NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS REDDITCH AND BROMSGROVE CLINICAL COMMISSIONING GROUP (RBCCG)
GOVERNING BODY MEETING

Thursday 23rd January 2014, 1:00pm
Council Chamber, Bromsgrove District Council

MINUTES – PART 1

Present – Members
Dr Jonathan Wells (JW) – Chair and Clinical Lead
Simon Hairsnape (SH) – Chief Officer
Tony Hadfield (TH) – Lay Member (Governance)/Deputy Chair
Deyhim Foroughi (DF) – Secondary Care Consultant member
Dr Richard Davies (RD) – Assistant Clinical Chair/Governing Body GP
Jo Galloway (JG) – Executive Nurse, Quality and Patient Safety
Paul Sheldon (PS) – Chief Finance Officer
Judy Adams (JA) – Lay Member (Patient and Public Involvement)
Dr David Law (DL) – Governing Body GP
Dr Rupen Kulkarni (RK) – Governing Body GP
Dr Saf Siwji (SS) – Governing Body GP
Linda Pratt (LP) – Lead Practice Manager
In Attendance
Andrea Guest (AG) – Head of Business Development and Operations
Karen Hunter (KH) – Head of Corporate Affairs
Chris Emerson (CE) – Head of Commissioning and Service Redesign
Mick O'Donnell (MO) – Head of Strategy
Bethan Flynn (BF) – Executive Administrator
Catherine Whitehouse (CW) – Deputy Executive Nurse, Quality and Patient Safety

Agenda Item	Minutes
1	**Apologies for Absence** There were no apologies for absence.
2	**Welcome and Introductions** JW welcomed members of the public and all Governing Body members introduced themselves. **Announcements** • Dr Saf Siwji (SS) has joined the Governing Body as a GP Member and the Medicines Management Lead. • Paul Sheldon (PS) has joined RBCCG as Chief Finance Officer.
3	**Notification of Items of Any Other Business** There were no notifications of items of any other business.
4	**Declarations of Interest in Relation to the Agenda** All Governing Body GPs and the Lead Practice Manager declared an interest in relation to Agenda Item 10.
5	**Declarations of Communication** There were no declarations of communication.
6	**To Approve the Minutes of the Meetings held on 24th October 2013 and 4th December 2013** The minutes of the meeting held on 24th October 2013 and 4th December 2013 were approved as an accurate record.
7	**Review Decision and Action Tracking System (DATS)** Please refer to Agenda Item 7 (attached).
8	**Future of Acute Hospitals Services in Worcestershire (this item took place after Agenda Item 15 at 2:45pm)** JW introduced Nigel Beasley (NB), Ear, Nose and Throat Surgeon at Nottingham University Hospitals NHS Trust and Chair of the Independent Clinical Review Panel (ICRP) and Dr Martin Lee (ML), Medical Director, NHS England (Midlands and East) whose role was to convene the ICRP. The experts were independent and objective. A wide range of people were chosen with an enormous amount of expertise collectively. Declarations of interest were also collected. NB was asked to Chair the ICRP as he is also Chair of the Clinical Senate in the East Midlands (Please see attachment 5C for presentation).

