NHS
Kernow
Clinical Commissioning Group

GB2021/088

Meeting of the Governing Body

Summary sheet

Date of meeting: 2 February 2021
For: Public session (Part 1)
For: Decision

Agenda item: Finance and performance committee chairs report

Author(s): John Yarnold
Presented by: John Yarnold
Lead director/GP from CCG: Clare Bryan, chief finance officer
Clinical lead: Dr Francis Old and Dr John Garman

Executive summary

Finance report
The committee received the finance report for month 9 and noted the current and the forecast financial positions.

Performance Report

The committee noted the report and raised a number of issues with the planned care team:

- level of virtual OP activity, although below target consistent with average performance across the country and the OP transformation group are addressing how to improve this
- Addition of >52 week waiters at Duchy hospital. The issue seems to be associated with the EPR system in use and in future the planned care commissioning team are now working with the provider and the NHSE regional office who currently hold the contract for private sector planned care to ensure this does not recur
- UHP additional trolley waits >12 hours. Not sure whether this was single cause variation and the performance will be monitored closely over the next couple of months in case there is a systemic issue
- A number of issues raised on MH, dementia prevalence, IAPT access and increase in out of county bed days still awaiting a response but will follow up outside of the meeting

Performance exception report
A report from infection control was presented in response to a question on the increasing numbers of E Coli and C diff. Although causation wasn't certain there

were indicators to suggest this may be due to prescribing protocols in the pandemic for concomitant prescribing of PPIs with steroids and antimicrobials. It was noted though that the increase started in summer of 2019 so other elements may be an issue, but possibly also linked to prescribing. We were led to understand that the issue is being passed to the CCG prescribing team to investigate further

RCHT access policy

As commissioners we are being asked to approve RCHT planned care access policy. The committee noted that the policy was very lengthy (76 pages) and unlikely to be read. There was a lack of cross referencing and some elements that were misleading (lack of explicit statement on when clock starts on referrals through RMS and omission of needing to demonstrate notice of appointment given to patient when removing them from the waiting list after a DNA). The planned care commissioning team were also suggesting that there should be a system wide policy and that we needed to seek assurance that staff involved in the process were adequately trained. The decision was bot to approve but to refer back to RCHT with these comments

Commissioning policies

A number of new policies were presented to the committee as follows:

- Spinal injections for sciatica
- Injections for non specific low back pain without sciatica
- Radiofrequency denervation policies

These were all approved; one existing policy was reviewed and included changes

- Removal of troublesome earwax. This policy was also approved

Recommendations and specific action the governing body needs to take at the meeting

The committee is asked to:

1. Note the report set out above
2. Receive a further update in February 2021

NHS
Kernow
Clinical Commissioning Group

Minutes of the finance and performance committee

24 November 2020
1.30pm
MS teams

Attendees

- John Yarnold, chair and lay member for fiscal management
- Clare Bryan, chief finance officer
- Fran Old, GP and governing body lead
- John Garman, GP and governing body lead
- Sam Cox, pa to chief finance officer and minute taker

Apologies

Minutes from the meeting

Item FPC2020/102 – welcome and apologies

John Yarnold welcomed all the meeting held via MS teams due to COVID-19 pandemic.

Item FPC2020/103 – declarations of interest

Declarations of interest made by members of the finance and performance committee were circulated with the agenda and supporting papers. The full declaration of interest register is available via the corporate governance team.

There were no new declarations of interest made.

Item FPC2020/104 – Ratify minutes of meeting held 27 October 2020

The minutes of the meeting held on 27 October 2020 were agreed and signed as a correct record.

Action grid: The action grid was reviewed and updated.

Matters arising: there were no matters arising.

Item FPC2020/105 – Finance update: month seven including COVID-19 expenditure

As previously reported, the 2020/21 financial regime changed at the end of September 2020. Over the past six months, NHS Kernow has received top up funding to bring back to balance and at month six, reported a requirement of £1.03million to bring back to balance.

