NHS
West Norfolk
Clinical Commissioning Group

MINUTES OF THE GOVERNING BODY MEETING HELD ON THURSDAY 27 NOVEMBER 2014 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 Imran Ahmed	(IA)	Governing Body GP Member
	Dr Tony Burgess	(TB)	Governing Body GP Member
	Dr Pallavi Devulapalli	(PD)	Governing Body GP Member
	Dr Mark Funnell	(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)
	Penny Sutton	(PS)	Lay Member, Patient & Public Involvement
	Sue Hayter	(SH)	Registered Nurse
In Attendance:	Maggie Carter	(MC)	Head of Clinical Quality & Patient Safety
	Kathryn Ellis	(KE)	Director of Operations
	Dr Jean Clark	(JC)	Head of Governance
	Stephen Wells	(SW)	System Sustainability Programme Lead (11.3 only)
	Sue Cook	(SJC)	PA to Chief Officer & Chair (Minute Taker)
	One member of the public		

ACTION

1 APOLOGIES

Apologies were received from Dr Bonny Rodrigues.

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

There were none.

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.

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

4.1 Procurement of Integrated Norfolk Community Eating Disorders Services

IM reported that the procurement exercise had concluded with no award of business being made on the basis that no compliant tender responses had been received. Due to the urgent need to secure service provision a short Part 2 confidential Governing Body meeting will take place at the end of this meeting to discuss the next steps and the outcome will come back to the January Governing Body meeting.

5 MINUTES OF THE PREVIOUS MEETING HELD ON 23 OCTOBER 2014

The minutes of the previous meeting held on 23 October 2014 were agreed as a correct record subject to an amendment to item 8, Accountable Officer's Report, page 4, final paragraph. This should read. " . . . and reducing the barriers between both primary and secondary care and other parts of the system, **introducing new models of care** which **are** aligned to the integration work being carried out by the CCG".

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

6.1 Eclipse Live Implementation and Training Timeframe (98/13): It was noted that as there is no meeting in public in December an update will be brought to the January Governing Body meeting.

6.2 Update on the Recommencement of the QEH (The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust) Home Birth Service (13/14): SC reported that a meeting had been arranged for early December involving CCG and QEH clinicians and senior managers, including Chief Executives, to clarify the position.

6.3 Section 256 Monies – Target: people aged 18-64 in contact with secondary mental health services in paid employment (28/14): Although this item had been closed, IM requested that it remain open until the action plan to ensure a significant improvement for next year had been received.

6.4 Explanation for very low achievement levels for Clinical Haematology and Lung Cancer (33/14): Although this item had been closed, IM requested that it remain open until further details had been received from the QEH.

6.5 Referral to Treatment Time (RTT) Capacity in Day Care (34/14): Although this item had been closed, IM requested that it remain open until the report from the sub-group had been received. KE said that the results were currently being collated and the conclusions will be reported to the January Governing Body meeting. The action log would be amended to reflect this.

6.6 Levels of service in place for young homeless of West Norfolk (36/14): Following the question raised by Ms Jo Rust at the last meeting, a response had been forwarded by PD. It was agreed to close this action.

6.7 Meeting with QEH Non-Executive Directors (NEDs) and CCG Lay Members (38/14): IM reported that this meeting is unlikely to take place before the Spring. However, IM (together with TB) had met with one of the two new NEDs and a meeting has been arranged with the other.

6.8 Service Review (Therapies) (39/14): TB had been in contact with the Head of Therapies and there were issues which had not been shared with the appropriate departments (this also links to 40/14). These will be picked up via the Clinical Quality Review meetings (CQRM) for both the QEH and Norfolk Community Health and Care NHS Trust (NC&CT) to provide the necessary assurance. It was agreed to close this action.

6.9 Concerns with the comprehension and speaking of good English on admission (41/14): SH explained that this will form part of the discussion with Catherine Morgan (Director of Nursing, QEH) at their next regular meeting following which it is hoped to close this action.

6.10 Discharge Summaries (42/14): The issue of timelier receipt of discharge summaries will be picked up via the CQRM process. It was agreed to close this action.

6.11 Discuss with Care Quality Commission (CQC) concerns with West Norfolk CCG being excluded from the County-wide safeguarding inspection (43/14): SC had raised this issue with Mark Gower, the safeguarding lead for Norfolk. As the CQC had undertaken an in-depth review into the QEH, it was considered appropriate to have a review of safeguarding at a later date. A decision as to when (or if) this takes place would be made once the QEH CQC inspection report had been received. TB added that the CQC was planning to visit West Norfolk GP Practices in the new year and safeguarding for adults and children would feature heavily in this process. IM reported that Practices had been notified of the CQC's intention to inspect a number of them between January and March 2015. This action would remain open and a judgement formed when the CQC report had been received.

