NHS
Southend
Clinical Commissioning Group

AGENDA ITEM 3a

NHS Southend CCG Governing Body Meeting in Public

Minutes of the meeting held on Thursday 29th May 2014 at 1330h
in the Boardroom, Suffolk House, Baxter Avenue, Southend on Sea

Attendees:

Name	Title	Organisation
Charles Cormack	CCG Chair	NHS Southend CCG
Dr Paul Husselbee	Clinical Chief Officer	NHS Southend CCG
Melanie Craig	Chief Operating Officer	NHS Southend CCG
Paul Sly	Interim Recovery Director	NHS Southend CCG
Dr Suparna Das	Secondary Care Consultant	NHS Southend CCG
Dr Bilquis Agha	GP Governing Body Member	NHS Southend CCG
Dr Krishna Chaturvedi	GP Governing Body Member	NHS Southend CCG
Dr Brian Houston	GP Governing Body Member	NHS Southend CCG
Dr Peter Long	GP Governing Body Member	NHS Southend CCG
Dr Kelvin Ng (arrived at 1335h)	GP Governing Body Member	NHS Southend CCG
Linda Dowse	Chief Nurse	NHS Southend CCG
Janis Gibson	Lay Member PPI	NHS Southend CCG
Steve Downing	Head of Finance	NHS Southend CCG
Dr Andrea Atherton	Director of Public Health	Southend Borough Council

In Attendance:

Angela Paradise (Minutes)	Head of Corporate Services	NHS Southend CCG

General Business

1.0 Welcome and Apologies for Absence

1.1 Charles Cormack welcomed the Governing Body members and gave a special welcome to members of the public. He also gave a special welcome back to Linda Dowse after her period of absence.

1.2 Apologies for absence were received from Dr Fahim Khan, GP Governing Body Member, Ashley King, Chief Finance Officer, and Simon Leftley, Corporate Director for People at Southend Borough Council.

2.0 Declarations of Interest

2.1 No declarations of interest were received in relation to the meeting agenda.

3.0 Minutes of the Meeting held on 27th March 2014 and action log

3.1 The Minutes of the Governing Body Meeting held on 27th March 2014 were reviewed for accuracy.

The Director of Public Health raised that paragraph 16.9 on page 9 needs to be reworded in relation to the CCG's uplift. Since the meeting was held, this paragraph has been reworded to read:

Chair's Signature ……..

"The Clinical Chief Officer replied that the CCG will receive an increase in allocation of funding over the next two years and there had been recognition that the CCG had been under funded. All CCGs had been given uplift but NHS Southend CCG was still not receiving its target level of funding."

Resolved: Subject to the above amendment the Governing Body approved the minutes of the meeting held on 27th March 2014 as an accurate record.

3.2 The Action Log was reviewed and updated.

Resolved: The Governing Body noted and agreed all completed actions.

4.0 Clinical Chief Officer Update

4.1 The Clinical Chief Officer informed the group that the CCG is already 16% of the way through the 2014/15 financial year. The CCG needs to build on its successes from 2013/14 but also strengthen the organisation and deliver finances whilst continuing to put the citizens of Southend at the centre of everything it does. The organisational structure is being reviewed and there is confidence in the system that this will support the achievement of CCG goals.

4.2 A significant amount of work has been undertaken on the CCG's two-year operational plan. There have been workshops and listening events to help shape the CCG's strategy and the final document will be concise, easy to understand and deliverable. The Central Eastern Commissioning Support Unit will cease to exist after September 2014 and there will be further updates in relation to this.

4.3 The Urgent Care Working Group, made up of partner organisations, plans to deliver sustainable improvements particularly in relation to A&E, which has recently improved but still has some way to go. The standards in A&E are not purely about day to day target achievement but a consistent achievement of a standard of performance that the public deserve.

4.4 Two meetings of the Joint Clinical Executive Group across Southend and Castle Point and Rochford CCGs have taken place and work is progressing well. This group discusses and agrees clinical issues upon which it can make recommendations. Clinical leads have now been newly appointed to deliver service transformation in a range of areas, supporting the work of the CCG in embedding clinical leadership.

