Healthy Future

NHS Hammersmith and Fulham Clinical Commissioning Group

Minutes of the Governing Body meeting held on
Tuesday 8 September 2015 1.45pm – 4.00pm
(Public)
St Paul's Church, Hammersmith

Present

Name	Role	Organisation	Initials
Tim Spicer	GP Member (Chair)	H&F CCG	TS
Vanessa Andreae	Interim Vice Chair/ Practice Nurse Member	H&F CCG	VA
James Cavangh	Interim Vice Chair/GP Member	H&F CCG	JCa
Peter Fermie	GP Member	H& F CCG	PF
Paul Skinner	GP Member	H&F CCG	PS
Zohreen Ashraff	GP Member	H&F CCG	ZA
Michele Davison	GP Member	H&F CCG	MD
Tony Willis	GP Member	H&F CCG	TW
Christine Elliot	Co-opted GP Member	H&F CCG	CE
Samia Hasan	Co-opted GP Member	H&F CCG	SH
Jane Wilmot	Lay Member	H&F CCG	JW
Philip Young	Lay Member	H&F CCG	PY
Alan Hakim	Secondary Care Consultant	H&F CCG	AH
Rohan Hewavisenti	Lay Member	H&F CCG	RH
Clare Parker	Chief Officer	H&F CCG	CP
Keith Edmunds	Chief Finance Officer	H&F CCG	KE
Janet Cree	Interim Managing Director	H&F CCG	JC

In attendance

Name	Role	Organisation	Initials
Mary Mullix	Deputy Director, Quality and Safety	CWHHE	MM
Mark Jarvis	Head of Governance and Engagement	H&F CCG	MJ
Shelley Martin	Head of Finance	H&F CCG	SM
Beverley MacDonald	GP Mental Health Lead	H&F CCG	BM
Stuart Lines	Assistant Director of Public Health	London Borough of Hammersmith and Fulham	SL
Jennifer Goddard	Programme Manager Planned Care and Mental Health	H&F CCG	JG
Jane Beckford	Infection Control Nurse	CWHHE	JB

Apologies

Name	Role	Organisation	Initials
Susan McGoldrick	Vice Chair/GP Member	H&F CCG	SMc
Trish Longdon	Lay Member	H&F CCG	
Jonathan Webster	Director of Quality and Safety & Secondary Care Nurse Member	H&F CCG	JW

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Minutes

Item	Agenda Item /Discussion	Actions
1.	**Welcome, Introductions and Apologies**	
1.1	The Chair welcomed everyone to the meeting. He specifically welcomed Keith Edmunds to the meeting as the new Chief Financial Officer.	
2.	**Declarations of Interest**	
2.1	No interests were declared other than those already recorded.	
3.	**Minutes of the Previous Meeting**	
3.1	The minutes of the meeting held on 14 July were **approved** subject to the following changes: AH was present at the meeting.	
4.	**Matters Arising**	
4.1	There were no matters arising from the minutes.	
5.	**Action Log**	
5.1	It was noted that the report on the CSU transition had not been included on the agenda. CP said that although a report had been written it focussed on the process of transition and did not address whether the expected benefits had been realised. She said that further work was required to demonstrate financial assurance and to provide an assessment of whether the changes have had a positive impact on staff morale. In response to questions CP confirmed that shared service Directors and staff were accountable to the CCGs. She also confirmed that the staff survey would be re-run in order to gauge the impact of the changes on staff morale. Members **agreed** that the current action should be closed and await the report to be presented at a future meeting.	
6.	**Ratification of Chair's Action**	
6.1	TS advised the Governing Body that the annual statutory engagement obligation report needed to be submitted by the end of September. He sought the Governing Body's approval to sign this off following review by the Engagement and OD committee in September. The Governing Body **approved** Chair's action for this report to be submitted. TS advised the Governing Body that in January the Finance and Performance Committee had considered the proposal to re-procure the Expert Patient Panel service. The Committee had approved the proposal and associated funding. Unfortunately it did not prove possible to appoint after the tendering exercise and it was decided to re-tender. This had now been completed. TS sought Governing Body approval to delegate the final decision on contract award to Central London CCG as they were leading on the re-procurement exercise. The Governing Body **approved** the delegation to Central London CCG.	
7.	**Chairman's Report**	
7.1	TS reminded the Governing Body that at its seminar on 1 September it had discussed proposals set out in the paper at item 10 – Like Minded, the case for change for mental health services. He said that during this	

