**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP PARTNERSHIP BOARD**

**MINUTES OF THE MEETING HELD ON THURSDAY 15 JANUARY 2015 AT 2PM**

**SOCIAL ENTERPRISE CENTRE, 84 WELLINGTON STREET, GRIMSBY DN32 7DZ**

**PRESENT:**

Mark Webb Chair

Dr Derek Hopper Vice Chair/Chair of CoM

Cllr Mick Burnett Portfolio Holder for Tourism and Culture – NELC

Juliette Cosgrove Strategic Nurse

Cathy Kennedy Chief Financial Officer/Deputy Chief Executive

Helen Kenyon Deputy Chief Executive

Dr Thomas Maliyil *(Items 1 to 10)* GP Representative/Vice Chair Council of Members

Dr Peter Melton Clinical Chief Officer

Dr Arun Nayyar *(Item 6 on)* GP Representative

Dr Rakesh Pathak *Items 1 to 12)* GP Representative

Joe Warner Managing Director – Focus independent adult social care work

Cllr Peter Wheatley Portfolio Holder for Health, Wellbeing & Adult Social Care – NELC

Sue Whitehouse Lay Member Governance and Audit

Stephen Pintus Joint Director of Public Health

**IN ATTENDANCE:**

Jeanette Harris PA to Executive Office (Minutes Secretary)

Lisa Hilder *(Item 5)* Assistant Director Strategic Planning

Laura Whitton Deputy Chief Finance Officer

**APOLOGIES:**

Philip Bond Lay Member Public Involvement

Mandy Coulbeck Locally Practising Nurse

Joanne Hewson NELC Deputy Chief Executive (Communities)

Mr Perviz Iqbal Secondary Care Doctor

Julie Taylor-Clark Interim Director of Nursing, Quality and Transformation

**1. APOLOGIES**

Apologies were noted as above.

A welcome was extended to Stephen Pintus, the new Director of Public Health.

**2. CONFLICTS OF INTEREST**

No conflicts of interest were declared.

**3. APPROVAL OF THE MINUTES OF PREVIOUS MEETING:**

The minutes of the Partnership Board meeting held on 13 November 2014 were agreed to be a true and accurate record.

**4. MATTERS ARISING**

 The actions outlined on the action summary sheet were noted.

**5. LOCAL IMPLEMENTATION PLAN (LIP) UPDATE**

Lisa Hilder advised the Board that the CCG is now well into the planning round and outlined the contents of a presentation which covered the following:

*Dr Peter Melton arrived.*

* Background and context
* Planning framework
* Priorities set out in the five year forward view
* Our vision
* Planning timetable

Following the presentation it was noted that representation was provided at the Chief Executive Forum by Helen Kenyon and Joe Warner and that health, rather than Adult Social Care, is the main focus of this group.

The Carers Strategy was approved a year ago and the Board was reminded that this strategy included a number of particular initiatives which tie back into the Local Implementation Plan (LIP). A new Carers Centre and provider, commenced in April 2014 and a number of initiatives have been emerging from this which will assist in delivering the LIP.

The amount of resilience funding built into the baseline for 2015/16 was queried and it was explained that whilst the exact figure is not yet available, resilience planning is commencing now and will continue throughout the year, based on the system that was put into place last year. In the past resilience planning has been hampered by the late notification of the amount of funding involved and its receipt; however now that the funding is being built into the baseline there will be time to develop appropriate measures throughout the year to meet winter pressures.

The difficulties experienced by some patients in obtaining a timely GP appointment was raised; in response Cathy Kennedy advised the Board that the CCG are supporting two submissions to the Prime Minister’s Challenge Fund, developed by two different groups of GP Practices; these submissions detail plans for increasing access to GP services. However it was also noted that if the submissions are unsuccessful the CCG will need to give serious consideration on how to implement the planning without the one-off funding being offered by the Prime Minister’s Challenge Fund; in this event this priority would need to be considered alongside others going forward.

The introduction of an on-line access service for patients to book GP appointments was discussed. The discussion noted that feedback indicates that the flexibility offered by this service has been well received, but the problem remains about the capacity in primary care and the actual number of appointments available.

The next Board workshop will be examining the LIP the priorities and activities that are being proposed as well as the planning timetable.  However Board members were reminded that should they be unable to attend the workshop they will need to ensure that they are cognizant with the Local Implementation Plan.