6.12 Structure of the Programme Advisory Group (PAG) to be added to the West Norfolk CCG website (44/14): SC suggested that it would be helpful to add the structure of the entire System Sustainability Programme, not the PAG in isolation and confirmed that this would be uploaded by the following Monday.

6.13 Update on technology relating to Near Patient Testing to be sourced (45/14): JI reported that following discussions at the last Governing Body meeting the potential for using/piloting near patient testing had been added to the Quality, Innovation, Productivity & Prevention (QIPP) pipeline which will be taken up through the Clinical Executive.

6.14 Recording of Ambulance Response Times for single paramedic and double-staffed vehicles (46/14): A report had been received which although containing helpful information did not clarify this specific issue.

KE will pick up and provide an electronic response off-line in advance of the next meeting. **KE**

6.15 Low levels of Access to Psychological Therapies (47/14): An update had been included in the Performance Report (Agenda Item 12.2). It was agreed to close this action.

6.16 Independent Audit of Ambulance Handover Times (48/14): The audit is now complete with a solution being worked through with the aim of an agreed position going forward.

6.17 Pharmacy Workforce Issues: TB referred to an action attributed to him in the minutes which had not been included in the action log relating to pharmacy workforce issues. TB had not yet had the opportunity to investigate this and an update would be provided in due course. It was agreed to add this item to the action log.

7 DECISION LOG

The Council of Members had been advised of the decisions taken at the meeting held on 23 October 2014.

8 ACCOUNTABLE OFFICER'S REPORT

SC gave a brief update on the system sustainability programme work noting that the McKinsey Contingency Planning Team (CPT) is in full operation working closely with the CCG, QEH and Monitor. As part of this work a very productive clinical meeting had been held on 19 November attended by over 60 clinicians from across the West Norfolk health system; with a further meeting planned for 10 December. At a recent West Norfolk Alliance (WNA) Chief Executives' group meeting a proposal had been put forward to develop a single WNA HR function with common contracts of employment, terms and conditions to include more flexible working, and organisational strategic objectives to facilitate alignment. SC had attended an Integrated Pioneer Assembly with Roger Hadingham (RH) which had been an interesting opportunity to gain an insight into what is happening with other pioneers in different parts of the country. A meeting had also taken place with Gillian Johnson, the new national support manager, who will be co-ordinating extra resources and making sure there is link-up with other workstreams. The CCG had been invited to apply to become part of the second wave of pioneers and SC had made a very robust response that West Norfolk had been included within the first cohort and treated as full member and that the conditions that had resulted in being given associated status still applied.

SC had attended a meeting with managers from care homes with nursing, organised by Rob Jakeman (Integrated Commissioning Manager) and Sarah Taylor, from the CCG Quality Team. This had been an interesting meeting looking at some of the issues around the interface with care homes and the hospital that challenge both sides and seeking ways to improve these.

SC had attended the annual general meeting of the West Norfolk Community Transport Project the previous week. This is a successful business model which provides a very valuable service to people in West Norfolk.

In the forthcoming week SC will be attending a follow-up meeting regarding the Barker Review, at the King's Fund, which is looking at recommendations to further health and social care integration, particularly continuing health care.

In relation to the integrated pioneer assembly, PJ asked if any of the other pioneers had been identified as facing similar challenges to our own. The CCG could benefit from pulling in external advice but it has to be relevant and what is needed is people who have faced similar practical challenges. SC said that the pioneers are all quite different; many of them have a particular focus such as information technology and new innovative contracting mechanisms. There are no other areas which are undertaking such a broad and ambitious piece of work; West Norfolk is leading edge. SC pointed out that one of the advantages of using the pioneer framework is that it allows a direct line to Monitor, through to Whitehall and policy makers. It is about testing new ways of doing things as a forerunner to amending national policy. It was noted that the Isle of Wight was presented at a CPT Commissioning Intentions Group as having a lot of similarities, particularly in relation to demography and services and this is being followed up. Any other suggestions on remodelling care would be welcomed.

SH was pleased to note that a meeting had taken place with care homes and asked if there had been any input from the QEH or NCH&CT. SC said future meetings would involve other providers. Care home managers had valued this opportunity to share concerns separately with Commissioners. TB pointed out that the acute provider and care homes had been meeting on a quarterly basis for some time.

