MINUTES OF THE GOVERNING BODY MEETING
HELD ON THURSDAY 24 SEPTEMBER 2015 AT 9.30AM
IN THE COMMITTEE SUITE, BOROUGH COUNCIL OF KING’S LYNN & WEST NORFOLK

Present:

- Dr Ian Mack (IM) Chair & Governing Body GP Member
- Dr Sue Crossman (SC) Chief Officer
- John Ingham (JI) Chief Financial Officer
- Dr Tony Burgess (TB) Governing Body
- Dr Mark Burgess (MF) Governing Body GP Member
- Dr Paul Williams (PW) Governing Body GP Member
- Professor Paul Jenkins (PJ) Secondary Care Doctor
- Revd Hilary De Lyon (HDL) Lay Member (Audit & Deputy Chair)
- Sue Hayter (SH) Registered Nurse

In Attendance:

- Dr Bonny Rodrigues (BR) Consultant in Public Health Medicine
- Kathryn Ellis (KE) Director of Operations
- Heather Farley (HF) Governance Manager
- Emily Arbon (EA) Communications Manager
- Sue Cook (SJC) PA to Chief Officer & Chair (Minute Taker)
- Three members of the public
- One member of the Press

ACTION

1 APOLOGIES

Apologies were received from Dr Imran Ahmed, Dr Pallavi Devulapalli, Cathy Gale and Maggie Carter.

IM then suspended the meeting to take questions from members of the public.

2 QUESTIONS FROM THE PUBLIC ON AGENDA ITEMS OR OTHER CLINICAL SERVICES COMMISSIONED BY WEST NORFOLK CCG

There being no questions, IM reopened the meeting.

3 DECLARATIONS OF INTEREST

There were no new declarations of interest. It was noted that all declarations of interest were shared on the CCG’s website – www.westnorfolkccg.nhs.uk. Members were reminded of the opportunity to declare an interest at any point during the meeting.

4 NOTIFICATION OF ANY ITEMS OF URGENT BUSINESS TO BE DISCUSSED DURING THE MEETING

There were none.

5 MINUTES OF THE PREVIOUS MEETING HELD ON 30 JULY 2015

The minutes of the previous meeting held on 30 July 2015 were agreed and signed as a correct record.

6 ACTION/MATTERS ARISING (not covered elsewhere on the agenda)

6.1 Section 256 Monies – Target: People aged 18-64 in contact with secondary mental health services in paid employment (28/14): SC had discussed this with Harold Bodmer, Director of Adult Social Services, Norfolk County Council (NCC). Although NCC is monitored on the achievement of this target it is the Norfolk & Suffolk NHS Foundation Trust (NSFT) who is responsible for making it happen. Discussions will therefore take place with NSFT to confirm how this is being monitored and recorded. A one-off update will be provided in the next Performance report following which this action will be closed.

6.2 CCG Response to Borough Council of King’s Lynn & West Norfolk (BCKL&WN) Detailed Policies and Sites Plan (32/14): This will be included as an agenda item for the October Governing Body meeting.
6.3 Clinical Effectiveness Policy – Hip and Knee Arthroplasty, clarification sought on the clinical effectiveness of each of the different types of total hip replacement (13/15): A study is in place, the findings of which will be submitted to the Clinical Executive (CLEX). It was agreed to close this item.

6.4 Clinical Quality Review Meeting (CQRM) presentation/report re post-partum haemorrhages to be shared with GB members as soon as possible (16/15): This would be discussed further at the Patient Safety & Clinical Quality Committee (PS&CQC) and an update would be provided via the Committee’s report to the October Governing Body.

6.5 To investigate more fully the opportunities and risks regarding the transfer of Wisbech Practices into West Norfolk CCG (19/15): Members noted that this had not progressed due to other pressures and it was agreed to bring an update to the January Governing Body meeting.

6.6 To provide a quality assessment on the new single point of access for Norfolk Community Health and Care NHS Trust (NCH&CT) (Downham Market locality, the hub is based in King’s Lynn) (23/15): The effectiveness of the hub remains a high priority for the CCG and a full report will be brought to the next PS&CQC and included in future reports to the Governing Body. It was agreed to close this item.

6.7 To provide an update on the 18 week Referral to Treatment Time (RTT) for Musculoskeletal Physiotherapy (24/15): A report for 18 week performance from NCH&CT had confirmed an improved trajectory. Members noted that this issue had been raised at a recent stakeholder event held in Swaffham. It was agreed that the CCG should continue to look at this data and KE said that the intention was to incorporate stakeholder feedback into the gathering of commissioning intentions for next year for each of its providers.

6.8 To discuss with the Elective Care Committee the problems with referring patients to The Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust (QEHKL) (29/15): The Trust was in the process of investigating the difficulties reported around access and availability of appointments and updates would be received via the re-established, fortnightly Elective Care Committee. This action would remain open.

