**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**PARTNERSHIP BOARD**

**MINUTES OF THE MEETING HELD ON THURSDAY 9 MAY 2013 AT 2PM IN THE VICTORIA SUITE, TUKES CAFÉ, 3 BRIGHOWGATE, GRIMSBY DN32 0QE**

**PRESENT:**

Dr Derek Hopper Vice Chair/Chair of Council of Members

Dr Sudhakar Allamsetty GP Representative

Cllr Mick Burnett Portfolio Holder for Tourism and Culture – NELC

Dr Cate Carmichael Joint Director of Public Health

Juliette Cosgrove Strategic Nurse

Mr Perviz Iqbal Secondary Care Doctor

Cllr Ros James Portfolio Holder for Housing and Well Being - NELC

Cathy Kennedy Chief Financial Officer/Deputy Chief Executive

Helen Kenyon Deputy Chief Executive

Geoff Lake ASC Strategic Advisor

Dr Arun Nayyar GP Representative

**IN ATTENDANCE:**

Bev Compton NELC

Jeanette Harris Executive Office Administrative Support (Minutes Secretary)

Tracey McErlain-Burns Interim Executive Nurse Advisor to the Governing Body

Laura Whitton Deputy Chief Finance Officer

**APOLOGIES:**

Jack Blackmore Strategic Director People and Communities – NELC

Philip Bond Lay Member Public Involvement

Mandy Coulbeck Locally Practising Nurse

Dr Peter Melton Chief Clinical Officer

Dr Rakesh Pathak GP Representative

Mark Webb NEL CCG Chair/Associate Non-Executive of the CTP

Sue Whitehouse Lay Member Governance and Audit

1. **APOLOGIES**

Apologies were noted as above. It was noted this was the inaugural meeting of the Partnership Board following the CCG becoming a statutory body on 1 April 2013. A welcome was extended to Bev Compton from North East Lincolnshire Council, who is deputising for Jack Blackmore and also to Lesley Wyatt, a researcher from Bristol University who is carrying out research on evolving CCGs.

1. **CONFLICTS OF INTEREST**

No conflicts of interest were declared.

1. **APPROVAL OF THE MINUTES OF THE PREVIOUS MEETING – 14 MARCH 2013**

The minutes of the meeting held on 14 March 2013 were agreed to be a true and accurate record.

1. **MATTERS ARISING**

There were no actions to be noted from the matters arising from the previous meeting.

**5. REVIEW OF 2012/2013 BUSINESS PLAN DELIVERY AND TRIANGLE OBJECTIVES**

The supporting paper provides a summary of the achievements for each of the 7 clinical triangles during 2012/2013 as well as an update for an 8th area which focuses on palliative and end of life care; this is one of the CCGs priorities for improvement hence its inclusion in the paper.

This is the second year the Triangles have been in place and they are seizing the opportunities and challenges being presented to them and making specific achievements in the past year in each of their areas. One of the focus areas has been reducing non-elective admissions into hospital and the introduction of GPs front-ending A&E together with the presence of a paediatric consultant and team in A&E has had significant benefit and is well liked by the users of the service.

The Triangles are currently having objectives set for the coming year and these are being aligned to the organisation’s strategic priorities and corporate objectives.

A question was raised over the last sentence in Point 3 of the Prescribing and Medicines Management Triangle report which states “a significant piece of work has also been undertaken with regard to the transfer of prescribing codes from the Care Trust Plus to the relevant organisations eg CCG, NELC. The query related to where within NELC the funding for transferred prescribing codes has been allocated. It was clarified as the responsibility for certain prescribing services has shifted to different organisations the funding is being moved within the system to the most appropriate areas and in this case the funding elements have been allocated to Public Health and sit with Dr Cate Carmichael. It was also flagged that a piece of work is currently underway in relation to Health Visitor prescribing and the allocation of resources for this from GP budgets.

**6. NEL CCG BUSINESS PLAN AND TRIANGLE OBJECTIVES 2013/2014**

The Corporate Business Plan for 2013/2014 is a live document and will be refreshed throughout the coming year to keep in line with changes that will take place as the year progresses.  The Plan outlines the focus areas where the CCG will be looking for significant improvement or change within the coming year.  The 3 agreed key areas have been coloured red within the paper to show their significance and have been discussed and agreed with the Health and Well Being Board.

