AGENDA ITEM 6

'Working together to promote high quality, affordable healthcare'

NHS
Redditch and Bromsgrove
Clinical Commissioning Group

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

Thursday 24th July 2014, 09:30am
Council Chamber, Redditch Town Hall

MINUTES – PART 1

Present – Members
Dr Jonathan Wells (JW) – Chair and Clinical Lead
Simon Hairsnape (SH) – Chief Officer
Paul Sheldon (PS) – Chief Finance Officer
Tony Hadfield (TH) – Lay Member (Governance)/Deputy Chair
Catherine Whitehouse (CW) – Deputy Executive Nurse, Quality and Patient Safety
Judy Adams (JA) – Lay Member (Patient and Public Involvement)
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

Agenda Item	Minutes
1	**Apologies for Absence** Apologies for absence were received from Jo Galloway, Dr Richard Davies, Dr David Law and Deyhim Foroughi.
2	**Welcome and Introductions** JW welcomed members of the public and all Governing Body members introduced themselves.
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** There were no declarations of interest in relation to the agenda. It was noted that DL, as a Bromsgrove Town GP, would have an interest in agenda item 10.
5	**Patient Story – Stroke Pathway** CW presented this patient story which focussed on Jackie's experience of the Stroke Pathway. JW stated that the advice given to Jackie from NHS 111 should be raised as a significant event and CW confirmed that it would be. CW commented that both Trusts that provided Jackie's care appreciated the balanced feedback received. JW noted that the CCG is working hard for local specialised Stroke community beds. CE confirmed that the bed capacity requirements have been completed and WHCT is working to develop its staff. JA asked if there is there a limitation on how long patients can be placed with the Community Stroke Team, is there also integration with adult social care etc.? CE confirmed that work is on-going and that further work with social services needs to be taken forward. CW noted that there isn't a limitation; it is open ended to fit patient needs. JA asked if CW felt Jackie was more open as she had a 1:1 discussion rather than feeding back to the organisation delivering the care. CW felt that this was the case. Jackie was in her own surroundings and after the most acute period of her care. Although CW thinks Jackie also provided feedback whilst on the ward she appreciated that others may not feel confident to do so. JA said that as a CCG we need to invest more in improving the process for patients. JA feels that there are barriers for patients. CW agreed that this is work to take forward across the wider health economy. Q: Councillor Graham Vickery noted that he attends the Ambulance Board. He queried the insistence of NHS 111 communicating directly with the patient. A: It was noted that this is a common complaint and that it will be fed back to the Board.
6	**To Approve the Minutes of the Meetings held on 22nd May 2014** The minutes of the meeting held on 22nd May 2014 were approved as an accurate record. It was noted that the agenda had the incorrect date of the meeting. Presentations and notes to be added to separate section of website for ease of reference.

