitation and reablement. Palliative care services should be available to support people with dementia achieve a peaceful end of life.

The personalisation agenda, with a focus on support delivered through self-directed support and ultimately personal health budgets will help change the way people with dementia access personal support services in the community. Support for carers is key and this will be progressed through the Portsmouth Joint Carers Strategy.

People with dementia, their carers and the wider community will be involved in improving and developing both a dementia friendly city and needs-led dementia services through a thriving dementia network.

2. CURRENT POSITION

2.1 We have a well respected and responsive secondary care service provided by Solent NHS Trust which affords excellent communication channels between GPs and Consultant Psychiatrists and provides excellent referral to treatment timeframes.

2.2 We have a specialist mental health inpatient unit, The Limes, at St James which was built just 5 years ago. Delayed discharges from The Limes have been consistently below the national target of 7.5% for many years which means that people are not having unnecessary and inappropriate stays in hospital.

2.3 Delayed discharges from QA for dementia patients are also much lower than our neighbouring CCGs, currently 17 days average. However, we acknowledge that this is still too long and these delays can often contribute to a further deterioration in mental health. The CCG has agreed with secondary care providers (Portsmouth Hospitals Trust and Solent NHS) a quality incentive scheme (CQUIN) for this year which will aim to reduce this further to 11 days.

2.4 For 13/14 there is a national quality incentive scheme (CQUIN) for dementia for acute NHS service providers (Portsmouth Hospitals NHS Trust) which has three parts:

i. Find, Assess, and Refer
ii. Clinical leadership
iii. Supporting carers

For Q1, PHT are reporting that they have achieved parts ii and iii but part i remains a challenge and they have failed to achieve the target of 90% for each element (Find, Assess and Refer) for 3 consecutive months. Anecdotally, Solent NHS report that they have yet to see an increase in referral rates as a result of this CQUIN and further investigative work is required to understand if and why this is the case.

2.5 We have a thriving third sector and organisations such as Alzheimer's Society and Age UK, are vital sources of support.

2.6 Reducing anti psychotic prescribing for newly diagnosed patients is a priority for the CCG and we have set ourselves a target of reducing from a baseline of 14.8% (2011) to 12% by April 2014. Early results for Q1 indicate that we have already achieved a reduction to 8.33%

2.7 The long standing partnership between the Local Authority and the CCG which has resulted in joint strategies for Carers, End of Life, and Accommodation for Older People provides a positive environment for working together to improve the health and social care outcomes for Portsmouth residents.

3. CHALLENGES AHEAD

3.1 However, despite these positives, there are challenges ahead if we are going to meet the rising demand for services. We will need to:

- Harness the expertise of the third sector to support people with lower levels of need to live well with their dementia and maximise their independence
- Support carers to continue to care for their loved ones and stay healthy themselves
- Support the role of Primary Care in early referral for diagnosis and ongoing support or dementia patients
- Focus secondary care resources on supporting people with high and complex needs.
- Ensure that people attending or admitted to QA with confusion or a diagnosis of dementia receive the best possible care and are discharged as soon as it is medically safe to do so to prevent further deterioration of their mental health

3.2 We have already started work to tackle these challenges:

- We have commissioned the Alzheimer's Society to provide a memory café which will run weekly from two venues (one in the north and one in the south of the city) from November. This will be a vital source of support and information for people who are newly diagnosed with dementia and their carers

- We have commissioned a number of one year pilot projects to test out different ways of supporting people with dementia and find out what works:

    - Dementia Voice Nurse (Housing 21) who acts as an expert practitioner, advocate and facilitator. The dementia voice nurse will be a point of contact for families and carers *providing* support and training, reducing real or perceived carer isolation and breakdown.

They will also liaise with external agencies and provide a consistent link with families, GP's and other healthcare practitioners

  - Dementia Advisors (Solent Mind) working at QA and in the local community. The Advisors will work with dementia patients and carers before patients go into hospital to ensure their needs are met and understood; will work with patients in hospital to ensure their care is person-centred and will also work to develop a 'dementia friendly community' by raising dementia awareness with local agencies such as the police, retailers and community centres
  - Telecare (PCC) - working with local pharmacists, will be trialling the use of assistive technology options to help people manage taking their medication. The technology will include automatic medication dispensers and stand-alone medication reminders to help ensure people are taking their medication as prescribed.