6.9 Cancer 62 day waits - Discuss with West Norfolk CCG colleagues the histology service and the QEHKL service (30/15): TB reported that there had been a significant improvement this month in the waits for cancer specialties with the exception of Dermatology. It was noted that the Trust had made it clear that if improvements did not continue to be made it would seek to re-tender this contract. TB reported that the CCG had been invited to attend fortnightly meetings where any long waits are discussed. With regard to reviewing the impact of continued waits, KE reported that the CCG does receive a detailed individual patient by patient breach analysis and this documented evidence is actively reviewed. The Governing Body noted that progress was being seen in this area and further updates would be provided through performance and quality reports. It was agreed to close this item.

6.10 Discuss the concerns with the recommendations made by the Contingency Planning Team (CPT) and the concern with risking clinicians’ time if confronted by a mandate; Write to Chair of the new group (31/15): Members noted that a new East of England Urgent and Emergency Care Network had recently been established. This Network will have a single System Resilience Group (SRG) representative for the Central and West Norfolk systems. IM had spoken with the Chair of the Central Norfolk SRG to seek assurance as to how this network will function, and also PJ’s concerns which would be reported to the first meeting of this new group. The importance of senior clinician representation had been emphasised too. An update would be brought to the October GB meeting.

6.11 To ask a GB GP to write an article for the CCG’s newsletter on the five policies approved on 30.07.15 (32/15): IM to ask the newly appointed GP representing the CCG on the Norfolk Policies Group to write an article. Action to remain open.

6.12 Opportunity for a representative for younger people with dementia to sit on the Dementia Advisory Group (33/15): SC had spoken with the Mental Health Commissioning Manager about trying to reach young people living with dementia and NSFT will be asked if it could recommend somebody who is known locally.
There were no other matters arising not covered in the Action Log.

7 DECISION LOG
The Council of Members had been advised of the decisions taken at the meeting held on 30 July 2015.

8 ACCOUNTABLE OFFICER’S REPORT
SC referred to the CCG’s stakeholder engagement events which had just been completed; four had been held, at venues in Hunstanton, King’s Lynn, Downham Market and Swaffham. Each of them had a very different tone and feel with different representatives at each event. A very interesting and stimulating debate format had been used this year which was very constructive. The comments and essence of each of the debates will be captured and fed into the commissioning intentions with providers, where appropriate, and individual feedback will be given where requested. A summary will also be included on the CCG’s website.
SC reported that the CCG’s “Choose Me not A&E” Campaign had been recognised nationally with the team being shortlisted for a national Health Service Journal award and invited to an awards ceremony the previous evening. Whilst the CCG did not win, it was a real achievement to be named as finalists and the team was warmly congratulated.
SC reported that a second “Break the Cycle” week was about to commence with the QEHKL and its partners. This will focus intensively on actions that have the most impact and effect in moving patients through the hospital. It was noted, however, that learning from the previous event in April had not yet been received; this was essential to ensure the second week focused on the right issues.
SC drew attention to this month’s finance report which highlighted a deterioration in the CCG’s financial position over the last two months, such that a deficit is being reported. JI and SC had been in discussion with NHS England’s (NHSE) sub-regional team to discuss the options including the production of a Financial Recovery Plan and as a result the CCG would be having enhanced monitoring of its financial position. It was noted that NHS England continues to be pleased with all other areas of performance and is very supportive in ensuring a return to financial balance.
SC reported that confirmation of the CCG’s Quarter 4 assurance rating was still awaited. This had been raised with the NHSE sub-regional team and the CCG had been advised that this had been due to unexpected delays and a response was expected in October.
SC had attended the NHSE EXPO in Manchester at the beginning of September. One of the key speakers had been Jeremy Hunt, Secretary of State for Health, whose presentation has included the New Models of Care, a comprehensive initiative to boost NHS staff health at work, and a new nationally-specified occupational health service for GPs under pressure, ie with the requirements of seven day working. A further speaker, Tim Kelsey, National Director for Patients and Information had assured attendees that the NHS would be paperless by 2020 and urged the Government to ensure this is properly funded.
SC said that commissioning intentions were being developed at pace, very much with an over-arching system-wide approach to West Norfolk services. SC was looking forward to the New Models of Care, and further integration between health and social care including other partners such as the Borough Council, who were working with the CCG on this agenda.

