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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

21 MARCH 2018

PART ONE PUBLIC - MINUTES

A meeting of Part 1 of the Governing Body, of the NHS Dorset Clinical Commissioning Group was held at 2pm on 21 March 2018 at Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TG.

Present:
Forbes Watson, Chair (FW)
Mary Armitage, Secondary Care Consultant Member (MA)
Tim Goodson, Chief Officer (TG)
Teresa Hensman, Audit and Quality Chair (TH)
Stuart Hunter, Chief Finance Officer (SH)
David Jenkins, Deputy CCG Chair/Public Engagement Member (DHJ)
Karen Kirkham, Locality Lead for Weymouth and Portland and Assistant Clinical Chair (KK)
Blair Millar, Locality Lead for West Dorset (BM)
Ravin Ramtohal Locality Lead for Christchurch (RR)
David Richardson, Locality Lead for Poole North (DR)
Ben Sharland, Locality Lead for Central Bournemouth (BS)
Elaine Spencer, Registered Nurse Member (ES)
Jacqueline Swift, Primary Care Commissioning Committee Chair (JS)

In attendance:
Sally Banister, Deputy Director, Integrated Care Development (SB)
Kath Florey-Saunders, Head of Service Delivery (KFS) (for item 9.5)
Colin Hicks, Service Director – Mental Health and Learning Disabilities - Dorset Healthcare University NHS Foundation Trust (CH) (for item 9.5)
James Jackson, Deputy Locality Lead for Purbeck (JJ)
Conrad Lakeman, Secretary and General Counsel (CGL)
Steph Lower, Executive Assistant (SL)
Vanessa Read, Deputy Director of Nursing and Quality (VR)
Sally Sandcraft, Acting Director of Primary and Community Care (SSa)
Sally Shead, Director of Nursing and Quality (SSh)
Charles Summers, Director of Engagement and Development (CS)
10 members of the public

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Action

1. Apologies

1.1 Jenny Bubb, Locality Lead for Mid Dorset
Colin Davidson, Locality Lead for East Dorset
Nick Evans, Locality Lead for Poole Bay
David Haines, Locality Lead for Purbeck
Mufeed Ni'Man, Locality Lead for East Bournemouth
Simon Watkins, Locality Lead for Poole Central
Simone Yule, Locality Lead for North Dorset

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of members present.

3. Declarations of Interest/Gifts or Hospitality

3.1 A Conflict of Interest was declared by the Chief Officer and Chief Finance Officer regarding item 21. Conflicted executives would withdraw from the meeting for that item. SL

4. Minutes

4.1 The minutes of the meeting held on 17 January 2018 were **approved** as a true record.

5. Matters Arising

5.1 The Governing Body **noted** the Report of the Chair on matters arising from the Part 1 minutes of the previous meeting.

6. Chair's Update

6.1 Sally Shead, Director of Nursing and Quality and Mike Wood, Director of Service Delivery would both be retiring at the end of March. On behalf of the Governing Body the Chair thanked them for their contribution to the CCG.

6.2 The Governing Body noted Dr Karen Kirkham's appointment as clinical advisor as part of the NHS England Transformation Team.

6.3 The Governing Body **noted** the Update of the Chair

7. Chief Officer's Update

7.1 The Chief Officer introduced his Update.

7.2 The Governing Body **noted** the Update of the Chief Officer.

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8. Strategy

8.1 **Draft Integrated Care System Operating Plan 2018-19 Update**

8.1.1 The Chief Officer introduced the Draft Integrated Care System Operating Plan 2018-19 Update.

8.1.2 The Governing Body **approved** the recommendation set out in the draft Integrated Care System Operating Plan 2018-19 Update.

9. Delivery

9.1 **Quality Report**

9.1.1 The Director of Nursing and Quality introduced the report on Quality.

9.1.2 She welcomed comments on the revised format of the report and said work was progressing regarding production of an integrated report for quality, finance and performance.

9.1.3 The Governing Body noted that the November scorecard information for Never Events for Poole Hospital NHS Foundation Trust (PHFT) should read 0 rather than 8.

9.1.4 There was continued concern regarding Never Events, particularly the two further Never Events at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) which brought the reported total to eight since April 2017.

9.1.5 At the request of the Audit and Quality Committee, a letter regarding Never Events had been sent to the Chief Executive of RBCHFT. A response had been received and the Governing Body directed that this be circulated. SL

9.1.6 There was concern that the root causes were not being clearly identified and there was a need for investment in education and training.