4.5 The CCG has taken a look back at the complaints it received during 2013/14. At previous governing body meetings patient stories have been shared and some of these have come from complaints. The CCG is committed to learning from the complaints it receives however, it is noted that the complaints system is fragmented and can be confusing. As such, it is receiving priority attention by NHS England.

4.6 The CCG has received 59 complaints in 2013/14; 18 in primary care, 23 in secondary care, 8 in community care and mental health, 9 relating to Individual Funding Requests and 1 relating to public health.

4.7 If the complaint is about the CCG or a service it directly commissions, then the Quality Team will investigate it. If complaints relate to one of the CCG's providers, the CCG will ask the provider to investigate and share the final response with the CCG. All complaints relating to primary care services (GP practices, dentists, pharmacies and opticians) are investigated by NHS England.

4.8 Specifics: Some complainants also involve their MP in the process and the CCG then includes the MP in all correspondence. This is the same for Healthwatch.
Difficult cases: One complainant has threatened legal action against his GP, claiming he underwent private cataract surgery on the advice of his GP and now requires compensation. This complaint has been closed pending further instruction.

4.9 Two of the complainants from 2013/14 took their case to the Ombudsman as they remained dissatisfied with the outcome of their complaints, both relating to cataract surgery. One was following an individual funding request (IFR) and the other was in relation to apparent advice received from a consultant in relation to private treatment. Since the meeting, the Ombudsman's office has confirmed that the IFR-related complaint has not been upheld.

4.10 The monthly Quality, Finance and Performance Committee (QFP) receives a report on the numbers of complaints and the areas in which they fell. The CCG has been able to identify a trend from the complaints it received during 2013/14, relating to three separate patients who attended A&E with foot pain and were sent home without full diagnostics. These three patients all ended up having broken bones confirmed at subsequent appointments. This was flagged to the hospital's complaints manager who confirmed that the Trust were already aware and were undertaking an internal investigation.

4.11 Two specific meetings were held during 2013/14 as a result of two separate complaints to ensure the organisations involved learned from past events. One was a multi-agency debrief which resulted in recommendations for service improvements. The second was a meeting between the CCG and representatives from the CHC team in relation to how to manage complaints about CHC funding. It became clear that the CHC team were treating complaints about funding in the same way as enquiries. There is now a clear process as to who deals with CHC related complaints as they can come in via different routes.

4.12 The CCG continues to evaluate complaints received about our patients' experiences of the services they access. We continue to work closely with Healthwatch Southend, sharing information that patients find useful to assist them with their enquiries. Our complaints processes are clearly identifiable on our website.

4.13 In order to provide additional assurance around complaints, a monthly report will also be presented to the weekly operational executive group, in addition to the monthly QFP report, to ensure any further trends/issues are identified, thereby enabling early intervention.

The CCG Chair stated that he endorsed the learning from complaint received during 2013/14.

Resolved: This item was a verbal update and was noted by the Governing Body. The CCG Chair stated that he endorsed the learning from complaint received during 2013/14.

Clinical and Service Development

5.0 Five Year Strategic Plan

5.1 The Chief Operating Officer presented the Five Year Strategic plan and the covering paper which sets out the process taken to date. The plan now requires formal approval by the Governing Body prior to its submission to NHS England on 20th June 2014.

5.2 The plan identifies specific services for inclusion including co-commissioning and also includes the CCG's recovery plan. Progress on the plan is reported to the Quality, Finance and Performance Committee with whom approval sits for the process.

Resolved: The Governing Body noted the CCG's progress in relation to the Five Year

Strategic Plan.

6.0 Service Restriction Policy

6.1 Dr Brian Houston presented the paper outlining changes to the Service Restriction Policy (SRP). He commented that ideally this policy should be called service quality rather than restriction as the title can be misleading, however, the revised document was discussed at the Joint Clinical Executive meeting on 3rd April 2014 and the GPs present at that meeting agreed with the clinical standards. The SRP adheres to NICE guidance and all pathways have been agreed across Southend Borough Council and the South Essex CCGs, all of whom have adopted the same SRP.

