**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP PARTNERSHIP BOARD**

**MINUTES OF THE MEETING HELD ON THURSDAY 14 May 2015 AT 2PM**

**SOCIAL ENTERPRISE CENTRE, 84 WELLINGTON STREET, GRIMSBY DN32 7DZ**

**PRESENT:**

Mark Webb Chair

Dr Derek Hopper Vice Chair/Chair of CoM

Juliette Cosgrove Strategic Nurse

Cathy Kennedy Chief Financial Officer/Deputy Chief Executive

Helen Kenyon Deputy Chief Executive

Dr Thomas Maliyil GP Representative/Vice Chair Council of Members

Dr Peter Melton Clinical Chief Officer

Dr Arun Nayyar GP Representative

Sue Whitehouse Lay Member Governance and Audit

Stephen Pintus Director of Public Health

Laura Whitton Deputy Chief Finance Officer

Cllr Mick Burnett Portfolio Holder for Tourism and Culture – NELC

Dr Rakesh Pathak GP Representative

Joe Warner Managing Director – Focus independent adult social care work

Nicky Hull Primary Care Professional

**IN ATTENDANCE:**

Kaye Fox PA to Executive Office (Minutes Secretary)

**APOLOGIES:**

Philip Bond Lay Member Public Involvement

Joanne Hewson NELC Deputy Chief Executive (Communities)

**1. APOLOGIES**

Apologies were noted as above.

**2. CONFLICTS OF INTEREST**

No conflicts of interest were declared.

**3. APPROVAL OF THE MINUTES OF PREVIOUS MEETING:**

The minutes of the Governing Body meeting held on 12 March 2015 were agreed to be a true and accurate record.

The minutes of the Partnership Board meeting held on 12 March 2015 were agreed to be a true and accurate record. Dr Maliyil requested clarification on Agenda item 14 Commissioning and Contracting report – MOU, he stated that he could not recollect delegating powers to the Clinical Chief Officer and that the appendices for the MOU were still outstanding and therefore members did not have complete information. Cathy Kennedy responded that the MOU had been brought to the last Board meeting without the appendices to ask members for endorsement for the clinical Chief Officer to sign the document off once the appendices were in place. All other members agreed that this was the case and that the minutes were an accurate record. Cathy Kennedy stated that the MOU including appendices had been discussed at length at the Care Contracting Committee (CCC) and agreement in principal was reached on its content, but would be subject to formal sign off once other parties to the MOU had also agreed to sign. Cathy Kennedy stated that the she was happy to share the appendices and arrange a more detailed discussion if any members would like to talk this through.

**4. MATTERS ARISING**

The actions outlined on the action summary sheet were noted, any outstanding actions will be picked up within the agenda.

No questions were raised.

**5. CHAIRMAN’S ACTION**

**Co-Commissioning Joint Committee Terms of Reference**

The Chair of the Partnership Board took Chairman’s action to approve the Terms of Reference following a notification from NHS England (NHSE) that an amendment was required in respect of the voting rights; the document has been brought to the Board for information.

It was queried as to whether this would give NHSE overall control of all decisions. Cathy Kennedy stated that NHSE will be able to control decisions taken by the Committee only on matters that directly relate to NHSE accountabilities. On all other matters it is ‘one member one vote’ with the chair having a casting vote. The Chair of the NEL Co-Commissioning Committee is the CCG Governing body chairman. It is anticipated that if there is anything contentious at the committee it will be escalated for the attention of the Partnership Board. It was noted that if the CCG takes on full delegated responsibility in future (Level 3) then the NHSE voting rights disappear. It was noted that for the Co-Commissioning meeting to be quorate representation from NHSE has to be in attendance, a question was raised around capacity within NHSE and the practicalities of someone being able to attend all Co-Commissioning Committee meetings. Cathy Kennedy stated that NHSE have nominated 2 people to attend but any employee of NHSE is able to deputise and carry the vote. Each member of the Co-Commissioning Committee has a deputy, it was confirmed that if Dr Maliyil and Dr Hopper were unable to attend they could choose to have 2 deputies or 1 deputy to cover both votes.