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	discussion Governing Body members had fully supported the need to move to a more outcome focussed model of service. TS sought confirmation from Governing Body members that they were prepared to endorse the approach set out in the paper. The Governing Body formally **endorsed** the Like Minded approach as described under item 10 of the agenda. TS provided a briefing on the development that was planned for the Old Oak/Park Royal areas. He said that this would provide significant new housing, employment opportunities, a new fast link rail service and new station. He invited the Governing Body to endorse a proposal for the CCG to support development work being undertaken and the application for it to be one of NHS England's Healthy Towns initiatives and for that support to be communicated formally to those making the bid. The Governing Body **endorsed** the proposal to support the bid. TS reported that he would be attending the Health and Wellbeing Board on 9 September. One of the items under discussion would be the 2015/16 flu campaign. He stressed the importance of working jointly with the Council to ensure that vulnerable patients and residents and those in the identified at risk groups were able to access flu immunisations. He asked the clinical members of the Governing Body in particular to show strong leadership in this, ensuring that they and their staff were immunised. He said that it was important for practice staff to recognise that as they come into contact with significant numbers of people they needed to ensure that they took all reasonable precautions to avoid passing on the virus to patients. The Governing Body **noted** the report.	
8	**Chief Officer's Report**	
8.1	CP introduced her report. She said that it was presented in a different style, setting out the learning opportunities from across the CCGs. She highlighted NHS England London region had held an away day in July, reflecting on the previous year, the challenges ahead and the possible ways forward. She said that there were important discussions on the financial challenges ahead and a presentation from Professor Tim Briggs on clinically led innovation driving improved quality of care and efficiency through reducing variation, use of standardised techniques and equipment and only allowing providers to provide a service if they had enough patients to make it efficient. CP advised the Governing Body that all CCGs had responded to a letter from Dame Barbara Hakin to review all systems and processes for managing and monitoring declarations of interest and gifts and hospitality. She confirmed that in respect of conflicts of interest the processes were robust. Processes for registering gifts and hospitality were being strengthened to ensure that they were equally robust. CP advised the Governing Body that the merger between Chelsea and Westminster and West Middlesex was progressing well and that work was on going to realise the benefits of the merger.	

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	CP congratulated Elizabeth Youard and the contracting team in the CCG on finalising the Imperial College Healthcare Trust (ICHT) contract. CP advised the Governing Body that following the AGM in July the annual report was now available on the web site. The Governing Body **noted** the report.	
9.	**Mental health urgent care business case**	
9.1	JC introduced the paper. She said that the Governing Body was being asked to approve additional expenditure in order to deliver the changes required for a new, more efficient care pathway for people in mental health crisis. She said that the service would provide a single point of access, improve access for patients in relation to assessment and crisis intervention, assist with delivering improved access standards and was a key component of the mental health transformation plan. She said that the additional investment contributed to achieving the parity of esteem national priority. It was anticipated that the revised model would reduce A&E attendances by people with mental health problems. JC confirmed that the Governing Body was not being asked to approve expenditure for the street triage model of care at this time. AH advised the Governing Body that the system resilience group supported the model outlined in the business case although questioned why this was only being provided on a five day a week basis rather than seven days a week. It was agreed that this would be clarified. PY sought clarification as to whether agreement was also required from Hounslow and Ealing CCGs. BM confirmed that Hounslow CCG had already approved the proposed investment and that Ealing would be considering the business case shortly. In response to questions about integration with other services and support of service users for the model BM confirmed that West London Mental Health Trust were working collaboratively with other providers and were, in addition, working with primary care colleagues in Hounslow. She said that this was something that could be explored in Hammersmith and Fulham. She also confirmed that there was a stakeholder group involved in the implementation arrangements which included users, carers and local groups. KE sought assurance that funding had been identified for the proposals and that funding would only be released once staff were in post. JC confirmed that the funding was included as part of the CCG investment plan for 2016/17 and that funding would only be released once staff were in post. The Governing Body **approved** the business case.	JC/BM
10.	**Mental health Like Minded strategic case for change**	
10.1	This item was not discussed further as the proposal was endorsed under item 7.	