6.2 The Chair asked what the main changes are. Dr Houston confirmed that the thresholds have changed in some area, for instance, trigger finger, which now includes an injection before treatment. The Chair asked whether this meant patients will potentially face additional difficulties on obtaining treatment. Dr Houston confirmed that whilst this is the case, the focus is on quality of experience and getting the right treatment. Historically the hospital has taken a variable approach to the SRP and the changes enable a more proactive approach to be taken to ensure the policy is followed consistently.

6.3 The Director of Public Health commented that the public health team have been heavily involved with the SRP but noted that the full document had not been circulated with the meeting papers. Dr Long added that the web links require updating and the document overall requires refining to make it evident that the policy promotes quality.

6.4 Dr Chaturvedi stated that the full document is needed in order for approval to be given. Dr Agha added that the document appeared to include things that are already being provided. Dr Houston commented that all GPs present at the Joint Clinical Executive in April had given their support to the SRP.

Not resolved: It was agreed that the full Service Restriction Policy should be recirculated and brought back for approval.

7.0 Joint Commissioning Plans for 2014-15 Reablement and transferring Social Care Monies

7.1 The Chief Operating Officer presented the joint commission plans for 2014/15 reablement and transferring social care monies, stating that this was about money that is received by the CCG to make investment to improve overall health gain for the local population. Work is underway with partners to agree investment plans and once funds have been formally identified the success of each scheme can be determined. The Joint Executive Group (JEG), which is a sub-committee of the Health and Wellbeing Board, monitors the schemes against key performance indicators.

7.2 The Governing Body were asked to approve the £1m reablement funding as set out in Appendix A and to approve the draft investment plan. The final investment plan will be delegated to the JEG to bring back in July 2014 for approval.

7.3 The Lay Member for PPI stated her support of this approach and her confidence that this scrutiny will improve outcomes.

7.4 Dr Long asked who would scrutinise the outcomes. The Chief Operating Officer confirmed that Dr Adenike Popoola would undertake clinical scrutiny and the Chief Operating Officer would do so from a management perspective. There is an expectation that services will report to these individuals against defined performance metrics. The CCG will monitor reduction in admissions and identify any proxy indicators at the very least; the JEG is

ideally placed to do this. Dr Long added that this approach has the potential to strengthen services.

7.5 The Secondary Care Consultant sought clarification on the funding, specifically as to whether the better care fund is existing money that is being transferred to the CCG. The Head of Finance confirmed that the £687k identified in the paper is new to the area team but not to the CCG and forms part of a pooled budget. As such it is part of the Area Team's allocation and is included within the £4.735m figure stated. The Lay Member for PPI asked whether the CCG has any contingency in place. The Chief Operating Officer replied that whilst there is a very small contingency, it depends on the success of other schemes and whether these free up any funds. Any future year's investment will be based on delivery.

7.6 The Clinical Chief Officer confirmed that people should receive care in the most appropriate setting; services should allow choice. Dr Ng added that the outcome measure should be that people end up in residential care where this is appropriate – it should not be about getting a reduction in numbers of people entering residential care homes. The Chief Operating Officer agreed that this should be reflected in the wording.

Action: To review the wording in the outcome measures to accurately reflect the outcome measure.

Resolved: The Governing Body agreed the proposal for funding.

8.0 Stakeholder Report

8.1 The Lay Member for PPI presented the stakeholder report, outlining that there had been some areas of high performance for the CCG and other areas where performance was less so. It was noted that some actions have already been undertaken and engagement is a strong focus for the CCG going forward. The Patient Participation Group Forum (PPGF) had met earlier that day; the forum has a new Chair and is clear on its role going forward.

8.2 The Clinical Chief Officer queried why the figures have dropped in relation to the CCG's ratings. The Lay Member for PPI confirmed that the CCG did not have an Executive Lead for engagement in post until September 2013 and the formulating of new engagement processes took place in October. To date there has been limited take-up for the steering group; letters have been sent to community members inviting participation and will be followed up with telephone calls.

