NHS
Thurrock
Clinical Commissioning Group

Board Meeting – Part 1
26 February 2014
Culver Centre

Present:	Dr A Deshpande	Chair of the Board
	Mr L Green	Deputy Chair – Lay Member
	Dr Nimal-Raj	Interim Accountable Officer
	Ms M Ansell	Chief Operating Officer
	Mr A Olarinde	Chief Finance Officer
	Ms J Foster-Taylor	Executive Nurse
	Ms L Buckland	Lay Member – Audit Chair
	Mr R Vine	Practice Manager
	Dr P Martin	GP Board Member
	Dr V Raja	GP Board Member
	Dr A Bansal	GP Board Member
	Dr R Arhin	GP Board Member
	Dr A Bose	GP Board Member
	Mr R Harris	Thurrock Council
	Mr R Chaudhari	Senior Commissioning Manager
	Ms C Celentano	Business Manager
	Ms G Curtis	Deputy Business Manager - Minutes
Apologies:	Dr L Grewal	GP Board Member
	Dr S Das	Secondary Care Consultant
	Dr R Mohile	GP Board Member
	Mr A Stride	Head of Corporate Governance

1.	**Welcome & Apologies**
	Dr A Deshpande welcomed all to the meeting. Apologies for the meeting were noted as above. Dr A Deshpande asked for any declarations of interest that are not already on the register to be declared, none were declared.

2.	**Minutes of the meeting held on 29 January 2014 and Action Log**
	The minutes of the meeting held on 29 January 2014 were reviewed and agreed by the board as an accurate account. Action Log: 1. Item 4 BCF - This is going to the CRG and also the Thurrock Coalition on 20th March. An addition is being added to the BCF plan stating that we are working on a joint engagement and co-production plan with Thurrock citizens. Mr R Harris is proposing a joint task and finish group across the CCG's and LA's, this will not be completed by the 4th April. 2. Tobacco Control Information - Mr R Harris confirmed that he will chase Public Health for this information and to send to Ms C Celentano for distribution to the board. **Action RH**. 3. Item 5 CSU - To be completed by 27th August 2014 4. Safeguarding Post Meeting Dates - Action completed 5. Out of Area LAC Information Circulation - This hasn't been circulated to the board, but has gone to the Q&G group. This will be covered in the next Safeguarding Paper 6. Inspection Information Circulation - This will go to Time to Learn to update the GP's 7. Mr A Stride to circulate Section 69 - Carry forward. 8. Daphne & Desmond Training Procedure - Mr L Green updated that a letter has been received from the Thurrock Diabetes Group as requested, this was found to be old information from their UK headquarters, enquiries have been made with NELFT and all training is up to date. Mr L Green has since gone back to the Thurrock Diabetes Group and updated them. Dr Raja at CEG had also raised this with the GP's.
3.	**Enhanced Services**
	The Enhanced Services paper was prepared by Mr W Guy and presented to the board by Mr R Chaudhari. This paper overviews the progress of the Enhanced Service Task Group and provides an overview of the potential options for the future commissioning of services. These options were considered by the Finance and Planning Group with a recommendation of awarding contracts to existing providers whilst undertaking an AQP procurement. Following Board endorsement of the process, the Enhanced Services Task Group met over July – October 2013 to review services currently commissioned under Locally Enhanced Services. Due to the transfer of PMS/GMS contracts to NHS England, Locally Enhanced Services need to be commissioned under an alternative contractual medium from 1st April 2014. The Task Group had a two phase process, a) to confirm the commissioning case/requirement for the existing range of services and b) propose a route for commissioning services. These recommendations were to be taken forward as an AQP procurement in November 2013, however, due to a number of issues including challenge from the LMC on the readiness of primary care to successfully complete a AQP process, this has been put on hold. The LMC provided the following feedback: *The LMC are concerned regarding the ability of general practice to respond to this AQP. This would put at risk a sizable proportion of current general practice income (primarily a provider concern) but also could weaken patient pathways if the ultimate coverage of providers in the market place is more restricted than at present. The LMC*