9 CHAIR'S REPORT

IM reported that he had attended large number of meetings relating to Monitor's CPT process. These had included meetings with McKinsey, Monitor's CPT appointees, and joint meetings with the QEH, Monitor and McKinsey. In the previous week IM had attended the first in a series of clinical working groups (as referred to earlier by SC in her report) organised under the auspices of the Clinical Reference Group, which had given local clinicians the opportunity to be fully appraised of the challenges and to look at the very good work already undertaken on elements of pathways of care. This had been a very well attended and positive first meeting. IM added that he had been reflecting on other systems available in England and more widely in the UK and other health funded European systems.

On 11 November IM had chaired a meeting of the Council of Members which had looked at issues relating to the CPT progress and also at current performance which will be discussed in more detail later in the meeting.

IM had attended a meeting of the West Norfolk Partnership Governance Group, whose membership includes chairs and leads from public organisations. One of its agenda items had been a discussion on progress with regard to integration in West Norfolk.

IM had worked with clinical and managerial colleagues to complete the Norfolk and Waveney Stroke Network's response to the Health Overview and Scrutiny Committee (HOSC) report on Stroke Services in Norfolk. The HOSC remains very supportive of stroke services in King's Lynn and is in the process of meeting to consider this response (IM had sent his apologies). An action plan will be produced which will form a substantive part of the work of the Stroke Network over the coming months.

10 PATIENT EXPERIENCE, SAFETY AND CLINICAL QUALITY

10.1 Clinical Quality and Patient Safety Report

MC introduced the monthly Clinical Quality and Patient Safety Report drawing attention to the key risks highlighted in the Executive Summary. Particular reference was made to outstanding concerns relating to medicines management and medicines reconciliation. It was noted that the CCG is working closely with the NHS England Local Area Team (LAT) including the Medical Director, who are providing support.

QEH:

HDL raised two concerns, firstly expressing disappointment with regard to the considerable delay in reducing the number of Clostridium Difficile (C.diff) cases and asked when an improvement would be seen. Secondly, regarding workforce issues and again it was disappointing to note that the Allied Health Professionals (AHP) turnover had increased to over 20% and HDL asked if there were any particular reasons for this increase and if so, what changes had been put in place to address this. With regard to C.diff, MC said that a lot of work is taking place to achieve changes, including bringing in experts from across the region with support from Public Health and appointing a locum consultant who is a specialist in this area. Numerous ward visits have taken place and the situation is being monitored very closely. However, it is not possible to give an exact date as to when this will be back on track. TB said that advice had been taken from Public Health colleagues and pointed out that it is very difficult to redesign a trajectory once it has been breached. The Trust has attempted to reduce the number of cases and where plans have been drawn up these will continue to be implemented. Any changes need to be incorporated into every day working practices and unannounced and announced visits will continue to be undertaken until this has happened. IM added that there is a C.diff action plan produced by Public Health which will continue to be monitored to ensure achievement.

With regard to AHP turnover, there are two areas one being Pharmacy (referred to earlier) and the other is therapies. The Head of Therapies is actively recruiting but it has to be recognised that this is a challenge and not just for AHPs. The QEH is looking at how it can recruitment more innovatively locally across its entire workforce. HDL queried whether it was possible to use 'golden hand cuffs' as an incentive for staff to stay. MC said that the Trust is looking at all these sorts of things including incentives used by other organisations. PS asked if it would be possible to identify the number of nurses trained locally and how many of these were retained locally. MC said that the University of East Anglia is one of the highest in terms of academic entrants but of all the newly qualified nurses country-wide only 25% were going into the NHS. The QEH is working closely with the College of West Anglia to provide more local training. IM said this was a valid point and highlighted the importance of improving educational opportunities for people in West Norfolk to gain qualifications to allow them to enter nurse training.

PD referred to the high number of Quality Issue Reports (QIRs) for Medication/ Prescribing and TB said this was a result of primary care colleagues continuing to report difficulties in reconciling medicines. The CCG was working with the QEH to address this particularly around its discharge summary arrangements.

