

**Agenda Item: 4**  
**NHS Bedfordshire Clinical Commissioning Group**

**MINUTES**

**Minutes of the meeting of the NHS Bedfordshire Clinical Commissioning Group Governing Body held in public on 30 March 2017, at Jordan's Mill, Holme Mills, Langford Road, Biggleswade, Beds SG18 9JX, commencing at 14.00 and concluding at 17.15.**

**Members Present**

Dr Alvin Low*	Clinical Chair	AL
Dr Chris Marshall*	Locality Chair – Leighton Buzzard	CM
Emma Barter*	Locality Chair – West Mid Beds	EB
Dr Sanjay Sharma*	Locality Chair – Chiltern Vale	SS
Dr William Hollington*	Locality Chair - Ivel Valley	WH
Dr David Howard*	Locality Chair – Bedford	DH
Dr Ratan Das	Deputy Chair – Bedford Locality	RD
Dr Robert Sherwin	Secondary Care Clinician	RS
Alison Borrett*	Lay Member – Patient and Public Engagement	AB
Roland Ginn*	Lay Member – Finance and Performance	RG
Heather Moulder*	Registered Nurse	HM
Ben Jay*	Chief Finance Officer	BJ
Ian Brown*	Assistant Director of Public Health	IB

\*voting member

**Others in attendance**

Diana Blackmun	CEO Healthwatch, Central Bedfordshire	DB
Anne Bustin	Healthwatch, Bedford Borough	AB
Donna Derby	Director of Commissioning and Performance	DD
Clare Steward	Director of Strategy and Transformation (Interim)	CS
Jane Meggitt	Director of Communications and Corporate Affairs	JM
Maria Laffan	Deputy Director of Quality	ML
Jill Hall	Head of Corporate Governance (Interim)	JH

**1. Welcome and Introduction**

A minute's silence was observed as a mark of respect for two Bedfordshire GPs who had died since the last meeting, Dr Tariq Hafez and Dr Shiv Sekaran.

**2. Apologies for absence / changes in membership**

Apologies for absence were received from Matthew Tait, Accountable Officer; Anne Murray, Director of Nursing and Quality who was replaced by Maria Laffan, Deputy Director of Quality, for this meeting only; Muriel Scott, Director of Public Health who was replaced by Ian Brown, Assistant Director of Public Health for this meeting only.

**3. Declarations of Interest**

AL declared an interest against agenda item 9 – GP Five Year Forward View as he is a partner at his practice. Locality chairs similarly declared their interests.

**4 Conflicts of Interest Register**

AL reported that he was a partner at his practice and not a member.

**5. Minutes** of the meeting held on 26 January 2017 were approved as an accurate record of the meeting.

**6. Action tracker**

All actions were either complete or on the agenda.

**7. Report of the Chairman**

AL provided an update of activities he had been engaged in since the last Governing Body meeting in January. In particular the following was discussed and noted:

- RS enquired if SMART goals had been set for the Right Care Delivery Group (RCDG) and how these were reviewed. In response it was noted that none had been set. DD further added that existing working groups, which were disease specific, had Executive sign-off and reported in to the Executive Management Team.
- HM asked if the RCDG should report via the Director of Commissioning and Performance into the Integrated Commissioning and Quality Sub-Committee (ICQC), in response DD explained that it would report into the Executive Management Team and any issues relating to quality would report to the ICQC.

**RESOLVED**

**That the Governing Body DISCUSSED and NOTED the report of the Chairman.**

**8. Accountable Officers Report**

The Governing Body noted and discussed the regular report of the Accountable Officer which provided an update on activities of the organisation since the meeting in January 2017. In particular the following was highlighted and discussed:

**Sustainability and Transformation Plan (STP)**

Key areas of progress were noted including:

- The appointment of Optum as the third party supplier to develop and support implementation of a collaborative savings programme across system partners, an initial report was due at the end of March.
- An event to support General Practice around access, workforce, collaboration and new models of care was being held on 3 May 2017.
- Engagement packs on the development of an accountable care organisation were now complete and ready for the engagement sessions being held throughout March. The outputs would be used to inform the STP leaders' away day on 10 April.

**NHS 111**

DD reported that the new 111 and Out of Hours service had started on 30 March, this would provide an integrated clinical hub for the handling of 111 calls.

**Mental Health Consultation**

DD highlighted that there would be a number of patient and public engagement fora taking place to inform the commissioning of a modern mental health service. The Governing Body noted that as part of the consultation the CCG would be talking to local OSCs and the local Foundation Trusts. HM suggested that the consultation should span across other services and groups not directly linked to mental health.