7	**Review Decision and Action Tracking System (DATS)** None carried forward.
8	**Future of Acute Hospital Services in Worcestershire (FoAHSW)** Through the Independent Clinical Review Panel (ICRP) Modified Option 1 has been developed. JW is the Chair of the Clinical Sub-committee under which there are three Task and Finish sub-groups: • Emergency Care (Dr Marion Radcliffe – Chair) • Women's and Children's (Dr Sally Rumley – Chair) • Planned Care (Dr David Farmer – Chair) Key features of Modified Option 1 were retention of A&E, a Networked Emergency Centre (Majors at WRH), maintaining 95% of existing attendances at the Alexandra Hospital, Redditch. Losing overnight paediatrics (ICRP were very clear about this) was due to the loss of a Consultant Led Unit at the Alexandra Hospital, Redditch and also lack of middle grade Doctors. Modified Option 1 has been signed off by the Programme Board and will be taken forward to consultation. SH explained the process. Modified Option 1 has been confirmed/approved by Nigel Beasley (ICRP) and Clinical Senate. PS has been working with colleagues to see if the Option is financially sustainable; which they believe it is. Assurance will now be needed from NHS England. This will then be followed by public consultation. The Programme Board are scheduled to meet with NHS England Regional Team on 6th August 2014. Consultation is due to start at the beginning of September 2014 for a full 12 weeks, subject to approval to proceed by NHS England. This would enable the CCGs in Worcestershire to be in a position to make a decision by early January 2015. It is anticipated there could be a tripartite Board meeting with all three CCGs in Worcestershire later this year. JA expressed some concern as to how 'majors' will be defined in relation to ambulances, and how will they know where to go? JW confirmed this had been a major part of work of the Emergency Care Task and Finish Group. The paramedics will follow confirmed protocols and there is work being done with WMAS to ensure patients are transported to the right place at the right time. A Consultant led A&E Department will be retained at the Alexandra Hospital, Redditch which means that 95% of patients will still arrive there and initially be assessed and treated there. JA queried how feedback will be balanced if there is a bigger response in one area than another, SH stated that there is no absolute number. However it would be important that each CCG positively encourages and seeks to obtain the fullest feedback possible from their area. Q: Councillor Graham Vickery congratulated JW and the CCG on the leadership undertaken in getting to Modified Option 1. In relation to maternity services he queried if it was the CCG's intention to commission maternity services outside of Worcestershire, given the figures indicating that half of births would be undertaken at WRH, some at an MLU and the rest would go outside of the County. A: SH confirmed the CCG would seek to commission these services to meet the choice and wishes of mothers and families, recognising a proportion will want to go to WRH, a proportion would be happy to go to Warwickshire and a proportion would want to go to Birmingham Women's Hospital. It is however acknowledged that there will be a need to expand capacity which is likely to take 2-3 years for this capacity to be fully available. JW advised that he updates the GPs within the Member Practices on a monthly basis and will formally check with them, prior to consultation, for their views.

9	**Clinical Navigation Pilot** It was noted that the Clinical Navigation Unit pilot project is a key strategic priority for this year. AG provided a summary of the detailed information provided in the supporting paper which explained the way in which it will function, together with finance and activity modelling and sensitivity checks. It was noted there is a financial risk if the focus is only on attendances as there would be a shortfall in costs and savings. JW highlighted this is a very exciting pilot, emphasising it is totally separate to the Future of Acute Hospital Services in Worcestershire programme and is something the CCG has been working towards for a couple of years. It was noted that the CNU would not be cost effective till Phase 2 which would commence in December 2014 so the aim would be to bring this forward if possible, and there is a need for very close monitoring of the programme. AG confirmed that there will be a number of admissions avoided but did not want to mislead Governing Body around the immediate effect of the project. The CCG already has a wide range of community services available which need to be fully integrated into the CNU. Robust ambulance protocols will be key and WMAS have been engaged right from the start of discussions. It is intended to introduce a primary care hotline as a 24/7 service that healthcare professionals can access. Evaluation and review has been discussed and there will be very robust Key Performance Indicators (KPIs), which can be shared with Governing Body members if requested. PS highlighted the focus needs to be on admission avoidance with a risk if the focus is only on attendances. Discussions regarding the ways in which cost risks can be mitigated are taking place with Care UK and these discussions will continue. The key is to finding the balance between the CCG, Care UK and WAHT to ensure nobody is put at financial risk. SS queried if there is flexibility around Phase 1. AG responded that part of the phasing has been because of recruitment, recognising it is a challenging start date. Care UK has indicated they are confident that they can deliver so it is felt there is some opportunity to be flexible. There are a number of milestones over the next couple of weeks which, if signed-off, will not stop us delivering Phase 2 earlier than identified. It also needs to be recognised this is a significant change for WAHT which needs to be approached in the correct way. MO highlighted this this is something that the public want, with a recent survey related to urgent care services indicating 99% only wish to be admitted if necessary and wish to make better use of local services. TH requested clarification on the following: is Care UK independent of GPs and Practices; how will repeat attenders be managed and if other local CCGs will be contributing to the cost as the service is provided to patients from out of area. SH responded that Care UK are a national company who do employ some local GPs and, if this was an issue for a Governing Body member they would need to declare their interest. The monitoring data will be shared to include data on repeat attenders. It was also highlighted there is a need to be really clear as to what this service delivers; recognising it is not a walk in centre. The CCG is in the process of agreeing sharing the cost with neighbouring CCGs as it is not just a service for local patients. AG and PS noted the difficulties of understanding Appendix 2 and will bear in mind for the future. JA highlighted the importance of getting enhanced patient feedback on the service. SS queried the costing and how the CCG will differentiate between the patients seen in the CNU and in A&E. PS confirmed this is being addressed WAHT so that patients can be matched and gave the assurance the CCG will not be paying twice.