9.1.7 RBCHFT had undergone a recent Care Quality Commission inspection and the report was awaited.

9.1.8 South Western Ambulance Service NHS Foundation (SWASFT) was not achieving the standards for new response times. The CCG was working with SWASFT and fellow commissioners across the South West to review whether additional resources were required.

9.1.9 The Mortality data for Dorset County Hospital NHS Foundation Trust (DCHFT) for August – November 2017 had not been included on the scorecard and the Governing Body directed that a post meeting note be provided regarding this information. VR

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9.1.10 The Governing Body noted that the ongoing issues regarding the initial Looked After Children assessments in the Dorset County Council area had been discussed at the recent Corporate Parenting Board. Commitment to the actions required had been given.

9.1.11 The Governing Body **noted** the Quality Report.

9.2 **Performance Report (to include Quality Premium)**

9.2.1 The Deputy Director, Integrated Care Development introduced the Performance Report.

9.2.2 GP demand had reduced by 5.7% across all specialities, but within the trusts there remained capacity issues in performance that was affecting waiting times.

9.2.3 There remained issues at DCHFT regarding the 62-day cancer wait. An action plan was in place to improve the position.

9.2.4 The Governing Body **noted** the Performance Report.

9.3 **Finance Report**

9.3.1 The Chief Finance Officer introduced the Finance Report.

9.3.2 He expected the CCG would deliver its forecast financial position by the year-end.

9.3.3 There remained two specific areas of pressure - Salisbury Hospital NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

9.3.4 A formal dispute resolution was underway with Salisbury NHS FT. Yeovil NHS FT was over-performing but dialogue was ongoing.

9.3.5 Prescribing continued to be overspent due to the issues regarding Category M drugs and the lack of comparable stock. The position was likely to improve for February.

9.3.6 All Dorset provider trusts were expecting to achieve their planned financial position.

9.3.7 The Governing Body **noted** the Finance Report.

9.4 **Assurance Framework**

9.4.1 The Director of Nursing and Quality introduced the Assurance Framework Report.

9.4.2 The Governing Body **noted** the Assurance Framework.

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9.5 **Mental Health Delivery Plan**

This item was taken after item 9.8.

9.5.1 The Head of Service Delivery introduced the Mental Health Delivery Plan.

9.5.2 Children and Young People (CYP) Access for Dorset was on track to deliver 30% of the Access Key Performance Indicators in 2017-18. There was concern regarding the remaining 70% who were not accessing treatment and what the system was doing to address this.

9.5.3 Whilst the Mental Health Delivery Plan target was 30%, the transformation funding would assist with the implementation of early intervention programmes that would enable that target to be exceeded.

9.5.4 Local authorities were also developing the 'whole schools' approach which aligned with the proposed developments in the Green Paper. The plan was to assign mental health workers to school but this needed to be worked through in more detail.

9.5.5 The Governing Body noted that the Access targets for Children and Adolescent Mental Health Services (CAMHS) were expected shortly.

9.5.6 The Committee noted the move away from a tiered system to a system model that would look at the overlay of the different types of support from community through to schools.

9.5.7 There would be protected learning time for GPs to inform them of the changes to a system model.

9.5.8 There would be an opportunity to bid to pilot some of the work through the current Government consultation paper.

9.5.9 With the move to place based care, work was needed to address the mental health agenda within locality working.

9.5.10 The Governing Body **approved** the recommendations set out in the Mental Health Delivery Plan, however the CCG Deputy Chair asked to be disassociated from the CYP access target due to his concerns raised regarding meeting only 30% of demand.

K Florey-Saunders and C Hicks left.

9.6 **Annual Review of Governance Documents**

9.6.1 The Secretary and General Counsel introduced the Annual Review of Governance Documents.

9.6.2 The Governing Body noted under the Stakeholder Engagement section, the proposed changes to the Standing Financial Instructions had not been

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recommended for approval by the Audit and Quality Committee as they had been suggested after the Audit and Quality Committee had met.

9.6.3 Since the report was published, there were two further proposed changes recommended for approval as follows:-

Anti-Fraud, Bribery and Corruption Policy

- delete the reference to P Vater and amend to Chief Finance Officer
- amend the title of NHS Protect to NHS Counter Fraud Authority.