Discussing the report, Anne Bustin of Bedford Borough Health Watch, asked where the engagement events had taken place and level of attendance, in response JM explained that events were held in the four locations across the STP footprint, Milton Keynes, Bedford Borough, Central Bedfordshire and Luton, all of which had good attendance, there had also been over 350 responses received online. An event was held in a Temple in Bedford and future events would include engaging with young people.

#### **RESOLVED**

**That the Governing Body NOTED and DISCUSSED the regular report of the Accountable Officer.**

### **9. Integrated Quality Safety and Performance Report**

#### **Performance**

The Governing Body received the report of the Director of Commissioning and Performance and the Director of Nursing and Quality. The report set out the organisations latest position against a range of national and local indicators. In particular the following was highlighted:

- Performance against the Cancer 62 day first treatment following GP referral indicator had deteriorated from a position of 84% in December to 81% in January against a target of 85%, it was noted the breaches were across a number of Trusts. Cancer 31 day subsequent treatment – radiotherapy performance had also underachieved. It was noted that NHS England were carrying out a deep dive into cancer services. DH asked if patients receiving private radiotherapy treatment were being included in the numbers, DD to confirm.

**Action: DD to confirm whether patients receiving private treatment were included in the numbers.**

- Ambulance response rates across Bedfordshire had been good, however the CCG was measured against East of England Ambulance Service (EEAST) performance which had seen an improvement in Red 1 responses to 74.83% in January against a target of 75% and Red 2 responses had deteriorated despite a decrease in activity.
- Other areas of performance the Governing Body were asked to note included 18 week RTT including 52 week breaches, and A&E 4 hour waits where performance in the last quarter had improved and would end the year achieving just below the 95% target. It was further noted that all under-performance was raised at the quality meetings with the Acute Trusts.

During discussion HM welcomed the improving cancer performance at East and North Herts Trust.

IAPT and Dementia diagnosis rates were highlighted and discussed, in particular it was noted that there was an action plan in place to improve the position, however capacity issues coupled with a national shortage in specialists meant that the system either needed more psychiatrists or changes to pathways. AL reported that there were patients with mild pre-dementia that were not being followed up who might later develop dementia. During further discussion it was noted that patients with memory problems were being encouraged to seek early support. CM highlighted the need to work closely with public health on dementia awareness, in response, IB reported that public health were doing preventative work for vascular dementia which was included in the strategy for adults and children. It was also noted that the Diabetes Prevention Strategy raised the importance of identifying

early signs of dementia. RD reiterated the importance of education in supporting this approach.

## **Quality**

### MRSA

It was noted that there were zero cases of MRSA reported in January, to date there had been five cases reported, two were being reviewed but currently none were attributed to lapses in care. It was noted that MRSA targets were based on previous year's cases.

### C. Difficile

There were currently 63 cases reported, this was three above the ceiling of 60 cases in year.

The Governing Body discussed the report in detail, in particular Milton Park, it was noted that following the CQC inspection an action plan had been put in place to address the findings in the report, progress from which would be fed back to the CCG. It was noted that AM had attended a Risk Summit, led by NHS England (NHSE), following which actions were being monitored by both AM and the Quality Lead at NHSE. Milton Park was given an initial CQC rating of 'Inadequate', but this was moving towards 'Requires Improvement'. It was further noted that an additional oversight meeting with Milton Park had been arranged for Monday 3 April.

HM raised the issue of C. Diff and whether such concerns were discussed at the Quality Review Meeting (QRM) for Bedford, particularly the internal monitoring of their antibiotic policy. In response it was noted this was monitored with acute trusts via an antibiotic CQIUN.

ML updated the Governing Body on two red risks highlighted on the Corporate Risk Register:

## **CHC**

- Fast track patients with palliative care needs. This is being addressed by the commissioning team with the view of putting it back under the community services procurement process for particular palliative care/end of life care for these patients in their last 28 days.
- From domiciliary care provision point of view, the approach is to secure domiciliary care provisions under an NHS contract in order to ensure detailed monitoring.

HM reported that CHC was part of a big national programme being rolled out over two years led by NHSE, Bedfordshire had been named as one of the ten development partners, which was really good news for the area as the strategic improvements areas to be rolled out by the national team were looking at fast-track, procurement and contracting. AL welcomed this news and highlighted that the national support would be very beneficial to Bedfordshire patients.