	Questions around table: JW thanked NB for the presentation and report. It was noted that the annexes would be published for paediatrics and maternity. NB said it was made clear in the report that capacity would have to be available elsewhere for paediatric admissions and maternity before any of the changes are introduced. All of the recommendations in the report are subject to more detailed work being undertaken. Q: SH asked for numbers in terms of what will continue at the Alexandra Hospital site. A: NB said that 38,000 people walk into A&E which they would continue to do so. Ambulances would continue to take patients to the Alexandra Hospital but transfer if sick etc. Children in ambulances would be taken to Worcester Royal Hospital (WRH). DL said it is important we probe more about maternity services as this is a particular concern to the public. DL wondered if a Paediatric Assessment Unit (PAU) could support a Maternity Led Unit (MLU). NB stated he was not a paediatrician or obstetrician. MLU's operate better as standalone as they take low risk pregnancies. Approximately 500 patients would be the uptake in the area. There are very specific guidelines from the Royal College in relation to MLUs and Consultant Led Units of different sizes so his recommendation is made on that basis. DL referenced specialised services and his concern that this is only a small percentage of the workload of the overall hospital. DL queried whether an alternative provider could agree for Worcestershire Acute Hospitals NHS Trust (WAHT) to continue to provide the specialised services. DL also suggested that it may seem as though Option 2 doesn't work because of the rest of Worcestershire so Redditch and Bromsgrove has been forced to compromise. NB felt that with a modified version of Option 1 nobody would be 'taking a hit' although he understands the feeling in terms of maternity services; he questioned why an alternative provider would provide a hybrid model of services. Hospitals such as UHBFT look at developing around large cohorts of patients. The ICRP could not envisage a situation where another provider would not want to take specialised services. Q: DL asked if travel distances were reasonable for our patients. A: NB reflected upon his own experiences in relation to this and went on to describe how patients from Hereford and Worcestershire will also be required to travel to other places. ML stated that the ICRP wasn't asked to speak to other providers although they did interview some providers as part of panel activities essentially about clinical services models. JW felt the ICRP was asked to look at the work up of both Options 1 and 2. Questions from the public: Q: Neal Stote (NS), Save The Alex Campaign asked if there are possibilities of rotation so you could then have 24 hour consultant cover? A: NB confirmed that the ICRP looked at other areas that do this. It doesn't appear sustainable as it would dilute the pool of skilled practitioners over time. The ICRP did not feel it was a sustainable solution. Q: NS reflected upon the recommendations within the report. It has taken two years to reach this point and it is likely to be another year before finally agreed. The Option 1 provider may not be able to afford what is set out in the recommendations. What

	guarantees do we have as a population that if we support the modified Option 1 that it will be affordable for the provider? A: NB advised that the ICRP can only make recommendations. It is up to the statutory bodies to look at what is safe and sustainable to deliver. The proposal from the ICRP is for NHS RBCCG Governing Body to accept the recommendations. Approval is on the basis that the CCG engage in further work around the model and assess for financial viability, secure a robust delivery plan, address transport issues and fully engage with WMAS. Following completion, there will be a formal twelve week consultation; only at this stage will a final decision by NHS RBCCG Governing Body be required. Q: Wendy Johnson, Save The Alex Campaign – their research shows that a vast majority of patients would travel to Birmingham not Worcester as the transport is already in place so would those services at WRH still be sustainable? A: NB said that their assumption is that patients would travel to Worcester. NB recognises that patients have a choice. SH referred to the new radiotherapy unit build at WRH which is nearing completion. Patients are currently sent to three different hospitals, which is difficult to manage. Q: A Member of Save The Alex Campaign is concerned about families in Redditch. Were families consulted when options were drawn up? A: SH said that the ICRP had taken a view around best clinical practice. We now need to have dialogue with local people. NB added that there are four subcommittees – there is also a patient engagement subcommittee entirely focused on these types of issues. Q: A Member of Save The Alex Campaign said that the public feel ignored. Six of the original options were discarded and we've come out with two options. Over the last two years the Alexandra Hospital has been gutted of services and hospital staff are so demoralised nobody will go there for a job. A: SH stated that as a CCG we need to consider options which are clinically and financially viable. Experts have reviewed those options and what we are hearing is that there are considerable concerns around one of those options. What we can't do is put an option out that is not clinically or financially viable. Q: Member of Save The Alex Campaign – if we put two options to the public and they chose to have maternity services left where it is, what will happen? A: JW said the ICRP has identified that this is not safe due to not being able to have overnight paediatrics. It wouldn't be safe and as commissioners we couldn't support something that was not safe. JW urged people to read the report or refer to his blog. NB emphasised that the Royal College of Obstetricians and Gynaecologists have done significant pieces of work and they are the experts that we need to listen to. NB assured that he took the views of every panel member into consideration. ML referred back to the morale of the staff. He has visited the Alexandra Hospital and is impressed by the staff there. One of the worst things for the staff at a hospital going through such change is the uncertainty which is why we wanted to get a good strong clinical model. Q: A Member of Save The Alex Campaign asked if this has all been reviewed with finances in mind.