9.6.4 The Governing Body **approved** the recommendations set out in the Annual Review of Governance Documents and further recommendations set out in 9.6.3 above. SL

9.7 **Annual Review of Declarations of Interest**

9.7.1 The Secretary and General Counsel introduced the Annual Review of Declarations of Interest.

9.7.2 He had recently met with the Fraud Auditor regarding a review of the Conflicts of Interest regime and the Governing Body noted the Fraud Auditor's comments regarding the robustness of the CCG's regime.

9.7.3 The Governing Body **noted** the Annual Review of Declarations of Interest.

9.8 **Integrated Care System (ICS) Delivery Update**

9.8.1 The Deputy Director, Integrated Care Development introduced the Integrated Care System (ICS) Delivery Update.

9.8.2 The Governing Body **noted** the ICS Delivery Update.

10. Wider Healthcare issues

10.1 **Urgent and Emergency Care Delivery Board**

10.1.1 The Acting Director of Primary and Community Care introduced the report on the Urgent and Emergency Care Delivery Board.

10.1.2 The Governing Body **noted** the report on the Urgent and Emergency Care Delivery Board.

11. Committee Reports, Minutes and Urgent Decisions

11.1 **Reports**

11.1.1 There were no reports to note.

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11.2 **Minutes**

11.2.1 Draft Primary Care Commissioning Committee (Part 1 – Public) – 7 February 2018

The Governing Body **noted** the draft minutes from the Primary Care Commissioning Committee (Part 1 – Public) held on 7 February 2018.

11.3 **Urgent Decisions**

11.3.1 The Secretary and General Counsel introduced the Urgent Decision regarding the future of Maternity and Paediatrics in Dorset.

11.3.2 The Governing Body **noted** the Urgent Decision regarding the future of Maternity and Paediatrics in Dorset.

12. Questions from the Public

12.1 The Chair introduced the Public Questions item.

12.2 A member of the public asked the following questions:-

1. Does the CCG's Governing Board have any member listed with the title of Dr, whose Doctorate qualification is not in fact medical?

2. If so, will the CCG's Governing Board undertake to immediately ensure that the misleading title of Dr is removed from all of the CCG's website, publications, presentations, correspondence, etc, with regard to any person whose Doctorate is not in fact medical?

Response

No, to the best of our knowledge no member of the Governing Body uses the title Dr whose qualification is not medical. That said, the CCG has no means to control the titles used by members of staff or the Governing Body. If a person has a Doctorate they are entitled to use the title.

12.3 A member of the public asked the following questions:-

Dorset CCG CSR Decision-Making Business Case – September 2017

1. In the above plan, the forecast need for Acute Beds in Dorset is said to be 2,467. This is then forecast to reduce to 1,632 by improvements to 'out of acute hospital care' and 'change in average length of stay'. When one factors in changes planned to beds at Dorset County Hospital, Poole Hospital and Bournemouth Hospital, it appears that the planned provision will be 1,565. You identify that 67 beds will be created/needed to make this number to 1,632, but it does not seem to

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be clear where they will be. Can the CCG please provide this information?

Response

As a CCG we don't commission specific numbers of beds from any of our providers, we commission services. This means that our providers can (and do) flex their capacity to deal with both

- *short term fluctuations in demand and capacity (for example, dealing with the impact and aftermath of adverse weather conditions)*
- *longer term changes (such as shorter lengths of stay reflecting new technologies and improved clinical practices).*

The bed numbers on pages 104 and 105 of the Decision-Making Business Case (DMBC) are indicative of the position in 2014 and the likely position in 2021, reflecting the impact of these factors (i.e. changes in demand and changes in practice).

The 67 "Other" figure reflects the anticipated change (increase) in patients choosing to use non-Dorset services (such as Salisbury or Southampton) should Bournemouth become the main emergency site and Poole the main planned care site. The CCG discussed the impact of this with both of these providers who confirmed they could provide this additional capacity for Dorset without change in their infrastructure.

2. Can the CCG also please briefly explain, in lay-man's terms, what the 'out of acute hospital care' will be, and how the average length of stay will be achieved?