*Dr Nayyar arrived.*

*Lisa Hilder left the meeting.*

**6. PRIMARY MEDICAL SERVICES CO-COMMISSIONING**

The supporting paper before the Board reflects the previous conversations and e-mail discussions that have taken place with Board members over the past few weeks. The Board were reminded that the submission date for the CCG application is 30 January 2015.

Following a virtual consultation with Board members, a consensus was reached for joint co-commissioning arrangements with NHS England from 1 April 2015 and a Chairman’s action was taken to this effect on 23 December.

It was highlighted that this will be a significant change for the CCG and attention was drawn to Section 2 of the supporting paper which outlines the emerging local proposals and governance arrangements, encompassing NEL CCG, NHS England and NEL council.  It was also highlighted that the Joint Co-Commissioning Committee referred to in Section 2.2 of the local governance draft proposal will be taking decisions on behalf of the CCG Partnership Board and has a national requirement to meet in public.

A pooled fund, equivalent to a Section 75, is being proposed for primary care health services.  The CCG is accustomed to working with a Section 75 arrangement and feels it is important for this to be implemented now; however the Local Authority has requested more time to consider the amount of funding they will be required to put into the pool. Therefore the pooled fund will initially have contributions from NEL CCG and NHS England only.

The Board is not due to meet again until after the 30 January submission date and it is being proposed that Dr Melton Clinical Chief Officer, be authorised by the Board to approve the content of the CCG application on 30 January 2015.

Cathy Kennedy requested feedback and views from Board members on the contents of the whole of Section 2 as outlined within the supporting paper, as soon as possible.

**ACTION: All**

The role of the Care Contracting Committee was raised and in particular the possibility of a potential overlap between it and the proposed Joint Co-Commissioning Committee. It was decided that further conversations need to take place over this to ensure these two Committees will be working in tandem with each other where necessary.

**ACTION: C Kennedy/H Kenyon**

It was queried who, between the CCG and the Joint Commissioning Committee, would have the authority to make decisions in relation to overspend.  It was clarified that the current draft risk share proposals would mean that if an individual partner is responsible for an overspend they would hold the liability, however if an overspend occurs across the partnership it will have to be managed jointly by all partners.  The risk involved for each partner will be proportionate to the amount of pooled funding they have contributed; the CCG contribution will therefore be less than that of NHS England.  It was also highlighted that any overspend will inform risk reporting to the Board which ensures there will be opportunities available for agreement on how to manage it.

It was queried whether the Partnership Board would be able to overturn a decision taken by the Joint Commissioning Committee. In response it was explained that it is proposed that the membership of the Joint Commissioning Committee consists of eight individuals, five of whom are members of the Partnership Board. It is expected that this will mitigate the risk of any decisions being taken that the Partnership Board does not agree with. It was also highlighted that there is a dispute resolution process that can be implemented if there is disagreement amongst members of the Joint Commissioning Committee.

It was reiterated that in principal the Joint Commissioning Committee will be leading development of primary medical services, which are purely GP services, and inform part of the CCG’s strategic plan.

It was queried whether an invitation should be extended to the LMC to be an attendee at the Joint Commissioning Committee meetings and it was agreed that this suggestion will be given further consideration.

 **ACTION: C Kennedy**

**The Partnership Board agreed to ratify the decision taken by the Chairman on 23 December 2014 to proceed with Joint (Level 2) co-commissioning arrangements for primary medical services from 1 April 2015. It further agreed to authorise the Clinical Chief Officer to approve the content of the CCG application on 30 January 2015.**

**7.   SERVICE TRIANGLES MID-YEAR REVIEW UPDATE**

The supporting paper was taken as read but it was noted that it provides a helpful stocktake of the work undertaken by the Service Triangles in the last six months.

The establishment of the new Community Care Triangle was highlighted and it was explained that whilst formal objectives will not be set for this Triangle until April 2015, bringing them into line with the other six, a meeting has been held to agree their areas of focus in the interim.

Helen Kenyon reminded the Board of the successes achieved in national awards by the Unplanned Care Triangle and the Older People and Dementia Triangle for A&E and significant improvement in dementia diagnosis respectively.