	A: NB confirmed it hadn't as they were a clinical review panel. Q: It was asked what the timeline was for the proposed changes? A: SH said that Agenda Item 8 details this and will be added to website etc. Over the next two weeks the key Governing Bodies will decide if they agree with the recommendations and work will then take place around a financial review. NHS England has to ensure everything 'stacks up' before we go to public consultation. We are unsure of how long the process will take but the paper states approximately 6 months. We will then go to full consultation with a decision at the end of 2014. Changes will be carefully implemented. Q: Member of public – assuming recommendations are accepted today then do we envisage talking to other trusts about providing maternity services at Alexandra Hospital. A: JW said we wouldn't as it is not clinically viable for PAU overnight. Q: GV asked who will provide this consultation. Is it all Worcestershire CCGs? NHS England? Worcestershire Acute Hospitals NHS Trust? Or will it be carried out collectively? A: SH confirmed that the statutory obligation sits with the three Worcestershire CCGs and there are mechanisms to consult jointly linking with other local CCGs e.g. South Warwickshire. Local communities can come together as a Joint Health and Overview Scrutiny Committee. There is also a commitment to look at transport and to understand what is needed, fully explore options and address issue as best we can. JW thanked NB and ML and urged public to read the report and appendices. NHS RBCCG Governing Body referred back to the paper circulated as Agenda Item 8 and approved the three recommendations outlined.
9	**Patient Story: Safer Sleep Approach** CW gave an introduction to the patient story which was entitled 'Bed Sharing with Baby – is it worth the risk?' (Please see attachment 5D for presentation). JW commented that it was a useful presentation that highlights holistic care.
10	**Local Enhanced Service (LES) Joint Clinical Review Recommendations for 2014/15** The role of Chair was handed to TH. Due to conflicts of interest the Governing Body GPs and Lead Practice Manager left the room for this item. SH explained what GP enhanced services were; that they were direct award or to be market tested and explained the above conflicts of interests. SH confirmed that NHS RBCCG Governing Body approved at the last meeting for Treatment Room services to be market tested. At this point in time the CCG has some concerns which are outlined in the Quality Impact Assessment (appendix 1). NHS RBCCG Governing Body is requested to support an extension for a further 6 months to allow development for a robust service specification and to establish if the risks can be mitigated sufficiently. JG added that the CCG's process is that a detailed Quality Impact Assessment is undertaken and her role is to sign those off. In this instance, JG would be

	looking to defer sign off until the concerns are addressed. Q: GV asked what the treatment room services are. A: AG said it is made up of a number of diagnostics and interventions which are outlined in the Quality Impact Assessment i.e. it is an enhancement to the core services delivered in Primary Care such as an urgent blood test, ECGs or particular wound dressings. Specifically, issues such as location and access for patients require further consideration. TH asked if Governing Body members agreed to pass the decision to SH as Chief Officer. Governing Body members authorised this and the proposal was agreed.
11	**CCG Safeguarding Children and Adults Commissioning Strategy** JG gave an overview of the strategy and SH noted its importance. Q: Councillor Pat Witherspoon raised an issue about working with schools in view of the growing number of schools that are becoming academies and the autonomy they have. A: JG made reference to the role of the Worcestershire Safeguarding Children Board across agencies; however, she would highlight this with the Chair of the Board. Q: RK commented that there are not enough safeguarding sessions as he was unable to book on to a session until December. A: JG noted the different levels of training available and LP advised RK of the online training available. LP will bring this to the attention of the practices. Q: JA noted that with the emphasis more on children and vulnerable adults with their own budgets the CCG may need to build something into the strategies in the future as they will be open to abuse. A: JG agreed that this was a really good point and that there is a strategy currently being developed. TH highlighted that the report states it isn't just physical abuse it is also financial abuse particularly with elderly people and the CCG need to take finances into account when looking at safeguarding. Governing Body approved this strategy.
12	**Integrated Quality, Performance and Finance Report** It was noted that this was a detailed report. **Quality** JG introduced the quality section of the report. Clostridium difficile – at the end of Quarter 3 is within trajectory for the CCG. Other Infection Prevention and Control Issues – there has been some Norovirus within the locality. This has been well managed and there are good systems in place to reduce spread. Serious Untoward Incidents – Worcestershire Acute Hospitals NHS Trust (WAHT) continue to make progress with the quality root cause analysis investigation reporting and timelines. Midwife to Birth Ratio – the ratio had risen to 1:34. JG has been assured by the Trust that the year to date position is 1:31 which is a positive improvement and the Trust continues