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11.	**Business planning**	
11.1	JC introduced the item. She reminded Governing Body members that they had contributed to the business planning process over the last couple of months during seminar discussions. She said there would be an on-going iterative process before a final document was produced. She said that there would be three documents produced. The first would be the contracting intentions letter that would be sent to provider Trusts on 30 September. This would be followed by on internal business plan document and a public facing prospectus which would provide information for the public on the CCG's commissioning intentions. JC emphasised that there was close working with the London Borough of Hammersmith and Fulham to ensure that there was appropriate synergy between relevant elements of each other's plans. She said that priorities would be focussed on whole systems development, primary care transformation and mental health transformation. There would be an emphasis on reducing variation and increasing standardisation across a number of specialties. She said that the CCG had a QIPP target of £6m and were currently working through the 2016/17 plan. PY raised concern that there would not be sufficient resources to deliver all that was ultimately set out in the commissioning intentions. He sought clarity on how prioritisation would be undertaken. CP acknowledged that the plans were ambitious and that the use of resources would need to maximised across the CCGs. TS suggested a similar approach to prioritisation to that used in the Like Minded document, a value based approach, could be adopted more generally. VA suggested engagement with the local population could also help with determining the priorities. This latter point was supported by JW. The Governing Body **noted** the progress being made with the business plan.	
12.	**Latent TB infection screening programme**	
12.1	JG introduced the paper. She said that the proposal set out in the paper was for the delivery of a latent TB infection screen strategy, funded by NHS England. She said that NHS England were working on a business case in order to make the funding recurrent. JG advised the Governing Body that the service would be delivered collaboratively across Hammersmith and Fulham, Central London and West London CCGs working with ICHT and Chelsea and Westminster NHS Foundation Trust. Subject to receipt of national guidance and sign off by the TB Control Board the plan would be implemented from 1 October. PF highlighted that there may be groups of people who it might be beneficial to screen proactively and wondered whether this should be done. JG emphasised that the eligibility criteria had been drawn up by NHS England and that the plan would have to be implemented based on these criteria. TS wondered how many new registrants would fit the criteria. However, it was acknowledged that this was difficult to determine, made even more so because many might not understand the questions being asked.	

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	SL wanted to ensure that information within the TB Joint Strategic Needs Assessment was being used to inform and drive local provision. JG confirmed that data from Public Health England had been used. The JSNA data and recommendations would be taken into account as the service is implemented. VA welcomed the proposal. She said that the previous processes had been difficult and that the new arrangements should provide a positive public health benefit PY suggested that this needed to be part of a bigger London-wide TB strategy as this was a small part of a bigger problem. JG said that there was a national strategy for TB which had identified 10 evidence based actions. CP confirmed that TB had not been included in the London-wide work programme. The Governing Body **approved** the proposed screening plan.	
13	**Quality Strategy**	
13.1	MM introduced the strategy. She advised the Governing Body that it had been prepared with the support of a wide group of stakeholders. She said that the strategy put forward some aspirational targets that would be reviewed as the strategy progressed. It was noted that part of the quality agenda would be to get a better understanding of variation within and across services in order to determine how best improvements can be made. Once the baseline work on service variation had been completed an appropriate ambition would be included in the strategy. It was noted that the Quality, Patient Safety and Risk Committee had reviewed the draft strategy at its meeting on 25 August and were content to recommend it to the Governing Body to approve. The Governing Body **approved** the strategy recognising that there would be additional work required in relation to specific ambitions in respect of the variation work that would be undertaken over the coming months.	
14.	**Patient and public engagement communications and equality**	
14.1	The Governing Body **noted** the report.	
15.	**Finance**	
15.1	SM introduced the report. She reported that at month four the CCG was on target to deliver the planned £9.15m surplus. However, she highlighted that there continued to be pressures in relation to the acute contract position which was over-performing by £3.23m in year, with a forecast year end over-performance of £7.63m. This represented a £0.4m worsening of the position from month three. She said that reserves of £1.83m had been released in full which would reduce the full year over-spend to £5.91m. SM said that the Section 75 final adjustment from 2014/15 had been reflected in the month four position. She advised the Governing Body that this was a one-off benefit of £0.56m due to the difference in the Q3 position reported in the final out turn.	