	commissioned BMA Law to provide an overview on the contestability commitments of CCGs. Rules for the CCG: The CCG are required to: publish/advertise opportunities and contract awards, establish qualifying criteria, maintain strict record-keeping, manage conflicts of interest and prevent anti-competitive behaviour. Mr R Vine asked if AQP practices have to be registered with Monitor and that is it the assumption that all providers will become AQP providers. Mr R Chaudhari confirmed that they are presently looking at the existing providers for the next year on the requirements, terms and conditions that are currently in place. Mr R Vine asked when these will be reviewed. Mr R Chaudhari informed that he will discuss with Mr W Guy and provide feedback. **Action RC** Ms L Buckland confirmed that she receives the paper and stated that all lay members need to have an active role with the group as the group has not met for 6 months. Ms L Buckland asked for the meeting to be reconvened so that issues can be discussed. Ms M Ansell confirmed that this meeting does need to be reconvened, however due to capacity the meeting will not take place until June. Mr R Chaudhari to explore. **Action RC** Mr R Vine informed that an email needs to be sent to practices for enhanced services. Ms M Ansell agreed. **Action RC to send the email to all practices.**
4.	**Finance**
	Mr A Olarinde presented the Operational and Strategic Planning Progress Update. The below points from the paper were noted for the information of the board. There are two key papers that summarise the operational and strategic planning to date; a) Progress Update This paper provides the Board an update on the five year financial planning process. This update provides clarity on Running Cost Allowances, Indicative Programme Allocations in addition to a further iteration of the financial summary for the five year period. The paper also provides an update on QIPP planning for 2014/15. b) Draft Operational Plan This paper is a summary of the Operational Plan. The Operational Plan provides an overview of how the CCG intends to deliver the NHS Operating Framework requirements over a two year period. This includes the NHS Outcome Ambitions, NHS Constitution, Better Care Plan and other key measures. This paper provides the Board with an update on the planning process for the five-year period 1st April 2014 to 31st March 2019, and the progress made since the last report in January. The background and planning guidance underpinning this was summarised in the report presented in January. Since the update provided to the Board in January, CCG Running Cost Allowances have now being published for the five-year planning period. The values for the CCG were provided within the board paper and these have been adjusted for population change based on the Office of National Statistics latest available population

projections. The expected 10% reduction in 2015/16 has also been reflected. Taking account of population growth, the RCA per head are

Indicative CCG Programme Allocations have also now being published for Years 3 to 5 of the planning round to support CCGs in their financial planning.

It should be noted that NHS England have developed a CCG Allocations Policy that aims to move CCGs from a 'quantum funding' uplift to a 'funding per capita' basis. This is new formula is deemed to be fairer and more equitable as it balances the three main factors in healthcare needs: population growth, deprivation, and the impact of an ageing population. A pace of change, moving CCGs from their actual allocation shares to their target allocation shares is then applied, recognising the need to address underfunding whilst not destabilising health economies.

The allocations indicated imply that the CCG's allocation per head in 2014/15 is £1,090 against a closing target of £1,079 hence a distance from target of 1.02%. In 2015/16, the allocation per head is £1,097, excluding BCF, against a closing target allocation of £1,092 resulting in a distance from target of 0.44%. For context, the 2015/16 Closing distance from targets for Essex CCGs ranges from -5.21% to +2.84%. Similarly, the uplift in allocations for the CCG together with the range for Essex CCGs.

Dr P Martin expressed confusion as there was previously an issue of underfunding. Mr A Olarinde explained that there are many variable within the outcomes and there has not been an opportunity for CCG's to express their points of view. Mr A Olarinde continued to highlight the positive side that there is a reduction in the gap for 2015/16. .

Financial Planning - The first draft of the financial plan was shared at the last board and submitted to the Local Area Team of NHS England on the 31st January. The plan has been refined further as additional information becomes available and also in the light of initial feedback received.

The first formal submission was made on 14th February to the National, Regional and Local Area Offices of NHS England, including the Operational Plan, BCF Plan and Activity Plan in line with the national time-table. The updated financial plan is depicted within the report, and it reflects the allocations that have been confirmed. The detail underpinning the plan and current assumptions were shared at Finance Committee on the 18th February. A summary of the Operational Plan is also attached as a separate paper.

Mr R Vine noted than there is a current struggle for running costs this year and asked if we are going to be able to take on more work with less resource, also how do we improve patient care. It was agreed for this to be added to the risk register. **Action AS**

Mr A Olarinde informed that running costs are calculated per head of the population, this is information that all CCG's need to provide. There will also be a 10% reduction in management costs in 2015-16..

Mr L Green stated that from a patient perspective it looks like a controlled way of reducing running costs and eventually forcing a merger with another CCG in order to return to a larger organisation.

Ms L Buckland informed the board of the response from NHS England Audit Chair that there should be more collaborative working.