## **Risk 96 - Dermatology Service Provision**

- The dermatology risk was around the notice that was served on that contract. There were concerns of deteriorating quality of the service as a consequence. The teams had been to some of the clinical areas to undertake quality visits however in the data that came back from the provider there had been no deterioration in the statistics for DNA's and no increased feedback from GPs through the yellow in-form in regards to quality of care issues, there was a period of complaints from patients

but that had now stopped. It was noted that the risk would remain on the risk register during the transition period.

The Governing Body were assured by the actions being taken to mitigate and manage the risks.

#### **RESOLVED**

**That the Governing Body NOTED and DISCUSSED the report and CONFIRMED their assurance on the management of risks.**

### **10. General Practice Forward View (GPFV) Plan**

CS introduced the report and reminded members that the Governing Body had given delegated authority to the Accountable Officer to submit the document to NHS England on 24 February 2017 therefore the GPFV required retrospective approval by the Governing Body.

Members were reminded that the plan built on and expanded the existing work programme in Bedfordshire to support the development and sustainability of primary care and was aligned to the STP.

CS summarised the report in a presentation.

The Governing Body discussed the report at length, in particular it was noted that a public version was being prepared. In response to a comment from HM on how a patient would see the difference, it was noted that the primary care localities had been very supportive of the plan and case studies in relation to the positive impact it should have on patient care.

Discussing the report the following was highlighted and discussed:

- In response to a comment from SA regarding the diversity of the population in Bedfordshire CS responded that the document was not intended as a public health report but more as a context setting document around the GP Forward View. It was noted that some of the money allocated was based on population and looked across the needs of the population, it was further noted that GP contracts were based on capitation. DH reported health and social parameters were being addressed through the Health & Wellbeing Board's (HWBB) and a lot of the parameters were in the HWBB's strategies going forward. IB confirmed that this was the case and he was involved with developing the strategy which was based in the JSNA process, taking into account the wider determinants of health. These factors would be taken in the round when making decisions about planning services in ways that minimise health inequalities which is a duty of the CCG. AL confirmed the both HWBB's in Bedfordshire did hold the CCG to account over health inequalities. DD reported that the CCG had a lot of information about diseases and occurrences within populations and through a number of mechanisms was using this to look at determinants by disease.
- RS commented on the detail of the document and asked that an accessible version was put on the website to convey what the CCG was trying to achieve. AL reported that this was a technical version for the submission and CS confirmed that once feedback on the submission had been received from NHS England, it would be clear as to whether any further revisions would need to be made prior to a public version being written and published on the website.

EB added that the localities had been fully involved in the development of the document and had been thinking about how they could work differently, it was suggested that at a

future meeting that a report be produced by the localities on what they had been doing. RS felt that the document should be broken down into accessible parts. EB reported that a plan on a page had been developed, but there was still work to do on working collaboratively. CS reported that the plan had been brought to the Governing Body before.

**Action: Localities to report on the GPFV to a future meeting – July**

HM felt that what was put on the website needed to say what would be different for patients in terms of the service they receive now against one they would receive in the future, it was noted this could be in the form of case studies.

CS reported that the document had gone in as a submission and that the Localities were very supportive of getting it right but it was now how this was made more meaningful for our patients.

**RESOLVED**

**That the Governing Body APPROVED the General Practice Forward View Plan submitted to NHS England**

**11. Finance Update Report M11**

BJ presented the finance report for M11. In particular highlighting the following:

- An anticipated outturn position of £9.1m based on the latest data and QIPP position;
- BJ reminded members that the organisation had come from a £43m deficit position, resulting in a £50m turnaround in two years;
- The organisation had delivered strongly against the savings target but there were still a number of risks, particularly around acute contracts where the value of some challenges ran into a few million. Discussions were continuing with the acute trusts to resolve the disputes;
- The worst case scenario was described if all the challenges went against the organisation, which could result in a £4m surplus, however this was still within business rules of a 1% surplus;
- BJ explained the 1% non-recurrent head room (£5.3m) which was treated at year end and was not a sum the CCG could spend and sat outside the £9.1m and would not contribute to this figure;
- BJ reported that since month 6 there had been a 2.5% increase in activity across the acute footprint putting immense pressure on NHS finances;

During discussion RG reported that the Finance and Performance Committee had discussed and scrutinised the financial position at its meeting and recognised the risks to achieving a £9.1m surplus control total. BJ reminded members that the financial year ended on 31 March and that the position with the acutes would be confirmed by 18 April. An audit was being conducted between 18 April and 24 May. Discussions were continuing to settle the contract disputes with BHT which may need to go to arbitration. It was noted that the position with Milton Keynes NHS FT had now been settled.