- We have commissioned an independent review of Solent NHS' secondary care service to explore what could be done differently. This has identified some areas to focus on which need further discussion and consultation over the next 9 - 12 months:

  - Exploring the role of primary care in the ongoing and routine monitoring of stable patients
  - The role of secondary care services in the provision of day treatment services
  - Optimising the configuration of the Limes to provide specialist inpatient services for people with high levels of challenging behaviour who currently are placed outside of the city
  - Allocating resources to support the right level of psychiatric liaison services in QA

4. CONCLUSION

4.1 We are fortunate in Portsmouth that we have a good foundation to work from but to make the best use of the Portsmouth pound and meet the rising demand for services we will need to change the way services are delivered. Patients and carers may find these service changes difficult and we need to ensure that patients remain at the centre of our decision making and that we take the time to understand the impact of potential changes on our patients, their carers and that the quality of their care is not affected as a result.

5. RECOMMENDATIONS

5.1 The Governing Board is asked to:

(i) note the progress of these developments and;

(ii) receive an update early in 2014 on further progress

Suzannah Rosenberg
Head of Integrated Commissioning Unit
2 September 2013

NHS
Portsmouth
Clinical Commissioning Group

GOVERNING BOARD			
Date of Meeting	18 September 2013	**Agenda Item No**	11
Title	**Minutes of Other Meetings**		
Purpose of Paper	To accept the following: • Minutes of the Clinical Commissioning Committee Meeting held on 3 July 2013.		
Recommendations/ Actions requested	Accept		
Author	Various		
Sponsoring member	Innes Richens – Chief Operating Officer		
Date of Paper	10 September 2013		

NHS
Portsmouth
Clinical Commissioning Group

Minutes of a Meeting of the Clinical Commissioning Committee held on Wednesday 3rd July 2013 at 1.00pm – 3.30pm in the Committee Room, CCG Headquarters, St James' Hospital

Summary of Actions

Agenda Item	Action	Who	By
5	Joined Up Services for the Elderly The CCG Executive Team to proactively engage with PCC to discuss how integration could progress to ensure benefits to all parts of the system.	CCG Executive Team	Future meeting
9	Quality Report – Out of Hours C Pond to source and indicate target thresholds against performance.	C Pond	Next meeting
9	Out of Hours C Pond to obtain clarification of process for direct bookings, and information on delays and call backs	C Pond	Next meeting
11	At the next TARGET session, practices will be informed of the policy & guidance. They will also be updated with the details of the new Safeguarding Nurse (once recruited).	D Alalade	TARGET Sept. 13
12	2013/14 Planning Paper OPMH Services Suzannah Rosenberg to produce a paper for this committee regarding the review of The Lowry Day Centre Service use	S Rosenberg	Future meeting
13	Primary Care Development – Nurse succession Julia O'Mara to provide Katie Hovenden with Allan Jolley's contact details at the Wessex Deanery.	J O'Mara	Next meeting
14	Stakeholder & 3rd Sector group management Innes Richens to draft the proposal for engaging with stakeholders & 3rd Sector groups and circulate for information. To be discussed at a future meeting.	I Richens	Future meeting

Present:

Dr Dapo Alalade - Clinical Executive Member
Dr Linda Collie - Clinical Executive Member
Dr Elizabeth Fellows (Chair)- Clinical Executive Member
Katie Hovenden - Director of Professional and Clinical Development
Tom Morton - Lay Member
Julia O'Mara - Practice Nurse Representative
Jackie Powell - Lay Member
Dr Jonathan Price - Clinical Commissioning Lead
Dr Matthew Smith - Consultant, Public Health, Portsmouth City Council
Dr Kevin Vernon - Clinical Commissioning Lead
Dr Tim Wilkinson - Chair of Governing Body/Clinical Executive Member