Contract negotiations and QIPP - NHS Contracts are still being negotiated and are expected to be signed by 28th February 2014. QIPP Plans are being developed by Commissioning Officers working closely with QIPP Lead Clinicians and other CCG and CSU staff. Proposed schemes agreed by the QIPP Committee have been shared with Providers in order to be factored into the finance and activity models. Final agreed metrics will be reflected within the contract schedules, with the CCG Finance Plan updated in the light of the outcomes of contract negotiations.

The current QIPP requirement for 2014/15 is £8.62m; of which £7.3m have been identified as provided to the board. Commissioning Officers are developing plans to cover the current shortfall of £1.3m with further schemes also identified to cover slippage in project implementation and delivery. A stock take on the position regarding QIPP Planning will be undertaken by the QIPP Committee at their next meetings of 27th February and 6th March to ensure that there are detailed plans underpinning the programme, which will be monitored by the PMO.

Mr A Olarinde confirmed that at present the value of the Better Care Fund is £10m, however, in 2015/16 some of the funding for BCF needs to be made up from CCG savings.

Mr A Olarinde confirmed that all contracts need to be signed by 28th February, if they are not signed there will be a Head of Terms. However, we are reasonably optimistic for the signing of the contracts to take place prior to the deadline.

Mr A Olarinde also confirmed that on the 4th April the submission of the 5 year plan will take place, the draft submission will be presented at the March board meeting.

Mr R Harris asked if there is a reduction in Continuing Healthcare next year planned. Mr A Olarinde informed that there is currently a risk share in place for Continuing Healthcare spend which is being shared with BBCCG, the risk share is coming to an end, thus for we will be only paying for Thurrock Continuing Healthcare patients.

Mr A Olarinde presented the month 10 finance report to the board for noting.

The financial position at Month 10 is a cumulative surplus of £1,481k year to date, with a forecast outturn surplus of £1,779k at year-end. In month 10, the CCGs forecast includes the impact of the actions detailed in the Financial Recovery Plan, which will enable it to deliver its mandated 1% surplus. However it is important to note the pressures and risks inherent in the reported position as follows: over performance on the Acute contracts and the volume of continuing care cases. These are offset by actions detailed in the Financial Recovery plan, lower than budgeted expenditure within community services and the management of centrally held reserves.

The detailed monthly financial reports continue to be scrutinised by the Finance and Performance Committee with actions identified; this includes monitoring of the FRP to ensure delivery of the agreed actions.

Budgetary Allocation - There was no further budget adjustment in month 10, hence the CCG budget remains £184,598k; of which Program budget is £180,498k and Running costs budget is unchanged from the opening allocation of £4,100k. The CCG is not

anticipating any material change to its budgetary allocation for the remainder of the financial year.

Acute Contact Activity - A summary of the position relating to NHS acute providers as at period 10 (January 2014) was presented to the board, this indicates significant over-performance on the BTUH contract. There is also pressure indicated on the BHRT and SUTH contracts, as well as on the London provider contracts.

GP Prescribing - The financial position for GP prescribing for April to November was presented to the board. This indicates that the budget of £20.73m is forecast to overspend by about £170k. The YTD position includes an increased prescribing expenditure over the winter months. This reported position includes an element of income to period 9, relating to specialised services drugs. This element has been recharged to NHS England.

Continuing Healthcare – There continues to be pressure on the Continuing Healthcare budget, FOT pressure of £1.9m needs updating as £1.65m is reflected within the report, with the number of cases continuing to increase in 2013-14, growing from 182 in June to 382 as at the end of December, a net growth of 200 cases. The Essex wide Task and Finish group is overseeing the implementation of the agreed actions for the remainder of the year as well as considering the options for ensuring longer-term sustainability.

Running Costs – The running costs budget of £4.1m currently shows a £253k year to date surplus and forecast outturn of £287k underspend as at month 10.

Mr L Green asked if there are QIPP schemes ready from the April financial year start in order to meet the large savings increase required. Mr A Olarinde confirmed that in terms of schemes in place we currently have the following: the new C2C policy has been approved, which is hoped will result in contractual savings. In principal the blocked contract for emergency care has been agreed.

Dr P Martin asked if the information for overspend on the NHS acute provides wipes out the savings detailed under reserves. Mr A Olarinde confirmed this is correct. Dr P Martin asked if the savings are going to be recurrent. Mr A Olarinde confirmed this and detailed that there is assurance within the 5 year plan with a management contingency.