CM thanked BJ and the finance team for the hard work in turning the finances around. CM commented on the external pressures and asked if the STP would change this. In response BJ highlighted that the increased level of activity and overspend in acutes would have been difficult to counteract without the programme of savings and QIPP. In terms of the STP it was noted that the financial flows would be considered differently. SA thanked the finance team for all their excellent hard work.

AL referred to the Governing Body Assurance Framework and particularly risks 31 (Risk to QIPP delivery) and risk 51 (Acute over performance) and asked BJ to comment. Referring to risk 51 BJ acknowledged the increase in acute activity since month 6.

In response to risk 68 it was noted that a significant proportion of the QIPP programme delivered in the later part of the year and that this risk had diminished since the paper was written. RG highlighted that a reduction in the QIPP of £1.6m had been taken. It was further noted that the risk would always remain high and that as the ambition for next year was no less the risk would inherently remain a high. BJ confirmed this.

### **2017/18 Financial Plan**

BJ introduced the report which set out the financial plan for 2017/18, it was noted that the plan had been to Finance and Performance Committee who had discussed the detail for next year. The Governing Body noted that 2017/18 would be a challenging year.

The Governing Body discussed in detail the report, in particular focussing discussion on:

- 2017/18 QIPP savings programme and ensuring plans in place were robust;
- Acute contracts;
- Moving activity out of hospitals and how this would be done differently, it was noted that there would be changes in pathways and avoidance going to A&E, it was noted that MK already had an urgent care centre;
- Members noted that 90% of QIPP had been delivered in year which was a significant achievement, BJ highlighted that the processes in place needed tweaking to ensure a high delivery rate in 2017/18.

### **RESOLVED**

**That the Governing Body NOTED and DISCUSSED the monthly financial position as at month 11 and NOTED the financial plan 2017/18 and compliance with planning requirements.**

## **12. Workforce Update**

The Governing Body received the report of the Director of Workforce which provided an update on the position in relation to performance, equality & diversity and the staff survey results.

### **Workforce report**

HS updated on key workforce performance indicators, particularly Mandatory Training which was up to 92.1% and appraisal returns of 90%. Discussing the report RS commented on interim and agency spend and how this compared against the previous year. HS highlighted that the organisations ambition was to have no interim or agency staff. BJ reported that the level of spend had not significantly changed from last year, however there had been a 25% decrease since December 2016 and with the implementation of IR35 interim staff were being moved on to fixed term contracts. It was noted that the organisation was holding a 20% vacancy rate and the use of interim and agency was key to ensuring the organisation could function and discharge its duties.

### Appraisals

It was noted that the appraisal process and paperwork had been refreshed, the process for appraisals was explained. An audit of the quality of appraisals was being carried out which included feedback to managers.

### Staff Survey

The Governing Body noted the results of the staff survey and welcomed the increase in the number of responses from 71% in 2015/16 to 85.4% 2016/17, and how the information would be used. Members were particularly interested in the increase in bullying and harassment.

### **Equality and Diversity Report 2016**

Paul Curry, Equality and Diversity Manager introduced the report. It was noted that the results of the Staff Survey were being evaluated and an action plan would be developed. One of the focus areas was around unconscious bias and that recruitment training would include this as a part of the equality and diversity section.

In response to a comment on staff communications and engagement in light of the STP, it was noted that the STP Workforce meeting had met with staff side representatives regarding the move to an Accountable Care System (ACS).

### **RESOLVED**

**That the Governing Body:**

- 1. NOTED the Workforce Report for Quarter 3 of 2016/17;**
- 2. NOTED the staff survey results and endorse the actions being taken to act on the feedback from our staff;**
- 3. NOTED the contents and conclusions of the Workforce Equality & Diversity Report 2016 and AGREED the actions proposed around recruitment;**
- 4. NOTED and ENDORSED the OD Plan; and**
- 5. NOTED and ENDORSED the HR and ODL Improvement Work Programme for 2017/18.**

### **13. Risk Management Report**

The Governing Body received the report which provided a summary of the organisation's risks to achievement of its strategic objectives via the Governing Body Assurance Framework and the Corporate Risk Register. In particular the following was highlighted and discussed:

- Workforce should be looked at more widely than just primary care;
- The IMT & IG risk registers were now reporting to Finance & Performance Committee;
- Two risks of a concern were strategic risks 5.1 & 5.2. BJ commented that the actions in place to address risk 5.1 was to make sure that the risk around resource allocation was managed differently through the current financial year;
- In terms of 5.2, the contract management processes. BJ identified that there are a number of areas where the detail of the contract management could be improved. Strengthening the team and going through a stronger process of managing contracts throughout the year, to avoid a similar situation in trying to tie down some of the contract challenges which have emerged over the course of the year but have not been resolved. RG reiterated that building the workforce capability in finance was still work in progress, some good steps had been made recently with appointments that would be joining the organisation shortly and that there was still work to do in to secure permanent capability in the contracting team.