Month seven, is the first month of the fixed envelope regime. Reports for the first six months and a month seven return have been submitted and now awaiting the retrospective top up for month six, however we have been aware there could be a delay.

Item FPC2020/106 – Risk and assurance framework

Jess James reported the Quality Committee had reviewed their red risks and there were a number that would re-assigned back to the finance and performance committee as these related to performance and not patient harm. The risks will be sent to the risk owners to review and adjust the scores if patient safety isn't a performance risk.

RR10676: SLS risk: Due to an unexpected invoice from Cornwall council for £1.8m for 2019/20, the risk score to be increased. This is a financial issue at present, but a cause for concern as there is no clear CCG commissioner responsible for this risk.

Jess James reported that there were a number of risks that were referred to the quality committee that were being referred back as the quality risk was believed to be low. John Yarnold suggested that the current scores were an amalgam of risk and quality and perhaps these should be rescored to reflect the lesser impact of the performance target breach

ACTION: Jess James to amend the risk score to 20 and add to GB report.

There were no further actions required on the RAF.

Item FPC2020/107 – Better care fund update

Gill Thornton joined the call at 2.05 and provided an update on the better care fund, noting the report covered the final submission on 2019/20 and included a report on quarter two 2020/21.

The committee noted a detailed financial plan for this year had not yet been agreed, partly due to the fact that national guidance has not been published but there were planned elements such as the generic support workers at a cost of £1,4000,000 that were not included in the iBCF and are being covered non-recurrently through COVID-19 funding. This together with the agreement on shared of the SLS remain unresolved for this year and future years.

Item FPC2020/108 – Exception report for RR10711, cancer update

Loraine Long joined the call at 2.40. Clarity was requested by committee members on Risk: RR10711: there is a risk UHP fail to consistently achieve the national cancer, performance targets (62 day, 31 day and 2 week waits) resulting in harm to patients, poor performance and harm to reputation. The concerns were around the upper GI and the root cause of this issue as well as around the issues around colonoscopy and endoscopy, noting endoscopy lists have been reviewed and capacity increased, but a risk remained. Loraine Long advised there are national issues with these specific pathways, but there are plans in place with peninsula cancer alliance (PCA) to improve these services by focusing on the early stages of the pathways and support meeting not only the 2 week urgent referral for suspected cancer but also the new 28 day faster diagnosis standard (FDS), which should improve both the 31 and 62 day targets.

Loraine Long to update the risk register and provide an update to the committee if this issue hasn't been resolved or the actions proposed are not having an effect.

Item FPC2020/109 – 2020/21 performance reporting month five, September

John Groom joined the call. John Yarnold noted the committee had raised a number of issues regarding outpatient performance at RCHT, and in particular the low level of virtual appointments compared to other hospitals and the increase in follow ups. John Groom noted the ratio for follow ups has been due to consultants not seeing new patients. A piece of work is being undertaken to address these issues and an update to be shared at a future meeting.

Harm reviews for 52week waits. John Groom noted these are clinical reviews, but there wasn't an effective reporting mechanism in place. A dashboard is being developed.

Action: John Groom to take an action to consider additional assurance around clinical waits and clinical harm and update to the Feb meeting.

Following concerns raised at the October meeting, Sarah Foster requested exception reports on ambulance handover delays, dementia diagnosis and memory clinics and infection control. The updates are submitted below for information:

Ambulance handover delays – Julie Green

All CCGs and acutes are seeing increased handover delays. This has been exacerbated at RCHT due to the necessary ED building work which has reduced the assessment and handover bays temporarily. Also, due to social distancing there is no corridor queuing. Patients who would have previously been brought into the department and wait in the corridor now are not permitted to do this. There are also flow requirements within the hospital which mean the processing of patients for safety reasons takes longer – such as determining the patients COVID status and

thus where to direct their care to – red for COVID, green for non COVID and amber where there is uncertainty. The testing machine capacity at RCHT has been increased but there are still issues with waiting for the test result. Additional issues relate to flow within the hospital. The requirement for social distancing means capacity is also under pressure and onward care such as packages of care and care home placements all take longer due to COVID and are in reduced supply. All these factors impact on the front door flow for arrivals.