Dr R Arhin asked in terms of the 5 year plan, are there any losses carried forward as well as the surplus. Mr A Olarinde confirmed that this is for the current year, we have to reach a surplus of 1% and that any deficits will be carried forward into next year.

Mr R Vine asked that if we have a surplus why do we have to apply to receive this back. Mr A Olarinde confirmed that this is the correct process.

Ms L Buckland complimented the finance team as there are 9 CCG's reporting a deficit but we are not one of them. Ms M Ansell confirmed that this is also the case within Essex, this is also the 2nd year that we have not reported a deficit along with improvements in patient care.

Dr A Bose thanked the team for all their hard work. We should now start moving away from planned and unplanned care and focus attention on other subjects such as

	medicines management and unplanned admissions for asthma, COPD and diabetes. Dr P Martin informed that in terms of medicines management the quick wins have already been implemented, we now need to look at acute overspend. at period 10 (January 2014) was presented to the board, this indicates significant over-performance on the BTUH contract. There is also pressure indicated on the BHRT and SUTH contracts, as well as on the London provider contracts. GP Prescribing - The financial position for GP prescribing for April to November was presented to the board. This indicates that the budget of £20.73m is forecast to overspend by about £170k. The YTD position includes an increased prescribing expenditure over the winter months. This reported position includes an element of income to period 9, relating to specialised services drugs. This element has been recharged to NHS England. Continuing Healthcare – There continues to be pressure on the Continuing Healthcare budget, FOT pressure of £1.9m needs updating as £1.65m is reflected within the report, with the number of cases continuing to increase in 2013-14, growing from 182 in June to 382 as at the end of December, a net growth of 200 cases. The Essex wide Task and Finish group is overseeing the implementation of the agreed actions for the remainder of the year as well as considering the options for ensuring longer-term sustainability. Running Costs – The running costs budget of £4.1m currently shows a £253k year to date surplus and forecast outturn of £287k underspend as at month 10. Mr L Green asked if there are QIPP schemes ready for the large increase. Mr A Olarinde confirmed that in terms of schemes in place we currently have the following: the new C2C policy has been approved, which is hoped will result in contractual savings. In principal the blocked contract for emergency care has been agreed. Dr P Martin asked if the information for overspend on the NHS acute provides wipes out the savings detailed under reserves. Mr A Olarinde confirmed this is correct. Dr P Martin asked if the savings are going to be recurrent. Mr A Olarinde confirmed this and detailed that there is assurance within the 5 year plan with a management contingency.
5.	**QIPP**
	Dr R Arhin presented the QIPP and Commissioning report to the board for noting. The following items were brought to the board's attention and discussed. Core QIPP - The QIPP members were presented with the current performance on the 13/14 QIPP projects and year end forecast delivery. The committe also discussed 14/15 projects by workstream in detail and agreed further work needed to be done to firm up the projects. The group was also presented with some details around key transformatinal projects which are likely to have both quality and financial impact for next year. These projects include MSK, emergency ambulatory and Frail/elderly pathway redesign, and Respiratory service review including formulary review. Stakeholder QIPP – Providers were requested to do a presentation on 13/14 achievements with regards to service provision and potential QIPP projects for 14/15. There was representation from all stakeholders and the discussions did highlight that

joint projects developed involving multiple stakeholders were more benficial in driving up the quality of care for the local poulation. On execeptionality the clinical leads also discussed the new proposed SRP and have virtually agreed to recommend the board to endorse the policy. The policy once agreed will be embedded witihn the provider contracts for next year.

Practice Visits - 18 practices were identified for practice visits of which 17 practice visits have been completed. These visits went well and key actions were agreed specific to the practices. Following practice visits we have noticed an uptake from practices that have previously refrained from taking part.

Winter Pressure - COPD reviews are underway by the community COPD team for patients with MRC level 3 and above. Patient passport/booklets have been delivered to both the community COPD team and the respiratory team in BTUH.

Respiratory Service Review - The review group has identified key gaps in current service provision; discussions are underway with the providers to implement new model of care for COPD patients in line with the outcome of the review. This is currently being driven through the respiratory network.

MedeAnalytics - The CCG has identified a mede champion to work with the practices and raise monthly challenges on the acute care data. This will be initially trialled on a pilot basis before a full roll out to all practices.

Primary Care MDT's - 14 MDTs took place in January, 137 patients were discussed and positive feedback has been received from GPs and good attendance from all stakeholders was noted. Efforts are underway to ensure practices achieve a minimum of 4 MDTs to qualify for their QoF points.