The delivery of the Corporate Business Plan is inputted into a management system tool and monitored on an on-going basis by the Delivery Assurance Committee (DAC) on behalf of the Partnership Board.  The DAC will escalate any exceptions or concerns to this Board throughout the year as necessary.

The trigger mechanism for escalation to the Board was raised and in response Cathy Kennedy advised that the DAC examined the risk areas and took a judgement as a Committee on what needed to be escalated and that this decision was not left to one only individual.  Alongside this mechanism high risk areas are routinely escalated to the Partnership Board within the exception section of the Integrated Assurance Report.

It was also noted that the minutes of the DAC come routinely to the Partnership Board.

**7. QUALITY ASSURANCE**

7a Review of CCG Clinical (Quality) Accounts

Tracey McErlain-Burns was welcomed to the meeting.

The review of the CCG Clinical (Quality) Accounts was commissioned by Dr Peter Melton and Cathy Kennedy.

A list of 30 stakeholders was provided to inform the review and advice was sought from the Yorkshire and Humber Quality Observatory on sample size to be assured of a representative opinion. The reviewer sought to speak with 20% of the stakeholders to gather 80% of the opinion however, 23 stakeholders accepted the invitation to participate in the review which means that 80% of stakeholders put forward their opinion and there was an extremely high level of consistency amongst the stakeholders who participated.

Attention was drawn to the linear scale within the paper where participants placed their scores on a scale of 0-10 on the current arrangements compared to those in place at any time in the preceding 18 months. As demonstrated by the scale there is a perceived negative shift for the current arrangements in comparison to those in place previously.

Three interdependent recommendations were made:

* The CCG should establish a health and adult social care/quality governance committee, under the leadership of a clinician for a period of 12 months with a clearly expressed intent that the Council of Members assumes the responsibility for providing assurance on standards of clinical quality, safety and experience at the end of that 12 months
* A wall chart (5 feet x 3 feet) should be published visually displaying the linkages between committees and headlining terms of reference, meeting frequency, who chairs the meeting. This should be on display at Athena for 3-6 months and produced in A3 poster format for GP practices to display in communal staff areas
* Addressing the descriptions of disconnect, confusion and reported lack of feedback following escalation, all the key committees featuring on the wall chart should end their meetings with a summary of what was discussed, what the outcome was and who is leading any action. Those summaries should then form part of a monthly team brief as a vehicle for cascading information and enabling everyone working in the CCG to feel a partner in its success

Thanks were proffered for the clarity of the report and for the way it outlined issues identified and provided a clear and considered route for resolution. It was highlighted that the clinical leadership referred to in the first recommendation is key and a critical role for forward progression. It was also noted that priority needs to be given to implementing this structure quickly to provide support throughout the organisation.

**The Partnership Board agreed their support for all 3 recommendations as outlined above.**

7b Response to Francis II Report

Tracey McErlain-Burns outlined the contents of the supporting paper “how do we measure up to the Robert Francis QC findings following his inquiry into Mid Staffordshire Hospitals NHS Foundation Trust” and stressed that the outlined position is a point of time assessment and that the organisation now needs to focus on the described next steps to ensure proactiveness and progression.

The recommendations being put to the Board are:

* “Measuring up to Francis” is placed on the Board Assurance Framework as one of the organisation’s key risks
* The Quality Governance Committee is tasked (subject to a separate report) to assess and implement a programme of strengthening improvement steps

It was highlighted that the paper details the measures already in place and that the CCG is not starting from a “zero” base.

The meeting’s attention was drawn to the “next step” suggestion of establishing a programme of commissioner led quality visits to all commissioned services and it was noted that a number of Board members will have a personal responsibility to take this forward as there should be a mix of clinical, lay and officer members’ involvement. The importance of using the visits as a format to gather soft intelligence was stressed as the greatest benefit will derive from talking to patients, families, carers and observing how care is being delivered and the culture it is being delivered in.

Tapping into wider networks to identify best practice is desirable and it was agreed that a future board workshop in approximately 9 months’ time could be used to explore this further from the perspective of a number of different organisations.

**ACTION: Board Workshop Agenda**

**The Partnership Board agreed their support and approval for the 2 recommendations contained in the supporting paper as outlined in the Minutes.**

7c Keogh Review and Summary Hospital Mortality Indices (SHMI) Update

Helen Kenyon outlined the contents of the supporting paper and drew attention to the improvement in the SHMI data for both NLaG and HEY in the previous quarter but advised that whilst both Trusts have shown an improvement further progress is required.