8.3 It was noted that GPs should be invited to comment on the GP engagement element. Dr Long stated that it was disappointing to see a downturn in percentage points; there has been a lot of work undertaken at pace, presenting a challenge for GP engagement, however, it should be noted that improvements have been seen in the use of IT and communication methods with GPs.

8.4 The Secondary Care Consultant noted that during 2012 the CCG was in shadow form and therefore further improvements in the results could be expected next year. Dr Agha agreed with Dr Long in that there had been a lot going on and the pace of change was a challenge for some GPs, particularly single-handed GPs; it is important that the CCG gets all GPs on board.

8.5 The Chief Operating Officer noted that the full report is also available and will be circulated to members.

Action: To circulate full stakeholder report to all Governing Body members.

Resolved: The Governing Body noted the stakeholder report.

Chair's initials ……

Quality, Finance and Performance Scrutiny

9.0 Integrated Quality, Finance and Performance Report

9.1 The Clinical Chief Officer presented the integrated performance report which includes headlines for finance, quality and performance, particularly focusing on A&E performance at Southend University Hospitals NHS Trust and other key performance indicators. It was noted that Steve Downing, Head of Finance, was in attendance in behalf of Ashley King, Chief Finance Officer and would provide an update on the financial position.

9.2 Headlines include the A&E standard which is still below level and the hospital has not met the annual target for 2013/14, RTT 18 weeks which has not been delivered against specialty level and cancer 62 days on which the hospital are providing a remedial plan. In addition, IAPT did not meet the target. The Ambulance service has met its Southend target but EEAST is not meeting its overall targets.

9.3 Performance

9.3.1 A&E

The Chief Operating Officer confirmed that A&E is on track to achieve May, which is the first month achieved since November 2013. Whilst this is expected at this time of year to the generally lower number of attendances, A&E remains a concern. The Urgent Care Working Group meets every week to address A&E performance which will have a significant impact on winter if issues are not addressed now. A remedial action plan has been agreed by the Area Team and the hospital is working hard to deliver this.

9.3.2 Dr Houston noted that the numbers of attendances are not going up which shows that this is not about GP access, rather that it is accepted that there are problems in the system. However, it is also accepted that some patients attend A&E when they cannot obtain an appointment in primary care. It was noted that GP triage in A&E sees all minors. Dr Ng asked what action will be taken by the A&E department. The Chief Operating Officer confirmed that a number of steps have already been taken; staffing gaps have been addressed with the appointment of eight middle grades and a group of Spanish nurse. Consideration is also being given to a Rapid Assessment Team (RAT) although space remains an issue in A&E due to their not being enough cubicles to assess patients. There is also an Emergency Care Intensive Support Team, overseen by the Emergency Care Director and a retired A&E consultant, although there is a lot of work to do before the winter.

9.4 18 weeks

The hospital have made improvements since the last validated data was received in February. Since the report was written it is no longer appropriate to state that specialty level compliance would be achieved by Q1. The whole system is fragile and the hospital is undertaking a capacity review, including a look back at historical data and modelling. One patient was showing as a 52 week breach; this patient has now received treatment and the failure here was caused by a need to see a specialist at the Royal Free Hospital.

9.4.1 18 week recovery plan will include highly detailed trajectories, due for discussion at a meeting with the hospital tonight.

9.5 Cancer

9.5.1 The narrative is based on the hospital's current position. The standard was achieved in February but consistent anxiety remains in this area. The hospital are making improvements and are providing a high level of clinical input. The CCG is expecting the hospital/s recovery plan in June. Dr Long queried whether all breast complaints are to be progressed under the two-week wait route. The Clinical Chief Officer confirmed that he had heard the same thing and that the two-week wait route is often appropriate due to the patient's level of anxiety.

9.5.2 An error in the IAPT data was acknowledged within the report and should read that the service achieved 12.8% rather than 12.6% in relation to patients receiving psychological therapies. It was agreed that accurate data would be circulated.

Action: Accurate IAPT data to be circulated to Governing Body Members.

9.6 Ambulance

9.6.1 Whilst Southend Ambulance service is performing against its target, there is a risk of other areas not performing and vigilance is required in relation to ambulances being turned away. Plans are in place to ensure Southend is not put in a problematic position.