Telehealth - Currently 40 devices in use, team is working with GPs, community geriatrician, specialist services for identifying suitable patients. This is also being promoted through MDTs.

RRAS - Service remains busy with 7 day working pattern now in place, Mon- Fri 9am-9pm, Saturday, Sunday and bank holidays 9 am – 5 pm. The service has had 235 referrals in January 2014, of which 7 resulted in admission to secondary care and 1 admission to day hospital.

Paediatrics - Sickle Cell – meeting undertaken with Community to understand any gaps in service experienced by the services. Draft spec / requirements drawn up and meeting currently being arranged with Community and Acute colleagues to drive this forward.

High Impact Pathways – acute colleagues undertaking an audit (in tandem with SE Essex) and will have data back with us by Children's CEG in March (19th)
CAMHS – Stakeholder events being held throughout February to discuss potential future model

QIPP 2014/15 - QIPP target for next financial year is £8.7m. Likely QIPP savings by work streams identified so far have been summarised below. Details of the various projects underpinning these savings will be presented once business cases for the projects have been developed.

Dr A Bansal asked if MSK is a block contract. Mr R Chaudhari confirmed that this will

be a block contract from next year. Work is being undertaken to tighten the pathways.

Dr V Raja asked if Telehealth is still on-going. Mr R Chaudhari confirmed that this is still in place and the devices are still in use. However nationally there is no evidence. Ms L Buckland asked how do we obtain and undertake an evaluation of Telehealth due to mixed views. Mr R Chaudhari confirmed that at present there is not a tool, however we have found that those using Telehealth have a reduction in unplanned care admissions.

Terry Bradfield (member of the public) confirmed that the use of Telehealth has improved his experience of being a patient and is useful.

Dr A Bose informed that not everything can be based on evidence, we may find that there are not huge savings but there is an improvement for patients.

Mr R Vine asked what evidence could be collected with small numbers in Thurrock.

Service Restriction Policy

Mr R Chaudhari presented the service restriction policy to the board. The policy is presented to the board with the recommendation of endorsement for implementation, subject to the agreement from all 4 CCG's boards. The following comments followed these discussions. It was noted that this has been endorsed by the QIPP committee.

Mr L Green asked what patient consultation has taken place for the service restriction policy within other CCG areas and could a list of the changes from the previous policy be provided Mr R Chaudhari confirmed that this has gone to patient groups within other areas.
Action: list of changes made from previous policy to be provided RC

Ms L Buckland noted regarding individual funding requests, it is disappointing that we do not all have the same thinking, it has been decided that a review needs to take place for IFR's. Ms L Buckland is seeking assurance for tighter governance for IFR's. Ms L Buckland is a holding a meeting to discuss this as we do not feel we are getting value for money for the services provided by the CSU.

Mr R Vine wouldn't recommend the policy as it was only distributed 1 week prior to the meeting, thus for there has been no time for review.

Dr P Martin confirmed that there are some areas to be explored regarding CSU issues with IFR's. Dr P Martin to brief Ms L Buckland of these issues to take forward. **Action PM/LB**

Mr R Chaudhari informed that SRP lists the procedures and not the IFR process which is separate to the SRP document.

Dr A Bansal asked where are IFR request received. Mr R Chaudhari confirmed that they go to the GP and the providers.

It was confirmed for the policy to come to the March board to give members an opportunity to review.

Ms L Buckland asked if we are the last board to agree this procedure and how is this going to affect the time scales in place. Mr R Chaudhari confirmed that we are not the