From an information governance point of view, JI asked if any of the QIRs required anything to be enacted contractually with the Trust; it was agreed to pick this up off-line. Secondly, the QEH previously had a very good mortality rate but this had increased for August, and JI asked if this was a cause for concern. TB said that information is received very close to Governing Body meetings and there had not yet been an opportunity to interrogate the Trust on its data. However, this had not been highlighted in regular meetings with the QEH Medical Director and was still below the predicted rates but TB would follow this up. **JI/TB** **TB**

PW referred to communications between the hospital and GPs in particular the problems mentioned earlier concerning illegible discharge summaries. PW made a request for the Trust to use the electronic systems that exist to get discharge summaries to GPs in a more timely way. IA said that several clinician to clinician meetings had taken place where it was agreed to email electronic versions to GPs but this had suddenly ceased and it was not known why. It was agreed that the Quality Team would investigate this further. **MC**

PS made reference to a recent House of Commons debate where King's Lynn had been mentioned as one of three hospitals actively turning patients away from A&E. IM said that the Chief Executive of the QEH had refuted this and A&E performance would be discussed later in the agenda.

NCH&CT/Norfolk & Suffolk NHS Foundation Trust (NSFT):

HDL referred to the NCH&CT workforce data and in particular the high turnover rate for the West and asked what was being done to improve this. Secondly, the NSFT executive summary mentions four out of area placements; where did those patients have to go and what happened to them. MC said that NCH&CT had held a successful recruitment day locally and recruited nurses from out of the county but this was not reflected in this report. With regard to NSFT out of area placements, KE said that it was not possible to comment on that level of detail but positive work had taken place to help mitigate placements. This had included a successful bid for funding associated with rapid and intermediate response for patients in a crisis.

NCH&CT:

In response to a query from IA, TB confirmed that catheter-associated UTIs relates to measuring inpatient facilities. Reference was then made to the thresholds listed in the Patient Safety section, and in particular whether "0" was appropriate. MC agreed that thresholds are something which need to be looked at further, particularly for Falls which are county-wide ones; and local information should be added in.

IM referred to MSK Physiotherapy and the lack of data since April 2014. MC said that a local report is monitored on a monthly basis and this data will be built into future reports. KE added that as a result of the contract negotiations for 2015/16 more local data will be provided to improve such discrepancies.

NSFT:
With regard to the earlier discussions about West Norfolk patients who had been placed out of area, SH asked if information was available as to how many people were placed in West Norfolk from out of their area. MC said this level of detail is received and IM said it would be helpful to drill down to understand exactly who is going where.

TB confirmed that by the end of January the CCG should be able to provide a complete picture, or if not a report on the current position, with regard to the external review of unexpected deaths.

Linking back to the previous discussion, MF said that the threshold column for the Patient Safety section of the NSFT dashboard was meaningless and MC agreed to review this for future reports.

PD referred to the caseload targets on dashboard 2 and asked if there were any plans to increase the workforce especially with the drive for the increase in dementia rates. MC said there are vacancies and active recruitment is being undertaken. The CCG is working very actively on caseloads and this report does not reflect what is happening currently. KE said that a key issue for the 2015/16 contract negotiations is to understand what is driving these particular caseloads. PD said that going forward there is national drive for dementia to be included in primary care and she would be willing to be involved in any discussions. IM said that the number waiting is increasing incrementally and this is clearly an issue which needs to be addressed in making sure initial assessments and plans are put in place for those individuals.

Out of Hours (OOH) GP Service/111 Non-Emergency Helpline:
Reference was made to the percentage call backs within 10 minutes which was quite a low percentage and TB said that this metric will be reflected in the new contract negotiations. IM said that this was a valid point about the 111 service and the new process for tendering may well help in this respect. IM commented that the remaining metrics for the OOH service were excellent.

Care Homes:
IM welcomed the addition of data relating to Care Homes and looked forward to future updates. It is important that the CCG looks at ways to support the recruitment of people who work in care homes, as well as in other parts of the health and social care system. MC said that there is a lot more work underneath this to understand what is required in terms of quality monitoring and this good and positive work is to be commended.

10.2 Patient Safety & Clinical Quality Committee Chair's Report

SH introduced the report which outlined the key areas discussed at the Patient Safety & Clinical Quality Committee (PSCQC) meeting held on 18 November 2014. SH made reference to the fact that the Committee had been unable to review the Patient Safety & Clinical Quality report for November as information from the Commissioning Support Unit (CSU) was not up-to-date. As a result the Committee requested the Governing Body to consider the following proposal:

- **Each month the Governing Body will have an executive monthly dashboard on the main providers;**
- **This will be supported by a detailed report on the PSCQC discussions;**
- **Each quarter there will be a detailed quality report on all providers which identifies trends and analysis of the data.**

This proposal was APPROVED.