In Attendance

Alex Berry - Chief Commissioning Officer
Michael Drake - Head of Performance and Planning
Suzannah Rosenberg - Head of Integrated Commissioning
Terri Russell - Head of Primary Care Engagement
Michelle Spandley - Deputy Chief Finance Officer

Linda Foster - Assistant Development Manager (Minutes)
Claire Pond - Clinical Quality Officer, NHS South CSU (Item 9)

1. Apologies and Welcome

Apologies were received from Dr Jim Hogan, Innes Richens, Jo Gooch, Jan Matthews, Julie Hawkins and Julian Wooster

2. Declarations of Interest

None

3. Minutes of Previous Meetings

The minutes of the Clinical Commissioning Committee held on Wednesday 5th June 2013 were approved as an accurate record.

The summary of actions from Clinical Commissioning Committee held on Wednesday 5th June 2013 were discussed and reviewed as follows:

Agenda Item	Action	Who	By	Progress
3 (1.5.13)	Innes Richens to prepare a message to practices regarding OOHs performance after the contract review meeting.	IR	Next meeting	In hand – EF to link with IR.
5 (1.5.13)	Dr Jim Hogan to raise the issue of CCG representation on LETB at the next Wessex Assembly.	JH	Next meeting	Dr Andrew MacFarlane is the representative.
6 (1.5.13)	Innes Richens and Mark McLaughlin to set up a working group to oversee delivery of actions in relation to The Francis Report and report back to CCC.	IR	Next meeting	In progress – the Quality team are looking at dates
5	Sarah Malcolm to work with Jon Price and Vicky McDonald-Wood to review services provided by the Rowans, particularly Hospice at Home, in terms of identifying funding gaps.	SM/JP/VMW	Next meeting	Work in progress. A business case for Hospice at Home to be produced.
5	JSNA Steering Group – suggestions for new pieces of research to be forwarded to Jon Price or Matt Smith	All	ASAP	Work in progress
6	Plans for revision of the Front Door to be brought to the next CCC meeting as a specific agenda item.	MD/LF	Next meeting	Actioned
6	Mike Drake to circulate the response from PHT regarding analysis of re-attendances at A&E once received.	MD	ASAP	Actioned

Agenda Item	Action	Who	By	Progress
6	Mike Drake to highlight the difference between RTT performance at PHT level and CCG level at a future meeting.	MD	Next meeting	Actioned
8	Jon Price to provide information to Melissa Way on additional outcomes which should be included in the Integrated Care Plan	JP	Next meeting	Actioned
8	Mike Drake to ask Melissa Way to update the plan with average numbers of patients on the CFC Register ie 0.5%	MD	Next meeting	Actioned –plan updated
9	Claire Pond to pull out the data for Portsmouth Category A calls and report next time.	CP	Next meeting	Actioned – in report
10	Jo Gooch to ensure governance of the AIMS project reports into the IT Enabling Change Board	JG	Next meeting	Actioned
11	Programme Budgeting Benchmarking Information Report – Any questions to be sent via email to Michael Drake and the Planning Team	All	Next meeting	None received
12	Jo Gooch to take the Informatics Strategy to the CCG Governing Body Meeting in July 2013 for ratification/final approval.	JG	Next meeting	Actioned Governing Board July 2013
14-17	Draft SHIP Priorities Committee Policies for Recommendation Tim Wilkinson to check that Alex Berry's team (Planned Care) will make PHT aware of the recommendations which have been endorsed by this Committee.	TW	ASAP	Actioned
13a	Catherine Powell/successor to bring CCG Safeguarding Children Strategy to this meeting.	CP or her successor	Future Meeting	Will be available for the August meeting.

4. Deferred Items/Matters Arising

None

5. Clinical Priority: - Joined Up Services for the elderly

Suzannah Rosenberg presented a paper to update the Clinical Commissioning Committee on the progress of delivering integrated community services and highlighted certain areas:

- Evaluation is being undertaken of a Central Cluster pilot that has been operating over 5 practices over the last 6 months. Integrated working with 1% of the practice population

with the most complex needs. The pilot has shown improved communications, hospital admissions have fallen slightly and overall the amount of domiciliary care was reduced. Also there is a reducing trend in the amount of CHC eligibility across the city.