	with its assertion that a ratio of 1:30 will be achieved by March 2014. Eliminating Mixed Sex Accommodation – there was one recent breach reported for a RBCCG patient cared for in ITU at The Royal Wolverhampton NHS Trust. This has been followed up with lead CCG commissioner. Alexandra Hospital Concerns – The Royal College of Surgeons will be undertaking a two day visit at WAHT as part of the invited review mechanism and commissioners will be meeting with them as part of their review. Colorectal Surgery Review – DL is linked in very closely with this work. High risk patients have all been reviewed and the Trust expects to have reviewed all low risk patients by the end of February 2014. 12 Hour Trolley Breach in A&E: there was a breach reported at Worcester Royal Hospital in December 2013. A root cause analysis has been completed and findings shared with commissioners. Safeguarding – Looked After Children Health Assessments – JG highlighted the current concern regarding the target for health assessments not being achieved. The poor performance relates to administrative issues within social care and requests not being submitted for action. JW made reference to the Norovirus position being much better than last year and asked if it just luck or are our systems working? JG responded that the comparatively positive performance is due to a mixture of both. She highlighted that systems and processes have been strengthened significantly and recalled a recent period of on-call where she was very pleased to note that a Norovirus outbreak at WHAT was managed quickly and efficiently. Q: DL queried the accuracy of the data on Page 9 (mortality). JG agreed to look into this and highlighted that overall the figures do represent a decline. **Performance** CE introduced the performance section of the Integrated Report. A&E 4 Hour Wait – Worcestershire Acute Hospitals NHS Trust (WAHT) has been failing the standard but looks to be on target for January 2014. A remedial action plan and trajectory has been received. Ambulance Standards – 'Red 2' response continues to be a problem nationally and we are not an outlier. The CCG must work with the West Midlands Ambulance Service to improve the situation. 18 Weeks Referral to Treatment (RTT) – the accuracy of reporting will be picked up with WAHT. The CCG has an action plan and is closely working with WAHT to manage the capacity. The CCG has a revised trajectory from WAHT and it will take 6 months for them to get back on track. CE noted that our GPs need to think carefully about referring into the acute sector and consider if they can use primary/community care. JW referenced the TIA figures on page 14 and noted that we can see performance rising since the centralisation of stroke services which is really positive and proves that the CCG was right to support this. JW also noted that he is not happy to encourage use of independent sector providers. CE stated that patients have the right to be treated within 18 weeks. JW agreed and