### **RESOLVED**

**That the Governing Body NOTED and DISCUSSED the report.**

### **14.. Report of the Committee**

The Governing Body received and noted the update report from its subcommittees. The Chair of the Audit and Governance Committee reported that External Auditors had carried out some early work and would return at year end and that the Internal Auditors had completed a number of reports and provided management feedback.

15. **Proposed items for next Governing Body** meeting to be held on 4 May 2017.  
The report was noted.

16. **Questions from the public**

**Q1. I have a son who has mental health problems. I attended this meeting July last year and reported how bad the out of hours service was. I would like to know that it has improved, is it now possible to get through without having to go through multiple call centres? And how many staff they have? And what is happening with the contract?**

DD: I haven't been able to get that level of detail however this is not the actual out of hours service as we know it. This is the crisis line for mental health, which is integrated with the council, so I am reliant upon council colleagues for some of the detail as the CCG does not have access to rotas and details of staff. I am happy to respond to you in full via your email and we will make it clear that we had a public question and contain it in the minutes as an addendum to say this is the written response that has gone back to you.

**Action: DD to respond directly via email**

**My second question was March 3<sup>rd</sup> in Bedford I attended the annual ELFT Bedfordshire planned consultation event. I was quite concerned that a lot of their plans seemed to be in the investigating the need and thinking about what they were going to do. There were no plans for building accommodation in Bedford to replace Weller Wing. Are the Governing Body happy with the contract with ELFT?**

In response AL reported that there was a commitment to building inpatient facilities in Bedfordshire. There was a recognition that it isn't enough to say that we have something planned and we are challenging ELFT that we need clearer and tangible plans about where the facilities will be and the patients it will take on. DD added that there is a fine line between formal plans and consulting with patients and public involvement, benefits of the Mental Health Strategy was that users of the services can be involved. Challenges in Weller Wing were known some time ago but due to a lease break it meant that some transitional changes could be made. We are working with ELFT on a consultation and involvement to ensure we can gather the views of service users and their families. For a number of reasons services, including safety and attracting and retaining good staff, services need to be centralised and having lots of disparate services is not feasible. There is a 3-4 month involvement and consultation period, a strategy will be developed that will come back to Governing Body. DD reported that the CCG was happy with the service from ELFT and explained that there had been fewer mental health service complaints. The contract management arrangements gave assurance that they are meeting the standards we require.

**Q2. I wonder if Donna Derby could unpack a bit about the trauma & orthopaedic 85% figure. It's been about the same for the last two GB meetings and you mention patient choice and capacity, in terms of patient choice if I needed a knee operation I would choose to see a knee specialist rather than a shoulder specialist I would choose to wait for an operation however that wouldn't be patient choice that would be what is clinically appropriate.**

DD: Patient choice in essence means a patient can go anywhere in the country to see the specialist they feel appropriate. People generally like to go to their local hospital and therefore the capacity doesn't always match the number of referrals coming in. Trauma and orthopaedics has always had a problem and with the ageing population and the need for more hip and knee replacements there is always more need than capacity available. Patients can seek out a hospital with a short waiting time and through the Choose and Book process can apply.

JF responded but felt it sounded like an interaction between capacity and patient choice and it might be their own individual circumstances to go further away so it might be that they don't see it as choice. AL added that it is about personal preference too and that it was important to look at these performance metrics and see where patients prefer to go as this will affect the performance metrics. JF added regarding primary care and black and ethnic minorities, and asked if there was an opportunity to have one specialist working on a project to that community as interpretation access to services is difficult and making it administratively easier.

CS reported that this couldn't be answered in isolation and needed to be thought about in a wider context as it was multi-faceted. Will take it away and look at it outside the meeting.

**Action: CS to work with AL look at how interpretation services could be used for individual projects**

**17. Date of next meeting**

4 May 2017, Rufus Centre, Steppingley Road, Flitwick, MK45 1AH