- Portsmouth Rehabilitation and Reablement Team (PRRT) have moved to 7 day working with a community geriatrician support.
- The Grove Community Bed pilot is doing well; open 7 days per week until 10 pm at night. 14 beds providing mostly 'step down' bed care by nurses and HCSWs.
- 8 community based reablement pilots have been launched to help support people stay safe in their own homes after hospital discharge.

Suzannah gave an overview of the next steps planned for the various areas of integrated commissioning work. There was discussion around delivery of the 3 KPIs agreed with Solent NHS to support additional re-investment in community services. In particular, engaging with GPs managing the community 'bed stock' to create step up beds, integration of PPMH CMHT and Intermediate Care Services with the cluster/virtual ward model and piloting proactive case management of patients who have not yet reached the criteria for inclusion in the risk stratification cohort.

The team are looking to pilot a 4 bedded area/unit for older patients with challenging behaviour in a nursing home environment in the Portsmouth area. A business case to be worked up with the possibility to link primary care and Solent NHS.

The Committee agreed it would be a good time to proactively engage with PCC to discuss how integration could progress to ensure benefits to all parts of the system.

Action: CCG Executive Team

The Clinical Commissioning Committee noted the contents of the report

Update on Long Term Conditions

Alex Berry gave a verbal update to the Clinical Commissioning Committee on LTCs. A more detailed report will be provided for the next meeting.

- The planned care team have done a lot of work on pathways for heart-failure and respiratory, these are being shared with commissioning leads, community providers and the acute trust, and are close to being signed off.
- Neurology services were discussed with GPs at one of the Commissioning Evenings and a number of actions are being undertaken as a result.
- Discussions and work is on-going regarding gynaecology, lower GI and endoscopy pathways.

6. Clinical Priorities: Children, Families and Maternity Services update

Jackie Charlesworth presented a paper to update the Clinical Commissioning Committee on the progress on commissioning children, families and maternity services:

Priorities for 13/14
A rag-rated chart showed progress to date and achievability of the priorities for 13/14.

CAMHs Review
Jackie reported the review will be finished by the end of July. It was noted that the model required for Portsmouth patients' needs to be seamless and not impacting on savings.

Maternity Services Liaison Committee (MSLC)
Jackie advised that in respect of the MSLC Review, there have been some funding issues but work is on-going. The MSLC will continue to be funded for the remainder of the financial year in partnership with SEH CCG, and the name will be changed to "Maternity Watch".

Palliative Care Review
A SHIP review of children's palliative care concluded that a fixed number of hospice beds should be contracted across the PCTs/CCG in order to provide inpatient palliative care. However usage is low in Portsmouth as most children are supported to die at home via the children's continuing care nursing team commissioned from Solent NHS. Children in Portsmouth that need a bed in a hospice can currently go to Naomi House via the continuing care route as spot purchased beds. The CCC supported the proposal to NOT purchase palliative care beds and to continue with existing arrangements.

Annual Medical Assessments
Changes to national policy for the annual medical assessments of 'looked after children' and those in the Youth Justice system are being looked at. Work is in progress to clarify the process and whether to use capacity in paediatric services or commission from Solent NHS.

COAST
The implementation plan is being finalised to deliver the COAST local quality measure.
Good news, stories of best practice and triumphs to be used to feedback to practices.

Relationship with the Wessex Local Area Team
- Health visiting Immunisations
- Vaccinations for children with disabilities.

Jackie Charlesworth will be meeting with Nikki Osborne to identify and clarify what local commissioning involvement entails for both issues.

The Clinical Commissioning Committee noted the progress made on Children, Families and Maternity Services

7. Plans for Front Door Revision

Alex Berry provided a verbal update to the Clinical Commissioning Committee on the plans for Front Door Revision at the Emergency Department PHT.

The three local CCGs have been working with partners to ensure that the patient journey is effective and of high quality at the Emergency Department (ED). Attendances at ED have increased by 4-5% which is in line with increases nationally.