	last board to agree this procedure. Ms M Ansell noted that this could cause implications with the signing of the BTUH contract for Thurrock and Basildon & Brentwood. It was suggested for the procedure to be agreed in principal as non-agreement could leave the CCG open. MR R Vine asked are we confident that BTUH are going to sign every aspect of the contract. Mr A Olarinde noted that the intention is for the contracts to be signed with a list of items that need to be explored further. The procedure was agreed in principal and for the procedure to be presented to the next board for further discussion. Dr R Arhin confirmed that the procedure went to the QIPP committee and received clinical engagement, it was also confirmed that there are only slight changes to the procedure.
6.	**Thurrock Council Update**
	Mr R Harris attended the meeting to present the Thurrock Council update, the following items were noted from the report. Better Care Fund - Thurrock Better Care Fund Draft Plan was submitted to NHS England on the 14th February. Plans will now go through a process of assurance. The assurance process to be applied was communicated to CCGs and local authorities during week commencing 10th February. Comments will be fed back to CCGs and local authorities by the 6th March. Final plans will need to be submitted by the 4th April, with any issues flagged up in the initial assurance process being resolved by that time. The Council and CCG will continue to work on the Plan through project board arrangements in place. The final submission will be brought back to the CCG Board on the 26th March. In addition to the development of the Plan, work will now take place to resolve a number of integration 'issues'. This includes issues concerned with governance, and issues concerned with service transformation. It is unlikely that solutions will be developed for all issues before April, and work will continue throughout 14/15. We are proposing to establish a Governance task and finish group between the Local authority and the CCG to resolve the details of the governance model. Care Bill - The Care Bill is consistent with the ambitions captured by the Better Care Fund. As such, it is likely that work to prepare for and implement the requirements of the Care Bill will take place as part of the BCF Plan arrangements. The Care Bill will provide a number of challenges for local authorities in particular, especially when the Dilnot recommendations are implemented in. The Council will be putting arrangements in place imminently to identify what work that needs to take place and to carry out that work. A Care Bill Programme Board will be set up, to which the CCG will be invited to attend. Health & Wellbeing Board - The next Health and Wellbeing Board takes place on the 13th March. A special Board meeting was held on the 10th February to sign off the first submission of the Better Care Fund Plan. The CCG also presented the draft 2-year plan. The meeting of the 13th March will be an extended meeting to take account of a busy agenda. Items will include the near-to-final BCF Plan, Learning Disability update, Primary Care Strategy, Public Health Responsibility Deal, and the Children's Safeguarding Board Annual Report. Mr R Harris requested for Thurrock CCG to identify a replacement for Dr P Malik on the Health & Wellbeing Board. **Action Thurrock CCG** Integrated Commissioning - Part of the health and social care integration

arrangements being discussed concern options regarding to an integrated commissioning approach. Different options are currently being considered, which may include a phased approach towards full integration of commissioning functions across health and adult social care.

Budget - The Council must remove in excess of £33 million from its general fund by 2018, this equates to approximately a quarter of the Council's budget. Adult Social Care's budget makes up approximately a third of the Council budget, with much of that budget being statutory and demand-led and therefore difficult to cut. This is a very serious situation and will mean some radical and difficult choices being made :

- Significant outsourcing.
- Reviewing all areas of non-statutory, discretionary expenditure
- How we can manage demand better
- Stopping some functions within the Council
- Reviewing all terms and conditions for staff
- Increasing charging
- Shared services with other authorities
- Minimum 10% cuts across the board

Over the next few months, the Council will be looking at a variety of scenarios aimed at achieving the £33 million. It is important that when we do this, we recognise the possible implications of any changes we make to other partners. We will continue to keep the CCG updated and work to identify and possible consequences and unintended consequences of savings proposals.

Ms M Ansell confirmed that a stakeholder workshop to discuss Mental Health joint working across South Essex will be taken place.

7. Quality Report & Policies

Ms J Foster-Taylor presented the Quality Report to the board for assurance and approval.

Compliments and complaints – Information is now provided by area and trend data will be available for the next report. It was informed that there were six complaints received for Thurrock and two for Basildon & Brentwood in December. It was confirmed that the NELFT complaints team regularly review outstanding action plans and are working with the owner of the action plans to ensure that they are completed within a timely manner. The NELFT complaints team has started to record and monitor complaints handling satisfaction data, for December this was 100%. A complaints satisfaction survey is in development and will be implemented on the 1st February.

IAPT - Thurrock CCG is below expected trajectory. Current perfromance is 6.52% against current trajectory of 9.45%. A contract query has been raised and SEPT who are now providing weekly data against recovery action plan. Recovery plan has measurable actions within it to achieve the minimum 10% required. Dr P Martin informed that patients are experiencing significant waits. Ms J Foster-Taylor confirmed that there has been an increase in capacity and that if there are any further issues with waiting times to email her.

Mixed Sex Accommodation - There have been no reported breaches in the three community hospitals since the last report. Patient satisfaction is sought at the time of discharge and patients are asked to score their experience between 1-10.