With regard to the amended terms of reference for the PSCQC circulated with the report, KE suggested that membership include a representative from the contracting team who could provide an oversight on quality issues. SH said this would be covered in the membership section where it stated that other attendees could be co-opted and invited as required. **With this clarification the Governing Body APPROVED the amended terms of reference for the PSCQC.**

ACTION

11 STRATEGY AND COMMISSIONING

11.1 System Sustainability Programme Update

SC explained that until it is possible to share detailed information, verbal updates will continue to be given to the Governing Body. Members noted that the work of CPT is progressing but there are challenges in aligning the CPT programme with locality programmes. The main emphasis has been on clarifying the nature, depth and consequences of problems pertinent to West Norfolk. The first output will be a public document setting out the Evidence for Change building on the initial Case for Change document and a debate on the key issues. KE will be producing this document and there will be a range of opportunities for public debate and comment. As referred to earlier in the Chair's report, the first of the clinical working groups had been an opportunity to connect with a much bigger group and range of clinicians. Valuable views from that meeting would be captured as part of the process to start to test the viability of the clinical baseline in relation to best practice, clinical standards, population characteristics and size, etc. This will be part of a process to build 'clinical options' to shape a clinically and financially sustainable service.

KE said that by the end of February/March there will be a set of solutions coming out to clinicians and other working groups identifying the way forward for the local health economy. KE is working through the process with JC to decide what is brought back to future Governing Body meetings to provide assurance on the output of this work. `

IM asked when the Case for Change document which is commonly part of this type of process is likely to be produced and what assurances will be put in place for considering and improving it and for public engagement. In the case of any final output document from the process the impact of Purdah, ie the pre-election period which requires particular care for any public body publishing documents for public consultation at this time, was raised. JC said that no guidance on when Purdah applies had been received to date but this would be followed up. SC said that this will be called an Evidence for Change document which the CCG will own and publish. The timeline will be dependent on joint working and achieving fully analysed and up-to-date information which is a progression from the original Case for Change document. KE is working on a publication date for the end of January with public engagement events early to mid-January. IM encouraged Governing Body members to discuss any issues with colleagues to ensure there is wide sharing of information. **JC**

11.2 Policy on Shared Care Funding Arrangements

JI introduced the paper explaining that earlier in 2014 the Governing Body was presented with a draft Policy on Shared Care Funding Arrangements ("Shared Care Policy") which it was unable to approve due to a number of queries to be resolved. Further discussion was held at the CCG Executive Team meeting in July 2014, which again resulted in a range of queries. These were sent to North & East London CSU (NELCSU), who had drafted the policy, and who sent a comprehensive briefing paper in response. This response, along with the policy, was discussed at the Executive Team in November 2014, at which it was agreed to recommend to the Governing Body the ratification of the attached policy.

A key point to note from the NELCSU comments is that the proposed CCG policy is derived from the previous Norfolk Primary Care Trust (PCT) policy, and that in governance terms it is important that the CCG does have a policy on such matters to govern the decisions that are made on a regular basis. Also, it should be noted that this same policy is being discussed and agreed by all the Norfolk & Waveney CCGs.

The Governing Body APPROVED the Policy on Share Care Funding Arrangements subject to clarification of the age ranges covered and an assurance with regard to the process relating to frail older people. **JI**

11.3 Eastern Pathology Alliance (EPA) Contract Update

KE introduced the paper explaining that this had been quite a complex transition to a new provider. The analysis in the paper covers two broad areas, firstly a comparison (Appendix A) setting out an overview of the service that existed prior to the new EPA contract and some of the characteristics of the service post-EPA. The second focus of the paper is to investigate the quality concerns which have been raised and page 5 includes an analysis presented in terms of QIRs on a month by month basis since April 2014. The contractual arrangements for this service continue to give cause for concern and KE is still awaiting sight of the final contract and has arranged to go through the contractual process in detail.