9 CHAIR’S REPORT
IM said it had been two months since there had been an opportunity to report back to the Governing Body. During this time IM had:
- Attended a meeting of Chairs and Chief Officers in Norfolk to discuss issues of common interest;
- Attended the launch of a piece of research conducted by Broadland Housing Group entitled “Going Round the Houses: How can health and housing sector professionals forge better links and what might the benefits be?”
- Chaired a meeting of the Stroke Network to look at stroke performance and it was pleasing to note that the recently published Atlas of Variation had identified very good data with regard to stroke performance in individuals going into hospital in Norfolk.
The Network is preparing to report back to the Norfolk Health Overview and Scrutiny Committee (HOSC) in December as a result of the action plan it produced following the earlier HOSC report.

- Met with the Chair of NSFT to discuss concerns over mental health services in West Norfolk and to look at the way forward in terms of ensuring there is clear improvement in services locally.
- Chaired meetings of the SRG looking at maintaining improved performance of the 4 hour A&E imperative and preparing for winter. This includes the funding allocation for winter pressures and agreeing with QEHKL a package of measures around intermediate care beds.
- Attended the HSJ Commissioning Summit which had discussed the challenges to the NHS over the coming two years. This had been attended by national figures in addition to CCGs.
- Held a one to one meeting with the newly appointed Chair of the Health and Wellbeing Board to discuss the form and function of the Board going forward.
- Attended two of the stakeholder engagement events, one in King’s Lynn and one in Swaffham, the latter also attended by HDL, Lay Deputy Chair. TB, Clinical Deputy Chair had chaired the first event in Hunstanton. These events had proved to be a valuable source of intelligence and dialogue.
- Chaired a meeting of the CCG Council of Members where issues of finance, particularly the current financial challenges, and performance of providers had been discussed. Representatives of NCH&CT had been in attendance, at IM’s request, to discuss directly with GPs the new referrals hub, staffing of the service, work of community matrons and improving links between GP practices and Trust staff.

BR referred to the “Going Round the houses” launch and explained that Public Health was engaged in a similar piece of work with Freebridge Housing Association. A community engagement exercise is planned and by the end of next year there will be a community-led solution. IM said that BR had been present at the launch too and there was a statutory requirement to support health promotion. This had been a positive event and good progress could be made for Norfolk on the back of this report.

10 PATIENT EXPERIENCE, SAFETY AND CLINICAL QUALITY

10.1 Clinical Quality and Patient Safety Report

SH introduced the new format of the Clinical Quality and Patient Safety Report which has been based on the key headings from the CQC inspection reports. Members noted that the Out of Hours (OOH) and the East of England Ambulance Service NHS Trust (EEAST) sections are work in progress.

QEHKL

- **Clostridium Difficile (C.Diff) Infections:** HDL noted that a number of Governing Body reports referred to C.difficile infections and was concerned to see an increase in cases and queried whether this suggested a link across providers, a seasonal affect, or something else. TB said that the Trust is actually operating at a lower number of cases than would have been expected given its performance last year. The Trust, through Dr Ian Hosein (Interim Associate Medical Director for Infection Prevention and Control), has undertaken a significant amount of work in this area particularly around antibiotic prescribing for C.difficile infections. As such it is looking to narrow the spectrum of antibiotics used, prescribing from its Formulary only, and giving high doses for a shorter period of time. This is a problem for the hospital and the community, and it is about identifying those patients coming into hospital with the infection and isolating them as quickly as possible; C.difficile does not spread from patient to patient in the hospital. There were more cases in June and July but no conclusion can be drawn from this. BR added that one of the problems with C.difficile is that it can remain dormant and the problem lies within various sections of the pathway. Public Health is working with the Trust to ensure that it take all steps possible to reduce cases. MC, together with the Public Health Nurse, has carried out an inspection with a further one planned for September.
On the antibiotic front, work is going on in auditing GP practices who are not complying with good practice and with Microbiologists on possible changes to the software used for reporting. SH said that the figures for May and June may not have been ratified and the Trust can appeal against cases and has done so in the past.

- **Catheter-associated UTIs:** PW referred to the consistently high number of catheter-associated UTIs and referred to a company which had introduced a new kit for catheterisation which had resulted in a considerable drop in such cases. PW understood that a preliminary meeting had taken place with the QEH about using this company but asked if there was any further update. SH was not aware of anything and would raise this with the QEH Director of Nursing.

- **Quality Issue Reporting (QIR) Discharges:** SC referred to the number of QIRs around the discharge process and whether any of that detail was illuminating and would be useful for the forthcoming “Break the Cycle” week. TB said the majority of these QIRs came from GPs where reports had not been received in a timely fashion. In addition to timeliness, there were also ongoing and significant problems regarding legibility. It was noted that the QEH is trialling electronic discharge and this will be rolled-out from the end of the month.

**NCH&CT**

- **Serious Incidents (SIs):** HDL said that 7 SIs had been reported for July but there had been 12 in June for which no explanation had been given. TB said that it was not possible to provide this detail without going back to the source data and would advise HDL off-line; however, he was not aware of any trend.