It was also noted that the Clinical Lead for Unplanned Care has recently attended a Health Overview Scrutiny meeting and found it to be beneficial.

The Council of Members has requested an update on the work being undertaken by the Service Triangles and the paper before the Board will be submitted to that meeting.

**8. REVIEW OF PARTNERSHIP BOARD TERMS OF REFERENCE**

Following a review of the Partnership Board terms of reference two changes are being proposed for submission to the Governing Body at its meeting in March. These are detailed on the cover sheet of the supporting paper and relate to Section 13.1 re the inclusion of a reference to the CCG’s conflicts of interest policy and to the Appendix to include the new Joint Co-Commissioning Committee in the diagram.

At a recent meeting of the Remuneration Committee it was agreed that a new officer role will be created entitled Director of Quality and Nursing. This role will have membership of the Governing Body and will provide strategic nursing advice to the Partnership Board.

Following the creation of the new officer role the Chairman and the Council of Members (CoM) reviewed the membership of the Governing Body, particularly the nursing and lay membership. As part of this review CoM have taken the decision to broaden the Locally Practising nurse role to that of Primary Care Professional which will make it eligible to other healthcare professionals.

A number of positions on the Governing Body will come to the end of their tenure on 31 March 2015 and will need to go out to advert or election. The Primary Care Professional and Secondary Care Doctor roles are due to be advertised and an election process will be implemented for the two GP representative roles. It was noted that the current holders of these positions are able to reapply/put themselves up for re-election if they wish to do so. The current Strategic Nurse role is changing into a lay member position and Juliette Cosgrove has been asked to remain on the Partnership Board for a further year in this amended role.

At the last meeting of CoM a discussion took place about the annual Chair and Vice Chair role of that Committee due to the impact a lack of continuity could have in light of the Board membership changes taking place within the next few months. Following discussion CoM voted to retain their current Chair and Vice Chair for the next 12 months.

It was also noted that there discussions are underway about the tenure of the Clinical Chief Officer role and an update on this will be brought to the next Board meeting.

**ACTION: M Webb**

Mark Webb informed the Board that due to workload pressures, Mandy Coulbeck has tendered her resignation from her position on the Governing Body and Partnership Board. Mark Webb, on behalf of the Board, thanked Many Coulbeck for her contribution to both these bodies and the work she has carried out on behalf of the CCG. A letter of thanks will be sent to her.

**ACTION: M Webb**

**The meeting agreed the submission of the proposed changes to the Terms of Reference of the Partnership Board to the Governing Body meeting in March.**

**9. PARITY OF ESTEEM AND MENTAL HEALTH CRISIS CARE CONCORDAT**

This item is being brought to the Board to ratify the CCG sign-up to the Parity of Esteem and Mental Health Crisis Care Concordat.

Over the past few months two specific engagement meetings have been held, and were well attended by the various organisations and stakeholders involved.  A Concordat Group has been established to ensure the right principles are in place to take forward the work of the concordat.  It was noted that the CCG already commissions the services concerned from a range of providers and community involvement is in place.

It was suggested that a different title could be adopted when promoting this amongst members of the public as “parity of esteem” is not self-evident.

**The Board ratified the CCG sign-up to the Parity of Esteem and Mental Health Crisis Care Concordat.**

**10. QUALITY REPORT**

The supporting paper was taken as read but the following was highlighted:

A report is awaited from the CQC in regard to its second inspection at Ashwood Surgery which took place on 7 January 2015.

One case of MRSA was reported in November 2014 which means that the CCG will have breached the zero target set for 2014/15. It was also noted that the CCG will not be able to meet its target for C Difficile which is proving to be very challenging.

There appears to be a significant increase in the NLaG serious untoward event numbers but this is related to the inclusion of 30 pressure ulcers which have not been classified as serious incidents in the past. The comparative figure year to date, excluding the pressure ulcers, is 43 in 2013/14 and 33 in 2014/15.

NLaG’s reporting methodology for timely SHMI data produces slightly different figures to the national statistics which are released sometime later but is robust enough to take a view of trends and is indicating rates within the expected range.