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16.	SM advised the Governing Body that the out of hospital contract had gone live in month and that the activity and finance plan from the Hammersmith and Fulham GP Federation had been reflected in budgets. As a result of some slippage a one off benefit of £0.45m had been released into the position for month 4. SM drew attention to the overall forecast overspend which remained above the level the CCG is able to mitigate through the release of acute reserves, QIPP reserves and contingency. She highlighted that the planned surplus remained contingent on receiving £1.8m support from the Collaborative. In summary SH reported that the underlying position at month four was a worsening from plan, a reduction of £3.28m, moving from a surplus of £9.34m to £6.07m. This reflected the use of non-recurrent mitigations to offset the over performance against acute contracts in the forecast outturn. During discussion CP sought clarification on whether other CCGs were seeing over performance in their ICHT activity. SM confirmed that this was the case. PY commented that this was not the case for Ealing CCG and wondered whether a deep dive of the Imperial situation had been undertaken in order to better understand the underlying issues. SH confirmed that there was regular scrutiny and discussion of the situation as part of the finance and performance committee agenda. JC confirmed that there were actions being taken to bring the position back in to line. She highlighted the critical care audit work and the Referral to Treatment Time (RTT) work stream. She confirmed that reports on both of these pieces of work would go to a F&P meeting. KE highlighted that as the Trust no longer had a block contract they were passing on the additional pressures to the CCG. TS reminded the Governing Body that the CCG were not involved in the decision by the Trust to change the contracting arrangements. The Governing Body **noted** the report.	
16.	**Performance**	
16.1	JC introduced the report. She highlighted the on-going issues with the RTT performance and the work being done within ICHT in four specialties - ENT, general surgery, trauma and orthopaedics and urology. She highlighted that the incomplete pathway target was met in month 3 and was being met year to date. She said that the GP validation of patients waiting over 25 weeks had proved beneficial, with 25% of pathway reviews showing that patients no longer required treatment. JC confirmed that the CCG were continuing to monitor the use of choose and book as a way of enhancing capacity at ICHT. The agreed remedial action plan was being monitored monthly. She also reported that there had been significant progress on ophthalmology capacity plans, including additional clinic capacity and clinical staff. JC reported that ICHT met seven of the eight national targets trust-wide for cancer. They failed to meet the 62 day screening service standard (88%	

	against 90% standard). She reported that joint investigations were taking place into the breaches of the 62 day standard in order to inform the CCG of the mitigations that will be put in place to deliver sustainable performance. JC advised the Governing Body that a significant amount of work continued to be done within the ICHT to improve A&E performance. She said that the Trust achieved the 95% performance standard for month three, the first time since month six 2014/15. She highlighted, however, that the un-validated information for month four suggested that the Trust had narrowly missed the standard due to high volumes of patients in early July which impacted on bed flow. Progress was being made in agreeing a remedial action plan. VA advised the Governing Body that the Quality, Patient Safety and Risk Committee had taken the decision to escalate concerns highlighted in the performance report in respect of infection control rates and were concerned that no report had been received by the committee in respect of maternity transition. CP advised that the maternity dashboard report had now been completed and would come to future committee meetings. She said that the report highlighted that there was an increase in the number of women giving birth at a location where they were not previously booked to deliver. This was in line with expectations and expected to reduce. The report also highlighted an increase in the level of post partum haemorrhage although this was most likely linked to changes in reporting. PY sought clarification on whether the correct performance measures were being used to record the percentage of patients known to specialist palliative care who were discharged for terminal care in the community uploaded to Co-ordinate My Care rather than recording the number of people who die in their preferred place of death. MM confirmed that the report was an exception report and that it only therefore reported where the requirement was not being met. AH highlighted that there was no data in the report for the percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS screening service for the CCG. He sought clarification as to whether this was because there had not been any patients. It was agreed that this would be clarified. The Governing Body **noted** the report.	 JC
17.	**Board Assurance Framework**	
17.1	BW introduced the report. He advised the Governing Body that work had been done since the earlier discussion on the BAF and that an action plan was now included. He highlighted that concerns had been expressed in relation to risk 11 – LCW and Care UK (111). This entry was being updated. In respect of risk 23 – strategic change (reputation), it had been agreed that this would be incorporated into risks 21 and 22. During discussion CP confirmed that there were no plans to have a specific	