- **QIRs:** IM queried whether the QIRs for Referral-Delay/failure to act on and Issues relating to INR results/tests related to the operation of the hub. TB confirmed that they were and this had been highlighted to the Trust's management team who were looking into how this can be resolved. Two practices appear to have problems and the Trust has arranged to visit them. Although this is being progressed, Members emphasised the need to resolve this quickly as there is a potential impact for patients.

- **Pressure Ulcers (PUs):** JI understood that one of the benefits of appointing a Tissue Viability Nurse (TVN) would be a reduction in PUs and looking at the current figures this did appear to be the case. JI asked whether any assessment of the initial investment had been undertaken. TB was not aware that there had been an assessment of the TVN’s performance to date. However, the prevention of PUs should be within the remit of any registered nurse and the TVN will actually be involved once the patient is referred. Also, there may not be improvement in incidence but there will be in length of stay. These concerns have been highlighted to the Trust, and this will include involving care home staff and carers in protecting patients from pressure injuries.

IM queried whether there were any contributory factors identified in the Root Cause Analysis (RCA) for the PUs. TB said that the TVN could contribute in a positive way to the RCAs. SH said that the team was aware of the inconsistencies in RCAs and MC and SH are involved at an early stage to ask challenging questions before these are signed off. Part of this is about education, and it was noted that the TVN had been undertaking a lot of work with Sarah Taylor (Care Home Quality Lead); however, this is a large task given the constant changes within the care homes workforce. IM requested that a further paragraph be included in next month’s report on PUs including what the RCAs have defined as predisposing factors.

- **Communication between NCH&CT and Practices:** PW referred to a long-standing problem regarding communication between the Trust and those practices which do not have SystmOne and asked if there was any update on progress. TB said this is something the Trust is working on and is part of the hub action plan.
It was noted that this had been raised at the recent Council of Members’ meeting (mentioned in IM’s report) and the Assistant Director for West Norfolk had given an assurance that it should be entirely possible for the named nurse to diary meetings on weekly basis to discuss patients, so that all health professionals are aware of what is going on. It was agreed however that an electronic method of communicating between the Trust and all practices is the solution and telephone calls/faxes is not suitable. SH said that this forms part of the monthly CQRM discussions and is also linked to the sharing of patient information. IM said that a brief paper should be submitted to the Governing Body to clarify issues around Caldicott 2 - information: to share or not to share, and the Health and Social Care (Safety and Quality) Act 2015.

**NSFT**

- **Unexpected Deaths:** HDL referred to the fact that there had been 6 unexpected deaths already this year and although appreciating that receipt of formal information takes some time, was there anything the CCG should be aware of at this stage. TB said that although such deaths are very distressful they are not a measure of quality within a trust. It will not be possible to provide any further information until the RCAs have been undertaken, which will be discussed with the CCG before sign-off. IM said that HDL is the CCG’s lay link with the NSFT Board and is in the process of setting up a meeting with the Chair of the Trust who is its Non-Executive Director (NED) link with their western locality and suggested that this issue be raised with him to gain assurance and understanding. PJ referred to the statement on page 13 that, “The Trust is moving towards reporting deaths per 1000 patients to enable benchmarking with other Trusts”. To say ‘moving towards’ is not good enough; reliable statistics are required in order for the Trust to compare itself with other providers. If the Trust is going to look critically at this it needs to be clear of the confounders and perhaps a conversation needs to take place about how it looks at these. The numbers are not huge and the RCA is the crucial part. TB said this was a well-made point to take back to the CQRM around benchmarking data. RCA’s have improved but there is still more work to do.

- **Implementation of Lorenzo:** KE said that this links to the piece of page 15 of the report regarding the implementation of Lorenzo and its continuing impact on capacity within services. As such KE has written to the Trust to formally ask for an updated position on progress with regard to implementation of this system. Once a response has been received a view will be taken as to whether to take contractual action.

- **Vacancy Rate:** IM expressed concern that the West vacancy rate is the highest across the Norfolk system and asked that assurance be sought as to what steps are being taken to address this.

- **Complaints:** MF was concerned to note that there was no data relating to complaints; is it an oversight or is this information not being shared. TB said that this was not clear and it would be raised with the Trust.

**OOH**

It was noted that as this data relates to July it refers to the old provider. A separate report for the new provider IC24 will be provided in future. IM queried what steps had been taken to monitor performance and quality over the transition period. KE said that there had been a county-wide programme lead by Norwich CCG setting the plan for mobility of the new system and an exercise had been held, attended by one of the CCG’s commissioning managers, to review the lessons learnt from the mobility of the new service. An interim report had also been received at the SRG regarding performance over the first few weeks. MC said that quality incidents were being looked at in depth following which a view would be taken. It was noted that there was a full suite of Key Performance Indicators (KPIs) to measure OOH provision.
PW referred to incidents where patients from his practice had dialled 111 and had been connected to the Cambridgeshire provider and not the Norfolk provider. KE said the appropriate transfer of calls had been flagged with the provider and it was hoped that these were teething problems. KE would get back to PW as soon as a response had been received.