A lot of work has been put in place to drive improvements forward and this is being overseen by a community-wide SHMI group which meets on a regular basis. A review and refresh of the SHMI action plan has been carried out to update and incorporate some further findings from some external work undertaken.

It was noted that the SHMI information is produced quarterly, but uses data gathered over the previous year and therefore always reflects activity over the past 12 to 18 months, rather than picking up on purely current practice. The information is produced in this way to ensure that there is sufficient data available to allow analysis and comparisons. As a consequence actions that have been taken in recent months will not be seen to have had a significant impact on published SHMI figures straight away.

A second indicator called the RAMI, which uses more recent data but measures mortality in a different way, is giving an indication the progress is being made in reducing the SHMI rating.

Because of its published SHMI rating NLaG is going to be subject to a Keogh Review which will be carried out in 3 stages ie information gathering and analysis, rapid responsive review and risk summits. The CCG will have a representative observing the review as it takes place. The Keogh review team will also be conducting listening events prior to the hospital review visit, and a specific session will be held with the CCG to obtain the organisation’s view.

A query was raised over whether there was a difference in the SHMI rates for the 2 NLaG hospitals and whether there are different issues and actions in place for each of the hospitals. It was also noted that the improved NLaG SHMI rate was derived from data from both hospitals and the question was asked as to whether there had been a greater improvement in 1 hospital over the other and if so, which hospital had demonstrated the best improvement and why.

It was confirmed that the published SHMI data is a combination figure for both hospitals and that further investigation will be required to drill it down to each specific site. It was confirmed that the SHMI action plan does identify specific action and outcome requirements for north and north east Lincolnshire and that these are not always replicated in both areas; Leads are in place at each end of the patch.

It was queried whether we are able to identify whether the improvement in the SHMI figure has occurred due to remedial actions put in place or chance. It was also suggested that the Board would be provided with more assurance if it knew what key actions are showing improvement and those that were not.

In response it was clarified that whilst some actions could have been put in place to improve the SHMI rating they would not have improved the quality of patient care both in and outside the hospital environment. The refreshed SHMI action plan is concentrating on improving the quality of service provided to patients and has a 6 month focus on specific issues before rolling on to other specifics. Improvement in quality of service in these areas will lead to an improvement in the SHMI figures. Quality indicators have highlighted areas that are driving the excess mortality rate and these are part of the current focus ie community end of life care, respiratory, stroke and sepsis.

It was also noted that those hospitals with the worst SHMI ratings had the lowest amount of funding and staffing levels and all experienced difficulties in the recruitment of quality staff.

A query was raised over the non-accreditation of the local Stroke Unit and the meeting was advised that whilst the Stroke Unit was accredited originally, national accreditation standards are being updated on a regular basis and the revised standards are often very demanding to meet; however actions and plans have been put in place to enable the Stroke Unit to meet the latest accreditation standards.

In relation to the Keogh Review it was flagged that in addition to issues that need to be addressed the Review will look at good practice in place and actions being taken others can learn from. It is hoped that we will have already put in place a number of the remedial measures the Keogh Review may suggest.

**8. STRATEGIC PLAN FOR SUSTAINABLE SERVICES**

The sustainable services programme is being developed collectively with other organisations and is looking to provide quality services and meet increasing demand within the constraints of the funding available.

A presentation was given which covered the following points:

         Commissioners vision for a new model of care for Northern Lincolnshire

         Case for change for sustainable services

         Development of options which increase primary and community care

         Some of the options for primary and community based services

         Hurdle criteria for options assessment

         Explaining community based care

          Ambulatory care

         Short term step up/step down care

         The case for change engagement approach

         Next steps

Following the presentation a question was posed over the type of impact assessment that has been undertaken. Cathy Kennedy advised that to date the assessment has been a database one which is why it is now very important to initiate dialogue with clinicians and stakeholders so that judgements can be made as to whether it or not it feels right.  It is not possible to trial every initiative and change individually as the time this would take is not viable but the programme is actively looking at what has been implemented and works well elsewhere.  However assumptions cannot be made that what works well somewhere else will automatically work here and it is therefore vital that discussions are held with clinicians and stakeholders to ensure a correct level of balance.

It was also acknowledged that balances and checks will need to be put in place to monitor the options implemented and that if it becomes apparent that something is not working in the way anticipated it will need to be addressed immediately.