Dr Jim Hogan chairs the working group that have designed the new clinical model for the Front Door ED which addresses the number of attendances. The model has a GP at the front door of ED, who will triage the patient on arrival. Ambulance arrivals will also be triaged, if they do not go straight into majors.

The service specifications will be circulated for comment in the next few weeks.
KPI measures are key to ensure that the patient is re-directed in the right way.
The CCG Executive are encouraged to read through the specifications and send comments to Alex Berry.

The aim is for the model to be in place by the end of September, in time for the winter months. Discussions are on-going regarding staffing.

The model is explained briefly as below:

'seen' the patient is triaged an appointment is booked with the patient's own GP,
'treat' patient will be seen and treated in a primary care setting/area, or
're-direct' the patient is redirected into the emergency department

A paper outlining the proposals will be taken to the CCG Governing Board on 24 July 2013

8. Integrated Performance Report

Mike Drake explained that this is the first of the new Integrated Performance Report, which combines the finance and performance positions and in time will also include the Quality report.

Mike presented the report and highlighted the CCG Performance Dashboard which provides a holistic view for the CCG. Mike gave an overview of the headline achievements for the first month of 2013/14.

A significant achievement was noted, in that PHT have achieved 97.7% of patients admitted, transferred or discharged within 4 hours of arrival at A&E. This is the first time since September 2012 that the 95% target has been reached.

Key risks to the CCG delivery and the mitigating actions taken were noted for the following:

Referral to Treatment Time (RTT)
PHT has flagged that it will underperform at Trust level with regard to Trauma and Orthopaedics in July and are issues with regards to RTT for Urology. A letter of concern has been sent through the contractual route.

Ambulance handovers
Ambulance handover delays remain a significant challenge. PHT and SCAS have formed a working group to address the level of delays. Penalty charges have imposed scrutiny of delays. CCG will charge PHT for handover delays, and SCAS will in turn charge the CCG for their costs. It is envisaged the Front Door redesign model will help reduce delays.

Cancer waits
A letter of concern has been sent to PHT regarding cancer waits. The response received advised of follow up remedial action to address this.

Hospital Standardised Mortality Ratio (HSMR)
PHT's HSMR for April was 102. The Quality Team undertook a review of HSMR. Assurance was sought that the number would return to 100 (national average)

Finance
CCG allocations have been published however risk remains around Specialised Services 'maximum take' deduction of £12m. The CCG is working closely with the Wessex Area Team to ensure Specialised Services remain cost neutral to the CCG. Michelle Spandley reported that the issue should be resolved by the end of July. She added that financial pressures around the system have an impact for the CCG.

IAPT
Negotiations are on-going with Solent NHS regarding the IAPT Service.
Michelle Spandley and Suzannah Rosenberg to meet with Solent this week regarding financial issues.

The Clinical Commissioning Committee accepted the Integrated Performance Report

9. Quality Report

The Quality Report was presented by Claire Pond Clinical Quality Officer for NHS South Commissioning Support Unit. Claire highlighted the main issues contained within the detailed report:

NHS 111 Service
Claire Pond explained that the NHS 111 service is making strides now. She explained the process for patients calling the 111 Service.
The Quality Team may undertake a review of 111 and how it connects to other services.

Out of Hours
Claire Pond to source and indicate target thresholds against performance.
Claire Pond to obtain clarification of process for direct bookings, and information on delays and call backs.

Action: C Pond

SCAS
The SCAS Action Report will be included in the Quality Report for next month's meeting.

Guildhall Walk
Claire Pond has been chasing the Local Area Team for an update on Guildhall Walk HealthCare Centre; it is hoped to be able to share this by the next meeting.

PHT headlines:
Health Care Acquired Infections (HCAIs)
0 cases of MRSA, 1 case C.Difficile against month trajectory of 4
SIRIs – 4 grade 3 pressure ulcers, 2 unexpected deaths, one delay in treatment.
Assurances are in place and the situation is being monitored.