Presently we are at level 2 which is joint responsibility for commissioning with NHSE, moving to level 3 would provide the CCG with full responsibility, it was suggested that this is brought back to a future meeting to identify what the impact has been at level 2, and whether the CCG wished to move to Level 3..

It was agreed that the minutes from the Co-Commissioning Committee meeting are brought for information to the Partnership Board and Council of Members.

**ACTION: Kaye Fox**

**6. PATIENT EXPERIENCE UPDATE**

The report submitted to the Board was taken as read. Gemma Mazingham introduced herself to members and provided a brief outline of both her role, and the role and responsibilities of her team. Gemma Mazingham informed the members that they are looking at new ways of using patient experience intelligence to help inform the commissioning cycle. The team have started to work with providers and mechanisms are being put in place to record their compliments and complaints performance which will be included in the quarterly report that goes to the Quality Committee meeting. Information gained has already helped to inform and improve the quality of services. The Friends and family test (FFT) is another mechanism used to gain intelligence from the services that they use. Data from provider organisations is now more easily available although this no longer a CQUIN. NELCCG has agreed to keep the FFT as a key performance indicator for the local area. An intelligence portal has been created as a mechanism for professionals to directly feed in concerns in respect of care provision of any type; this is used to triangulate information and identify the best route to take forward to mitigate risk, which could include action taken through safeguarding or the contract team. Gemma Mazingham stated that the link to the portal had been circulated but agreed to advertise again to make clinicians aware.

**ACTION: Gemma Mazingham**

As of 2013 the CCG no longer receives and handles complaints in respect of GP Practices, following discussions with Philip Bond, it was agreed that engagement with the Chairs of PPGs (Patient Participation Groups) would assist in filling the gap and the group meet quarterly. Gemma advised that this mechanism facilitates a two way stream of communication as issues can be raised by the Chairs but information is also provided from a CCG perspective.

It was confirmed that although the CCG doesn’t currently receive information from St Hugh’s and NAViGO, contact is being made to address this as it has been identified as a gap for future decision making.

Gemma Mazingham informed members that she is working with Sally Czabaniuk on the Engagement Strategy to identify how ‘Patient Experience’ is at the forefront when planning or introducing new systems that could have an impact on services. It has been suggested that it should be included in the plans that the Service Leads produce as this will ensure that Patient experience is embedded in to the commissioning cycle and that patient experience is at the heart of everything we do.

It was agreed that going forward Patient Experience would become an additional section of the Quality Report, showing exceptional results both positive and negative to keep people informed. If at any point a significant issue or trend is identified it will be brought back to the Board as an Agenda item.

**ACTION: Gemma Mazingham**

**7.   2015/16 BUSINESS PLAN**

* **NELCCG Business Plan**

The paper brought to the Board identifies the significant achievements the CCG has made on the delivery of the 2014/15 Business Plan and identifies headline items for 2015/16. The CCG achieved 94% of its objectives in 2014/15; the remaining 6% are on-going items which cross over to 2015/16.

Discussions are taking place within a number of forums to fully populate the plan identifying key priorities the CCG will concentrate on in 2015/16. A conclusion of these discussions will be drawn up within the next 3 to 4 weeks and the detail of the plan will be taken to the Delivery Assurance Committee (DAC) for sign off.

It was agreed that when the 2015/16 Business Plan has been signed off by DAC it will be brought back to the Partnership Board as an item for information.

**ACTION: Cathy Kennedy**

A question was asked about Releasing Community Capacity, and it was confirmed that this is a community initiative that is being worked on jointly with the Local Authority and Community groups encouraging volunteer groups to build up initiatives to help communities to support themselves. People are being trained up as champions, and the intention is to decrease the reliance on public sector services.

Prescribing Practice – it is noted that there are significant cost pressures in prescribing medicines, and the business plan will focus on a number of priorities for action.