### Safeguarding Adults and Children

TB was pleased to report that the designated doctor for safeguarding children and designated doctor for Looked After Children (LAC) and designated nurse for safeguarding had been appointed. TB drew attention to the OFSTED inspection report of children’s services in Norfolk which is expected to highlight the waiting times and capacity to deliver initial assessments for LAC. The CCG is sighted on this and IM said that the Health and Wellbeing Board had been aware of this for some time and the need for it to be resolved as soon as possible.

KE queried whether there was a clear understanding of the current status of Deprivation of Liberties (DoLs) applications and whether there were any issues. TB said that the Adult Safeguarding team is working on this and taking legal advice; clarity as to what level that sits at has not yet been achieved.

The Governing Body **NOTED** the Quality Report for September 2015.

#### 10.2 Patient Safety & Clinical Quality Committee (PS&CQC) Chair’s Report

It was noted that two reports had been circulated this month, one relating to key issues discussed at the meeting held on 18 August and the other on 15 September. Many of the issues raised had already been highlighted during the Clinical Quality & Patient Safety report discussions. HDL queried the reference to 39% of Adult Speech and Language Therapy (SALT) patients seen within 12 weeks and queried how long the remainder had to wait. SH said that NCH&CT had been asked to identify this and it would be taken up via the CQRM. It was pointed out that these were low numbers and were ongoing, not urgent referrals.

The Governing Body **NOTED** the PS&CQC report outlining the key issues discussed at its meetings held on 18 August and 15 September 2015.

### 11 FINANCE AND PERFORMANCE

#### 11.1 Finance & Quality, Innovation, Productivity and Prevention (QIPP) Report as at August 2015

JI reported that, for the first time since its establishment, it was disappointing to report that the CCG’s financial position had deteriorated to a year to date deficit of £0.5m which is £1.5m adrift of the planned surplus to date. This is largely due to two factors, an increase in Trust activity and under performance of QIPP savings and there is a significant piece of work being undertaken to look at these two issues. Given that the CCG is reporting a deficit, discussions have taken place with NHS England about the consequences of this, as a result of which the CCG is required to produce a Financial Recovery Plan (FRP). A draft FRP will be submitted to NHS England by 5 October. This will be reviewed at the Finance and Performance Committee before it comes back to the Governing Body. JI said that whilst the CCG is preparing a plan there remain a number of significant risks to delivery of financial duties and these are listed in section 7.1. JI also drew attention to measures that the CCG has put in place/establishing in order to deal with financial recovery, as shown in section 1.4. One in particular is the appointment of an interim turnaround director. One thing to note, however, is that the CCG is not alone in this respect, and is looking to learn from colleagues locally and further afield.

HDL said that it is a credit to the whole executive team that the CCG had not reached this position sooner and it is now down to everyone to do all they can to address this situation as quickly as possible. HDL added that it would have been helpful to have known about the QEH’s overspend and scale of over-performance at an earlier stage.

SH queried the elective excess bed-days at the QEH and JI said that this is an area which is being pursued. At present it is not possible to clarify this, however the impact of changes to tariff is a line of enquiry being pursued.
JI has spoken with the Trust’s Director of Finance who is working with the CCG to help information flows

TB referred to the over-performance in Ophthalmology day cases, especially vitreous body injections, pointing out that his practice had seen an increase in patients receiving this treatment and perhaps this should have been picked up sooner and included in the contracting round at the beginning of the year. JI said that variances in plan are being reviewed and agreed that this should have been anticipated.

With regard to prescribing and in particular pain management, PW said that an increase in the use of some products had been seen due to the appointment earlier in the year of a new consultant. With regard to eye injections, when this treatment first came out it was considered to be a day case procedure and therefore a tariff price was agreed. However, the latest recommendation is that this should be an outpatient procedure which incurs a different tariff.

KE said that it is important that the joint activity review with the QEH of the significant over-performance seen in months 1-3 culminates in a clear set of actions. IM said that a number of bilateral discussions had taken place with senior managers and Governing Body members to understand this data. GPs on the Council of Members had also been alerted of the need for clinical interrogation of the data.

MF said that with the exception of Addenbrooke’s, all the Trusts with whom the CCG contracts with are in a negative position and this across the board spread of pressure is unusual. Each trust is trying to maximise its income and that pressure may be having a pan-provider effect. JI said that as Addenbrooke’s is a block contract this does not apply and although some of the percentage variances are significant, they are for relatively small contracts. However, this is being looked at as is the increase in referrals to private providers.