Keogh Mortality Review - The extended Clinical Quality Review Group continues to monitor progress against the recommendations of the BTUH Keogh report. This Group has representation of Executives from the Trust, BBCCG and the Monitor Improvement Director. It has been agreed that the Chief Nurse of BBCCG and the Director of Nursing at BTUH will work together to develop a 'test and challenge' programme to pick up on any outstanding issues from the Keogh review, CQC and the McKinsey review of Quality Assurance, for BBCCG to carry out prior to the Mike Richards team hospital inspection expected in mid-March

Maternity – In December, Basildon Hospital scored; above the national average for the first two 'touch points', just below the national average for the third and well below the national average for the fourth, 30 compared to 74.

Queens Hospital Romford – as a result of the CQC's findings from the review undertaken in October 2013, Queens Hospital, BHRT have been put into special measures. It was detailed that a Keogh type visit will be taking place.

East of England Ambulance Trust - The CQC published their report on East of England Ambulance Service following a routine inspection on 10, 11, 12 and 20 December 2013. The trust met 5 out of 7 standards. The standards not met were Outcome 4 - Care and welfare of people who use services and Outcome 13 – Staffing. The CQC judged that both these standards had a 'Moderate Impact'. The report has shown significant improvement for East of England Ambulance Service NHS Trust following an unannounced inspection in December. They spoke to people who used the service and staff as well as revised information given to them by the provider and local Healthwatch. Although most patients spoken to were happy with the length of wait for an ambulance, CQC had continued to receive a number of complaints about the length of time they had waited for an ambulance to take them to hospital. Staff in A&E departments stated that they had good relationships with the ambulance crews, and were positive about verbal and written handover information. Fire services stated that they often had to wait excessive times for an ambulance to arrive which, on occasion, caused them delays in being able to cut people out of cars following RTA's. CQC found significant improvements in a number of areas since their last inspection. Staff sickness absence rates had reduced, and performance development reviews had increased considerably. Complaints relating to ambulance delays had decreased as had the number of serious incidents. The trust had consistently met its targets in relation to less urgent calls, and there was evidence to show that long waits for back up vehicles to transport people to hospital in life threatening instances were decreasing in some areas. Improvement was needed in response times to life threatening 999 calls as well as getting people who had suffered a stroke to a specialist center.

Care Homes – the following reports have been published since the last meeting:

- Barn & Coach House, Grays
- Belmaine Avenue
- Gallimore Lodge, Grays
- The Homsteads, Stanford-le-Hope
- Emmanuel House, Tilbury
- Hollyrose House, Grays
- Meesons Lodge, Grays
- 117-119 Molland Lane, South Ockendon
- Whitehall House, Grays

It was confirmed that the findings of each report are in the public domain via the CQC

website.

Healthcare Acquired Infections – Post infection review meetings for MRSA Bacteraemia have been completed and final assignment has been agreed. Contaminants are finally assigned to the organisation where the blood culture was taken and recorded on the Data Capture System. We have questioned the PHE on their reporting of contaminants and have been informed that these must continue to be reported as part of the mandatory reporting on the DCS, conflicting with advice given by them previously, advising use that they can be removed following appeal.

Clostridium Difficile – a brief summary and progress against action plan was presented to the board. Medicines management have agreed to support anti-microbial stewardship again.

Adult Safeguarding - Safeguarding encompasses six key concepts: empowerment, protection, prevention, proportionate responses, partnership and accountability. Currently within South Essex there are 3 Safeguarding Adults Boards one for each local authority – Southend Essex & Thurrock, subgroups of the boards including an Essex NHS Safeguarding Adults Leads subgroup but an agreed process across the 3 local authorities. The Safeguarding Adults agenda is not as clear cut as the Safeguarding Children's agenda due to the differences in the legal status of the process and issues of capacity and consent. The allegations of abuse that are raised are often not easily proven due to issues around lack of documentation or evidence and because of these factors allegations which are raised are often not substantiated or are found to need case management rather than being deemed as abuse.

Dr V Raja – enquired regarding IAPT, a letter has been received informing that not enough patients have been referred, however if the patient does not send their half of the form then they do not get an appointment. Ms J Foster-Taylor informed that she will explore this further. Ms J Foster-Taylor has a meeting with Hugh Johnson, SEPT to understand IAPT Thurrock Service delivery better. **Action JFT**

Ms M Ansell confirmed that there has been a risk summit for EEAST and going forward there will be better leadership for Essex. It was confirmed that Liz James, CSU contracting team will update the board at the next meeting.

Policies
Ms J Foster-Taylor presented the policies to the board for comments and approval. The policies were approved.

8. CEG Update

Dr V Raja explained the following to the board from the Clinical Engagement Group.