	The Governing Body approved the recommendations to: • discuss the value of introducing Clinical Navigation at the Front Door of the Alexandra Hospital, Redditch; • approve the necessary levels of investment to support the implementation of the 12 month pilot; • mandate the Chief Finance Officer and Head of Business Development and Operations to negotiate a risk share benefit scheme with Care UK.
10	**Virtual Ward – Red Ward Interim Learning and Recommendations** AG presented the paper which outlined a request for a further extension to the Red Ward element of the Virtual Ward Pilot due to the interdependency with the Clinical Navigation Unit Pilot. It was noted the CCG is focussing on the Red Virtual Ward at this stage, with the provision of a breakdown of ward referrals related to this activity. The paper also provides details on finance and activity. With regards to the future at the Princess of Wales Community Hospital (POWCH) it was indicated that the CCG wants to see a redesigned medical model, and there is a need for Virtual Ward arrangements to remain in place through this transitional phase. AG highlighted the importance of the CCG not looking at projects in isolation. JW indicated he felt things are coming together for urgent care, particularly around maximising the use of POWCH. JA sought reassurance the CCGs plans will overcome the problem of underutilisation of the domiciliary element of the Virtual Ward programme. AG acknowledged there is a general frustration around this and any extension needs this to be specified to avoid on-going issues. RK asked if there has there been feedback from the GPs as their feedback is crucial. AG gave assurance the CCG will make sure it engages GPs as part of tailoring the revised agreement. PS highlighted the following risks: the savings detailed in the paper were not cash savings, and there are difficulties in counting what has not yet happened, which does present a risk going forward. PS also indicated a preference for the contracts to be managed under 'one roof' so the CCG are not directly contracting with GPs (recognising this relates to other projects also) as it helps to keep our distance as a Governing Body. PS indicated there will be a need to have a plan to move forward from 1st April 2015, given the pilot will have run for 18 months by then. The Governing Body approved the recommendations within the paper to: • note the interdependency between the Red Virtual Ward, the Clinical Navigation Pilot and the overarching developments at POWCH; • support the proposal to approach St Johns Surgery and negotiate an extension for the Red Virtual Ward from 1st October 2014 – 31st March 2015 (key emphasis upon reviewing the specification and negotiating the extension to appropriately incentivise St Johns to avoid unnecessary acute hospital admissions). Q: Councillor Graham Vickery saw these as marvellous developments but made a plea for patients to be informed throughout so they know where they are going to be treated, and what the options are for care etc. A: JW agreed with this and confirmed the CCG will be working very hard to ensure this.