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	Hammersmith and Fulham appendix to the report. Where there were specific risks that the CCG needed to highlight these should to be drawn out in the BAF were appropriate. The Governing Body **noted** the report.	
18.	**North West London care information exchange**	
18.1	The Governing Body **noted** the report	
19.	**Performance and quality reporting gap**	
19.1	BW introduced the item. He said that consideration had been given to whether there needed to be closer working between the Collaborative Quality and Finance and Performance committees, especially in respect of reviewing the integrated performance report. He said that the report put forward a proposal for improving this. The Governing Body supported the proposal. VA said that similar discussions had taken place within the CCG and that plans were being put in place to enable joint discussions between the Quality and Finance and Performance committees on the performance report. The Governing Body **agreed** the proposals in the report.	
20.	**Healthcare acquired infection annual report**	
20.1	JB provided an overview of the report. She said that the report provided a summary of the data on MRSA, MSSA, e-coli, CRE and c.diff related infections. The report provided details of the work being done across Trusts to respond to the challenge of the increasing risk of antibiotic resistance bacteria. JB highlighted the particular issue of increasing levels of CRE infection. The report identified priorities for 2015/16 which included focussing on Trust systems for prevention of infections associated with invasive devices, monitoring Trusts' systems for the implementation of the UK Sepsis Trust Clinical Toolkits for the prompt management of sepsis, exploring the threshold for testing stool specimens for c.diff, monitoring the Trusts' implementation of the toolkit for managing CRE, exploring the scope of the infection clinical network to cover antimicrobial prescribing across all CCGs and offering infection prevention and outbreak control training for nursing homes across the CCGs. In respect of CRE, JB sought clarification on whether those identified as carriers were considered a danger to others and whether there was any screening being undertaken. JB said that as CRE was a gut infection there was less risk of transmission and that the CRE toolkit recommended a risk based approach and assessment of high risk groups rather than blanket screening. She confirmed that there were no significant issues within the care homes sector in relation to CRE or other healthcare acquired infections. The Governing Body **noted** the report.	
21.	**Safeguarding adults policy**	
21.1	MM summarised the main points within the policy. The Governing Body **approved** the policy.	
22.	**AOB**	

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22.1	There were no items of any other business.	
23.	**Questions from the public**	
23.1	1. Question from Julia Arady, Save Our Hospitals There has recently been well-publicized pioneering brain surgery at Charing Cross, using new technology to identify malignant cells. The hyper-acute stroke unit there has also been rated as the best in the country. Wouldn't it make sense to maintain acute neurological services at Charing Cross permanently instead of transferring them in parts to St. Marys, especially when these services are also available less than 2 miles away at University College Hospital? CP said that the CCG fully supported the pioneering work being done and welcomed the improvements this had for patients. She confirmed that it remained the case that the evidence indicated that for some specialist areas care was better provided in a smaller number of centres which led to improved quality and outcomes. She said that there were no plans to change the direction of travel for co-locating the hyper acute stroke service alongside services for major trauma. 2. Suzanna Harris What is being done to address the ongoing high vacancy rate amongst community nurses in Hammersmith and Fulham ? VA said that CLCH had recently had some success in recruiting staff at bands 5 and 7. The majority of vacancies were at band 6. She shad that there was an action plan in place which included supporting staff locally to progress from band 5 to band 6. She said that there was also a plan to do more rotation with hospital based staff. TS acknowledged that workforce was a challenge and highlighted that the CCG was working with Health Education NW London (HENWL) on this. 3. Walter Harris We read that across London it is becoming harder to retain a full complement of GPs, because it has become less attractive for newly-qualified doctors, and increasing numbers of existing GPs reduce their hours or retire early. To what extent is this a problem in Hammersmith and Fulham, and what actions are the CCG taking in this matter ? JCa said that this was a London wide problem. He reiterated that the CCG was working with HENWL and the GP Federation on this issue. He said that a careers event was being held at ICHT to talk to junior doctors about	