In response to a query from TB, SW confirmed that although all Laboratories have been reaccredited in accordance with the current standards, any external quality assurance process should be specific to users of the service and it is not yet clear how this has been accommodated. SW also confirmed that from April 2015 sample integrity will be part of the quality assurance process. Concern was expressed that only six months into the service capacity modelling had been undertaken. Monitoring of complex investigations should have been factored in and there should be a mechanism for capturing repeat tests. PD queried whether it would be possible to integrate the IT systems at QEH and Norfolk & Norwich University Hospital to employ one service across two sites. SW would investigate this at local management group level as it was understood there was spare capacity in King's Lynn and SW was keen to explore this further. As more detail is provided through the QIRs there will be more evidence to challenge EPA. **SW**

PS raised two issues, firstly sample collection and transport times (section 3.3) pointing out that this is not a four hour limit, it is four hours plus. Secondly had the issue of results going to the OOH service been resolved. SW said this is being progressed and he had asked both the East of England Ambulance Service NHS Trust (EEAST) and EPA to provide information to obtain a comparison. KE said this is about understanding what has been said as part of the agreement contractually and differentiating those incidences where the provider is not responding; by the next update there will have been another level of analysis. IM explained that he had asked for this paper to be presented and was fully aware that a lot of this was work in progress but it was helpful to have the current update today.

MF referred to the increase in abnormal potassium results which PS said links to transport times. Clinical feedback about the pattern of demand was extremely helpful and although this trajectory was well known, KE was not sure if it had been factored into the contract. IM emphasised that this was an inherited tendering process and a number of issues were now being picked up that had not been addressed when the former PCT was involved. TB added that EPA's communication with clinicians about abnormal potassium results and transport times had been appalling. IM reported that near patient testing had been discussed as a possible option, together with the issue of transport times, and this will be taken forward by the QIPP workstream. SW would welcome further detailed evidence through the QIRs in order to challenge EPA robustly.

IA referred to the near patient testing for Health Checks undertaken by Norfolk County Council and whether this was really happening, and it was agreed to follow this up outside of the meeting. **SW**

IM said this had been a useful and good clinical debate to understand the work in progress. **The Governing Body AGREED the follow-up of QIRs and a further progress update would be brought to the January Governing Body meeting.**

12 FINANCE AND PERFORMANCE

12.1 Finance & QIPP Report as at October 2014

JI reported that the CCG is still on track to deliver a 1% surplus as required by NHS England but there are a number of risks to that as outlined in the paper.

One new pressure is the growth in the number of continuing health care (CHC) packages coming through with a significant backlog in the assessments undertaken. This data is being reviewed to identify any trends and will be included in future reports.
JI made reference to the improved QIPP process which is now becoming embedded and the CCG is currently looking at the capacity of the organisation to take forward specific schemes.

The headline position in respect of emergency activity is over-performance against plan which is largely as a result of the opening of the Ambulatory Care Unit (ACU) and ending of the GP 'Front of House' service in November. However, it should be noted that the cost of activity is flat as more patients are being treated on the same day and short stay basis.
In addition, this report updates the Governing Body on the CCG's Quality Premium that will be received in 2014/15 in respect of 2013/14 performance. This shows that the CCG is expecting to receive additional funding of £76k, which is just 9% of the £815k that was potentially available; whilst the CCG delivered on the three local measures identified for 2013/14, the failure of the local health system providers in achieving a range of performance targets relating to areas such as health care associated infections, A&E, cancer and Ambulance response times means that the amount available is reduced significantly.

KE reported that a Contract Query Notice (CQN) had been issued to provide further analysis in non-elective activity. The ACU was a relatively new initiative and PW asked what tariff was paid and JI confirmed that this is paid as an admission, in accordance with NHS payment regulations. This will be part of the ongoing review as to whether the ACU is value for money.

HDL referred to the useful graph summarising the QIPP dashboard (5.4) and the difference between planned service and actual service. However, it was disappointing to note that Planned Care and System Sustainability had no Forecast Actual Savings attributed. JI explained that this was due to the weakness of planning assumptions at the beginning of the year. MF had been involved in a lot of work to progress individual schemes but the focus has been on urgent care in view of the pressures identified. A number of initiatives are now coming through such as Map of Medicine and pain management but these are not expected to deliver significant savings this year. MF said he was equally disappointed in this graph but there will be a much stronger starting point next year. IM said that this work had been constrained by the major challenge of system reform and having a Trust in special measures.

SC asked for an assurance about the growth in volume of CHC packages and whether this is real growth in eligibility or connected with the consistency of assessments and the CSU team undertaking random audits. MC said the CCG was keen to undertake its own audit as this increase is concerning and there is work and analysis to do.