9.7 Quality

9.7.1 Serious Incidents (SIs)

The Chief Nurse provided highlights from the paper, noting that date ranges had caused some confusion. The Quality, Finance and Performance Committee had previously received a more detailed report and discussions had taken place in relation to the level of data required. Serious Incident categories are looked at by the National Patient Safety Agency and a lot of detail is not publicly available. It was acknowledged that some of the SIs have been on the list for some time; one of these was due to the hospital undertaking a more detailed review.

9.7.2 MRSA

There has been one case of MRSA in the community although the cause of the infection remains undiagnosed, and one in the hospital as a result of an infected cannula site.

9.7.3 Clostridium Difficile (C.Diff)

There have been three cases of C.Diff since the last quality report and the CCG's Infection Prevention Team are working closely with the hospital. The CQRG will be discussing legionella KPIs at its next meeting.

9.7.4 Friends and Family (F&F)

It was noted that there had been a drop in the net promoter score to 47, which is less than last year.

9.7.5 Patient Safety Thermometer

The point of prevalence for harm caused by pressure ulcers or falls, has dropped to 10.1%. The high number of pressure ulcers reported is due to automatic monitoring and vigilant staff.

9.7.8 It was noted that a more proactive approach to quality needs to be taken in care homes; GPs are now more active in care home visits and the Area Team are also visiting two practices.

9.8 Finance

It was noted that Month 1 finance is not yet available. The Chair expressed concern that having started the year with a £3.1m deficit, financial information was not going to be available until 3 months in to the financial year. The Interim Recovery Director confirmed that financial information would be addressed as part of the recovery plan.

Resolved: The Governing Body noted the Integrated Performance Report.

10.0 Final Draft Quality Accounts 2013/14

10.1 The Chief Nurse explained that it is mandatory for NHS Trusts to report their quality accounts, which provide numerous quality statements relating to the financial year. The CCG's responsibility is to review the commentaries and determine whether or not the provider has given a fair reflection on their quality performance.

10.2 The CCG has received quality accounts from South Essex Partnership Trust and Southend University Hospital NHS Foundation NHS Trust; as lead commissioner the CCG is expected to lead the commentary. It was noted that the final draft accounts had previously been presented to the Quality, Finance and Performance Committee for comment. The quality account is a public document and the commentary agreed by the Governing Body will be included. The Chief Nurse confirmed that the CCG needs to respond to the Trust today.

10.3 The Secondary Care Consultant queried whether the position on VTE was reflected appropriately in the hospital's quality account, bearing in mind two patients had a pulmonary embolism, one of which was very serious. In addition, the hospital's position on SHMI was noted but there was no indication as to the intended action. The Chief Nurse confirmed that the hospital are expected to revise their account based on commentaries received; the public will therefore also see the CCG's commentary.

Resolved: The final draft quality accounts for 2013/14 were approved by the Governing Body.

Governance & Corporate Business

11.0 Governing Body Assurance Framework (GBAF)

11.1 The Clinical Chief Officer presented the GBAF on behalf of the Chief Finance Officer.
11.2 The GBAF has received a significant overhaul, incorporating feedback from our internal auditors and also the interim recovery director, Paul Sly. Each risk owner has ensured that the controls and assurances for each risk are robust, and support the delivery of 2014/15 objectives.

11.3 Two new risks have been added, one to achieve financial planning metrics as set by the Area Team and the other to ensure the CCG manages the risks posed by Central Eastern CSU ceasing to exist beyond September. It is proposed that the previous risk number 2, around financial balance, is closed, as it is superseded by risk number 15.

Resolved: The Governing Body approved the Assurance Framework and agreed to the removal of risk two.

Chair's initials ……

12.0 Risk Management Strategy

12.1 The Risk Management Strategy has been revised, again with input from our internal auditors during 2013/14. Governance expert Jean Clark also reviewed this as part of the work undertaken to support the CCG with its governance arrangements. The strategy was been formerly approved by the Audit and Risk Committee and is presented today for ratification by the governing body.