	hoped that they would get back in to target. Q: NS, Save The Alex Campaign commented that by sending people to the private sector we are just taking care out of the NHS. A: JW thanked NS for his comments. DL remarked that when he uses the Choose & Book system with a patient they are often happy to choose to go to a private hospital which is paid for by the NHS; we have to be balanced around that. NS agreed and said it is also about the media being balanced. His concern is about creating the demand in the private sector. DL agreed that we shouldn't assume that private means a fantastic experience for patients. JW clarified that his point was that patients chose WAHT and we are effectively pushing them away. CE noted that the independent sector has good clinical feedback. **Finance** PS introduced the finance section of the integrated report. RBCCG is required to deliver a £1.8 million surplus by the end of the financial year. The latest position is an improvement to £742k which is really positive considering the position the past few months. PS noted that there were still risks in the system including WAHT over-performance as A&E usage was high in December 2013. University Hospitals Birmingham Foundation NHS Trust (UHBFT) also continues to over-perform which adds pressure; this may point towards a flow of patients to the north. It was noted that the CCG are unlikely to deliver the surplus of £1.8 million by the end of March 2014. Allocations have now been published and there are no unexpected surprises this year. The CCG is refreshing its Financial Strategy and this will be brought to Governing Body in March 2014. PS explained that the surplus would be returned to us next year; every penny that we deliver in surplus this year adds to our surplus next year. Q: Graham Vickery asked how much the over-spend is at UHBFT? A: PS estimated at 8/9% which is significant to the contract although this is worst case scenario as there may be additional charges i.e. specialised services. Q: JW queried specialised services. A: PS explained that UHBFT undertake a lot of specialised services work which will have impacted on the contract. There is challenge being put into the system around this.
13	**Patient and Public Involvement (PPI) Report including feedback responses to the Draft Prospectus for Local Acute Hospital Services 2014/15** JA made reference to the PPI Membership Scheme 'Now Have your Say' which is being promoted currently and is detailed in the report. NHS RBCCG currently has 158 members, (178 (total) pending). The Voluntary and Community Sector (VCS) are working on a similar scheme and it is hoped that the two schemes will run in parallel. Work has been undertaken in relation to external consultation of 'Future Lives'. NHS RBCCG has responded corporately and also as a PPI Forum. The responses will be available to view on the website. The Worcestershire County Council response will be

	published on 5th February 2014. Worcestershire County Council has also been undertaking a Bus Service Consultation and it was noted that both consultations will have an impact on local health services. The PPI Forum has increased in size and continues to meet monthly. In relation to NHS 111, one of the PPI Forum members was a member of the Contract Management Board. The Community Engagement and Social Marketing Manager has detailed and analysed the responses to the NHS RBCCG draft Commissioning Prospectus and JA thanked the Save The Alex Campaign for their work publicising this. In relation to Quality and Patient Safety, some members of the PPI Forum will be trained to become Quality Expert Members. These will be Level 3 PPI members, however if Level 2 members wish to become Level 3 members then the CCG will work with them to achieve this. The report identifies that members of the PPI Forum has been heavily engaged with other meetings. Q: JG asked how we are doing with representatives from our local public. A: JA said there is certainly additional work to be done in relation to the Black and Minority Ethnic community (BME) and also younger people, who are finding it difficult to attend the meetings. JA will provide a breakdown of representation at the next Governing Body meeting. Q: NS, Save The Alex Campaign (STA) wanted to acknowledge the cooperation with STA from the early stages. A: JW echoed this and felt it is really important and we will continue to need to work closely together. JA acknowledged the importance of the work that the PPI Forum and STA are doing; we want to get membership of the PPI Membership Scheme as high as possible.
14	**Draft Urgent Care Strategy** MO explained that originally this was going to be a longer slot on the agenda including a presentation. Dr Marion Radcliffe will attend to present at the next public Governing Body meeting. The Worcestershire health economy has a strong track record of providing effective out of hospital care in primary and community settings to help reduce the need for emergency hospital admissions. There are positive signs for us to build upon across Worcestershire and locally within Redditch and Bromsgrove: • Unlike the pattern seen nationally, the number of A&E attendances has fallen in recent years. In 2012/13 they were 3.6% lower than 2011/12. This year the position has been changing throughout the year – as at 12th January 2014 the total no of A&E attendances within the county was 2.6% down on the same period in 2012/13 with the Alex seeing 4.7% - or 2,034 - fewer attendances. • Emergency admissions for the same period are currently 2.6% lower than 2012/13 - although we recognise that this number is still higher than the unusually low year of 2011/12. For Redditch and Bromsgrove residents the reduction between 2012/13 and 2013/14 is 2.7% lower – or 292 fewer emergency admissions.