* **Section 75 Business Plan**

Helen Kenyon apologised that a paper had not been submitted for this item but explained that the Partnership

Operational Group had taken a slightly different approach to developing the business plan this year which covers the agreement for both services that the Local Authority provide on behalf of or in partnership with the CCG, and the ASC services the CCG provide on behalf of the Local Authority. A workshop was held in April to review the document for both the current and future years. An outline document has been produced and was taken to the Leadership Board on Monday for review.

Items that will be included in the plan are:

* Delivery of the Adult Social Care (ASC) efficiencies
* CAMHS commissioning as the current contract comes to an end April 2016
* Collaborative working

The Section 75 agreement needs to be reviewed in respect of the changes to the Care Act and the implementation of the reforms.

The proportion of the ASC savings was queried, and it was noted that the saving equates to 15% of the budget, it was asked how achievable this is, what are the risks and how we assess the impact on quality. Helen Kenyon responded by stating that we have confidence in the plan but there is a consultation taking place at the moment and that could have an impact on the deliverability of the plan, the £9million savings is a significant figure and is a cumulative amount over 3 years.

**ACTION: It was agreed that the Section 75 Business Plan will be brought back to a future meeting. H Kenyon**

**8. QUALITY REPORT**

The Quality report was taken as read but attention was drawn to the items listed below:

* **C-Difficile** - The CCG failed to meet the C-Difficile target for 2014/15, the target for 2015/16 has been reset through a nationally defined methodology and should be more achievable. It was noted that analysis would be undertaken in each case to see whether it was avoidable and to identify any interventions that could have taken place, and share the lessons learned.
* **MRSA** – 2 cases reported for 2014/15. 1 case has already been reported in April this year which means we have failed the target for this year. There is zero tolerance for MRSA, every organisation has been set a target of zero, a small number of organisations do achieve this.
* **Serious untoward incidences** - currently the CCG does not have data on this for GP Practices as it is held by NHS England, but going forward this information will be brought to the Co-Commissioning Committee. The increase in NLaG’s incidences was due to pressure sores requiring reporting as serious untoward incidences from 1 April 2014.
* **Patient mortality** – the published figure has plateaued.
* **Family Friends test** – the main concern relates to NLaG staff response to the question about whether they would recommend the care provided at the hospital to their friends and family, conversations are being progressed to better understand these results.

The Quality report will be further developed once the Director of Quality is in post.

It was noted that it is the role of the Quality Committee to provide the Board with assurance that issues are being dealt with and escalated if the actions are not sufficient or figures start going in the wrong direction.

It was agreed that the responsibilities of the Quality Committee would be an agenda item for a future Board workshop.

**ACTION: Helen Askham**

**9. INTEGRATED ASSURANCE REPORT**

This report was taken as read but attention was drawn to Ambulance turnaround times which have significantly improved but had temporarily dropped over the winter months. The resilience group has undertaken a large amount of work looking at how we better manage emergency care both in and out of hospital. Dr Peter Melton stated that through local intelligence and talking to ambulance crews there was a concern that ambulances are being heavily used for journeys to Scunthorpe in relation to the Stroke Care pathway and there is a concern that this will affect response times and access to ambulances in North East Lincolnshire. Dr Melton asked if there was any further robust intelligence that would confirm this. Cathy Kennedy stated that the figures in the report do not show this, there was a dip in response rates during the winter months but this has now improved. The re-organising of services and sending patients to other areas did not create capacity issues until other factors, winter pressures was added in and it became an issue. It was confirmed that the impact on Transport is taken into account when developing and changing services, and that representatives from EMAS are invited and attending meetings.

It was highlighted that part of the winter pressures was caused by problems with the flu strain mutating such that the vaccine was not effective, which saw an increase in the number of people contacting flu.

In 2014/15 non-recurrent winter resilience funds were released in August which only provided the CCG with a month or so for the CCG to plan initiatives with providers to support resilience through October to March. This year, 2015/16, the allocation is part of baseline funding which allows the CCG to plan better and put initiatives in place. It was also noted that recent national best practice guidance on the high impact changes for system resilience reinforces our confidence as these are the things that the CCG is already putting in place.