The CCC was asked to:

- Review quality and safety measures
- Review appropriateness of actions where suboptimal performance is identified
- Make recommendations for further action where required

The Clinical Commissioning Committee reviewed and accepted the contents of the Quality Report, no recommendations for further action were made.

10. Safeguarding Children & Adults

a) Update on Safeguarding Policy

Dr Dapo Alalade introduced a paper written by Catherine Powell (Consultant Designated Nurse Safeguarding Children). The DH commissioned report into the Saville allegations led by former barrister Kate Lampard, are still awaited. The report is likely to have implications and a number of recommendations for commissioning and provision of health services.

The Quality and Safeguarding Executive Group have considered a draft Safeguarding Children Strategy for ensuring compliance with national policy directives. Amendments to the strategy will be incorporated and the document will be brought to this Committee at a future meeting.

b) Serious Case Update – CONFIDENTIAL

A confidential paper was provided regarding an update on current serious case review activity.

The Clinical Commissioning Committee noted the paper.

11. Pan Hants Safeguarding Adults Policy – May 2013 for approval

Dr Alalade presented the Safeguarding Adults Multi-agency Policy, Procedures and Guidance document which has been developed by the four local safeguarding adults boards (4LSAB) covering Hampshire and the Isle of Wight. The full document was attached to the Agenda.

It was noted that the policy and guidance must be followed by GP practices, and that it would be useful for a summary of the guidance to be put onto PIP or for practices to be advised of the relevant sections in the policy.

At the next TARGET session, practices will be informed of the policy & guidance. They will also be updated with the details of the new Safeguarding Nurse (once recruited).

Action: D Alalade

The Clinical Commissioning Committee accepted and approved the Pan Hants Safeguarding Adults Policy

12. Portsmouth CCG 2013/14 Planning Paper

Mike Drake presented the 2013/14 planning paper. The review pack contained a summary of all plans submitted and included four plans required to be reviewed going forward. Mike outlined the details of the plans which were noted by the Committee members.

A discussion was held regarding the planned initiative already in place for the Redesign of OPMH Services & Implementation of the National Dementia Strategy. The outcomes of which are delivery of required OPMH services within reduced financial budget, that do not result in reduced quality or capacity to deliver support.

Suzannah Rosenberg advised there will be a review of The Lowry Day Centre day service use.

The Clinical Commissioning Committee agreed a paper to be brought to the CCC for discussion.

Action: S Rosenberg

13. Minutes of Other Meetings

The following were presented for noting:

- Minutes of the PSEH Commissioning Collaborative held on 8th May 2013
- Minutes of the Quality & Safeguarding Executive Group held on 14th May 2013
- Minutes of the Integrated Commissioning Board held on 14th March 2013
- Minutes of the IT Enabling Change Board held on 3rd April 2013

Matters arising from the Minutes of the PSEHCC meeting:

- **Primary Care Development**
  Dr Jim Hogan and the primary care development team will be looking at succession planning for GPs.
  Julia O'Mara to provide Katie Hovenden with Alan Jolley's contact details at the Wessex Deanery for details relating to nurse succession planning.

Action: J O'Mara

The Clinical Commissioning Committee accepted the above minutes

14. Any Other Business

Stakeholder and 3rd Sector group management
Innes Richens to draft the proposal for engaging with stakeholders and the 3rd sector groups, which will be circulated for information in due course and discussed at a future meeting.

Action: I Richens

Veterans
Dr Elizabeth Fellows advised that the Veterans Outreach Support have been awarded funding for their bid for LIBOR funds for the next two years. This is to deliver support to military personnel and veterans in the Portsmouth and South East Hampshire area.

15. Future Agenda Items for 7th August 2013

- **Domestic Homicide – Dr Alalade/Quality Team**
- **Clinical Priorities: 2 items for focus each month:**

  - Urgent & Emergency Care – Dr Hogan/Alex Berry

  - Care Closer to Home (planned care) – Dr Wilkinson/Alex Berry

16. Date of Next Meeting

The next meeting will be held on Wednesday 7th August 2013 at 1:00 pm in the CCG Committee Room, St James' Hospital.

Linda Foster 11.7.13 v2