**9. integrated assurance report**

The report being considered by the Board is the year-end report for the previous organisation and provides the opening position for the CCG but there is nothing new or specific to highlight from the report considered at the previous meeting.

The performance escalation section of the report outlines the patient flows through acute emergency services and the impact on performance.  During the last quarter patient flows have been extremely high which has made it very difficult to meet targets but this is not a unique local position and has occurred on a national footprint.

Analysis work undertaken over the past few months has identified that one significant cause of the increase in patient flows has been arrivals from outside the local area (Lincolnshire).

The Board noted that we have one of the lowest admissions per head of population nationally and that the current A&E project is being trialled in a vigorous manner to see if it has positive benefits and gives good value to the patient.  A lot of data is being collected and results from this should be available in approximately 6 weeks.

**10. finance report**

The supporting paper provides an update one month into the new financial year. There are no significant factors to report to date but attention was drawn to the risks that need to be managed in-year to achieve the planned position. The meeting was advised that the risk previously flagged relating to specialist commissioning has been mitigated in full following a further data validation exercise carried out between providers and commissioners. This has resulted in £6million funding being reallocated back to the CCG as the responsibility for certain types of activity will remain with the CCG rather than passing to NHS England.

**11. UPDATES**

11.1 Community Forum Update

At the last Community Forum meeting increasing the uptake of children’s immunisation for the measles virus was discussed and it was suggested awareness of this issue should be raised locally but subsequent to the meeting taking place a national awareness raising campaign has been announced.

11.2 Council of Members Update

The last Council of Members meeting approved the QiPP Plan, a continence products proposal and funding for EMIS to allow out of hours access to primary care records. It was also noted that Care Plus has received funding from MacMillan for further posts.

**12. ITEMS FOR INFORMATION**

12a Minutes from the Care Contracting Committee 23 January 2013 and 12 March 2013

The Minutes from the Care Contracting Committee meeting were noted by the Board.

12b Integrated Governance and Audit Committee Minutes 7 March 2013

The Minutes from the Integrated Governance and Audit Committee meeting were noted by the Board.

12c CMM Action Notes 19 March 2013

The action notes from CMM were noted by the Board.

**13. QUESTIONS FROM THE PUBLIC**

1. It was stated by a member of the public that the CCG is not engaging with the public as well as it could be and that it needs to put much more effort into raising its public profile.  It was suggested that magazine and newspaper articles is one way in which this could be done.  At a recent meeting of a community group of the over 50s a number of questions were raised including the following:

What are the Triangles?

What is NHS England and what does it do?

Why are people dying who shouldn’t?

Why are we using NHS111 when the newspapers are telling us it doesn’t work?

Why can’t we have drugs that NICE have said are okay?

In response Cathy Kennedy and Dr Hopper explained that the organisation recently held a media launch which was well supported by the local media and also had a slot on the TV programme Look North.  The Community Forum is comprised of elected members of the public and they are initiating awareness-raising which includes liaising with local magazines.  In addition a number of road shows are being planned throughout the summer as part of the Sustainable Services Programme.

Cathy Kennedy said that she will be very happy to visit any groups that wanted to learn more about the CCG and NHS and requested that the member of the public advised her of the future dates of the group that had been mentioned.

2. Two queries in relation to Care Plus were raised. It was suggested that it may be beneficial for funding purposes if local providers were brought together under the same NHS umbrella.  In response it was explained that in 2006/2007 a decision was taken to have an integrated delivery for health and social care and it is very important to maintain this.  When the Social Enterprises were set up their management costs were significantly reduced compared to their former NHS costs but it was acknowledged that it is right to question that this is still being achieved at the present time and in the future.

It was raised that in the past the local hospital has paid out for staff redundancy costs and the affected staff then went on to obtain employment with a different NHS organisation.  It was acknowledged by the meeting that NHS workforce planning needs to be addressed to minimise this occurring in the future.

3. It was queried whether the CCG is talking to Community Matrons and senior District Nurses in relation to sustainable services.  Cathy Kennedy advised that the CCG has been doing this but needs to do more and as discussed earlier in the meeting there will be a much wider covering of groups and individuals to gather views during the coming year.

**14. DATE AND TIME OF NEXT MEETING**

Thursday 11 July 2013 from 2pm to 4pm in the Victoria Suite, Tukes Café, Brighowgate, Grimsby