Response

'Out of acute hospital care' is care provided in a community setting e.g. community hospital/hub/ people's own homes or clinics, as opposed to in an acute hospital. The longer people stay in a hospital setting, particularly people who are frail, the more likely the chance that their functioning will deteriorate, therefore minimising their hospital stay is an import quality measure. Reducing length of hospital stay can be achieved by identifying on admission who is at higher risk of a longer stay due to their complex needs, and community and hospital staff working together, with them and their families, to ensure that all the support they require on hospital discharge is planned from the start, and that whilst in the hospital their tests and treatments are undertaken without unnecessarily delay. In Dorset we have made positive steps in reducing people's length of hospital stay, including treatments being undertaken as day case and outpatient procedures rather than an overnight stay.

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3. In the above plan, the number of community beds currently in place is 347. It is planned to close 135 of these. It is also stated that the CCG will increase this provision to 416. Can the CCG please say where the 204 new community beds will be located?

Response

Over the next five years as the acute hospital changes are made and the new integrated community model of care is introduced, we will be planning to increase the number of community beds in the East of the County, where currently there is less availability. This will also have a positive impact in the West of the County where we have people from the East utilising beds in the West due to availability.

4. Can the CCG please also advise specifically regarding the loss of Portland Beds:

   (a) where current patients at Portland Hospital will be assessed for continuing health care,

Response

As stated in the New National Framework for NHS Continuing Healthcare published on the 1st March 2018, it is best practice for people to be assessed for NHS Continuing Healthcare out of a hospital setting, in their own homes.

   (b) where current patients requiring end of life care are expected to have to go?

Response

A significant number of people choose to die in their own homes. The new model of integrated community services aims to support more people in their own homes and local communities. If, for some reason, it is not appropriate for someone to be cared for in their own home at the end of life, there are other options such as the community hospital/hub beds available in Westhaven/ Weymouth for people living in Portland and also access to hospice beds and care home beds if suitable.

   (c) if it is expected that end of life care will be provided by Weldmar Hospice in Dorchester, can the CCG please advise if assessment has taken place to ensure there is adequate capacity there?

Response

If people require specialist palliative care our hospices in Weldmar, Forest Holme and Christchurch Hospital can meet this need. Specialist teams provide advice and guidance to our locality integrated teams to support people at home, or to our community hospitals to support care at end of

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life within a community hospital bed. We have looked at the care people need to support them at end of life and the Integrated Community Services model of care has taken into account the community team and community bed capacity required to meet this need.

12.4 A member of the public asked the following questions:-

Westhaven Community Hospital

1. Of the 34 beds at Westhaven, we understand only 18 are occupied. It appears to be proposed that the hospital will no longer have community beds in favour of a "hub" system which uses beds in nursing homes and in people's own homes. Can you confirm that this is the aim for Westhaven or will some beds remain?

Response

The Weymouth Community Hospital and Westhaven reviews confirmed that the Westhaven site would not be large enough to become the community hub with beds and the site is less accessible for both private and public transport. In addition to this conclusion the likely cost to locate the beds on the Weymouth Community Hospital was identified and is substantially larger than anticipated due in part to the quality of the current infrastructure. The proposal that the Weymouth Community Hospital should be a community hub with beds continues to be recommended, however services including beds will be maintained at Westhaven Hospital until the community hub with beds at Weymouth Hospital is established and both staff and services have been appropriately transferred.

2. Does the process of finding community placements for those who were already living at Westhaven demonstrate that **all** current, and so future potential, patients can be so housed or are there indications that some community beds will continue to be needed e.g. because the original home is unsuitable, because of a lack of support from relatives or because care homes cannot manage the level of nursing or physical care required?

Response

As indicated in the response to Q1, there will continue to be community hospital beds in either Westhaven or Weymouth community hubs.

3. Community beds enable patients to be moved from hospital beds quickly or, for minor procedures, to avoid hospital admission altogether so as to increase hospital efficiency and improve recovery and rehabilitation near to family and friends. Westhaven also provides beds for elderly mentally ill who are difficult and expensive to look after in acute hospitals. What research been done to show that the twin aims

of freeing up hospital beds quickly and providing care close to home can be achieved with **zero** community bed provision?

Response

See responses to Q1 and 2 – there will be community hospital beds.