12.2 In terms of the CCG's approach to risk management overall, our internal auditors will be conducting an audit during Q2 and Q3, specifically looking at our approach to, and management of risk. This audit will include a specific focus on the corporate risk register (which is presented regularly to the Quality, Finance and Performance Committee) and the organisation's risk appetite. The auditors will also be attending a governing body seminar in relation to risk appetite.

Resolved: The Governing Body approved the Risk Management Strategy.

13.0 NHS SCCG Policies for Ratification

13.1 The Governing Body were invited to ratify the following policies which had been reviewed through the Joint Staff Forum or through the CCG's internal Policy Assurance Group. The Quality Finance and Performance Committee had approved the policies.

a) NHS SCCG Display Screen Equipment Policy
b) NHS SCCG Stress Management Policy
c) Emergency Planning and Business Continuity

- (i) Emergency Planning Team Work Programme 2014/15
- ii) Business Continuity Management System – Management Review Recommendations January 2014
- iii) Incident Response Plan May 2014
- iv) Incident Management Plan

Resolved: The Governing Body ratified the above named policies.

14.0 NHS SCCG Committee Minutes

- Clinical Executive Minutes 13th March 2014.
- Quality, Finance & Performance Committee Minutes 19th February 2014 and 19th March 2014

Resolved: the Governing Body noted the above named Committee Minutes

15.0 Questions from Members of the Public

15.1 Kim Woodyer-Byers, who works with the Squirrels Groups, expressed her disappointment that Simon Leftley was not in attendance at the meeting today. Kim stated her support for the monitoring arrangements outlined under item 7.

15.2 Mazjoub Ali commented that Basildon and Brentwood CCG were also not happy with the Service Restriction Policy the first and second times it was presented. The Chair reminded Mr Ali that the meeting was concerned with Southend's position rather than that of other CCGs.

15.3 Mazjoub Ali asked whether the local authority could use some of the money allocated for co-commissioning for other things. The Chief Operating Officer stated that Mr Ali was right to raise this point, but that co-commissioning is between NHS England and the CCG rather than joint commissioning between the CCG and the local authority. As a result, organisations need to manage their own risks and have the appropriate governance in place to ensure the correct use of the funds.

15.4 Mazjoub Ali queried the target of reducing the number of people in care homes. The Chief Operating Officer referred Mr Ali back to Dr Ng's comments earlier in the meeting, confirming that the word reduction would be removed.

15.5 John Sneed stated that having been born and brought up in Stafford he is more than aware of problems in hospitals and is very concerned about A&E. Mr Sneed asked when the CCG first became aware that something was wrong. The Clinical Chief Officer stated that Southend's A&E department has had problems for over 2 ½ years. When Mr Sneed asked why, then, was it only now that the CCG is pulling out all the stops, the Clinical Chief Officer replied that a robust programme of interventions has been undertaken since April 2013, using all available contractual levers which did lead to some improvement but then deteriorated again from November 2013. Despite the CCG's best efforts to performance manage A&E, performance did not improve and a risk summit was held in April, chaired by NHS England's Medical Director, David Levy. David is tasked with producing a recovery action plan which has now been accepted by the Urgent Care Working Group. A&E is likely to achieve the standard in May, although attendances this time of year do tend to be lower. The CCG is working with the hospital to sustain improvement as it poses a serious risk.

15.6 Denis Garne enquired as to why the CCG only appears to be concerned with financial risks and not clinical risks. The Chief Nurse explained that the first strategic risk faced by the CCG is the risk to patients and the quality and safety of services.

15.7 Molly Dennis, who works with older people, carers and learning disabilities, raised the issue of the appointments system which is in chaos. Molly explained that she is dealing with a number of events which appear to be down to communication issues between departments. The Chief Nurse stated that she would talk to Molly at the end of the meeting.

15.8 Kim Woodyer-Byers raised that she would like her group to be involved with the CCG. The Lay Member for PPI stated that she would talk to Kim about this.

16.0 Any Other Business

No other business was raised.

17.0 Date of Next Meeting

The next meeting will be held on Thursday, 31st July 2014 in the Boardroom at Suffolk House.

The meeting closed at 1530h.

Chair's initials ……