The minutes of last month's CEG was approved by the members. Stuart McAathur updated the group on the new CAMHS model, the important dates for stake holder events and the timescale prior to submission to the CCG Board in May this year. It will then go to through the procurement process later in the year and the appointment of a lead clinician will be specified in the service plan. All have been advised to participate in the stake holder events.

Dr Henry Okoi sought the help of member practices in identifying Sickle Cell patients on their list and send out questionnaires to them. This information is needed to help develop the services for the patients and request for information to be submitted before the end of March this year.

	QOF peer review was conducted for the practices which missed out during the first round. There were still a few practices which did not submit their data and hence they will have to organise their own peer review. Medianalytics – Mandy Ansell encouraged the practices to use Medeanalytics for assessing practice level data. She also recognised the additional time and resources that would be needed by the practices to undertake this and informed the group that the CCG Chief Financial Officer is working on a possible incentive scheme towards this. Dr Nimal Raj encouraged the practices to be involved in the sign up to the Prime Ministers Challenge Fund. Dr Bose updated the member practices on the on-going and future projects in Thurrock. Dr V Raja had informed the group about the recent CRG meeting and the concerns raised by the patients about Diabetes Education. Dr V Raja confirmed that there was good attendance at the meeting. Mr R Vine asked if the update by Dr A Bose was for the whole of Thurrock or just for the federation. It was confirmed that this was an update on the pilot, once there is a good outcome the rest of the CCG will be updated.
9.	**CRG Update**
	Mr L Green provided a verbal update to the board on the last Commissioning Reference Group meeting. It was confirmed that there has not been a meeting since the last board. There were no issues to raise this month and the next meeting will take place on the 20th March.
10.	**Policies**
	Ms M Ansell, in line with the board approved process for CCG policy development, seven new HR policies and one new HR procedural guideline, these are presented to the board for approval. Any comments on the policies should be made to Ms M Ansell. Ms L Buckland confirmed that the policies have already been through JSF. Mr L Green requested for more flow charts within the discipline policies. **Action Andrew Stride** All policies presented to the board were approved.
11.	**Process for Annual Report & Annual Accounts**
	Mr A Olarinde presented the process for the annual report and annual accounts to the board for approval. Under the CCG's Scheme of Delegation, the approval of the Annual Accounts and the Annual Report is a decision reserved to the Board. However, due to the deadline for the submission of the draft accounts and annual report to the Department of Health (6th June 2014) and its proximity to the date by which the preparation and audit of these documents will be completed, it is proposed

	that the Board agree to delegate authority to approve the draft accounts and annual report to the Audit Committee at their meeting on 3rd June 2014. The Board meeting scheduled for 28th May 2014 (the closest meeting date to the submission deadline) will be a seminar closed to the public and unsuitable for approval of the annual accounts and report. Members should note that the accounts would also be reviewed by the Finance & Performance Committee prior to formal approval by the Audit Committee, should the Board agree to delegate authority as proposed. In the interests of good governance and transparency, the draft accounts and annual report would then be formally received for information at the Board meeting in public on 25th June 2014. Members should note that in accordance with the CCG's Constitution and the CCG Regulations 2012, an Annual General Meeting (AGM) will take place in September 2014 (date to be confirmed). The annual report and annual accounts will be presented at the AGM. Ms L Buckland confirmed that this is an exceptional year, NHS England LB this is what is called an exceptional year, NHS E audit chair is supporting anything that needs to happen to support the process. Suggested the chair to be invited to the Audit committee. Mr R Vine confirmed that he was happy for the delegation to take place. It was noted that the annual report is not tailored for members of the public, it was suggested for a short overview to be distributed to the public. All agreed for the proposed delegation to take place.
12.	**AOB**
	Terry Bradfield (member of the public) informed the board that a friend saw on the news that patient data has been sold to insurance companies, his concerns are regarding bad postcode areas. Mr L Green confirmed that this is a rather unclear and confusing change for members of the public and has been poorly communicated, however the data sharing exercise has been cancelled for the next 6 months, this is for the public to understand the benefits and to review the way it is to be introduced. The government and NHS England have listened to the public and GP's. Terry confirmed that he fully supports information sharing for hospital data. Mr P Martin confirmed that this is not what the information is going to be used for. **Action LG to provide Terry with a copy of the letter from NHS England** Mr R Vine confirmed that there is an opt out form available for data sharing.
	Date of Next Meeting
	26th March 2014, 9.30am, Culver Centre