PJ referred to the table on page 4, section 3.4, and the increase in A&E attendances, pointing out that task to completion time is the most significant source of variability. Dealing with patients is the most important factor and the time taken to do this is directly related to the clinical complexity of the condition. IM agreed there were a limited number of explanations and emphasised the need for clinical interrogation to take place to get a clearer understanding of the issues and actions to be taken as a result.

JI referred to section 5 and the overview of the QIPP programme. There are approximately 40 schemes at present at various stages of implementation and delivery. As a result of refining these there is a bigger level of unidentified QIPP which is being focused on to try and bridge the gap. Section 5.5 gives an overview of the top 10 schemes which represent two thirds of the total value. The Finance & Performance Committee has undertaken an in-depth review of the top 6 and is assured that progress has been made.

IM said that the CCG needs to understand the reasons for the current deficit and to take all the actions it can to address this. Members will be aware that the CCG has a statutory duty to deliver a balanced budget and taking all actions necessary to do this. The CCG will have to look are more difficult decisions such as the reconfiguration of services if current measures fail to balance the budget. This will involve a lot of work from all colleagues including keeping members of the public informed of the steps taken to deliver this. A further detailed report will be provided to the next Governing Body meeting.

The Governing Body NOTED the significant deterioration in the CCG’s financial position which has resulted in a year to date deficit of £0.5m and a potential year end deficit of £2m if financial recovery measures are not successful. The Governing Body also NOTED progress with delivery of the QIPP plan.

11.2 CCG Financial Control Environment Self-Assessment

JI introduced the paper which gave a summary of the submission made to NHS England. The only area identified as “Improvement Needed” was the category of Commissioning Support Services where the lack of a signed Service Level Agreement (SLA) with North and East London Commissioning Support Unit (NELCSU) resulted in
the lowest rating.

The CCG is working to progress the SLA by the end of September after which point this rating will improve (agenda item 13.5 refers). IM said that the full submission had been reviewed by the Audit Committee at its meeting on 23 September.

The Governing Body **NOTED** the results of the Financial Control Environment Assessment submitted to NHS England in August 2015, which has been reviewed in detail by the Audit Committee.

### 11.3 Performance Report as at July 2015

KE presented the report highlighting the main performance concerns. In particular KE drew attention to the re-establishment of the Elective Care Operational Group and concerns around 62 day cancer performance which had been raised earlier.

HDL said that once again EEAST’s performance against response time standards had worsened with failure to achieve any of the national standards. A remedial action plan (RAP) had been put in place during 2014/15 to ensure delivery against the targets but this did not seem to be having any effect. KE said that pieces of work are happening, one aspect of which is the RAP which has been agreed with the Trust. However, there has been a growing increase in conveyancing rates and a response has been requested to this. There will be a focus on the RAP in next month’s report. IM understood that HOSC will be reviewing Ambulance services in October and it would be helpful to know the outcome of this.

HDL said that once again EEAST’s performance against response time standards had worsened with failure to achieve any of the national standards. A remedial action plan (RAP) had been put in place during 2014/15 to ensure delivery against the targets but this did not seem to be having any effect. KE said that pieces of work are happening, one aspect of which is the RAP which has been agreed with the Trust. However, there has been a growing increase in conveyancing rates and a response has been requested to this. There will be a focus on the RAP in next month’s report. IM understood that HOSC will be reviewing Ambulance services in October and it would be helpful to know the outcome of this.

TB referred to the access rates to psychological therapies and said that there is still work to do on both sides. It is about how to increase confidence from GPs on the service and ensure that NSFT’s RAP includes all the necessary components to make its services effective and easy to understand. IM said that as part of this the CCG is looking at giving GPs the opportunity to feedback on the quality of services for individual patients. MF said when offering the service to patients, the most important issue stopping them from taking it is the current waiting time of 4 to 6 weeks. IM said that the Clinical Executive was sighted on the need for earlier access for individuals in terms of support.

The Governing Body **NOTED** the current status of key operational performance indicators for 2015/16 and the actions being taken by the CCG to monitor and gain assurance on performance into the coming year.