11	**Financial Risk Sharing Arrangements** PS presented the outline framework explaining what the CCG would work to, acknowledging the Governing Body in March 2014 had given him a mandate to further explore risk sharing. The Governing Body approved the implementation of this agreement which will limit the exposure of the CCG to financial risk in 2014/15.
12	**Governing Body Assurance Framework – Risk Assessment** The paper provided further details on the individual risks previously identified and presented to the last Governing Body meeting. JW expressed his concern that two items have the 'acceptable'/residual rated as high. This was noted and assurance was given the CCG would be seeking to mitigate the risk levels to the lowest possible and all will be monitored closely. The Governing Body agreed the initial risk assessment as presented and the proposed allocation of responsibility against the individual risks.
13	**Integrated Quality, Performance and Finance Report** CE explained that the format of this report has changed slightly with the aim of working towards integrating quality, commissioning and finance, acknowledging there is further development required on the format of the report. **<u>Commissioning Headlines</u>** 18 Weeks Referral to Treatment Time (RTT): performance against this standard has deteriorated over the last 12 months at WAHT. The CCG has been working with NHS England regarding non-recurrent funding to support clearing the backlog of patients overall by the end of August 2014 and by speciality by the end of September 2014. This will be extremely challenging and WAHT are reporting 87% by October 2014 so further discussion is needed. Extensive independent provider capacity has been commissioned. CE thanked all GPs for undertaking waiting list validation which was mobilised very quickly and was a useful piece of work. An 18 Weeks RTT Task and Finish Group has been established and reports to the System Resilience Group that now oversees urgent and elective care delivery. There is also a need to ensure activity within other providers is not overloaded as a result of this work. A&E: the Alexandra Hospital, Redditch has consistent delivery of the standard but delivery at WRH brings overall performance although there has been a slight improvement recently. Stroke: there are further developments of the Stroke Pathway and all stroke and TIA targets continue to be met. Cancer: the CCG is considering issuing a performance notice. JW indicated the 18 week RTT issue emphasises the need to be getting on with the reconfiguration so services can be appropriately streamlined. CE stated that the Planned Care Project is looking at centralising elective orthopaedics at the Alexandra Hospital site with a need for this to be progressed as soon as possible. JW was uncertain of how much reorganisation of planned services is required. **<u>Quality Headlines</u>** Mortality at WAHT: it was noted there is a high risk of WAHT being seen as an outlier and very close monitoring is taking place. Maternity: the midwife to birth ratio continues to be monitored for sustainability. Contract Queries: – there are number at present; action plans are in place and reviews are being held at CQR meetings.

	Falls: a reduction in falls has been recorded and a Falls Steering Group has been set-up. CAMHS Tier 4 beds: NHS England are commissioning 50 additional beds nationally. These will take time to reach the system and there are continued concerns at WAHT in the interim. Health Assessments for Looked after Children: progress is being made in relation to the backlog and monitoring continues. A recovery action plan is in place. Stay Hydrated and Stay Healthy Campaign: this public campaign launched in July 2014. There is a Project Group working on a hydration tool and resource pack to be launched in Care Homes in October 2014. JW highlighted the data on page 15 draws attention to the fact that this CCG is not the only one in a difficult position around 18 Weeks RTT. CE agreed there are pressures across many of our providers. The CCG feedbacks concerns to the lead/host commissioner in these situations. In terms of mortality at WAHT JW indicated the need for the Group to be up and running as the data is often very raw and reviewing of the cases is needed. CW confirmed that DL is on that Group and noted the importance of the 'deep dive' needed and looking more in-depth at the quality of care for those patients in the over 75 age group. JA appreciated CAMHS is a national pressure but noted there have been difficult local scenarios and expressed a concern that some children may be placed in beds far out of County. SH explained that all the tier 4 beds are out of County and that CCGs in the Midlands have struggled to get beds within the Midlands. It is hoped that additional capacity nationally will allow repatriation of children currently occupying more 'local' beds, freeing them for our local children. JA raised a concern regarding the delays in CHC retrospective reviews. CW confirmed the CCG are exploring why that performance standard has not been met. JA also queried if these reviews will have a financial implication for us and PS confirmed that it would in terms of current cases as old cases were contained within the old accounts. **Finance Headlines** PS said that page 4 demonstrates the Assurance Framework is around the identification of risks. The CCG on target to deliver 1% surplus at the end of the year. Governing Body members noted this report.
14	**Patient and Public Forum (PPF) Report** JA drew attention to NHS RBCCG's Annual General Meeting which is due to be held on 9th September 2014 in the evening at Redditch Borough Council and encouraged members of the public to attend. The PPF continue to have involvement with major projects in the area. A brief summary to the 360 degree survey that had taken place was provided. KH noted that the full report is very long and detailed which is why it has not been included here however a link is available for people to view on the CCG website. Work is being undertaken to address the areas where further improvement is required. It was noted NHS England intend to repeat the survey next year.
15	**CCG Assurance 2013/14** Attached with the papers was a letter received from NHS England which summarised the outcomes of the CCG assurance reviews over the whole year. Two areas are 'assured with support' which is not a significant concern but further monitoring will continue into 2014/15. JW was unsure he agreed with the rating for 'domain 5'; SH confirmed this would relate to areas such as winter pressures.