The Friends and Family test target is being achieved by NLaG for inpatients but it is proving challenging to get responses from those attending A&E. This issue is being noted across the region and it is believed that filling in a questionnaire may not be considered a priority by those attending A&E Departments and it has also been noted that some of the questions posed are not relevant to this cohort of patients. The Area Team are looking into this and feedback is being given to NHS England but it remains a target that needs to be met. There is a financial incentive in place for this year to encourage NHS Trusts to meet these targets but it was noted this incentive will not be in place next year, however the CCG will continue to monitor this area.

*Dr Thomas Maliyil left the meeting.*

It was noted that Goole Hospital no longer accepts urgent medical admissions, and this has significantly affected its reported SHMI performance.

It was flagged that the Out of Hours provider is not listed in the serious incident report and it was agreed that they will be included in future if the data is available.

**ACTION: C Kennedy/S Cooper**

**11. HEALTHY LIVES HEALTHY FUTURES UPDATE**

A presentation update was given on the Healthy Lives Healthy Futures programme and highlights included the following.

Agreement has been reached on a different governance and leadership structure for the next phase of the programme and Karen Jackson, CEO of NLaG has taken on the role of Lead Accountable Officer for the programme and Dr Robert Jaggs-Fowler has taken on the role of Clinical Lead.

A clinical workshop took place last week which was well attended and generated positive feedback and proactive engagement from the secondary care clinicians present.

In future Robert Jaggs-Fowler will be attending the NEL CCG Clinical Leads meetings.

It was flagged that NLaG have a hospital sited in three different CCG areas and it was noted that a future board workshop will need to discuss this fully and explore the options this situation presents. Progress will be driven by the shift of focus to new care models for areas where appropriate care is not currently being provided.

It was highlighted that Karen Jackson will need to balance her role as CEO of NLaG with the significant time contribution she will need to make to the HLHF programme. The risks involved have been discussed with the NLaG Board and they believe that the Trust will be able to continue to maintain its leadership. It was also noted that the other options considered for this role also carried levels of risk and the decision taken to appoint Karen Jackson to this role appeared to be the most reasonable.

The challenging timeframe for large programme changes was raised and the Board was advised that some of the plans outlined are already in place and the necessary steps needed to achieve others have already been determined. This means that the scale of the gap to be addressed is being reduced and becoming more achievable. It was also noted that the work being undertaken by the extensivist programme is really starting to break down barriers and coming up with inclusive proposals.

**12. INTEGRATED ASSURANCE REPORT**

The supporting paper was taken as read but attention was drawn to the performance highlight for Adult Social Care performance, in particular the wheel diagram which demonstrates how we compare against our peer group.  It was flagged that the “offered re-ablement” position on the diagram is believed to be related to a method of counting and is being investigated; it is anticipated this will not prove to be a concern.

*Dr Rakesh Pathak left the meeting.*

Better payment practice is now back on track.

Contract cost pressures and A&E four hour waits appear under the performance escalation section of the report. Both these areas are continuing to be monitored but are being highlighted as a risk.

**13. FINANCE REPORT**

This month’s report to the Board includes the routine financial update and a briefing on the 2015/16 CCG allocation which was announced in December 2014.

Whilst the CCG forecasts that it will achieve the planned surplus of £6m attention was drawn to some significant variances relating to NLaG, continuing healthcare, St Hugh’s and other-non acute.  The four areas highlighted above have been discussed previously at the Board but have now shown a further increase.  Some one-off benefits in 2014/15 will be used to offset these increases in 2014/15 but plans are being formulated to manage these risks during 2015/16.

Since this report was written the CCG have been notified of a “windfall” benefit of £500k which relates to underspend on the national risk share pot for continuing healthcare retrospective claims. This “windfall” will result in an increase to the CCGs surplus in 2014/15 of £500k. All CCGs have been advised that they will have access to these monies in future years.

In relation to the 2015/16 allocation the Board was advised that the CCG’s uplift has decreased slightly (0.3%) from the indicative figure we had been notified of previously. The resilience funding which CCGs received during 2014/15 has now been allocated to CCGs at the start of the year.

The CCG has also been notified of its indicative uplift for primary care allocations, as part of co-commissioning. The uplift for North East Lincolnshire, and all other CCGs in North Yorkshire and the Humber, is lower than the national average as our historic spend per head on primary care is higher than in other areas.

It was confirmed that the level of unmitigated risk in 2014/15 has reduced but acute hospital spend is one area that still requires close monitoring.  However the expectation is that there are sufficient monies remaining within the contingency fund and earmarked reserves to cover this unmitigated risk should it materialise.