### 12 STRATEGY AND COMMISSIONING

#### 12.1 System Sustainability Update

SC gave a verbal update on progress with regard to system sustainability and transformation work post-McKinsey Contingency Planning Team (CPT) intervention and the development of a joint plan across the system going forward. Work continues to progress through several working groups including the Frail Elderly Group which has a largely clinical membership and an internal Frailty Operational Group to move on services for frailty patients in West Norfolk. This work including addressing the practice of front-line staff delivering more co-ordinated care. There are ongoing discussions around medical recruitment and innovation and solutions for continuing problems around recruitment particularly to community consultant posts, one of which is the possibility of joint appointments to attract high calibre staff. The CCG is looking at urgent care with the QEH following up on some of the work that was developed through the CPT and prior to that around a model of community care. A decision is awaited from NHS England regarding a small bid for additional funds to assist with the establishment of a Transformation Board which will be chaired by an external impartial chair. Membership is currently very tight as the West Norfolk Alliance Steering Group (involving all stakeholder Chief Executives) will be running alongside this. It currently comprises SC, KE, Dorothy Hosein (QEH Chief Executive), Finance Directors and the QEH Director of Operations. The Chair of the Transformation Board will report directly to NHS England and Monitor and the Board will report through the CCG Governing Body and QEH Trust Board, so there is a local route too. SC said it is not a decision making board; it will monitor delivery and progress against plan.
IM said that there needs to be total clarity about decision making and governance processes for this Board and a paper should be brought to the Governing Body.

With regard to publication of the final report, SC said that the original plan brought to the Governing Body in July had been signed-off by NHS England and Monitor as meeting the requirements for taking forward the CPT recommendations. This plan is now being developed to reflect the approach to joint working with further detail and depth including information about longer term pieces, and should be finalised by the end of November. KE said that clinical engagement is integral to setting out the long term vision and clinical pathways and will form part of the work over the coming weeks.

PJ said that Ernst & Young is developing a new urgent care methodology and invitations would shortly be received by IM, SC and KE to launch dates of 8 October in Manchester and 15 October in London. Invitations would also be sent to the QEH Chief Executive and Medical Director and equivalents in Norwich CCG.

It was agreed that the next reiteration of the transformation plan be brought to the Governing Body in November for discussion. This will include a paper on the governance arrangements for the new Transformation Board.

12.2 Continuing Health Care Pathway Proposal

SC explained that this was the first of two papers, with this one addressing the experience of the actual pathway for patients and their families and the second one (agenda item 12.3) looking at the process and governance around decision making. Continuing Health Care (CHC) is a mechanism that provides NHS facing care for patients that meet eligibility criteria. At present the pathway is a tortuous process with the costs of providing packages of care increasing year on year. This paper sets out a two stage proposal to improve the consistency, fairness and experience of assessing patients which is currently undertaken in hospital. The proposal does not change patients’ rights in any way but moves assessment out of the hospital including the Checklist.

SH queried where fast-track fitted in this new system. SC said fast-track is excluded and this proposal, if implemented, will provide better resources and capacity to move those patients who are in urgent need through the hospital.

TB said this was a well-crafted and argued paper and personally was aware of the frustrations of families when signing-off CHC applications. However, how confident is the CCG about moving assessment further down the line, and it was not clear whether there would be sufficient resources in the community to support it. SC said that the legal position is being tested out with a law firm looking at test cases being proposed. It does not challenge the legal position as the NHS will still maintain its responsibility for funding those patients until they have received a CHC assessment. With regard to resources in the community, evidence suggests a large proportion of those people discharged make a good recovery and there is capacity that would be realised through less documentation and CHC meetings which would no longer be necessary.

TB raised a concern with regard to those patients whose recovery or improvement is much more difficult to anticipate and how to ensure that this pathway is sufficiently robust. SC there is an issue about redefining the decision support tool around what is social care and what is health care and to really address the issue of patients who fall between health and social care and are not consistently assessed for funding.

IM asked what the implications were for implementing this for Norfolk particularly for Cambridgeshire who use Checklist. SC said that Cambridgeshire and Peterborough CCG is prepared to adopt the proposal and not undertaking Checklist and has allocated beds in Cambridgeshire to receive these patients.

The Governing Body SUPPORTED the adoption of Phase 1 of the proposed pathway for all patients in West Norfolk, with regular reviews, and to progress to Phase 2 as set out in the paper.
12.3 Proposal for Uniform Norfolk Continuing Health Care Review and Decision Making Framework

SC presented the paper which outlined a proposal to introduce a standard decision making framework for CCGs to use when commissioning and reviewing CHC packages. Currently all CCGs in Norfolk have an established panel which reviews these cases but there is some variability in the scope of the evidence used to support the decision making process. The proposed standardisation of the domains addressed in the process, based on best practice, will ensure a consistent approach for all patients within and between different CCGs.

IM queried the reference to Annex 2 in the paper which had not been included. SC said that this is a list of services which fall into NHS mainstream funding which the CSU is currently in the process of compiling and as it is in draft form it had not been circulated. Once the list had been finalised it would be circulated prior to sign-off. IM said it would be helpful for members to comment on this electronically or at the next meeting as patients will have considerable interest in what is on that list.

SH added that CHC is reviewed on a quarterly basis at the PS&CQC. SC said that all Norfolk CCGs will be going through a similar process and HOSC is aware of this too.