**10. FINANCE REPORT**

The report provided an update on the financial position that has been reported in the CCG draft accounts. The draft outturn position for the year has only changed by £3k from what was being reported at the March meeting, with no individual areas of spend having changed significantly from what had been projected. This provides us with confidence that the CCG are accurately forecasting figures, which will be ever more important in 2015/16 when budgets are very challenging.

The Board was asked to approve the proposed write off of one debt with a value greater then £50,000 . The debt relates to money owing as part of a deferred payment agreement, the client only owned 50% of the property, whereas the CCG had accrued for 100% of the property value. The client had no other assets with which to settle the debt. **Approval was agreed**.

The Board noted and agreed the need for chairman’s action to be taken to formally approve the 2014/15 audited accounts prior to their submission on the 29th May 2015.

**11. COMMISSIONING AND CONTRACTING REPORT**

The report submitted to the Board was taken as read. The report highlighted key pieces of work undertaken by the CCG in relation to commissioning and contracting activities over the past 2 months. Discussion had taken place at Care Contracts Committee (CCC) early this week around co-commissioning and what should go to the Primary Care co-commissioning Committee and what should go to CCC. It had been agreed that where Primary Care is deemed to be the most capable provider or the service is nationally prescribed to be delivered by General Practice it will be managed by the Primary Care Co-commissioning Committee going forward. All other matters will be managed by CCC. CCC Terms of Reference have been amended to note this change.

A proposal to restructure the Advocacy provision to provide Advocacy under one contract to maximise efficiency and capacity and provide additional advocacy in line with the Care Act requirements is being progressed.

Following the implementation of the Quality Framework a significant increase has been seen in CCG and self-funded placements to homes rated Gold and Silver, which has resulted in a rise in overall occupancy in these homes. There is a piece of work currently being undertaken to monitor this, as well as looking at whether there is anything that can be done to provide additional support to those homes graded bronze. It was noted that Bronze is above the CQC minimum standard.

Domiciliary Care procurement has been completed which moves from five to three preferred providers. The three providers have been identified and service users, carers and providers are being made aware of the successful bidders. The CCG is now working on a transition programme to ensure where service users have to transfer to another provider, this process is managed to cause least disruption to them. There has been a significant amount of user involvement in this process and feedback has been good. It was noted that the top three providers identified by the service users were the same three providers as identified via the management group.

The new Assisted Living Centre is now open, this has been developed as a model which is supported and led by the Community, it is open 6 days a week, but offers a 7 day service to support discharge from hospital.

**12. HEALTHY LIVES HEALTHY FUTURES UPDATE**

The written report has been brought to the Board for the first time. Members were asked to consider the report format and (developing) content and to comment as to whether it is appropriate and suitable to the needs of the Board

This will be a standard report to provide assurance as to whether things are on track. Planned developments of content include reporting against Quality Metrics but these are being developed and will be incorporated for the next Board meeting.

The report has been to the HLHF Programme Board where it was agreed that it will be going to all organisations Boards to ensure that information is received at the same time and is consistent.

The context of the report includes specifics for North East Lincolnshire including the local programmes of work for this area, as well as overall programme information.

Any comments on the presentation to be sent to Cathy Kennedy

**ACTION: ALL**

**Healthy Lives Healthy Futures Presentation**:

A HLHF presentation was presented by Dr Peter Melton. Discussion took place between the members as to whether SPA (Single Point of Access) should be used to cover the whole of North and North East Lincolnshire. The SPA in North Lincolnshire is very different to the SPA in North East Lincolnshire and is run by the hospital, the service provided in North East Lincolnshire is more comprehensive. It was agreed that the SPA required good local knowledge to enable people to be signposted in the right direction. The North East Lincolnshire SPA is working well and if put on a bigger footprint it would put at risk what is already in place and may become unworkable. It was suggested that other areas could use the North East Lincolnshire model or tweak to suit local needs.

**13. UPDATES**

**a) Community Forum**

Three points from the last meeting were highlighted.