SC referred to the Better Payments Practice Code (BPPC) and although this indicated that the CCG was performing well in respect of meeting the target for paying invoices, SC had received a number of individual requests to chase non-payment. JI explained the vast majority of invoices go through on a timely basis; there are a few instances where payment has been delayed and a new electronic system is being put in place which should address this. SC said that it is perhaps a certain type of provider, ie a small business, which is experiencing difficulties. It was suggested that the Chair of the Audit Committee investigate this as it is particularly important that small, local businesses are paid in a timely manner. JI said that Internal Audit would be visiting the CCG in November and he would ask them to focus on this issue. **JI**

With regard to planned care, PD said that the QEH has planned incentives and is there any room to be creative in the way that these are paid for, ie to give an incentive. IM said that the whole purpose of looking at system reform is to look at clinical pathways and best practice including better ways of remunerating pathways of care rather than using Payment by Results, and this will form part of the system sustainability work.

The Governing Body noted the financial position for West Norfolk CCG as at month 7; the current position with delivery of QIPP initiatives; and the level of Quality Premium funding due in respect of 2013/14 performance.

12.2 Performance Report as at September 2014

KE presented the report reflecting operational performance in key areas for West Norfolk patients to September 2014 and identifying areas where contractual action is being pursued. The main performance concerns focus on Ambulance response times, A&E 4 hour wait breach levels at the QEH, RTT waiting time targets, access to psychological therapies, issue of a CQN for 6 week diagnostics due to the QEH's continued capacity issues in Endoscopy, ambulance handover breaches, poor performance in stroke services and cancer standards.

Ambulance Response Times: This issue had been escalated to the NHS England LAT at the CCG's quarterly assurance meeting held that week. There will be direct communication between the LAT and the Ambulance Trust regarding poor performance. With regard to the two handover audits, the Ambulance Trust has indicated that it is very keen to work with the QEH to come up with a clear plan to stop the cohorting of patients; two meetings have been held and plan is expected by the end of the week. There is a general increase in A&E performance with particular dips on a Monday. It should be noted that the number of patients diverted from the hospital compared to other trusts is quite low. KE made reference to the "Choose me not A&E" campaign instigated by Emily Arbon, CCG Communications Manager, which encourages people to access other avenues where they have symptoms which are not life threatening or an emergency. In this connection IA is chairing a clinical conference on urgent care following the Governing Body meeting. It was noted that delayed discharges in Cambridgeshire is a continuing issue and IM reported that he is in dialogue with the Director of Social Services and this will be useful data to feedback.

Diagnostics and Cancer Standards: There have been a few months where the QEH has not achieved the required standard and the next step in contractual escalation is to notify the Governing Body and QEH Trust Board and to agree a remedial action plan.

Access to Psychological Therapies: Performance is improving with a range of activities that are happening off-line. Regular updates will be received at the CCG Clinical Executive (CLEX) and dementia is also one of the key areas. However, greater scrutiny of the plans is required to get to the required levels of performance.

With regard to the long-standing issue of Ambulance response times, HDL asked if an assurance could be given that by the end of March 2015 this will have been resolved. KE said that whilst the picture is improving month on month it was not possible to give that definitive assurance. SC understood that following her request for local data this is now being reported but has not been included in this month's report; when will this be expected. KE said although a lot of information is being provided it was disappointing not to have received this and it will be given priority.

NCH&CT workforce constraints: TB asked if it would be possible to have a synopsis of the Community Matrons' caseloads. MC said that Community Matron activity information is received and the CQRM will provide a full review and update on workforce recruitment and arrangements in January. The current key performance indicators are insufficient and Cal Deane (Head of Community Commissioning) will be leading a piece of work, with clinical input, to obtain transparent metrics for the 2015/16 contract.

A brief discussion ensued relating to breaches in colonoscopies at which point MF declared an interest in a provider of colonoscopy services. IM said that the key question is to ensure the QEH is making use of all mechanisms to meet the standard and this is the message which should be conveyed. KE backed this stance and said that part of the challenge is that the Trust considers itself back on track but the CCG has not had the granularity to support this. The CCG will continue to look at ways of resolving this issue.

A number of colleagues are working extremely hard to deliver performance and there is an appetite to refresh systems and processes. IM thanked KE for a very detailed report highlighting a number of important areas.

The Governing Body noted the current status of key operational performance indicators for 2014/15 and the actions being taken by the CCG to monitor and gain assurance on performance. The Governing Body noted the procurements that are in the process of being initiated/in progress in respect of services for Community Eating Disorders, Primary Care Mental Health Services, End of Life care provision and GP Out of Hours/NHS "111", where existing contracts will expire in the next 12-15 months.

13 GOVERNANCE AND ASSURANCE

13.1 Assurance Framework

JC presented the Governing Body Assurance Framework (GBAF) with updated risks.