	At the start of the process of developing the strategy, partners agreed three strategic principles that should underpin future urgent care services: • Admission prevention and avoidance - Enhance out of hospital urgent care services so we can avoid an emergency admission where possible. • Right care, right time, right place - Treat with the best care in the best place in the fastest time. • Effective patient flows - Promote rapid discharge to the most appropriate place for recovery in a planned manner. With these principles agreed, partners identified the specific objectives that all agencies would commit to working towards unblocking barriers and difficulties for patients. MO is asking for NHS RBCCG Governing Body members support to the principles and general direction of travel. JW commented that he is very pleased with the work that is going on around Urgent Care. Q: TH emphasised the importance of this paper. Currently the government debt is increasing year on year so as a health service we cannot expect them to be generous to us. It is frightening to see figures that show large increases in admission to hospitals due to the aging population. A: JW agreed with this. This is what our schemes are hoping to target. JA added that it is so important to work in partnership with our colleagues in other areas of the health economy. We are all under pressure and it will only be possible if we work together. DL also noted the importance of working with patients to make this work. Q: Councillor Pat Witherspoon, Chair of the Older People's Forums, commented that it's trying at times; you almost feel as if you're to blame. All of these people involved are over 50. It's about getting the message across to the young; getting the message across of what is coming to them. We need to be using far more schools and government arenas where we are teaching democracy. We need to use them for health purposes and not just government purposes. A: JW made reference to one of his public blogs which reflected that we should be celebrating people living older as a good thing. Henry Soulsby, Community Engagement and Social Marketing Manager will take the comments on board to work at further engaging. Q: Laura Middleton, Live Pregnancy said that if we prevent births then there will be less people to look after the elderly in the future. She is concerned the more we move maternity out of County it is going to dissuade people to give birth. A: JW thanked LM for her comments.
15	**Integrated Community Hub-Progress Report** AG introduced the report which provided an update in relation to progress. In June 2013 it was agreed that an update would be given at every public Governing Body meeting. AG stated that the Integrated Hub is just a term to reference to describe all of the developments at the Princess of Wales Community Hospital (POWCH). The Virtual Ward is a pilot scheme and medical cover is delivered by GPs from St Johns Surgery, Bromsgrove. As previously approved by Governing Body the cost of the pilot for

	2014/15 is £379,000 and this period runs through until September 2014. The 'Red Ward' (management of acutely ill patients within a community environment) consists of 18 domiciliary beds with patients cared for within their own homes, care homes and 12 ring-fenced beds on Cottage Ward at POWCH. It is noted that this is being well received by Worcestershire Acute Hospital NHS Trust (WHAT) colleagues. The 'Amber Ward' manages patients within a community environment and patients remain under the care of their registered GP. The 'Green Ward' is the proactive management of patients managed via the risk stratification software identifies the top 50 patients identified as 'at risk' and ensures advanced care planning to avoid future crisis and admission. GPs at the surgery where patient is registered undertake this. The CCG has Inclusive approach to work with local providers which includes Worcestershire Health and Care Trust (WHACT), WAHT, local Councils etc. Interactive discussions take place on a monthly basis via the CCG's Integrated Service Innovation (iSIM) meetings. AG referenced the graphs contained within the report; page 4 compares to figures last year and the reductions are positive. The CCG is focusing on targeted education into low referring practices. NHS RBCCG Governing Body is asked to note the progress of the Integrated Community Hub and that the Virtual Ward is evolving. An interim evaluation and recommendations will be brought back to the May 2014 Governing Body Meeting.
16	**Safeguarding Children and Safeguarding Adults Annual Reports** The Safeguarding Annual Reports were noted.
17	**CCG Assurance Framework Q2 Report** The CCG Assurance Framework Q2 Report was noted.
18	**Policies Approved by the Audit Committee** The policies approved by the Audit Committee were noted.
19	**Audit Committee Meetings: Summary Reports** The Audit Committee Summary Reports were noted.
20	**Quality and Patient Safety Committee Minutes – 30th October 2013** The minutes of the Quality and Patient Safety Committee held on 30th October 2013 were noted.
21	**Any Other Business** There were no items of any other business.
22	**Questions from Members of the Public** Q: NS, Save The Alex Campaign requested that now we have accepted the recommendations in relation to Option 1 that we do not allow this report to be 'dumbed

	down' because of finances. A: JW gave assurance that the CCG believes that this is a clinically sustainable model and we will be fighting hard in the system to build and retain the level of services identified as part of the recommendations.