	SH indicated he viewed this as a relatively positive letter and indicated he believes the process will move into a more traditional performance management approach in the coming year. JW indicated his concerns about this.
16	**5 Year Health and Care Strategy for Worcestershire** MO presented the 5 Year Strategy for Health and Care, a Countywide strategy covering the three CCGs in Worcestershire, providers, social care and the voluntary sector. There are no specific additional implications for the CCG, given it reflects the priorities already highlighted and addressed. JW commented he found the document interesting and thought it was very well laid out and clear. JA expressed her view that there is still a large amount of work to be done in terms of involving people 'with' rather than 'to' in terms of patient and public involvement. In particular there is a need to make sure people are asked to help with service developments rather than telling them what is happening. MO confirmed this is an ambition for the CCG.
17	**Urgent Care Strategy** It was noted that the Urgent Care Strategy has previously been presented to Governing Body. The key principles are: • Admission prevention and avoidance: enhance out of hospital urgent care services so that we can avoid emergency admissions 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. The CCG has comparatively good rates for emergency admissions which implies community and primary care is better than in other areas of the Country. However, further work still needs to be done and MO highlighted the work around the Virtual Ward and Clinical Navigation Unit pilot. Full details of the Strategy are available on the CCG's website. MO drew particular attention to the Walk-in Centre in Worcester and noted that SWCCG, as part of the response, have taken the decision to close the service. It was also noted this does not impact greatly on NHS RBCCG patients (1% usage). TH made reference to the document not including Kidderminster MIU within the services available and noted the importance of the public being made aware of that service in Kidderminster. However, MO clarified this information was included but noted the service in Kidderminster was pr0vided by WAHT, not WHCT
18	**Finance and Performance Committee Minutes – 23rd April 2014** The minutes of the Finance and Performance Committee meeting held on 23rd April 2014 were received for information.
19	**Audit Committee Summaries** The Audit Committee Summaries from 29th April 2014 and 20th May 2014 were received for information.
20	**Quality and Patient Safety Committee Minutes – 21st May 2014** The minutes of the Quality and Patient Safety Committee held on 21st May 2014 were received for

	information.
21	**Any Other Business** KH confirmed that the proposed changes to the Constitution, as previously presented to the Governing Body, had received approval from NHS England and the revised Constitution will be published next week. Particular attention was drawn to the revised options for quoracy in the situation where GPs and other member practice representatives were excluded from decisions through conflicts of interest.
22	**Questions from Members of the Public** Q: Councillor Graham Vickery asked what the implications were for commissioners with the proposals to lower the tariffs. A: PS responded that the CCG use the same set of tariff guidance and the CCG's financial plans are based on those assumptions. PS hoped there will be few implications to the CCG as planning assumptions are joined up to national guidance. Q: Mr Sandhu noted that on Page 11 of the 5 Year Health and Care Strategy for Worcestershire preventative care seems to be missed out. A: MO responded that it is not identified as a specific programme but is largely covered on Page 10 of the document. With urgent care we are aiming for people to manage their own health so it is not set out separately.
Date of next RBCCG Governing Body: 25th September 2014, 1:00pm-3:30pm, Council Chamber, Bromsgrove District Council	