Mental Health

1. Dorset had highly regarded mental health provision with five 7-bed units and one 14-bed unit (the Linden Unit at Weymouth) spread throughout the county for people with less serious mental health problems. This was a "rural-proofed" service. The Prime Minister has said mental health should be given equal importance to physical health. Mental health problems cover a wide spectrum where many non-acute conditions if left untreated may result in a worsening condition including suicidal or violent tendencies. The STP's provision for less serious mental health conditions is limited to "front rooms", open 3 days a week and two "retreats". What studies, research or investigations have been carried out to show that in-patient community beds **can be avoided altogether** in assisting mental health treatment and recovery?

Response

The Community Front Rooms (CFR) are being funded by additional CCG investment - so additional services. The recovery beds are not being decreased. The retreats and connection are from reorganising services in line with what people said they wanted- also we are dual running a retreat to test and evaluate it before rolling out further services to ensure that it is doing what we all hope it will.

2. Of the small rural units which used to exist, all but the Linden Unit have now been closed. As a consequence, the acuteness of the mental health conditions of those referred to the Linden Unit has increased while access to lower level care beds has been lost altogether. The STP proposes 16 new acute mental health beds, 4 at the Forsen unit at Charmouth and 12 at St Ann's in Poole. It is stated that the Linden unit will also move to St Ann's but only when replacement beds are in place. Is it intended that St Ann's will have **26 new beds overall,** 14 to replace the Linden Unit and 12 new acute beds, or are the 12 acute beds to replace the 14-bed Linden Unit i.e. there will not be 12 new beds but **2 fewer beds**?

Response

Please refer to the attached infographic which describes the current and planned bed numbers. There are to be an additional 16 beds.

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3. Can the CCG explain how the costs and benefits of mental health support are assessed please? For example:-

(a) Does the STP include a “saving” if the plan results in fewer suicides from acute depression and a “cost” if it results in more?
(b) Are savings to the social care system taken into account i.e. if a cost simply transfers from the NHS to social care would the saving be disregarded?

Response

There is no cost savings 'plan' on the back of the Acute Care Pathway. The Community Front Rooms (CFR) are being funded by additional CCG investment. Reductions in Out of Area Placements will pay for a proportion of the new beds. It should improve effectiveness of the system by reducing people needing to go to the Emergency Department and also MHA assessments by being able to support earlier - this was what was co-produced. CFR and retreats are for people with serious mental illness and what people asked for to provide support when they needed it and not only a bed based system.

12.5 The Chair confirmed written responses would be sent to the above individuals. SL

12.6 A member of the public referred to the challenges of living on Portland and asked if consideration had been given to the potential for being cut off from the mainland, for example, in adverse weather conditions.

Response

Such challenges had been considered as there were a number of areas where severe weather could cause issues. A key ambition for Portland was to enhance the services offered and bring together community services and general practice to improve access to services to reflect the needs of the local population. This would include greater support within Portland itself enabling individuals living and working in Portland to respond and provide services during such challenging circumstances.

In comparison to other areas, the proportion of people requiring a community hospital bed in Portland was low so it was important to note that putting the infrastructure into the buildings would lose the ability to put the resources into supporting the community of Portland. The aim was to match the level of demand with the type of services for different groups of individuals.

12.7 A member of the public referred to a recent conference supported by the CCG and asked whether the CCG supported the concept of CCG networking and if so, why had funding/support been withdrawn for the successful Public Involvement Health Network Group in Weymouth?

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Response

A similar question had been raised at the previous Governing Body meeting regarding the CCG's commitment to encouraging active Patient Participation Groups (PPGs). PPGs were an important source of communication with patients and were valuable in informing the transformation of GP practices. Specific investment had been made regarding enhanced support to local GPs and PPGs were seen as a helpful and influential tool to improve support to local services.

The Director of Engagement and Development had been involved in a recent discussion regarding the continued presence of a public/patient group within Weymouth and Portland and it was considered the best way forward was through the use of the PPGs. The last meeting of the Public Involvement Health Network Group was postponed. The CCG was committed to reconvening that meeting and the Director of Engagement and Development planned to attend to explain the decision taken.

13. Any Other Business

13.1 There was no other business.

14. Date and Time of the Next Meeting

14.1 The next meeting of the Governing Body of NHS Dorset Clinical Commissioning Group would be held on Wednesday 16 May 2018 at Vespasian House at 2pm.

15. Exclusion of the Public

It was resolved that representatives of the Press and other members of the public were excluded from the remainder of this meeting having regard to the confidential nature of the business transacted, publicity of which would be prejudicial to the public interest.

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