The continuing overspend at NLaG was raised and it was queried whether enough steps have been taken to lessen the possibility of this situation reoccurring during the next financial year.  It was explained to the meeting that the level of growth in activity, particularly in urgent growth, has taken us by surprise given that the plans which normally keep growth in check have been maintained.  However further steps that can be taken have been identified and will be implemented.

**14. COMMISSIONING AND CONTRACTING REPORT**

The supporting paper was taken as read but it was highlighted that an increasing number of complaints have been received about Abbey Care Home which is now in week six of the unbroken period of business as usual.  The complaints will be examined at a meeting next week but could result in the provider’s unbroken period of business being reset back to zero.

The domiciliary care contract is currently out to tender and it is anticipated that this will result in additional providers becoming available.

It was queried whether the steps taken to deal with the situation at Abbey Home Care was the best way to deal with the issues involved and it was also queried whether the patients already with this provider were getting the best care possible.  It was acknowledged that to keep returning to the beginning of the unbroken business as usual period is not advantageous and the situation is being very closely monitored.  If a deterioration of service continues or escalates the CCG will be looking to implement alternative steps.  It was confirmed that the care being provided to existing patients is being very closely monitored to ensure they are receiving appropriate and adequate care.

Attention was drawn to item 4 of the report which is a response to a previous Board suggestion that residential care services be required to provide a bond to help address the risk of an unplanned rapid home closure.  Whilst it would appear that it is not going to be practical or possible to implement this suggestion, work is being undertaken by the CCG to see what other measures may be possible to assist in mitigating this risk.

**15. UPDATES**

a) Community Forum Update

In December the group took a full morning out to review its performance and also to develop an action plan for this year. A number of items were identified and the plan was taken back to the Forum this week in a report format. The planning session was very well attended.

Board members stated that they would be interested in seeing the Community Forum forward plan.

**ACTION: C Kennedy**

Following the re-launch of ACCORD last summer it was decided that a Steering Group should be created to set the strategic direction for ACCORD. A number of ACCORD members put themselves forward for this Group and the selected individuals undertook a six week training programme, designed to increase their knowledge of the NHS and the CCG. The newly formed Steering Group will be holding its first meeting next week. Following discussions with the Chair of the CCG Philip Bond has agreed to chair the initial few meetings of the Steering Group to ensure they set off in the right direction but also to ensure CCG support in its initial stages of development.

Gemma Mazingham and Philip Bond have successfully established a PPG Chairs Group which allows the CCG to receive direct input from the PPGs and also offers a further opportunity for public and patient involvement. The third meeting of this group is taking place on 26 January 2015, with a good attendance confirmed. Dr Rakesh Pathak has been invited to attend to provide a briefing of the work carried out by the unplanned care triangle.

b) Council of Members Update

The majority of the matters discussed at the last CoM meeting have already been covered earlier in the meeting but it was highlighted that the deterioration in ophthalmology waiting times was raised. Validated data has been requested and this issue will be discussed further at the February meeting.

The meeting also received an update on GP fronting of A&E and the GP service out in the community which deals with requests for urgent GP home visits. This service currently operates from 10am to 6pm and consideration is being given as to whether it needs to be extended to cover out of hours.

**16. ITEMS FOR INFORMATION**

a) Care Contracting Committee Draft Minutes 19 November 2014

The Minutes from the Care Contracting Committee meeting were noted by the Board

b) CMM Action Notes 18 November and 16 December 2014

The Action Notes from the CMM meetings on 18 November and 16 December 2014 were noted.

c) Delivery Assurance Committee Minutes 29 October 2014

The Minutes from the Delivery Assurance Committee meeting held on 29 October 2014 were noted.

d) Draft Integrated Governance & Audit Committee Minutes 2 December 2014

Minutes from the Integrated Governance & Audit Committee meeting were noted.

e) Quality Committee Minutes 29 September and 24 November 2014

The minutes of the Quality Committee were noted.

**17. QUESTIONS FROM THE PUBLIC**

There were no questions raised by members of the public.

**18. DATE AND TIME OF NEXT MEETING**

Thursday 12 March 2015 from 2pm to 4pm at the Social Enterprise Centre, 84 Wellington Street, Grimsby DN32 7DZ