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	careers in general practice in the local area. He said that opportunities were being looked at in order to broaden opportunities and skill mix. 4. Anne Drinkell One year on from the closure of Hammersmith A&E the CCG is reporting an ongoing failure to meet the 4 hour waiting target within Imperial's remaining hospitals CX and St Marys. Part of the root cause is identified as unexpected surges in demand, staffing gaps, and an inadequate number of acute beds available (particularly monitored/high dependency beds). Simultaneously London Ambulance Service targets to respond to 75% of the most acutely ill within 8 minutes were missed consistently locally with around 65% of very ill people getting an ambulance in the target time. The explanation is again high vacancy rates, high levels of demand and unpredictability of surges in demand. We were assured that SAHF would improve acute care and that ambulance response and A&E waiting times would be within national targets. Given that this is not the case and that there is clearly a shortage of capacity in the system already is the CCG prepared to review the current plan to lose 300 acute beds at CX and it's acute services including A&E? CP said that this was covered in the Benefits Realisation and NHS England report that the Governing Body received in September. She said that the A&E changes had been made because of safety concerns and had not be predicated on the out of hospital services being in place. She said that the paper discussed last time had indicated a reduction in performance had been as a result of the national pressure on services and not as a direct consequence of the changes made in local services. She said that additional investment had been made into the ambulance service and that a previous Governing Body paper had set out how issues within the service were being addressed. CP said that no beds had yet been closed as a consequence of SaHF and that positive impacts had been delivered 2 years in to a 5 year strategy. She confirmed that beds would not be closed until capacity was in place in the community to respond. She confirmed that there were no plans to change the current direction of travel. CP acknowledged that A&E performance at ICHT was not consistently above the 95% target but reiterated that this was part of a national picture and was related to increased demand and not the changes to local services.	

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JC confirmed that there were on-going discussions between clinicians and managers about how performance could be improved across all three ICHT sites and that the improvement plan would enable us to monitor progress.

CP confirmed that planning assumptions were based on up to date population estimates.

5. Merril Hammer

I had the misfortune to need to attend the UCC at Charing Cross last Tuesday night. I have no concerns about the treatment received but was deeply concerned to be told not just that I needed to have a prescription made up immediately so that I could begin treatment that night for a severely pulled muscle causing significant pain but that there was no all night pharmacy at the hospital NOR was there a list of all night pharmacies available at the UCC. It was by sheer chance that I had an idea of where a pharmacy might be. But it necessitated travel, in pain, by two buses. As an older person who uses pubic transport I was left in an extremely difficult situation, while also trying to cope with extreme pain. There are other patients who are also, in various ways, vulnerable or with special needs (e.g. the even older, the disabled, those with children, etc) who must need urgent prescriptions made up after hours.

What will the CCG do to ensure that pharmacy services for urgent prescribed medicines can be made available close to or at an UCC? Surely, with commissioned services and with SaHF supposedly being about integrated care, it is possible to make it a requirement of hospitals with UCCs to have pharmacy services available 24/7.

Could the public also have a progress report on this matter at a future CCG meeting?

JC said that it was an expectation as part of the UCC contract that pain relief would be provided whilst a patient was in the centre. She said that they had a range of pre-packed medication available. She confirmed that UCC should be expected to be able to direct patients to the nearest pharmacy, including those that were providing extended hours and 24/7 opening. She said that the concerns raised would be fed back to the UCC. In relation to community pharmacy provision JC said that the Joint Strategic Needs Assessment on pharmacy provision had indicated that the current levels of provision were appropriate. She also confirmed that there were no pharmacists on site in acute hospitals over night.

	6. Do the GP and lay members of the Governing Body believe that the remedial action plans within ICHT are adequate? JC said that the action plans referred to earlier in the meeting were having an impact and improvements were being seen. She said that there were some national IT issues relating to choose and book that were being resolved and the improvements seen in A&E performance needed to get to a sustainable position.	

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