The Community Forum’s Action Plan for this year includes an aim to work pro-actively with the Voluntary, Community and Social Enterprise (VCSE) sector and the wider community to cascade and receive information. Their objective is to develop meaningful engagement with the VCSE as an integral part of the CCG commissioning cycle/NHS Engagement cycle. In order to achieve this, the Forum is to host an information sharing event with local VCSE leaders to explore networking and communication opportunities on October 21st from 9.30am to 3.30pm at Centre4. (Forum members are working with the NEL VCSE Forum to plan the event).

**ASC consultation** –Community Forum members were briefed to enable them to assist with questions on the ASC Efficiency savings consultation including proposed changes to transport. Members of Community Forum have been asked to encourage carers and service users to attend meetings to assist with the consultation and consequent council decision making. The consultation will run for 4 weeks and the Council will make a final decision in July.

**Community diabetic monitoring** –members were asked for views as to whether they as individuals or carers would be supportive of using a new technology. Comments have been captured including queries on safety, cost and impact, to inform a decision on local implementation.

**b) Council of Members**

Dr Derek Hopper stated that there had been a useful discussion around ADHD and the issues with some teenagers being discharged back to their GP once they reach the age of 18. A meeting was arranged and progress has been made; CAMHS are now going to look after teenagers until they are into their early 20s. There are other outstanding issues that will be progressed at a further meeting

Ophthalmology - a business plan to address some significant current issues including waiting times (as discussed at previous meetings) has been approved and will be being closely monitored.

A new Children’s specialist Community nursing team has been launched which aims to keep children out of hospital by GPs being able to refer directly to the Children’s Community nursing team.

Memory service is being inundated as it was thought that all patients had to be referred for dementia diagnosis; The Clinical lead for Older People will be looking at alternatives, and whether changes could be made to numbers referred and followed up.

**14. ITEMS FOR INFORMATION**

a) Delivery Assurance Committee Minutes 15 February 2015

The Minutes from the Delivery Assurance Committee meeting held on 15 February 2015 were noted.

b ) Quality Committee Minutes 26 February 2015

The minutes of the Quality Committee meeting held on the 26th February 2015 were noted.

C ) Bi-annual constitution changes update to Partnership Board

**17. QUESTIONS FROM THE PUBLIC**

The Board was asked why the Coroner’s report into 3 hip replacements was to be discussed in Part B of the Board as detailed on the 12th March matters arising sheet. In response it was explained the reason for this was because the report discussion will contain individual names. However, the outcome of the report will be included in the next public meeting Quality Report.

A second query was raised around the current Mortality SHMI rate being disappointing and that in meeting papers and reports it states that the review is on-going and that there doesn’t seem to be any planning to see if any improvements are being made. In response it was stated that the CCG had been very active in this agenda. The new Director of Quality has been appointed and will be commencing with the CCG in a couple of months, part of her role will be to look at this and whether there should be any additional activity. The Board wants to continue to see clear assurance and ensure that there is a grip of what is being done.

The Board also confirmed that the SHMI report goes to the Quality Committee where it is looked at and monitored, the CCG are working with NLaG to understand issues and raise our concerns. It was confirmed that NLaG is not an outlier at this time.

A third query was raised around the NLaG deficit budget and what Commissioners are doing to scrutinise the budget. The Board confirmed that the CCG has an open book approach working with Providers, an open book line by line review has been undertaken of the 5 provider organisations over the last 9 months, Price Waterhouse Cooper have challenged figures and a “single version of the truth” document has been drawn up and publicised. This approach has been praised by system regulators such as NHS England and Monitor.

A fourth query was raised around the stretched time when ambulances were not available; the Board responded that they would look in to this to find out if this is an issue.

**ACTION: Helen Kenyon**

A fifth query was made in respect of HLHF, the suggestion was that the CCG should be looking at a Lincolnshire approach. This was noted as being in line with the current discussions within that Programme.

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

Thursday 9th July 2015 from 2pm to 4pm at the Social Enterprise Centre, 84 Wellington Street, Grimsby DN32 7DZ