The Governing Body SUPPORTED the introduction of a standard framework to support decisions made on packages of NHS Continuing Health Care and APPROVED the adoption of recommendations in sections 2 and 6, subject to the opportunity to scrutinise Annex 2.

12.4 Paediatric Speech & Language Therapy Service – Approval of Preferred Provider

KE presented the report which provided the Governing Body with an update on the procurement for a new Paediatric Speech & Language Therapy service, described how West Norfolk CCG had been involved in the process, and requested approval of the outcome of the tender evaluation process and next steps.

The Governing Body accepted the assurances offered that due process had been followed and therefore APPROVED the selection of Bidder B as the preferred provider of the new Paediatric Speech and Language Therapy service. In addition members APPROVED that Bidder A should be included as a reserve preferred bidder, should this be required, and APPROVED that a Section 75 Agreement is entered into enabling the local authority partner (Norfolk County Council) to contract for this service on behalf of the CCG Partners.

13 GOVERNANCE AND ASSURANCE

13.1 Governing Body Assurance Framework (GBAF)

JI reported that the Assurance Framework (AF) had been reviewed by the Audit Committee at its meeting held the previous day. As a result of those discussions the risk rating for Risk 3.3 – Risk of failure to discharge financial duties of CCG, had been amended to 20, and is one of the risks which has returned to the AF. Members noted that there will be further work on the AF to ensure it is properly aligned to strategic objectives.

SC drew attention to the increased risk rating for risk 2.7 – Risk of not funding the Clinical Academic Reserve (CAR) on reputation and finances. This had escalated in terms of pressure on the CCG to pay this sum of money for this financial year which would be £0.5m, which is not built into assumptions. Members noted that further legal advice obtained collectively by the 10 CCGs continues to support the CCG’s stance and recommends pursuing the legal case. IM said that this had been discussed in more detail at the recent Audit Committee meeting. HDL, as Audit Committee Chair, will be progressing this with Audit Chairs across Norfolk to agree what further actions should be taken.

The Governing Body NOTED the updated GBAF.
13.2 Finance & Performance Committee Chair’s Report

The Governing Body NOTED the Finance & Performance Committee Chair’s report of the key matters discussed at the meeting held on 9 September 2015.

13.3 Audit Committee Chair’s Report

HDL explained that as the Audit Committee had only met the previous day it had not been possible to provide a written report. HDL said members had been delighted to welcome IM and it had been a lively and interesting meeting. The usual agenda had been followed including four reports from Internal Audit which had given reasonable assurance. Members had discussed the Internal Audit report on care homes and continuing concerns were expressed which will be taken forward and a further report provided to the next meeting. A discussion had taken place within the External Audit section relating to statutory reporting processes as a consequence of the current financial position. The Chief Financial officer and Senior Management Team were commended for looking at everything well in advance and making the necessary preparations.

SH asked for further details on the care home concerns. TB said that these related to ensuring that contract monitoring is effective, ie production of monthly reports, and reporting of quality markers and strengthening the relationship with NCC, ie to get a reduction in PUs. IM noted the valuable work of the PS&CQC in doing qualitative work and the need to triangulate with this.

The Governing Body NOTED the Audit Committee Chair’s report of the meeting held on 23 September 2015.

13.4 Emergency Preparedness, Resilience and Response (EPRR) Assurance

Members noted the considerable amount of work that had gone into providing this assurance, particularly that undertaken by Jean Clark.

The Governing Body NOTED the update on EPRR, the results of the self-assessment against NHS England EPRR standards and the CCG’s EPRR Annual Work Plan.

13.5 North and East London Commissioning Support Unit (NELCSU) Service Level Agreement (SLA)

JI reported that the CCG had been ‘out of contract’ with the CSU for some time due to significant performance concerns. This had been progressed internally through both the Finance & Performance Committee and Audit Committee and discussions had now concluded with the request that the Governing Body formally approves the agreement. KE said that given previous concerns it is absolutely critical to have a rigorous set of KPIs and SH said that this included the timeliness of reporting them too. TB said that supporting the Quality Team is absent from the range of services to be provided. SH said that the CSU does support quality and is fundamental to the work of the team. JI would take this point on board.

The Governing Body APPROVED the agreement of an SLA with NELCSU for the provision of Commissioning Support Services from 1 October 2014 to 30 September 2016, subject to the inclusion in the SLA of contractual sanctions should KPIs not be achieved.

14 ITEMS FOR INFORMATION

Members noted the links to the Audit Committee and Finance and Performance Committee minutes and the Register of Interests.

15 DATE AND TIME OF NEXT MEETING

The next meeting in public will be held on Thursday 29 October 2015 at 9.30am in the Committee Suite, Borough Council of King’s Lynn & West Norfolk.

There being no further business the meeting closed at 12.55pm.