PW asked for clarity on the target risk rating for Risk Ref 1.4, pointing out that the consequences should not be less than the target. JC explained that the onus is on the risk owner to agree the target but offered to look into changing the target ratings. **JC**

The Governing Body noted the updated GBAF.

13.2 Proposed Constitution Changes

JC introduced the report outlining changes to the Constitution which had been discussed at a number of fora including the Council of Members on 11 November 2014.

PD referred to the timetable pointing out that the consultation with stakeholders is dependent on any changes that are made, which so far does not impact on this. IM said that an analysis will take place as to whether any changes affect any particular stakeholder and if wider consultation is appropriate.

SC reported that at the recent Quarter Two Assurance meeting, referred to earlier, the LAT Director of Operations queried whether a version would be available in December. It was noted there was no pre-submission date but JC would value the input of this Director. TB said early sight would be helpful too.

SC explained that discussions were taking place with Fenland CCG about possible collaboration in particular a desire to return to a West Norfolk & Wisbech configuration at some point in time. SC and PJ would be attending a meeting of their Board that afternoon primarily to debate the work of the CPT but would raise this too. Discussions had also taken place with the LAT about the formal process for this and for written confirmation of its view. IM said the CCG would not want constitutional changes to affect the dialogue about establishing closer working and any formal changes would be reviewed at an appropriate later date.

SH asked about the links between the Finance & Performance Committee and Patient Safety & Quality Committee. JC said that one is looking at quality and the other at performance but agreed it was useful to triangulate and would review the membership. **JC**

The Governing Body APPROVED to the proposed changes to the Constitution and recommended them to the CCG membership for approval.

13.3 Audit Committee Chair's Report

The Governing Body noted the Audit Committee Chair's Report following the meeting held on 9 October 2014.

13.4 Emergency Preparedness, Resilience and Response

JC introduced the report on Emergency Preparedness, Resilience and Response (EPRR). In relation to business continuity, HDL asked for clarification in the event of a pandemic which would affect the governance of the organisation. JC would investigate and report back. **JC**

The Governing Body noted the update on EPRR, the results of the self-assessment against NHS England EPRR standards, and level of compliance.

13.5 Appointing Members of the Governing Body

GP and Non-Executive (lay, secondary care doctor, registered nurse) members of the Governing Body were formally appointed on 1 April 2013, as the CCG became a statutory body. The term of office was for 2 – 4 years to enable a phased turnover of these posts and ensure continuity. Three posts come to term on 31 March 2015, two posts end in March 2016 and the remaining posts run to March 2017. The CCG will be commencing the appointment process shortly for those contracts ending next March. The appointments process is as outlined in the West Norfolk CCG Constitution, published on the CCG website. The Constitution is undergoing revision and there is an opportunity to make changes to this process should this be required. The membership of the CCG will need to agree any changes to the Constitution before being submitted to NHS England by 6 January 2015.

HDL queried the eligibility for reappointment, ie someone who had served two years could be given another four years. JC said this was not detailed in the current Constitution but it could be included. IM said it was important to be clear about the advertised length of office for these individuals.

IM referred to the GP members' initial selection process and the requirement for candidates to be 'above the line' for capability and skills, which was the view of the Council of Members, and then subject to election by GPs in West Norfolk, which had not been translated into the final document. JC said she would be happy to include this. **JC**

At this point in the meeting, JI reported that JC had been appointed into the permanent role of Head of Governance.

Reference was made to the fact that the Governing Body membership is built with a clinical majority, which is the decision from the Council of Members Practices in forming the CCG, and does not formally recognise the contribution of other members. The suggestion of the Governing Body having non-voting members from the CCG senior management was also raised.

JC confirmed that all posts would be advertised in accordance with national guidance to be in place by 1 April 2015.

The Governing Body noted the appointment process and commencement of recruitment as outlined in the CCG's Constitution.

13.6 Senior Information Risk Officer Report

The Governing Body noted the work being undertaken within the CCG in respect of Information Governance (IG) under the direction of the IG Committee and Audit Committee.

14 ITEMS FOR INFORMATION

The Governing Body noted the 5 Year Forward View.

15 DATE AND TIME OF NEXT MEETING

There will be no Governing Body meeting in public in December. The next meeting will be in January 2015. There being no further business the meeting closed at 1.00pm.

In accordance with the Public Bodies (Admission to Meetings) Act 1960, the public and members of the Press were excluded from the remainder of the meeting where there was business of a confidential nature to be transacted, publicity concerning which could be prejudicial to the public interest (Item 4.1 above refers).