It is not demand driven, as ambulance activity has now returned to normal levels, although was higher than profiled in the post lockdown period (4 July onwards until the end of summer holidays and then a significant peak in September when schools and universities returned. However, in recent weeks activity has returned to slightly below normal levels. Increased demand in the peak weeks was driven by managed (so public) calls and there was no new increase in HCP or 111 demand.

Dementia diagnosis and memory clinic – Tim Francis

The memory assessment service referrals prior to COVID-19 were handled by each memory assessment service. During the initial lockdown a revised process was set up whereby all referrals were handled by the east memory assessment team (MAS) to triage and support. The east memory assessment service is recording and retaining the number of referrals it is receiving. However, this information does not appear to be feeding into the current report. The number of referrals to MAS before triage for September and October across the whole county was 276 referrals.

Allison Hibbert, our GP Clinical Lead for dementia has been working in that triage process. Many of the referrals from primary care could be easily diagnosed by GPs who have access to the patient history. Allison has therefore been working with those surgeries to be able to confirm the diagnosis without further need for assessment within MAS. This has enabled expedited diagnosis and has led to significant numbers of new diagnoses per month (at least 57 people in August and at least 80 people in September). This is against a local and national picture of a reduction in numbers of people with dementia due to Covid related deaths.

The MAS referral process form part of the development of the e-referral programme and is currently in development. At present it will be set up to still refer to each memory assessment service. The memory assessment service is currently under review as part of the Dementia Programme. That review will identify if there is a need to retain the single referral point established as part of Covid (and therefore amend the E-referral process and the data feed of referrals to Business Intelligence) or to retain the current standard referral to the individual MAS and therefore the existing BI data.

Infection control – Lisa Johnson

Both E.coli and C.diff can be found in the healthy gut so testing on admission is not helpful.

The E.coli infections we measure are bloodstream infections, the routes from the gut to the bloodstream are varied but quite often involve the urinary tract and follow a urinary tract infection which may not have been successfully treated.

The C.diff infections we measure are those causing infectious diarrhoea, these are often triggered by the use of antibiotics which change the balance of gut bacteria and allow C.diff present to gain the upper hand.

Once present in sufficient numbers the toxin they produce irritate the lining of the gut producing symptoms.

The common theme here is use of antibiotics and of course many people need antibiotics for other reasons making C.diff at least collateral damage.

We are just beginning to understand the patterns of antibiotic prescribing during the early pandemic but already can see that a certain amount of antibiotic prescribing was used as part of treating patients with COVID presumably to cover the risk of secondary bacterial infection after the virus.

80% of admissions in April and May had antibiotics for community acquired pneumonia.
Studies are emerging now to guide prescribing and tell us that bacterial co-infection in COVID-19 pneumonia is only 3%.

The precautions in place to prevent transmission of COVID-19 are designed to interrupt the respiratory transmission route, neither E.coli blood stream infection nor C.diff gut infection are spread in this way, but as pointed out by Dr Garmin C diff can be transmitted on hands and part of Covid preventative measures is paying more attention to hand hygiene so the explanations provided do not fully explain the rising cases.

It has to be said that both of these infections have been rising for some time and prescribing patterns as well as pre-existing conditions may play a part in this. Increased handover delays, flow requirements within hospital takes longer and requirement for social distancing is under pressure and packages of care are taking longer due to covid.

Clare Bryan noted Newton Europe had exited the system and there would be an impact on the urgent care plan and delivery as there were no resources to deliver this programme.

Future agenda planning:

- Review of rollover position and initial planning guidance or approach to planning and a draft position
- Savings plan for 2020/21
- SLS and cancer at January meeting
- MH S75 – update to be provided by Sarah Foster
- COVID-19 audit by NHSE/I

- Review of CCG Constitution to be added part of routine review
- Grip and control – standing agenda item.

Final copy for ratification

Signed by the chair:

Date: