NHS
Northumberland
Clinical Commissioning Group

Meeting of the Governing Body

This meeting will be held at 1000 on 15 February 2017 in Committee Room 2, County Hall

AGENDA

Time	Item	Topic	Enc.	Lead
1000	1.	Welcome and questions on agenda items from the public		J Guy
	2.	Apologies for Absence		
1005	3.	Minutes of the previous meetings and matters arising	✓	J Guy
	4.	4.1 Register of interests and review of conflicts of interest 4.2 Quoracy		J Guy
1015	5.	Accountable Officer and Chief Operating Officer assurance and key issues briefing	✓	V Bainbridge
1025	6.	Accountable Care Organisation Update		V Bainbridge
1050	7.	ECIP Review		S Brown
1115	8.	Vanguard Year 2 Evaluation	✓	S Brown
1140	9.	Board and Committee Minutes 9.1 Resource and performance 9.2 Financial regulation and audit 9.3 Engagement and quality 9.4 Primary Care Commissioning 9.5 Joint Locality Executive Board	 ✓ ✓ ✓ ✓ ✓	 K Bower S Brazier K Bower J Guy V Bainbridge
1155	10.	Any other business		J Guy
1200	11.	Date of Next Meeting: 19 April 2017		J Guy

NHS
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Minutes of the Governing Body
21 December 2016

Members Present:

Mrs Janet Guy	Lay Chair (Chair)
Mrs Karen Bower	Lay Governor
Mr Steve Brazier	Lay Governor
Dr Paul Crook	Lay Governor
Mr Mike Robson	Chief Finance Officer
Mrs Julie Ross	Chief Operating Officer

In attendance:

Dr Alistair Blair	Clinical Chair
Mr Stephen Young	Strategic Head of Corporate Affairs
Mrs Rachael Long	Corporate Affairs Manager
Mrs Vanessa Bainbridge	Northumberland County Council

NCCGB/16/51 – Agenda item 1 – Welcome and questions from members of the public

Janet Guy welcomed members of the public to the meeting and thanked them for attending, saying that it was good to know that that people are interested in the work of the CCG.

This is not a public meeting, but a meeting held in public. If members of the public had any questions on items on the agenda, they were asked to raise them at this point and the lead officer would then attempt to cover the question in their respective agenda item.

A member of the public asked if the CCG's financial position would have an impact on mental health services that the CCG commissions. Mike Robson agreed to answer this in the Financial Recovery Plan (FRP) agenda item.

NCCGB/16/52 – Agenda item 2 – Apologies for absence

Apologies for absence were received from Dr John Unsworth and Dr David Shovlin

NCCGB/16/53 - Agenda item 3 – Minutes of the previous meeting and matters arising

Governing Body members approved the minutes as a correct record.

Matters arising

There were no matters arising.

NCCGB/16/54 – Agenda item 4 - Register of interests, review of conflicts of interest and quoracy

The meeting was quorate and no conflicts of interest were declared.

NCCGB/16/55 - Agenda item 5 - Chief Clinical Officer and Chief Operating Officer assurance and key issues briefing

Julie Ross provided an update on key issues:

Health and Wellbeing Board – The board received presentations on the Vanguard programme and the Accountable Care Organisation (ACO). The Local Authority (LA) will support the CCG in its strategic commissioning role and will provide back office functions. It was agreed that it is important to have the support of the Health and Wellbeing Board, and it was clear that members were conversant with the ACO which, in terms of assurance, is helpful.

Primary care has voted on how they can be represented on the ACO Board. It has been agreed that a single federation will be created across Northumberland. Stage 1 of this representation is the federation, and ultimately this could then progress to a form of joint venture.

Handover delays at NSECH – The accounting system has been amended. Ambulance staff now start the clock 15 minutes from the arrival time to hand the patient over to the hospital and the four hour wait target clock for the hospital starts at this point. If the clock has started but no official handover has taken place ambulance staff will remain with the patient if deemed clinically appropriate. Performance remains sporadic with days of low and high handover delays. It was agreed that Governing Body will receive regular updates on the handover delays. Governing Body members were assured that Pamela Leveny and Siobhan Brown review the daily updates on progress, and the system is not currently under severe pressure in terms of beds. This will be monitored as winter progresses.

Restitution – The backlog of restitution cases has now been cleared and Governing Body members congratulated the team for their hard work. The CCG received over 400 cases, which were meant to be cleared by the end of September. Given the amount of work involved in clearing the inherited backlog, the original deadline was extended to December and the trajectory achieved.

Steve Brazier welcomed the change in accountability for handover delays, and asked how, as the figures are now being calculated differently, comparisons can be made to check whether they are improving. Alistair Blair said that the change does not affect the handover delay minutes, but it does affect the 4 hour wait figures. Karen Bower said that the CCG will need to continue to monitor the situation as there are still problems with getting ambulances back onto the road quickly.

Steve Brazier said that at a recent Audit Chair meeting, it was noted that NHS England were concerned by restitution clearances and have made an accounting provision for it. Mike Robson confirmed that the CCG have reached their target to assess all restitution cases, and that CCGs had contributed to a national risk share to pay for the cases, the amount that Northumberland CCG contributed was comparable to the amount due.

NCCGB/16/56 – Agenda item 6 – Overview of Accountable Care Organisation Business Case Assurance Process

Julie Ross presented the ACO business case assurance process.

Paul Crook asked what this would mean for primary care finances. Julie Ross said that the primary care budget is currently £50m. £43m for General Medical Services and Personal Medical Services contracts and the Quality Outcomes Framework contracts will be managed by the strategic commissioner. The remaining £7m will be managed by the ACO and used for enhanced services e.g. the population wide scheme and the practice medicines management scheme.

Paul Crook asked how strategic commissioners will ensure that the ACO will work efficiently to spend the funding and deal with it effectively. Julie Ross acknowledged that this is a critical point, and there will need to be strict financial regulation and assurance.

Governing Body approved the business case as a submission of intent.

NCCGB/16/57 – Agenda item 7 – Financial Recovery Plan update

Mike Robson presented the financial recovery plan, including an update on some of the schemes in place and how they are delivering, and details on what the plans are for next year.

He addressed the question from the member of the public on mental health funding and said that the CCG had not yet finalised the contract with Northumberland, Tyne and Wear Mental Health Trust (NTW) as they are part of the ACO, and it has been agreed that the timescale for ACO contracts to be finalised will be extended. The CCG will work together with the ACO on the contract and on pathway re-design. Discussions are ongoing with NTW about the contract and transformation of care into different settings and releasing costs from beds.

Julie Ross added that the CCG spends £56m on mental health services, a good proportion of which is paid to NTW. There is currently an additional £12m spent on mental health services, due in part to the rurality of the county meaning services are more expensive. It is important that the CCG do not look at the NTW spend in isolation, as some funding may move into community based treatments etc.

Alistair Blair said that the reductions in prescribing costs are positive, and have to be considered in context, Northumberland have the lowest Age Sex Temporary Resident Originated Prescribing Units (Astro PU) in the North East, which means that it is difficult to

reduce spend further.

It was noted that the press has highlighted that some CCGs are using private referral management systems to manage their referrals into hospital on elective, planned care. In Northumberland, GPs look at referrals within their practices, and then query them with the relevant consultants to ask if a referral is necessary, as a result Northumberland has low rates of referrals.

Karen Bower commented that the practice activity scheme has resulted in referral rates for three to four of the past months being lower than corresponding months last year, and noted that the aim of the scheme was not to reduce referrals but to reduce variation. Julie Ross agreed and said that as a result of the scheme there has been a reduction in referrals due to good referral management, the situation is monitored monthly.

Paul Crook said that managing patient referral rates is always a concern when considering whether this is affecting patient choice or second opinions. Alistair Blair said that not very many people request a second opinion, and that this does not directly affect choice.

Steve Brazier agreed that the CCG is doing everything it reasonably can, but noted that costs are still increasing; he asked if there are other system issues currently causing concern for the CCG. Mike Robson said that the system can potentially overheat due to high volumes; and this was currently being experienced. Julie Ross noted that problems arise as providers are required to achieve a substantial surplus in order for the proposed £11m Sustainability and Transformation funding to be awarded.

Governing Body members considered the update.

NCCGB/16/58 – Agenda item 8 – Conflicts of Interest

Stephen Young reported on the revised guidance on the effective management of conflicts of interest issued by the NHS England in June 2016.

It was noted that whilst the Conflicts of Interest Guardian has an important role within the management of conflicts of interest, executive members of the CCG's Joint Locality Executive Board have an on-going responsibility for ensuring the robust management of conflicts of interest, and all CCG employees, Joint Locality Executive Board members, committee members and member practices will continue to have an individual responsibility in playing their part on an ongoing basis.

The CCG has a robust system in place to effectively manage conflicts of interest, and the CCG Standards of Business Conduct and Declarations of Interest Policy has been revised to reflect the requirements of the new guidance.

The CCG submitted the first quarterly self-assessment on conflicts of interest compliance to NHS England in October 2016 and was rated as fully compliant.

Janet Guy said that this report was on the agenda partly because she asked for it, as there has been a lot of work done on conflicts of interests in the last year. All lay members have attended a conflicts of interest course this year, and Janet asked all members of Governing Body to read the guidance carefully.

Paul Crook commented that the new guidance was discussed at Audit Committee, and that NHS England had gone out to consultation on the guidance since June. Stephen Young said that the guidance is out to consultation, and any new guidance issued after the consultation period will be circulated when available.

Vanessa Bainbridge said that as we move towards the ACO the system will be required to recognise that some public sector officer will undertake dual roles in different organisations. While conflicts of interest will still be required to be highlighted and appropriate action taken in response it will also be important to adopt a flexible approach in future.

Steve Brazier noted that there will be an internal audit on conflicts of interest this year, which will be an unusual audit as the scope will be determined by NHS England rather than the auditors themselves. The result of the audit will be included in the annual report and accounts.

Julie Ross said that the examples used in the guidance are similar to the conflicts of interest that have arisen in the Primary Care Commissioning Committee, and that the CCG dealt with them in the same manner as recommended by the guidance.

Governing Body members considered the changes to the statutory guidance for managing conflicts of interest and the actions being taken by Joint Locality Executive Board and Governance Group.

Governing Body members recognised that all CCG staff and Governing Body members are personally responsible for declaring any conflicts of interest in a timely manner.

NCCGB/16/59 – Agenda item 9 – Board and committee minutes

Agenda item 9.1 Resource and Performance

Karen Bower reported on the work of the Resources and Performance Committee, the main points from the last meeting were:

- Committee members received a report on the North East Ambulance Service (NEAS) after requesting further information on benchmarking with other services. It was found to be difficult to get any benchmarking data from elsewhere in the country, but Northumberland are performing better than other rural areas that NEAS covers.
- Contract monitoring was discussed, in particular some issues around coding with Northumbria Healthcare NHS Foundation Trust and the Northumbria Specialist Emergency Care Hospital (NSECH). Julie Ross said that the counting and coding

NSECH challenges are pending further discussion with the trust and the LA. An update will be provided at the Resources and Performance Committee in January.

- Committee members received a report on the progress with prescribing savings as detailed in the FRP report.

Governing Body members noted and accepted the contents of the minutes.

Agenda item 9.2 – Financial Regulation and Audit

Steve Brazier reported on the work of the Audit Committee.

At the last meeting, the risk register and assurance framework were discussed, and committee members fed back some observations for discussion at JLEB.

There had been two internal audit reports published since the last meeting, on medicines management and business continuity and emergency planning, both were given a substantial assurance rating.

Committee members received a presentation on the FRP for the benefit of the internal and external auditors.

Steve Brazier also reported that the Auditor Panel had been involved in the process to select a set of external auditors for the next three years. The Panel submitted a selection paper to JLEB to endorse the recommendations of the panel.

Governing Body members noted and accepted the contents of the minutes.

Agenda item 9.3 – Engagement and Quality

Karen Bower reported on the work of the Engagement, Public Health and Quality Committee.

Committee members considered a report on engagement at the last meeting and were very complimentary about the improvements made to engagement processes over the last few years, some of which is due to Stephen Young being in post.

Committee members noted that the Local Safeguarding Adult Boards of Northumberland and North Tyneside are coming together into one board.

The quality visits programme was discussed, it was agreed that this had been a difficult programme to implement, and that the visits are now focusing on areas of concern. There are still improvements to be made on the visit formats using the 15 steps. North of England Commissioning Support Service is supporting the visit programme and it is improving.

Committee members received a report on choice in maternity services, and noted that the CCG works had to make sure that choice is embedded services.

Governing Body members noted and accepted the contents of the minutes.

Agenda item 9.4 – Primary Care Commissioning

Janet Guy reported on the work of the Primary Care Commissioning Committee.

Primary care attended a half day workshop in October with Professor Ham of the Kings Fund to look at the options of primary care construct and how primary care is represented on the ACO board. The model has now been agreed.

Seaton Medical Group had applied to extend the period of reduced service at its Newbiggin branch until January 2017. It was noted that recruitment has been successful at Seaton Park in recent months and therefore services will be reinstated.

Governing Body members noted and accepted the contents of the minutes.

Agenda item 9.5 Joint Locality Executive Board

Alistair Blair reported on the work of the Joint Locality Executive Board

JLEB members continue the scrutiny on finances and operational planning.

Committee members received reports on the ACO and the Sustainability and Transformation Plan.

It was reported that there has been an increase in dementia screening rates, and that Northumberland CCG is now performing at rates above the national average. It was agreed that this was encouraging particularly as this had been an area of previous under-performance.

Governing Body members received the minutes for information.

NCCGB/16/60 – Agenda item 10 Any other business

There was no further business to discuss.

Janet Guy said that this was Julie Ross's last Governing Body meeting. She noted that Governing Body members will miss her valued input, presentations and style. Julie has been part of the CCG since its formation four years ago, and has significantly influenced its development. In the last year she has had an enormous role in shaping the ACO. Fortunately, although Julie is leaving us, she is staying in the region. She will be a hard act to follow, personally she has been of huge value to Janet, as she only joined the organisation 18 months ago, and Julie has passed on some of her encyclopaedic knowledge of the CCG over the time Janet has been in post.

NCCGB/16/61 – Agenda item 12 - Date of next meeting

15 February 2017

Governing Body
21 December 2016
Agenda Item: 5
Accountable Officer and Chief Operating Officer report
Sponsor: Chief Operating Officer

NHS
Northumberland
Clinical Commissioning Group

Members of the Governing Body are asked to:

1. Consider the Chief Operating Officer report.

Leadership Changes in the CCG

The strategic commissioning function jointly exercised between the NHS Northumberland Clinical Commissioning Group (CCG) and Northumberland County Council since October 2016 has been further strengthened by the dual appointments of the CCG's Accountable Officer and Chief Operating Officer with the local authority.

Accountable Care Organisation

The Outline Business Case for the Accountable Care Organisation (ACO) was submitted to NHS England in December 2016. The Final Business Case, which will incorporate initial feedback, will be submitted in March 2017. A period of due diligence by the involved authorities will follow before the requisite assurance is given. To ensure that the CCG is fully prepared for ACO 'go live' at a future date, together with its key partners, from 1 April 2017 it will enter a comprehensive period of transition designed to ensure that appropriate governance and commissioning arrangements are in place.

Rothbury Community Hospital

Following the temporary suspension of inpatient admissions at Rothbury Community Hospital in September 2016 and a period of initial engagement with local people which informed the CCG Joint Locality Executive Board's decision making process, the CCG started a period of formal consultation on 31 January 2017 which will run until 25 April 2017. The consultation proposal is "Permanent closure of the 12 inpatient beds and shape existing services around a Health and Wellbeing Centre on the hospital site". The consultation document is available on line and has been widely distributed locally. The consultation includes a survey, a number of public meetings, drop-in sessions and focus groups, each designed to provide the widest opportunity for local people to comment.

Sustainability and Transformation Plan

A comprehensive period of public engagement on the first draft of the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (STP) was undertaken in January. The CCG, together with Healthwatch Northumberland and Northumbria Healthcare NHS Foundation Trust held a public meeting in each of the four localities. The meetings were

well attended by an informed audience. The opportunity was taken to outline the connection between the 5 Year Forward View, STP, Vanguard and the ACO and explain that the ACO is effectively the system's STP delivery vehicle.

Primary Care

The CCG's Primary Care Operational Plan was submitted in draft to NHS England in December 2016. The plan includes the GP Forward View and is built on the foundations of the Northumberland Primary Care Strategy, the Vanguard Primary and Acute Care System and the 5 Year Forward View. It provides an overarching action plan to deliver the primary care strategy.

System Pressures

Winter pressures continue to be experienced across the Northumberland health system. The Local A&E Delivery Board for Northumberland Tyne and Wear continues to discuss the operational issues being experienced and required actions in the short term. Opportunities are also being taken to ensure healthcare professionals and the public generally are fully aware of all primary care and community based services that are alternatives to A&E; including pharmacy and self-care options.

Governing Body
15 February 2017
Agenda Item: 8
Vanguard Progress Report and Evaluation
Sponsor: Transformation Director

NHS
Northumberland
Clinical Commissioning Group

Members of the Governing Body are asked to:

1. Consider the Vanguard Progress Report and Evaluation for Year 2 of Delivery.

Purpose

This report outlines Year 2 Vanguard progress.

Introduction

The Primary and Acute Care System (PACS) Vanguard is nearing the end of year two implementation, with the final year of funding confirmed for 2017/18 of £4.3M. The end of year two presents an perfect opportunity to evaluate the programme and the wider Northumberland system. The ethos of the Vanguard programme thus far has been to test new models of care, share learning and scale up the successes both locally and nationally.

The five stages of the PACS Vanguard are:

- **Stage 1:** the opening of the Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015.
- **Stage 2:** primary care at scale.
- **Stage 3:** complex care - enhanced care model.
- **Stages 4 and 5:** create an Accountable Care Organisation (ACO).

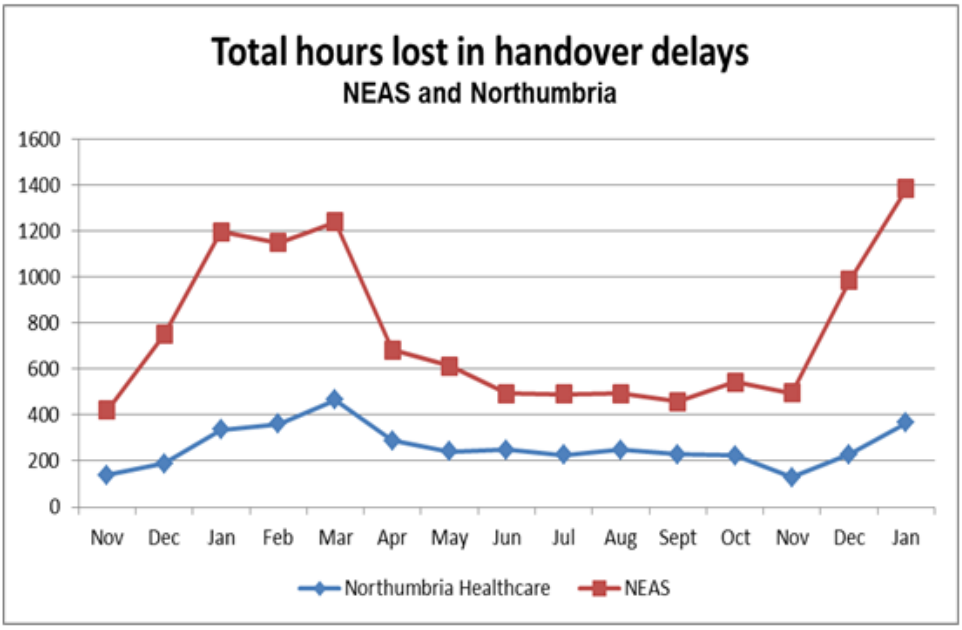
Evaluation

The evaluation will be focused on the clinical and care models in stages 1-3. ACO development updates have been regularly provided to Governing Body members.

Stage 1: Opening of NSECH

The opening of NSECH in June 2015 provided the Northumberland and North Tyneside populations with a centralised acute specialist service with the purpose of providing seven day senior decision making, faster diagnosis and improved clinical outcomes. Base sites at Wansbeck, Hexham and North Tyneside provide Urgent Care Centres and also outpatients, diagnostics and elective surgery. While benefits such as reduced length of stay have been realised and there is emerging evidence of improved clinical outcomes for certain conditions, the reconfiguration of the Northumberland healthcare system has also created unintended consequences including:

- Increased A&E attendances including low acuity patients who could be seen in primary care.
- Significant ambulance handover delays at NSECH.
- Increased healthcare professional ambulance transfers between sites.
- A need to better understand the purpose of the base sites and community hospitals post-NSECH opening.



Please note that the dip in Nov and Dec is attributable to other Trusts contributing significantly to handover delays as well as NSECH, therefore the proportion attributable to NSECH drops, though time lost remains substantial

Total hours lost handover delays	2015		2016												2017
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Northumbria Healthcare	138.12	188.15	334.5	360.35	464.75	287.38	241.87	247.4	224.92	247.45	228.87	223.65	128.05	227.85	365.32
NEAS	419.5	749.68	1196.8	1149	1238.3	683.75	611.92	492.42	489.17	492.12	458.6	543.13	495.65	983.82	1384.15

Response Actions

The Emergency Care Improvement Programme (ECIP) is a clinically-led programme that offers intensive practical help and support to urgent and emergency care systems, leading to safer, faster and better care for patients. ECIP's core workload is focused on extremely challenged systems. Northumberland CCG together with North Tyneside CCG, requested specific ECIP support from the North East Urgent and Emergency Care Network (UEC). The system enquiry was then commissioned and provided through the UEC Vanguard responding to the challenge experienced in the system with delayed ambulance response and handovers at NSECH.

The findings and action plan will be delivered by a Chief Officer-led system-wide group with an Independent Chair from ECIP, and held to account through the Local A&E Delivery Board, the Strategic Network for urgent and emergency care, NHS England and NHS Improvement; as well as individual organisational boards. It is worthy of note that, despite the issues currently faced in the Northumberland system, ECIP considered that it is still a very high performing urgent and emergency care system.

Stage 2: Primary Care at Scale

Northumberland has undertaken a capacity and demand analysis of all 44 practices across the county – as a tool to better understand pressure points and potential solutions for managing in-hours access to primary care. This significant piece of work has resulted in a comprehensive understanding of the pressures on primary care. It has also ensured practice engagement in the development of new care models. All 44 practices subsequently chose one of the following access models to deliver during 2016/17:

- New or improved access models such as Doctor First (where there are no boundaries to receiving care on the day requested – either by phone consultation or face to face).
- Care models for frequent attenders (for example, 'one stop shops' where patients can see a variety of professionals).
- Care models for patients with long term conditions (that gives extra time to plan care).

Access	Frequent Attenders	Long Term Conditions (LTC)
Increasing access could include: • Implementing Dr First or similar evidence base access model • Greater use of telephone consultations • Reduction in pre-booked appointments. • Development of a central call handling system, enabling faster access to the correct professional • Also screening requests for home visits • Other suggestions by the practice considered on an individual basis	Managing patients who attend GP frequently include: • Using tool to identify highest users of GP appointments • Dedicated sessions to provide longer appointments for this cohort • Wellbeing questionnaire and care planning approach use • Maximising skill mix within the practice	Managing patients with LTC include • Focus on quality aspects of care based on specific conditions relevant to the practice • A weekly GP session to deliver enhanced care • Development of personalised care plans • Review housebound patients with LTC • New chronic diseases recall system • Better patient information • Patient surveys to reduce DNA rates for LTC appointments • Reduce administrative time through streamlining patient results systems and online booking • Greater use of practice nurse and alignment of CDM review with medication reviews as a 'one stop shop • Enhanced patient education through shared decision-making methods and care plans

The hypotheses the Vanguard is testing are that:

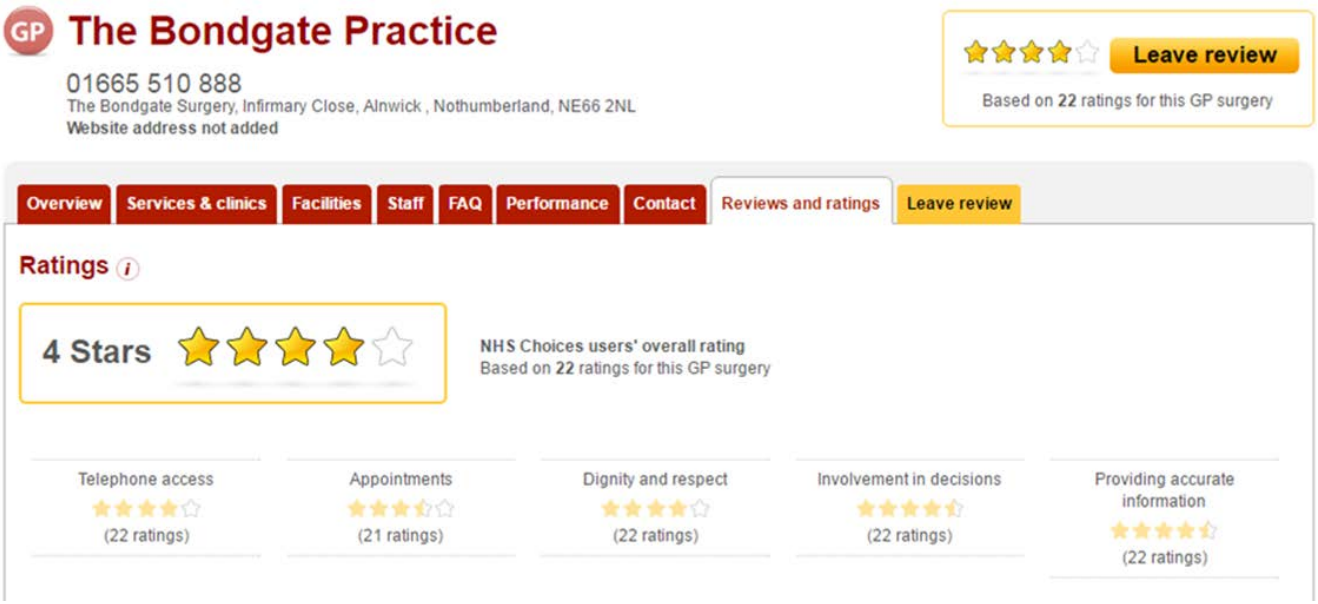
- *'Increased access to primary care reduces A&E attendances that could have been seen in primary care'* and that
- *'Practices who are helping 7-9% of their population per week will see a reduction in A&E attendances for their patients'*.

Dr First – practice example

In August 2016, The Bondgate Practice in Alnwick and its branch surgeries in Seahouses, Embleton and Longhoughton, introduced a new appointment system after listening to feedback from patients. Just three months after being introduced, the new system means 100% of patients are now able to get the advice they need, on the same day, from a practice GP, nurse or pharmacist .

Bondgate patients simply call their usual GP practice on the day that they need a consultation and can also now use a new online booking system to request a doctor to call them back. The new appointment booking system means GPs can talk directly with patients over the phone and are therefore much better able to judge how much time may be needed to support patients with their problems and, equally, who is the most appropriate health professional to meet their needs.

Around 70 per cent of Bondgate patients are now having their clinical needs met by speaking directly with a GP or other health professional over the phone, on the same day. Around 30 per cent of patients who need same-day advice still need a face-to-face appointment with a GP due to the complex nature of their problem and, since introducing the new model, they are also now getting same-day access. Do not attend rates (DNAs) have dropped to almost zero and the practice patient experience has increased to 4 stars from 2.5 stars:

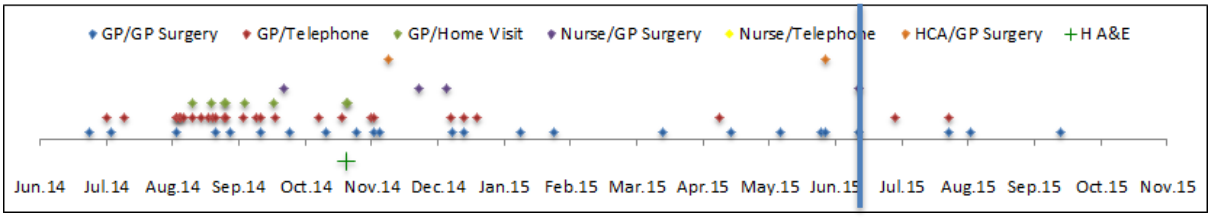


The Dr First model will cover 30% of the Northumberland population by the end of year 2, with the option open to other practices in year 3. It is likely that there will be a number of different access models in operation across Northumberland.

Initial Frequent Attenders model results are encouraging however further results need to be evaluated over a longer time period. This model releases significant time for primary care staff to treat other patients. A West locality practice identified that 6% of registered patients use 24% of all GP face-to-face, telephone and home visit consultations. When the test was replicated in two other practices it produced similar results: 5-7% of the registered population use 24-27% of GP face-to-face, telephone and home visit consultations.

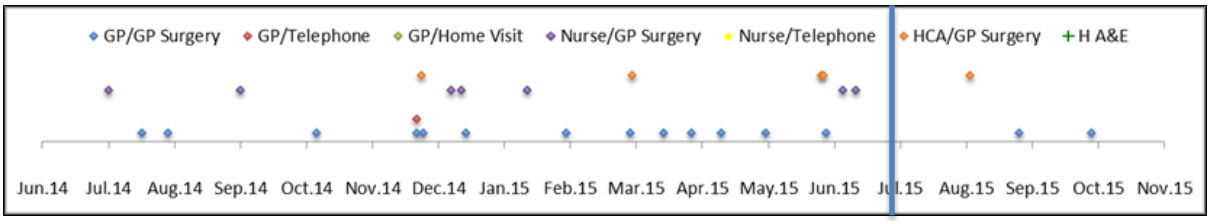
Thefor frequent attenders model includes extended 30-minute review appointments conducted by the GP and practice nurse together. The patient is also asked to complete a wellbeing questionnaire prior to the appointment, which allows them to prioritise their life and health needs ahead of the consultation. This information informs the discussion; and development of a life care plan and emergency health care plan. The results below show the decreased use of primary care services and the more appropriate use of fewer appointments.

Patient 1



Intervention

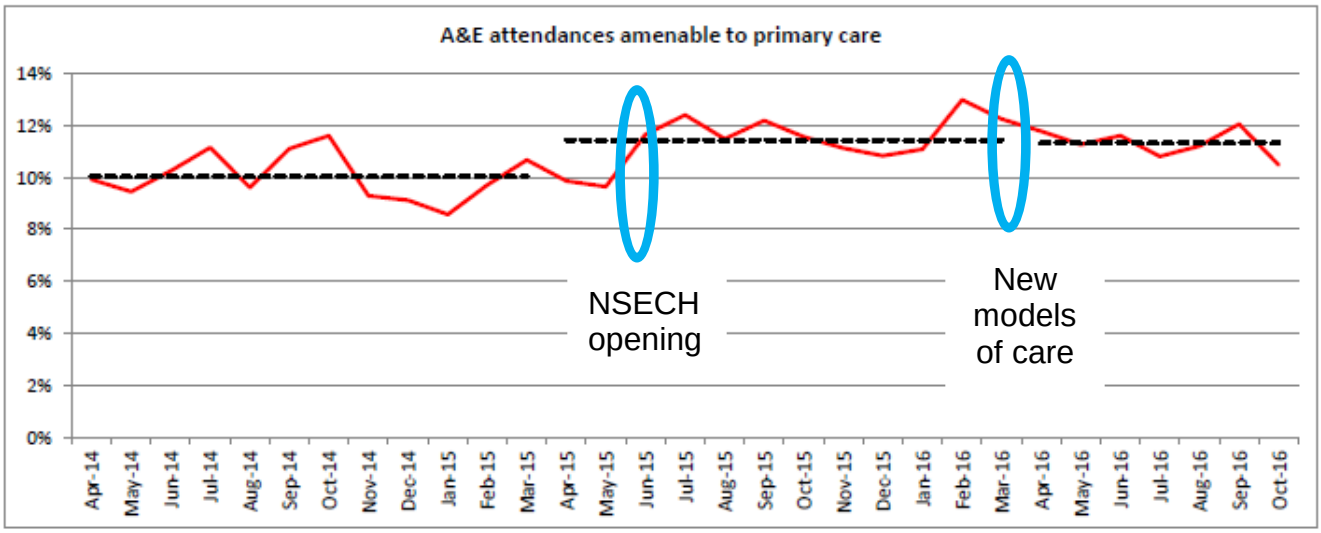
Patient 2



Intervention

Impact on A&E

Since February 2016, the CCG has witnessed a (cautious) trend of A&E attendances amenable to primary care decreasing:



Stage 3: Complex Care - enhanced care model & pharmacists

Enhanced care teams

The Vanguard has created locality-based integrated complex care teams to proactively manage those patients with the most complex needs in the community and provide a rapid response when a patient's condition deteriorates. This is being piloted in Blyth, with a view to rolling out any successful models at scale. The model of care includes:

Enhanced care team	**Multi-Disciplinary Team (MDT) wrapped round the complex patient**	**Acute visiting service – releasing time for GPs for other work**
• For high risk patients, care led by matron, pharmacist and GP • Involvement of community specialists as needed: Care of Elderly Consultant, Mental Health, Palliative	• Identification- A/E attendance/ high users, recent discharges, multiple medications, clinical opinion • Streamlining of care, action plan • Early warning indicators and escalation/ emergency anticipatory plans	• All patients are initially triaged by telephone • Many are assessed and managed by telephone • All patients who need to be seen are allocated to community matron, pharmacist, social care or GP depending on need- ~40% of visits do not need a GP

Care • Integrated clinical record • Focus on maintaining health and anticipatory planning	• Review at next meeting of actions and results	~25-30 hrs per month of GP time per 8,000 patients saved • Links to frailty assessment service

Pharmacy

The pharmacy team began to support two key services, the Enhanced Care Team (Complex patients) and the Acute Visiting Service in July 2016. The initial key findingsare:

- Visiting Service - An 80% reduction in the number of interventions and a 74% decrease in patients seen. Admission avoidance costs have decreased by 66%. The service has reported increased efficiency.
- Complex patient service - An 11% increase in the number of patients reviewed and a 42% increase in interventions (the team continue to exploring the scope of the service). There has been a 7% increase in the number of medications stopped where unnecessary (with associated cost savings).

Pharmacists in primary care

A cohort of newly qualified pharmacists, for the first time, is working as part of GP practice-based teams from the very outset of their NHS careers. This is allowing the new recruits to follow an entire patient journey from initial interaction with their GP, any community-based care, right the way through to any hospital admissions and discharge arrangements. The aim is to expose clinical pharmacists to ‘whole system working’ at the very start of their NHS careers, helping to develop a positive mind-set that fosters collaborative working, pre-empts any issues around medication and, ultimately, makes the experience of care as seamless as possible for patients.

Whole system impact – how will we know we have been successful?

The Vanguard models of care are working towards delivering the nine outcomes below:

Formal Evaluations

The following formal evaluations of the PACS Vanguard are being undertaken:

Regional Evaluation with four other North East Vanguards – delivered jointly by Northumbria, Newcastle and Durham Universities which will:

- Identify the potential organisational and cultural facilitators and barriers to the implementation of each of the North East Vanguard Programmes
- Explore the role of technology and digital solutions in the delivery of each Vanguard's aims and objectives
- Assess the costs and cost-consequences as part of an economic evaluation which will provide information on the sustainability of each programme
- Identify key aspects that can be shared across all Vanguard sites in the region and lessons learnt from the implementation to inform the Northumberland Tyne and Wear (NTW) Sustainability and Transformation Plan
- Draw upon the recent publication of the good practice guidelines, *Engaging local people* (NHSE 2016), to determine the nature and extent of attempts or plans to engage local citizens in reshaping New Care Models.

Local Evaluation – during 2017

Working with EXPLAIN (a market research company with huge experience of health and care) and Carers Northumberland, the CCG will evaluate the patient, carer and staff experience of the new care models – and in particular for the primary care, pharmacy and enhanced care models.

Recommendation

Governing Body is asked to note the progress of the Vanguard and the evaluation at the end of year 2 delivery.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Resources and Performance Committee
13 January 2017

Members Present:

Karen Bower (KB)	Lay Governor, Resources and Performance (Chair)
John Unsworth (JU)	Governing Body Nurse
Paul Crook (PC)	Governing Body Secondary Care Doctor

In attendance:

Mike Robson (MR)	Chief Finance Officer
John Warrington (JW)	Business Director Finance and Contracting
Janet Guy (JG)	Lay Chair
Rachael Long (RL)	Corporate Affairs Manager
Faye Menzies (FM)	Business Support
David Lea (DL)	Service Development Manager
Jim Dafter (JD)	Mazars

RP/17/01 Agenda Item 1 – Apologies for absence

Apologies were received from Steve Brazier and Stephen Young.

RP/17/02 Agenda Item 2 - Declaration of conflicts of interest and Quoracy

No conflicts of interest were declared and the meeting was quorate.

RP/17/03 Agenda Item 3 - Minutes from the previous meeting

The minutes of the previous meeting were agreed as a true and accurate record pending one amendment to page two; action update RP/16/52/02 to add “Steve Brazier added that the primary function of Internal Audit is process and CCG contracts but would be interested in seeing the Barnsley scope.”

The Following matters arising were discussed:

- **RP/16/60:** MR explained that the CCG is in discussion with the Local Authority (LA) regarding putting recommendations in place in relation to Continuing Health Care (CHC). The CCG is likely to take part in a regional project to look at CHC spending. PC asked where potential savings could come from. MR said that these would come from the LA in relation to charging rates and thresholds.
- **RP/16/63:** KB asked whether there was any clarification regarding the variations in contract summary figures between months four and five. MR explained that this was due to an error in month five data which has now been corrected. All other data is correct.

- **RP/16/64:** MR explained that the Northumbria Health Care Foundation Trust (NHCFT) legacy payment was made in April 2016 as part of the contract payment. JG noted her concern, as NHS Northumberland Clinical Commissioning Group (CCG) had been clear that the payment would not be made while counting and coding challenges remained unresolved. This position has been supported by NHS England. The Committee discussed the possibility of deducting the legacy payment from end of year contract payments.
- **RP/16/64:** KB asked whether any update is available regarding counting and coding challenges. MR explained that the challenges have been on hold due to the development of the Accountable Care Organisation (ACO). However, the CCG and NHCFT met late in 2016 and agreed to begin looking at the challenges again, with data and financial information currently being updated. The CCG will issue a letter to NHCFT w/c 16 January 2017.
  MR noted that incentives are available for NHCFT to reach its control. JG said that the CCG is under considerable pressure from NHS England (NHSE) to pursue financial challenges with NHCFT, however the CCG is aware of perverse conflicts within the system, resulting in the fact that it is not within NHCFT's interests to reach a solution. MR noted that deficit figures relate to previous years and that it is probably appropriate to charge to previous years and reduce figures for 2017/18. This is currently being discussed with Mazars. The CCG may not have charged appropriately in previous years.

RP/17/04 Agenda Item 4 - Action Log

Actions **RP/16/63/01, RP/16/65/01, RP/16/65/02** and **RP/16/65/04** were agreed as complete and will be removed from the log. The following actions were discussed in further detail:

- **RP/16/59/01:** DL provided an update regarding Talking Matters Northumberland (TMN) performance, noting that the contract with TMN has been under review by the CCG for the majority of its duration to date for a number of reasons, including triage to treatment delays and scorecard variations. Recruitment and retention has been an issue for TMN and the CCG has provided support to improve this. Scorecards have been seen to vary against published data by 4-9%. Following discussion with TMN, DL produced a reconciliation statement which highlighted issues relating to the recovery questionnaires supplied to patients. TMN have agreed to begin using additional clinical assessment tools from January 2017, which could result in capturing information for an additional 600 patients. A report on TMN performance will be presented at the March 2017 R&P meeting.
  PC noted that issues such as these should have been highlighted through TMN's Audit processes. KB asked whether penalties are written into the contract; MR to investigate this.
  KB asked whether patients are getting better but that there is no evidence to show this. JG noted concerns regarding TMN's ability to accurately capture data and whether therefore the CCG can be assured that patients are being treated appropriately. The Committee agreed that the contract requires close monitoring. DL noted that the contract includes a gain share agreement which is at risk if TMN are not achieving the mandated 50% performance targets.

JW asked whether TMN are able to demonstrate any improvement in waiting times. DL said that this does appear to be improving, which is partly down to improvement actions from TMN but that the volume of referrals has also reduced. JW noted that GPs could be making fewer referrals due to frustration over delays. JG noted that the situation needs to be carefully managed, as invoking penalties could cause further problems for TMN and exacerbate the issue.

DL said that an intensive support workshop is due to take place and that five TMN staff members are due to attend. KB asked at what point the CCG would consider terminating the contract. MR said that by the time the work is completed to understand the extent of the issues and develop and implement actions plans, the likelihood is that the CCG would not terminate early, but would not extend beyond the three year contract, assuming no improvements are made.

- **RP/16/60/01:** FM to follow up with JR regarding the Barnsley scope and circulate once received.
- **RP/16/61/01:** The ECIP report will be brought to the March 2017 R&P meeting following consideration by the Joint Locality Executive Board (JLEB). This action is complete.
- **RP/16/65/03:** Improvement plan capacity has been added to the R&P forward plan and will be presented at the March 2017 meeting. This action is complete.

Action RP/17/04/01: Report on TMN performance to be presented at the March 2017 R&P meeting.

Action: RP/17/04/02: MR to investigate whether penalties are written into the TMN contract.

Action RP/17/04/03: FM to follow up with JR regarding the Barnsley scope and circulate once received.

RP/17/05 Agenda Item 5.1 - Performance report received by JLEB in December 2016

DL noted that Governing Body members had received and discussed the performance report at the Joint Locality Executive Board (JLEB) meeting in December 2016. He asked for questions and comments by exception.

DL noted that the CCG is currently an outlier in regard to Early Intervention Psychosis (EIP), with a performance rate of 44% against a constitutional target of 50%. This appears to be a one off, in part due to low numbers. There can also be difficulties in co-ordinating treatment within two weeks. DL has reviewed the data and a more in-depth analysis will be included in the January 2017 performance report to JLEB. Performance for the quarter remains on track.

PC asked for an update regarding performance levels at the Northumbria Specialist Care Emergency Hospital (NSECH) over Christmas. JG asked whether the CCG has a feel for how much handover delays are due to increased volumes of patients presenting at A&E versus systemic issues. JW noted that he had taken part in a teleconference regarding handover delays where questions were raised regarding why

more in-depth triage does not take place, with patients referred back to their GP where appropriate. NHCFT is concerned that there are risks involved with sending patients away from the hospital without treatment. MR noted that high patient numbers keep performance levels high and that this presents a perverse incentive.

DL said that there have been incidences of 10 hour waiting times over Christmas and that patients remained reluctant to leave the hospital and be treated elsewhere even when given this option. The recent ECIP review focused on the whole Northumberland health economy and highlighted that there is a low number of alternative options to A&E available. Ambulance crews have been offered access to telephone calls with consultants for advice on the best place to take the patient. The Local A&E Delivery Board will consider the ECIP report and look to address its recommendations. ECIP will be in attendance to ensure actions are delivered.

DL noted that ambulance response time performance remains well below trajectory and that this is a concern regarding meeting the criteria of the Sustainable Transformation Plan (STP).

JW explained that, should inappropriate attendees be referred back to GPs from NSECH, this would not create a big impact for primary care as the patient volume would be divided between 44 practices. He suggested that performance based targets could be introduced which offer incentives for referring patients back to primary care and penalties for not doing so.

PC asked whether handover delays are currently being experienced at NSECH. DL said that improvements are being seen, however as NSECH improves, performance is worsening elsewhere in the region.

RP/17/06: Agenda Item 5.2 – Financial Performance Report (Month 8)

MR noted that Governing Body members had received and discussed the financial performance report at the December 2016 meeting of JLEB. He asked for questions and comments by exception.

KB noted that the report states that a £35.4million Cost Improvement Programme (CIP) requirement has been identified, but that there is £35.2m unmitigated risk. Is the difference due to £236k charge for exempt oversees visitors? MR confirmed this was the case.

MR explained that changes have been made to the forecast information used by the CCG and that this allows for further scrutiny. If December 2016 performance at NHCFT reflects that of November, it could result in the loss of the £1million headroom. NHCFT is investigating the data.

KB asked whether the coding issues for ambulatory care form part of the CCG's outstanding challenges with NHCFT. MR confirmed this and explained that the coding for ambulatory care reflects both the definition of care and the facility being used. There was a facility change in 2016 and it is possible that coding has changed due to the location of treatment rather than any changes in clinical practice.

PC noted that Accountable Care Organisation (ACO) finance shows that the CCG hasn't allowed for increased activity within QIPP targets. MR explained that QIPP targets were ambitious but achievable if the whole system is working together. However, this is not currently the case.

RP/17/07 Agenda Item 6.1 – Non-elective Care

MR presented the report which gave an overview of the non-elective impact in the overall QIPP programme. MR explained that a large return is not forecast due to many of the issues previously discussed by the Committee.

Financial pressures exist regarding the current use of NSECH versus what the facility was designed to be used for. This could possibly result in technical contractual challenges. JU noted that NHS North of Tyne (NoT) approved the business case for NSECH on the basis that it would not lead to overheating in the system and asked if this would be the basis for challenge. MR said that NHCFT has queried whether the opening of NSECH alone is the reason for pressures in the system, this would need to be proven. There is a still a lot of work to be undertaken to identify the primary factors. The Committee noted that collective solutions will need to be identified as part of the move towards ACO arrangements.

JG asked whether it is possible to go straight to arbitration. MR said that if there has been no attempt to make the case and reach a settlement, this would count against the CCG in arbitration.

MR explained that it is difficult to demonstrate the individual impacts of clinical pathway developments. JU asked to what extent it would be worthwhile to pay for a patient transport system to move patients away from NSECH to the base sites at Wansbeck General Hospital (WGH) and North Tyneside General Hospital (NTGH). JG felt that this would send the wrong message if the patient should in fact be seeing a GP. JW noted that minor injuries which require x-rays etc. should be diverted to base sites but noted that this type of system would rely on rigorous triage at NSECH.

MR noted that NHCFT as a business is focused on generating income but that within an ACO the focus will need to be on saving. An organisational culture change will be required to achieve this and work is required within primary care on pathway reviews.

DL explained that volumes of non-elective procedures have increased each year since 2014/15, even when taking into account the opening year of NSECH. Volumes of ambulance transfers to A&E have remained similar when comparing December 2015 and December 2016 data; there has been an 8% gain at NHCFT but a 7.6% reduction at Newcastle Hospitals (NUTH).

KB asked whether any impacts have been seen as a result of the night closure of the Primary Care Access Centre (PCAC) at WGH. DL explained that this data is not yet available but that discussions are ongoing with NHCFT.

JU asked whether the ECIP review is the reason for performance improvements in November. DL said that the pressure of the review may have made a difference to

triaging, however staffing also has an impact. JU noted the importance of identifying weak points within the system and introducing staff training to address these.

RP/17/08 Agenda Item 7 Any Other Business

There were no items of other business.

RP/17/09 Agenda Item 10 – Date and time of next meeting

10 March 2017: 0930. Ashington Meeting Room, County Hall.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Audit Committee
26 January 2017

Members Present:

Steve Brazier (SB)	Lay Governor – Audit and Conflicts of Interest (Chair)
Dr Paul Crook (PC)	Governing Body Secondary Care Doctor

In Attendance:

Carl Best (CB)	Internal Audit Director, Audit One
Jim Dafter (JD)	External Audit, Mazars LLP
Faye Menzies (FM)	Business Support
Mike Robson (MR)	Chief Finance Officer
Alyson Williams (AW)	Internal Audit Manager, Audit One
Stephen Young (SY)	Strategic Head of Corporate Affairs
Paul Bevan (PB)	Local Counter Fraud Specialist
Gary Walsh (GW)	North East Commissioning Support Unit (NECS) (Item 9 only)

AC/17/01 Agenda Item 1 Apologies for absence

Apologies were received from Cameron Waddell (CW).

AC/17/02 Agenda Item 2 Declarations of interest

There were no declarations of interest.

AC/17/03 Agenda Item 3 Quoracy

The committee was quorate.

AC/17/04 Agenda Item 4.1 Minutes of the previous meeting

The minutes were agreed as a true and accurate record.

Matters arising

- **AC/16/85:** MR and CW have discussed the treatment of prior year transactions within NHS Northumberland Clinical Commissioning Group's (CCG) and the impact for 16/17. CW has advised that the CCG can reflect these transactions through a change to the prior year accounts; work is ongoing to test transactions. MR will send the results of testing to SB once complete by email. SB asked if there would be ramifications for NHS England accounts. MR confirmed this and said that regular updates are provided to Jon Connolly and any final decison will be agreed with the area team. Changing treatment of prior years will have no impact on the CCG's accumulated deficit but it will ensure that the current year accounts are correct.

- **AC/16/85:** SB asked whether the Improvement Plan has now been formally approved by NHS England. MR said that there has never been a formal or minuted response. He noted that a quarter two assurance meeting is scheduled for 7 February 2017, but was unsure whether the CCG could expect formal approval or simply feedback on the detail. The Committee discussed whether formal approval should be requested, however it was agreed that the focus should be on assessing the current position and moving forward from there.
- **AC/16/85:** PC noted that the Consultant First initiative was discussed at the Joint Locality Executive Board (JLEB). The existing system was approved however further work will be undertaken to consider the benefits of an external Referral Management System.
- **AC/16/86:** An assurance framework report was provided to JLEB on 25 January 2017; however the item was deferred due to a busy agenda and will now be discussed at a JLEB development session in February 2017. SB confirmed the revised report reflected the issues raised at Novembers audit committee
- **AC/16/88:** AW confirmed that the cost improvement audit is now underway.

Action AC/17/04/01: MR to send the results of testing to SB.

AC/17/05 Agenda Item 4.2 Action log

All actions were agreed as complete and will be removed from the log.

AC/17/06 Agenda Item 4.3 Timetable / May Committee Date

The Committee discussed whether it would be necessary to bring the draft annual governance statement and draft annual report to the March 2017 Committee meeting. AW queried the submission dates and will send the submission timetable to SY. SY to review submission dates and confirm with the Committee via email whether the Committee will need to review the draft documents in March. The Committee agreed to review the draft governance statement at the March meeting.

At the March 2017 members meeting, CCG member practices will be asked to delegate authority to the Audit Committee to approve the CCG's annual accounts. The accounts will be reviewed at the May 2017 Audit Committee meeting ahead of final submission to NHS England on 31 May 2017.

Action AC/17/06/01: AW to send submission timetable to SY.

Action AC/17/06/02: SY to review submission dates and confirm with the Committee via email whether the Committee will need to review the draft documents in March.

Action AC/17/06/03: FM to add draft governance statement for March and annual accounts for May to the Committee forward plan.

AC/17/07 Agenda Item 5 Chief Finance Officer's Report

MR presented the report, summarising the financial position to date.

MR explained that there is an in-year Cost Improvement Programme (CIP) requirement of c£36million. This, added to the existing £5million deficit, will result in a forecast deficit at year end of c£41million. There is a continued underspend against running costs; some of this has been used to cover GPIT costs.

Outstanding debts relating to Leeds and Essex CCGs regarding S117 payments are currently in dispute. The CCG is gathering evidence to support its case. Outstanding debts relating to Macmillan Cancer will be cancelled as the amounts were raised after the end of the current agreement.

SB noted that, at the January 2017 JLEB meeting, there was discussion regarding the continued formal reporting of a £5million deficit when the actual position is £41million. The CCG has repeatedly discussed the actual financial position with NHS England but has been asked to continue to report the deficit as £5million. This is a risk in terms of accurate audit trails as there are no formal minutes of the discussions with NHS England. MR noted that NHS England are fully aware of the current financial position and also that the CCG will have no access to cash as the year end approaches to pay for any overtrading.

AC/17/08 Agenda Item 5.2 Period Nine Hard Close

MR explained that the process for a period nine hard close is to agree balances with other organisations, submit quarter three accounts and complete the cash predictions for the rest of the year.

The period nine submission for 2016/17 has included a requirement for £41million cash. NHS England are aware of this but continue to request that the CCG deficit is reported as £5million. The outstanding balance is currently shown as a debtor on the CCG accounts, this is unusual as the CCG is not a trading organisation and so is signalling the expectation of a receipt to cover the overall deficit. MR noted that many CCGs are failing to hit financial targets and that discussions regarding how this will be addressed should conclude over the coming weeks.

SB asked whether, without mitigation, the CCG would run out of money by the end of March. MR said that this would likely happen during February and that this position will be discussed with NHS England at the quarter two assurance meeting.

The period nine position was submitted on 19 January 2017 along with the governance statement. Mazars will begin to sample test the submission in February. JD noted that the Mazars audit report will consider the financial position as part of its Value for Money (VFM) assessment. However, in terms of governance, there is evidence that the CCG has been aware of the position throughout the year and that lay members have been well informed.

AC/17/09 Agenda Item 6 Audit Strategy Memorandum

JD presented the Memorandum and outlined key highlights:

- Mazars is on track to complete audit work by the 31 May 2017 deadline.
- Two significant risks have been identified:
    - Management override of controls.

    - Expenditure recognition
- The materiality level has been set at £5.063million.
- The triviality level has been set at £152k.
- A letter will be issued to the Secretary of State as a result of the financial deficit.
- No additional fees are expected over and above those outlined in the fee letter.

The criteria for VFM is the same as in previous years, however there are risks regarding the financial position. JD will lead work to look at CCG plans such as the Financial Recovery Plan (FRP) and QIPP schemes in relation to planned savings. He will also look at QIPP savings planned for 2017/18 and 2018/19. More information is required regarding the Accountable Care Organisation (ACO) and Sustainable Transformation Plan (STP) in order to assess the level of risk.

The Committee discussed whether it is possible to achieve a positive VFM conclusion at the same time as post a large financial deficit. SB noted that JLEB has implemented many VFM initiatives on prescribing and Consultant First, and the practice activity scheme. MR said that the CCG needs to show that it is doing as much as possible within the circumstances but felt that the deficit puts a positive VFM conclusion at risk.

JD felt that the best the CCG could achieve would be similar to the 2015/16 outcome; significant assurance apart from VFM. However the testing of VFM programmes and plans for 2017/18 savings would have to demonstrate positive VFM arrangements and outcomes. SB asked whether the 'unpalatable' list could also be taken into account. He noted that the proposals have been submitted to NHS England but the CCG has not been asked to take any forward. MR said that NHS England has signalled that CCGs should not consider actions such as rationing fertility services whilst the CCG is not meeting targets in fundamental areas, such as Right Care.

JD suggested that work to assess VFM could begin early, with initial findings presented at the March 2017 Audit Committee meeting. MR asked that detail regarding how the CCG is performing against the individual criteria is supplied in order to highlight areas which require further focus.

MR asked how the CCG can reflect the impact of pressures within the wider system, outside of the CCG's control, which affect the financial position. JD said that this would be encompassed within the wider report and reflected within expenditure and management override risks.

SB congratulated Mazars on their re-appointment as external auditors for the CCG.

Action AC/17/09/01: JD to begin audit work on VFM early and report back to the March 2017 Audit Committee meeting.

AC/17/10 Agenda Item 7 Internal Audit Progress Report

CB noted that AW has been formally appointed as Audit Manager following the AuditOne merger. AW now has an expanded portfolio and more support within the new structure. AW noted that she is working closely with the Audit Manager of South of Tyne which could result in a wider pool of benchmarking areas.

AW explained that four reports have been issued since the last meeting, all with substantial assurance. Good progress is being made against the audit plan and the remaining audits will be complete by March 2017. No issues have been identified to impact on the Head of Internal Audit Opinion and no changes to the plan are suggested. There were no outstanding actions to report.

AW provided the following updates:

- Fieldwork has begun on governance structures.
- Iain Flinn will carry out a conflicts of interest audit across all CCGs in the patch.
- An entry meeting regarding Vanguard and the ACO will take place on 26 January 2017.
- The Deprivation of Liberty Standards (DOLS) and CIP audits are underway.
- IG toolkit scoping will begin w/c 30 January 2017.

AW noted that the resource requirement for the outstanding audits is low and that timescales for the final submission of the Head of Internal Audit Opinion are more relaxed than the previous year.

AC/17/11 Agenda Item 7.2 Internal Audit Plan

AW presented the internal audit plan and noted that the plan has been spilt into two sections; services which are assumed to become the responsibility of the ACO and those remaining with the CCG as strategic commissioner. It is expected that the plan can be delivered against the agreed cost envelope regardless of the split.

SY noted that, as well as the split between ACO and CCG, the plan will need to take into account timescales for the ACO transition which are uncertain. AW said that the plan captures all potential risks regarding CCG functions but asked whether additional resource will be required to cover transitional arrangements. SY noted that is recorded in the CCG's risk register.

AW noted that there may be a need to increase audit on performance management when the ACO goes live. SY said that the way ahead in this respect remains unclear and will be established when the CCG and ACO governance structures have been fully determined.

The Committee reviewed the three year plan. SY noted that while the current assurance framework had been used as the basis for the plan transitional arrangements will need to remain a clear focus in the framework in the coming months.

SB asked, given the continued uncertainty of the ACO and how it may affect the assurance framework, whether there are areas of internal audit that need to be reprioritised at this stage. AW felt this was not required as all audit areas are beneficial and noted that audits relating to first year governance arrangements of the STP and the regional Value Based Commissioning (VBC) policy will be undertaken regionally. SB noted that the VBC policy had been approved by JLEB and asked whether this was a CCG policy. AW confirmed that John Warrington is the regional lead for VBC and that this was a regional policy enacted by CCGs.

Action AC/17/11/01: Internal Audit Plan to be formally approved at the March 2017 Audit Committee meeting.

AC/17/12 Agenda Item 8 Counter Fraud Update

PB provided a counter fraud update, noting that the date for submission of the self-review of CCG arrangements has been brought forward to 31 March 2017. No issues are anticipated.

SB noted that there was a previous Committee action regarding the CCG's inability to demonstrate effective fraud investigation as there have been no incidents of fraud to investigate. PB explained that a potential fraud incident relating to Personal Health Budgets (PHB) has now been identified.

SB asked what the legislative requirements would be should the allegation be proven as fraud. PB explained that there would be a criminal prosecution and any losses would be recovered through the usual debtor process. PB noted that the CCG had fulfilled all of its obligations in relation to the incident.

Action AC/17/12/01: PB to send details of the PHB fraud incident to MR.

AC/17/13 Agenda Item 9 Service Auditor Report

GW explained that the Service Auditor Report (SAR) is produced by Deloitte to provide assurance that the North East Commissioning Support Unit (NECS) is effectively delivering its internal controls and procedures. Over 60 controls were measured by Deloitte, with six exceptions reported. Four of these had been previously identified and declared by NECS, with action plans in place to ensure improvements.

The SAR covered the period up to the end of August 2016. A further report is due for the six months to 28 February and a bridging letter will be issued to cover March 17, as was the process for 2015/16. This allows for timely production of the accounts at year end. GW asked the Committee to consider the report and the actions in place for identified exceptions.

JD noted that Mazars have reviewed the SAR and found nothing that would cause any adjustments to the testing strategy or lead to material errors in the accounts. AW noted that the exceptions related to low level issues, mostly regarding lack of evidence. SB noted that the exception areas related to instances of processes not being documented but that there was no evidence of any controls failing. NECS have taken immediate remedial action to address these areas.

The Committee considered the SAR and confirmed that there were no ramifications for the audit plan, 2016/17 accounts or governance statements.

AC/17/14 Agenda Item 10 Governance Group Minutes

SY noted that the last meeting of the Governance Group focused on the information governance toolkit.

SB asked whether legal advice received from Ernst and Young (EY) represented a deviation from the Standard Operating Procedure. AW explained that EY had provided due diligence and not legal advice and so no deviation had occurred.

AC/17/15 Agenda Item 11.1 Chair's Briefing

SB to compile and share with Janet Guy

Action AC/17/15/01: SB to send briefing to the CCG chair.

AC/17/16 Agenda Item 11.2 Any Other Business

There was no further business to discuss.

AC/17/17 Agenda Item 12 Date of next meeting

23 March 2017.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Engagement, Public Health and Quality Committee (EPHQ)
Wednesday 18 January 2017

Members present:

Karen Bower (KB)	Lay Governor, Patient and Public Involvement (Chair**)**
Paul Crook (PC)	Governing Body Secondary Care Doctor
Cynthia Atkin (CA)	Healthwatch Chair
Jim Brown (JB)	Public Health Consultant

In attendance:

Annie Topping (AT)	Director of Nursing, Quality and Patient Safety
Stephen Young (SY)	Strategic Head of Corporate Affairs (Item 5.1 only)
Faye Menzies (FM)	Business Support
Margaret Tench (MT)	Safeguarding Children Nurse (Item 6.1 only)

EPHQ/17/01 Agenda item 1 – Introductions and Apologies for Absence

Apologies were received from John Unsworth and Janet Guy.

EPHQ/17/02 Agenda item 2.1 – Register of Interests and Review of Conflicts of Interest

There were no conflicts of interest.

EPHQ/17/03 Agenda item 2.2 – Quoracy

The meeting was quorate.

EPHQ/17/04 Agenda item 3 – Minutes of the meeting held on 16 November 2016

The minutes were agreed as a true and accurate record.

EPHQ/17/05 Agenda item 4 – Action Log/Matters Arising

Matters Arising

JB noted that the Drug and Alcohol Service contract has now been let to the existing provider. KB asked if there have been any changes to the nature of the contract. JB explained that there has been a 10% reduction in contract funding, however this should not result in any changes to the service. AT asked if a Quality Impact Assessment (QIA) was undertaken for the procurement process, noting that in Cambridge, taking a large chunk of money out of a contract had resulted in its collapse. JB confirmed that a QIA was undertaken and noted that Public Health (PH)

has been asked to make savings amounting to 27% of its budget. Options are currently being developed to look at what this will mean for commissioned services. Working with the Accountable Care Organisation (ACO) will be key. CA noted that there are contradictory messages when such large budget savings are required yet the Five Year Forward View (FYFV) pushes the prevention agenda.

Action Log

Actions **EPHQ/16/60/01** and **EPHQ/16/62/01** were agreed as complete and will be removed from the log. The following action was discussed in further detail:

- **EPHQ/16/63/01:** AT confirmed that Hilary Brown had not had sight of the quality visit report prior to circulation. AT has reinforced the correct process with the North East Commissioning Support Unit (NECS) and received commitment from them to ensure this is followed for future visits. AT noted that a further visit has taken place recently and the proper process was followed.

EPHQ/17/06 Agenda item 5.1 – Engagement

SY presented the report, highlighting the following:

Vanguard Co-Design Forum (VCDF): The next VCDF meeting will take place in Blyth on 26 January 2017; this will be the final meeting of year one. The central locality meeting in December 2016 focused on the ACO and the Medical Interoperability Gateway (MIG). Scott Dickinson (Chair of the VCDF) has noted that Vanguard funding achievement and the programme for 2017/18 has incorporated VCDF discussions.

The New Care Models (NCM) team has asked the Northumberland Vanguard to involve the VCDF in ongoing work regarding Empowering People and Communities (EPC). This presents an opportunity for the VCDF to focus on grass roots community engagement.

From February 2017 onwards, the initial proposal is that the VCDF will be led by Northumbria Health Care Foundation Trust (NHCFT) and will focus on involving the public and patients in designing health services from the outset. There will also be opportunities to involve more of the voluntary sector and Healthwatch in this work.

Phase one of EPC will look to map community assets and the VCDF will potentially become a wider EPC forum. CA noted that the Voluntary and Community Services (VCS) assembly could provide a useful sounding board for this work.

KB asked what level of support could be expected from NHS England. SY said that overarching central guidance is available. NHCFT will attend a national meeting of all EPC Vanguards. CA asked if self-management would be a focus of the EPC workstream. SY said that this will be woven into the process and that one of the main focuses will be isolation and loneliness.

Sustainable Transformation Plan (STP) Engagement: STP engagement events, facilitated by Healthwatch, have taken place in each of the four localities and were attended by the CCG and NHCFT. All meetings were well attended, however turnout was lowest in Blyth. The Committee noted the need to consider alternative ways of engaging with communities, other than meetings. SY highlighted the common themes discussed at engagement events:

- There was some confusion as to the differences between the STP, ACO, Vanguard and GP Forward View (GPFV). Information was shared as to how these elements fit together to improve the healthcare system.
- There was support and understanding for the CCG in terms of the lack of finance available.
- Discussion regarding EPC and patients taking more responsibility for themselves at community level.

JB asked whether any concern was expressed regarding consolidation of hospitals and acute services generally. SY said that there was some discussion regarding the potential/perceived loss of services as a result of the STP and the need to make financial savings.

CA noted that there were also discussions surrounding social care and recognition that funding in this area is limited. There was also concern regarding how the funding that is available is allocated. SY felt that a social care representative would be useful at future engagement events to help provide additional background. AT noted that there has been discussion at regional STP meetings about the need to engage with the public jointly with the Local Authority (LA) as issues are broader than just discharges. JB noted that Northumberland has the lowest level of delayed discharges in the country.

CA noted that social care eligibility criteria has changed over the years and that long term social care support within the community is limited. PC asked whether LA involvement with the ACO would further integrate social care. JB explained that the funding envelop will not be included due to the current requirements for means testing of budgets.

CA noted that, although Northumberland's contribution to the STP is essentially the creation of the ACO, there are areas that could impact on Northumberland patients due to regional changes. SY said that the STP will be consulted on as a whole but any major changes to services would be consulted on separately.

Rothbury Community Hospital (RCH): SY noted that the 'Save Rothbury Hospital' campaign group had attended three of the STP engagement events, with the exception of the meeting in the north.

The Joint Locality Executive Board (JLEB) has selected an option for public consultation. Consultation documents have been prepared and will be submitted to NHS England for review. Public consultation should begin by the end of January 2017, assuming assurance is received from NHS England.

Youth Engagement: The CCG will be presenting to sixth form students at King Edward VI high school to discuss healthcare in Northumberland. The ACO will look to move youth engagement activity forward.

SY said that there is a need to consider which elements of engagement will remain with the Strategic Commissioner and which will become part of the ACO. JB said that the ACO will provide opportunities to link up with youth engagement taking place in other organisations such as the LA, PH and Healthwatch. CA noted that she is chair of the Children and Young people's (CYP) Strategic Partnership Forum, which is attended by key engagement officers. The forum could present an opportunity to reach a wider group of young people. AT noted the need to ensure that feedback from young people is fed into the co-design process.

Member Engagement: The Committee considered the GP TeamNet (GPTN) statistics for December 2016. SY highlighted that Seaton Park Medical Group (SPMG) accounted for 58% of GPTN usage. This is due to the large size of the practice and also that SPMG uses GPTN as its intranet and therefore utilises all of the features. When comparing December 2015 and December 2016 data, even with SPMG data removed, usage has increased dramatically, as has the number of practices utilising GPTN. There are currently three practices not using GPTN; visits have been arranged to these practices and a webinar is to take place to share learning.

JB asked what the objectives of GPTN are. SY explained that there are multiple purposes including information sharing, governance and clinical pathways. GPTN was recently taken over by Clarity; the company will be exploring creation of a mobile app. JB noted his previously declared interest with regard to Clarity Informatics.

PC asked which elements of engagement will remain with the Strategic Commissioner and which will be covered by the ACO. SY said that this has not yet been considered as governance and staffing are still to be agreed.

JB asked whether CCG member practices have voted to become part of the ACO. SY said that this vote has not yet taken place as information to support decision making is still in development. A vote has been taken as to how the member practices as providers would be represented within an ACO, with a federation approach being the preferred option.

Healthwatch Feedback: CA noted that the Committee had previously requested an overview of practice specific comments from the Healthwatch feedback report. CA explained that 17 comments were received regarding GP practices, the majority of which were positive and just five were negative. Some negative comments focused more on the wider system than the care being received, others touched on appointment booking and patients feeling that doctors were not listening during consultation. AT noted that a CCG process is in place to review the performance of practices and so it would be useful if comments specific to practices could be shared with the CCG for discussion with the practice in question. CA said that Healthwatch's new Customer Relationship Management (CRM) system will identify this information.

EPHQ/17/07 Agenda item 6.1 – Update on safeguarding Children

MT presented the report and outlined key headlines:

- Two Serious Case Reviews (SCRs) are ongoing and a Domestic Homicide Review (DHR) has been concluded but is not yet published. Learning events have taken place and key lessons have been built into GP safeguarding training.
- There have been three suicides of young males by hanging. There was a connection between the first two deaths via the college both males attended. Work has been undertaken with the college, including PH suicide prevention activities. PC asked whether any of the young males were known to mental health services. MT confirmed that there had been heavy involvement in one of the cases but none in the others.
- An internal audit was completed in October 2017 with substantial assurance received. An action plan of low level issues has been developed and all actions completed. SY noted that Audit Committee will consider the safeguarding audit report as part of the overarching programme update report.
- Provider assurance is given to the CCG on a quarterly basis, with the exception of the North East Ambulance Service (NEAS), which covers large regional areas. MT and Fiona Kane attend the NEAS safeguarding board for assurance purposes. NHCFT and the Northumberland, Tyne and Wear Trust (NTW) give regular updates to the Northumberland Safeguarding Children Board (NSCB), no significant issues have been identified. PC asked whether there were ongoing concerns regarding NTW waiting times. MT said that Daljit Lally is leading a series of strategic meetings to address these issues.
- Primary care single agency training is ongoing and has been well received.
- There are currently no major issues in relation to Looked After Children (LAC). There are challenges regarding assuring assessments for LAC placed out of area, however a process is in place.

MT said that criminal proceedings are complete for one of the SCRs and preparations are underway for publishing the report. KB asked whether there are any issues of concern for the CCG. MT said that there are no specific CCG issues, however the SCR largely focused on the mother. Now that the father has pleaded guilty, an addendum will be added to the report to reflect the finalised criminal proceedings.

JB noted that the draft Suicide Prevention Plan is currently out for review. Some data issues have been highlighted and questions raised regarding who will implement the plan. MT felt it would be useful to be involved as chair of the Child Death Overview Panel (CDOP).

EPHQ/17/08 Agenda Item 6.2 – Quality Report

AT introduced the report, noting that Governing Body members had previously had the opportunity to consider and discuss the content at JLEB on 21 December 2016. She asked for any questions or comments from the Committee by exception.

JB expressed concern regarding ongoing high sickness absence rates at NEAS and asked if the rates are in line with other ambulance trusts. AT said that the CQC report for NEAS was good, however there were specific comments in relation to the comparatively low staffing levels. NEAS is currently recruiting and should be up to full complement by March 2017. Low staffing levels can cause stress for existing staff, this should hopefully be improved by recruitment efforts.

PC noted that in recent staff surveys, only 40% of staff said that NEAS was a good place to work. AT felt this was a reflection of stresses due to current activity and issues in the urgent care system. The CQC has written to NEAS following the recent ECIP review of the whole system and an action plan is expected from NEAS in response. JB asked whether the action plan will be reviewed by EPHQ however it was noted that is an operational issue and therefore not a function of the Committee.

KB noted that NEAS have been carrying vacancies for some time. AT explained that the CQC has recognised NEAS' efforts to address this, however staff recruitment takes time.

KB noted that there has been a reduction in Serious Incident (SI) reporting and asked if this is a positive trend. AT said that in general higher incident reporting but lower levels of harm are preferable, however the reduction could be positive. The position will be better assessed through the six monthly provider reporting when the data can be considered in context.

JB asked whether a local anti-microbial action plan exists. AT explained that there is a local Healthcare Associated Infections (HCAI) action plan with preventative actions identified. There are also local targets on antimicrobial prescribing and the CCG is doing well on these. The local HCAI working group has been held as an exemplar in relation to benchmarking activities and how work is linked with prescribing rates and shared with case reviewers.

PC asked whether the eight reported 'never events' represent a high volume. AT explained that most events were surgical and related to NUTH. Newcastle CCG as lead commissioner is overseeing the investigation process and at the last regional Quality Surveillance Group, they confirmed that a process is in place to work with the provider. There is also a regional learning event on never events to take place in February 2017 to pick up on lessons and develop improvement actions.

PC noted that the report stated that there have been fewer pressure ulcer serious incidents, however this did not seem to be reflected in dashboard figures. AT explained that safety thermometer data in the dashboard relates to only one day of performance reporting and also that not all pressure ulcers occur in hospital.

CA asked whether any work has taken place with care homes in relation to pressure ulcers. AT said that care homes are commissioned by the LA. Fiona Kane works with the LA around care home safeguarding and reports back to the Quality Intelligence Group (QIG). AT asked whether Healthwatch could share any issues in relation to care homes. CA confirmed that Healthwatch has not been carrying out 'Enter and View' visits and is not able to identify the providers from the feedback received. The

Committee discussed intelligence sharing between the CCG, Healthwatch and the LA.

JB suggested than an audit of a sample of pressure ulcer cases, to determine where pressure ulcers had originated from, may be worthwhile. AT said a piece of work is currently in progress to look at serious incidents related to pressure sores, and will discuss expanding the scope with the North East Commissioning Support Unit (NECS).

KB asked how many of the SI reports not received within deadline were relevant to the CCG. AT said that the issue of 'overdue reports' has been raised at providers' Quality Review Groups (QRG), and internal processes are being evaluated. JB asked how the decision is made as to which SI cases are reviewed by the SI panel. AT explained that all SI cases are reviewed by the panel, in line with the national process. The CCG performs well regarding timescales.

KB noted that the 'percentage not recommended' score for the NTW friends and family test is above the national average and asked whether any analysis has been undertaken to assess the reasons for this. AT confirmed that NTW has a process in place to analyse the scores and its findings and respond accordingly.

Action EPHQ/17/08/01: AT to discuss auditing of pressure ulcer cases with NECS.

EPHQ/17/09 Agenda Item 6.3 – Quarter Two Patient Choice Report

AT presented the report, explaining that the CCG reports against nine key areas outlined in the NHS choice framework. The report for quarter two focused on community services. However, the information available is limited to mental health services. CQC annual surveys have been used to compare data at national and trust level.

There was a 28% response rate to the mental health survey, which JB felt was too low for good comparison to be made. However, AT noted that 28% was a valid response rate for postal surveys for comparative purposes.

Of the 40 questions asked in the survey, five related to patient choice and comparisons made between 2015/16 and 2016/17 data. Other than one area, the CCG performed better than the NHS England average against all indicators. AT will share the figures with NTW at the next QRG meeting. AT is also looking for a comparable peer to benchmark against in order to identify areas of focus.

KB noted the need to obtain greater understanding of the reasons for low scoring in relation to agreement between patients and NHS services about the care patients will receive. The Committee felt that some responses may be due to the respondents perception of the question and that the survey was not worded in plain English.

Action EPHQ/17/09/01: AT to share patient choice data regarding community services with NTW at the next QRG meeting.

EPHQ/17/10 Agenda item 7 – Any other business

Public Health Skills and Knowledge Framework

JB presented the framework, which was developed in response to changes in the Health and Social Care Act, changes in staffing and budget pressures. It will be used to inform job descriptions and the range of work undertaken in relation to Public Health (PH) across all sectors.

JB noted that not all organisations recognise their PH role and that there will be opportunities to consider this further as part of ACO development. Population health is a key outcome for the LA and will be at the heart of the ACO. Alistair Blair is developing the ACO Clinical Strategy and JB has drafted a PH strategy for healthcare, a key objective of which will be making every contact count. The strategy considers the wider concept of health, including social determinants, debt etc. Conversations regarding the strategy will help to identify where the framework sits and how it will be delivered.

AT suggested that PH links with organisations such as NECS to look at building PH responsibilities into job descriptions would help managers to have conversations about these duties as part of the appraisal process. JB asked whether NECS will manage ACO recruitment. AT said that this has not yet been defined.

KB asked why education is not mentioned in the framework and JB agreed that teachers have a big role in health promotion and improvement. However there are considerations regarding the extent to which schools are willing to fund some of the work.

CA noted that a question raised at the STP engagement events was what the definition of prevention is. JB noted that the STP does not mention promotion of PH. CA felt that in order to change behaviours, the language needs to be clear and free of jargon.

AT asked how visible the strategy is regionally and whether conversations are taking place regarding where there may be opportunities and mechanisms to implement recommendations, such as local workforce action boards. JB said that there is currently a sense that PH is competing with other priorities rather than being embedded as core business and that additional funding is not available to increase influence. More marketing of PH is needed.

PC felt that perceptions of PH need changing and asked how this could be achieved. CA felt that PH should be threaded through the ACO in terms of self-management and prevention and that there could be opportunities to be imaginative and innovative without increasing spending. AT said that one of the challenges for the Strategic Commissioner will be to ensure that delivery of strategic health outcomes is embedded in contracts.

KB asked whether PH bodies across the STP patch will be working together to pool resources. JB said that this is already happening with some benefits but that finding the right way forward is a challenge under the pressure of reduced budgets.

Cynthia Atkin

The Committee noted that this was potentially CA's last attendance at EPHQ meetings and thanked her for her input.

EPHQ/17/11 Agenda item 8 – Date and time of next meeting

15 March 2017 at 0930. Venue: Warkworth Meeting Room, County Hall.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Public Meeting of the NHS Northumberland Primary Care Commissioning Committee
21 December 2016

Members Present:

Janet Guy	Lay Chair Northumberland CCG
Karen Bower	Lay Governor Northumberland CCG
Julie Ross	Chief Operating Officer
Mike Robson	Chief Finance Officer
Steve Brazier	Lay Governor Northumberland CCG

In attendance:

Stephen Young	Strategic Head of Corporate Affairs
Faye Smeaton	Business Support
Diane Gonsalez	Locality Manager
Jane Lothian	Local Medical Committee
Denise Jones	NHS England

NPCCC/16/113 Agenda item 1 - Welcome and questions on agenda items from the public

Janet Guy welcomed all members to the meeting. There were no members of the public present.

NPCCC/16/114 Agenda item 2 – Apologies for absence

Apologies were received from Scott Dickinson, Mike Robson and Cynthia Atkin.

Julie Ross noted that Siobhan Brown will be the NHS Northumberland Clinical Commissioning Group (CCG) lead officer for this Committee for future meetings as Julie is leaving the CCG.

NPCCC/16/115 Agenda item 3.1 – Declarations of conflicts of interest

Karen Bower is a patient of Wellway Medical Group, which will be discussed under item 5.3. The Committee agreed that this was not a significant conflict and that Karen would take part in discussions. Julie Ross is line managed by a partner of Wellway Medical Group; it was agreed that Julie would not take part in discussions under item 5.3.

Jane Lothian is an employee of Rothbury practice; the Committee agreed that Jane would not take part in discussions under item 5.5.

NPCCC/16/116 Agenda item 3.2 – Quoracy

The meeting was quorate.

NPCCC/16/117 Agenda item 4 – Minutes of the previous meeting

The minutes were accepted as a true record pending one amendment to show that Jane Lothian had submitted her apologies for the meeting.

NPCCC/16/118 Agenda item 4.1- Matters arising

There were no matters arising.

NPCCC/16/119 Agenda item 4.2 Action Log

All actions were agreed as complete and will be removed from the log.

Agenda item 5 Operational

NPCCC/16/120 Agenda item 5.1 Operational Update Report

Julie Ross presented the report and highlighted the following:

The Outline Business Case (OBC) was discussed by the Joint Locality Executive Board (JLEB) and the Governing Body on 21 December 2016. The OBC will be submitted to NHS England (NHSE) and NHS Improvement (NHSI) on 23 December 2016.

CCG members have voted for a federation approach in relation to establishing a primary care voice within the ACO. The vote had a large turnout and voting practices covered 98% of the population. Jane Lothian is working with Pamela Leveny to create a legal agreement for the federation. There is potential for the federation to develop into a joint venture over time.

Julie noted that Jane undertook a great deal of work to ensure a high turnout for the vote and also that Jane will be undertaking a big task in translating the federation approach into a legal agreement. The Committee thanked Jane for her work.

Seaton Park Medical Group (SPMG) has recruited a number of GPs and is consequently now able to resume the previously suspended Newbiggin branch surgery. The Committee congratulated SPMG for their work in this area.

The owner and PMS contract holder of the premises currently used by Felton practice passed away earlier in 2016, leaving the practice with no lease for the premises. The practice was then asked to immediately secure tenure, create an interim solution and a long term plan for the future of the practice. Tenure has been secured however the practice continued its efforts to secure new, larger premises in the area. The Committee noted that any relocation should be in line with its principle of cost neutrality and that the sustainability of the practice needs to be ensured.

Jane felt that the Committee should provide strategic guidance to practices concerning

similar issues to ensure that practices do not spend time compiling evidence for potentially unrealistic proposals. An overarching strategy could provide guidance. Mike Robson to liaise with Stephen Naylor to request that key overarching principles are written into the primary care estates strategy. The Committee will consider the principles in February 2017.

The primary care commissioning self-assessment has been assured as 'good'. The Committee thanked Stephen Young and Diane Gonsalez for their work in this area.

Action NPCCC/16/120/01: Mike Robson to liaise with Stephen Naylor to request that five key principles to be written into the primary care estates strategy. The Committee will consider these principles at its February 2017 Meeting.

NPCCC/16/121 Agenda item 5.2 Otterburn Branch Surgery

Denise Jones presented the report, highlighting:

- The Bellingham practice has applied to close its branch surgery in Otterburn, which currently operates for six hours per week.
- The practice wishes to close the branch surgery following a CQC inspection which highlighted concerns regarding lone working, infection control issues and the capacity to deal with an emergency situation.
- The MDU has advised that, should a serious incident occur at the branch and the practice had been aware of the possibility, this could cause significant issues.
- Following this advice, the branch was closed in March 2016 and a six month review of the provision took place.
- Subsequent to the results of the review, the practice is applying to permanently close the branch.

Denise noted that a number of the patients from the former Harbottle surgery are now registered at Bellingham practice and using the Otterburn branch. These patients therefore may experience more than one closure.

The practice has undertaken significant engagement with patients and stakeholders. Response rates from patients were low. Meetings have been held with two local parish councils, both of which raised concerns, as did the local MP. Stephen Young noted that the future of Otterburn was raised as a concern during the second phase of the Harbottle consultation and this has been cited in the Healthwatch report. Stephen further noted that the practice has looked into usage by former Harbottle patients and have concluded that these patients use both Bellingham practice and the Otterburn branch.

Julie Ross asked the Committee to note that the Practice has been transparent throughout regarding concerns over the branch surgery. Julie noted that Northumberland County Council (NCC) has now offered the Otterburn site to a local business. Julie recommended that the Committee approved the application for closure as the CCG is unable to underwrite the risks involved. Discussion will be required with NCC's Overview and Scrutiny Committee (OSC), the local councillor and MP before a formal approval letter is issued.

Jane Lothian felt that this is another example of where an articulated strategy would be helpful, particularly for the rural areas. Practices feel unable to run branches but need to undertake a great deal of work to close them. Jane also felt that it is important to be honest

with the public and explain that it is not possible to provide a CQC standard service in Otterburn within the currently available funding.

Janet Guy noted that there cannot be a list of criteria for practices to follow as each scenario differs but that a list of alternative methods of service delivery may be useful to practices that are struggling.

Karen Bower noted that there are only two buses in and out of Otterburn on a Friday and asked if there is a pharmacy in the area. Julie confirmed that there is not. Karen asked if having prescriptions delivered to patients is an option. Stephen Young will look into this further.

Karen asked if Otterburn patients travelling to Bellingham could be given priority at the pharmacy when picking up prescriptions, in order that they can ensure they catch the limited transport back to the village. Janet noted that this has not been raised as an issue in any of the patient engagement. Stephen will ask the Bellingham practice to consider this but noted that the branch surgery has already been closed since March 2016 without any issues of this kind being raised.

Action NPCCC/16/121/01: Stephen Young to investigate the possibility of prescriptions being delivered/priority pharmacy services in Bellingham for Otterburn patients.

Decision: The Committee approved the application to close the branch surgery in Otterburn.

NPCCC/16/122 Agenda item 5.3 Brockwell, Lintonville and Wellway Reconfiguration

Stephen Young presented the report, explaining that the proposed reconfiguration is not a full practice merger but a proposal to merge the back office functions to improve efficiencies. NHS England has confirmed that, as there are no financial implications and there will be no changes to patient lists, a full business case is not required.

Jane Lothian said that it is important for the CCG to support proposals such as this, as these kinds of arrangements make primary care services stronger and more sustainable. She asked why partners would be party to individual contracts. Diane Gonsalez felt that this would be as a result of legal guidance.

Janet Guy noted that the proposal is for an administrative but not full merger and asked how this works as the partners will be coming together into a single partnership. Denise Jones explained that a full merger would see all staff on new contracts for a single organisation and patient lists would merge. Janet requested clarity that under the proposed arrangements, GPs would only see patients from their own practice's patient list. Denise confirmed this was the case.

Decision: The Committee approved the proposed reconfiguration of Brockwell, Lintonville and Wellway practices.

Action NPCCC/16/122/01: Stephen Young to draft a letter to Brockwell, Lintonville and Wellway practices, on behalf of Janet Guy, confirming approval of the proposed

reconfiguration.

NPCCC/16/123 Agenda Item 5.4 Waterloo and Station Merger

Stephen Young presented the report, noting that the Committee has previously considered and approved the proposed merger with the caveat that costs to the CCG do not exceed £13k. The District Valuer has now assessed the proposed property changes and void space costs. Rent will increase from £26k to £63k as a result of the NHS Property Services revaluation across all properties and this would occur irrespective of the merger. The District Valuer has assessed the revised layout additional costs to the CCG as £14,841. Stephen noted that, while this is above the £13k previously agreed by the Committee, the increase is beyond the practice's control and the merger is still in line with the CCG's overall strategic direction.

Jane Lothian noted that the void space issues are a direct result of the practices merging in order to create efficiencies and felt that the practice should be supported in this. The practice could give notice on the entire Waterloo practice space, which would result in more costs to the CCG. Jane said that the Committee's principle of financial neutrality needs to be considered in the wider context of the clinical strategy. Karen Bower explained that the Committee had previously decided that the principle of financial neutrality applies to relocations and not mergers.

Julie Ross noted that if notice was given on the whole Waterloo practice, the CCG would be in a stronger position to re-let the space. Julie explained that the CCG is keen to support the merger and that the higher cost is marginal, but it does leave the CCG with a financial liability.

Janet Guy noted that the £13k was an estimated figure given to the CCG as a maximum cost and as such was accepted as the maximum cost. The additional cost may not be a large amount, but accepting it sets a precedent for creep in other areas. She asked if the practice could cover the additional cost themselves.

Julie noted that the District Valuer's assessment had been surprising to all parties due to the rent increases. She suggested that the Committee agreed to absorb the additional cost for void space on this occasion but to be mindful that the CCG is not in a position to routinely accept raised costs.

Decision: The Committee approved the merger of Waterloo and Station practices.

Action NPCCC/16/123/01: Stephen Young to draft letter to the Waterloo/Station practice manager and a response to the Solicitors.

NPCCC/16/124 Agenda Item 5.5 Rothbury Contract Variation

Denise Jones presented the application from Rothbury Practice to subcontract clinical rights and duties to Northumbria Primary Care (NPC). The Committee has previously considered similar arrangements in Cramlington and there are currently three practices in Northumberland operating similar arrangements. The practice has submitted a deed to NHS England; if approved, the same legal principles will apply to the Rothbury application as were in place for Cramlington.

Julie noted that as NPC are already running other practices in Northumberland, this proposal could be seen as a merger and asked how risks would be mitigated. Denise said that, as this is a sub-contract, some risks are mitigated. She explained that every time a deed for sub-contracting is received, NHS England perform checks to ensure details are in line with previous contracts.

Karen noted that the deed states that staff will be transferred to NPC and asked if this means that NPC will no longer be service providers. Denise explained that the partners will still own the practice and hold the contract for NPC and therefore NPC remains a service provider but will employ staff. Karen asked whether there could be a situation in future where there are no partners. Denise confirmed that this could not happen as someone must be in place to hold the contract. The agreement makes provisions to ensure that NPC cannot take over the practice.

Karen asked what the process would be if there are problems with the NPC service provision. Denise said that this is adequately detailed in the deed.

Decision: The Committee approved the application subject to receipt of the indemnity certificate from NPC and confirmation from NPC that it holds current registration with CQC.

Agenda item 6 Strategic

NPCC/16/125 Agenda Item 6.1 Vanguard Update

Julie Ross gave an update regarding the progress of the Vanguard programme:

- 60% of the population is now covered by a same day demand system, however there are significantly different access models across the patch. For example, NPC is still running a three day appointment system.
- SystmOne migration is going well and is expected to be cover 80% of Northumberland's population by March 2018.
- All practices have now signed up to the Medical Interoperability Gateway (MIG).
- There has been a spike in low acuity activity at the Northumbria Specialist Care Emergency Hospital (NSECH) beyond anything that was planned for. A proposal has been put forward to put a primary care triage into NSECH from January 2017. Although this decision lies outside of the Committee, Julie welcomed views from Committee members.

Stephen Young noted that Primary Care Access Centre (PCAC) at Wansbeck General Hospital (WGH) closed on 1 December 2016. Opening a primary care triage at NSECH could therefore result in adverse public perception.

Karen Bower said that placing primary care triage at NSECH does not fit with what the hospital was designed to do (provide emergency care). Jane Lothian said that modelling for NSECH was undertaken on the basis of a 'closed front door' and that access to primary care triage at the hospital will only attract more people to the hospital and dilute the services already available.

Janet Guy asked if research is available about whether it is possible to change public attendance behaviour. NSECH is already undertaking tasks that it was not designed for and as a result hundreds of additional people are turning up each day. The hospital either needs to begin turning people away or make a provision to deal with the extra demand. It is also important to consider the expense, as it costs £60 per person who presents at A&E, whether or not they require urgent attention. Stephen said that a great deal of work by the North East Urgent Care Vanguard team to better understand behaviours and consider how to change them is underway. The ACO is the ideal opportunity to address the issues at NSECH.

The Committee felt that NSECH's primary function is to provide emergency healthcare and was never designed to have any kind of primary care provision. The Committee also felt that the proposal was not consistent with the aims of the Vanguard Programme.

NPCCC/16/126 Agenda Item 6.2 GP Forward View Plan

The GP Forward View (GPFV) plan will be submitted on 23 December 2013. Julie Ross highlighted the key areas for consideration and will circulate the final submission to the Committee.

Decision: The Committee approved the GPFV plan for submission.

NPCCC/16/127 Agenda Item 6.3 Primary Care Assurance

Julie Ross presented the report, explaining that NHS England has published the final version of the "Primary Care Medical Services Assurance Framework" which outlines the process that will be used to assess the quality of primary care services. The CCG has an established process, using a national primary care web tool, to highlight any areas of concern and undertake work with the relevant practices.

One practice highlighted as requiring review in quarters one and two has been asked to submit an action plan. Julie suggested that any practice highlighted as 'review identified' is asked to provide their review reports for consideration at the private meeting of this Committee. This was agreed.

The Local Quality Group (LQG) has suggested that one of its members attends PCCC meetings to review let contracts and provide a quality overview. The Committee discussed this and felt that this is not required at each meeting but that a member of the LQG will be asked to attend and present reports at the private meeting as and when required.

Karen Bower noted that the quarter one and quarter two reports were very similar, however noted that the reports don't give a feel for the areas of concern. Stephen Young to raise this with Annie Topping.

Julie noted that it will be important to engage the ACO in Committee business going forward and that consideration should be given to inviting an appropriate ACO representative to attend future meetings. Siobhan Brown will present a paper regarding this at the February 2017 Committee meeting.

Action NPCCC/16/127/01: Stephen Young to discuss the inclusion of further details

regarding issues highlighted within primary care assurance reports with Annie Topping.

Action NPCCC/16/127/02: Siobhan Brown to present a report regarding ACO representation at the PCCC to the February 2017 meeting.

NPCC/16/128 Agenda Item 7 Any other business

Harbottle

Negotiations with Rothbury practice regarding ex-Harbottle patients is not yet complete. The current Service Level Agreement (SLA) expires on 31 January 2017. Stephen Young asked the Committee to approve the extension of the SLA as and when the need arises until negotiations are complete. Janet Guy said that the Committee will consider an extension to the current SLA if the need arises and that this may exceptionally have to be considered out of committee due to the potential timescales involved.

Julie Ross

Janet Guy noted that this will be Julie Ross' last day at the CCG and last attendance at PCCC. The Committee thanked Julie for her work and wished her well for the future.

NPCCC/16/129 Agenda item 8 Date and time of next meeting

1200 on 15 February 2017, Committee Room 2, County Hall

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Joint Locality Executive Board Meeting
Wednesday 25 January 2017, 0900
Chairman's Dining Room, County Hall

Present

Steven Mason (SM)	Accountable Officer (Chair)
Alistair Blair (AB)	Clinical Chair
Vanessa Bainbridge (VB)	Chief Operating Officer
Mike Robson (MR)	Chief Finance Officer
David Shovlin (DS)	Locality Director - West
Annie Topping (AT)	Director of Nursing, Quality and Patient Safety
Frances Naylor (FN)	Locality Director – Blyth Valley
Siobhan Brown (SB)	Transformation Director
Hilary Brown (HB)	Locality Director – North
John Warrington (JW)	Locality Director – Central

In Attendance

Stephen Young (SY)	Strategic Head of Corporate Affairs
Faye Menzies (FM)	Business Support
Janet Guy (JG)	Lay Chair
Paul Crook (PC)	Governing Body Secondary Care Doctor
Karen Bower (KB)	Lay Member - Resources and Performance and PPI
Steve Brazier (SBr)	Lay Member – Audit
John Unsworth (JU)	Governing Body Nurse
Jeremy Pease (JP)	ECIP Improvement Manager (Item 6.6 only)

JLEB/17/01 Agenda Item 1.1 Apologies for absence

There were no apologies for absence.

JLEB/17/02 Agenda Item 1.2 Declarations of conflict of interest

MR noted that, as Chairman of St Oswald's Hospice (SOH), he has a conflict of interest regarding agenda item 6.5. The Joint Locality Executive Board (JLEB) agreed that MR would not take part in the discussion for this item.

Conflicts of interest were highlighted for item 6.4 (described in the minutes for that item).

JLEB/17/03 Agenda Item 1.3 Quoracy

The meeting was quorate.

JLEB/17/04 Agenda Item 2 Minutes from the previous meeting

The minutes of the previous meeting were agreed as a true and accurate record.

JLEB/17/05 Agenda Item 2.1 Matters arising

There were no matters arising.

JLEB/17/06 Agenda Item 3 Review of actions register

The following actions were agreed as complete and will be removed from the actions register:

JLEB/16/254/01	**OBC/EY letter**
JLEB/16/254/02	**OBC amendments**
JLEB/16/254/03	**RADR data**
JLEB/16/254/04	**Health outcomes**
JLEB/16/254/05	**OBC discussion with PWC**
JLEB/16/255/01	**Heads of Terms**
JLEB/16/259/01	**STP funding breach**
JLEB/16/259/02	**Paediatric patients**
JLEB/16/263/01	**SIRMS**

JLEB/17/07 Agenda Item 4 Chief Operating Officer report

VB presented the report, highlighting the following:

- **CCG Accountable Officer (AO):** SM has been confirmed as the AO for NHS Northumberland Clinical Commissioning Group (CCG). The Appointments and Remuneration Committee (ARC) will meet 25 January 2017 to consider the appointments of AB as Clinical Chair, VB as Chief Operating Officer and Daljit Lally as System Transformation Director.
- **Urgent and Emergency Care (UEC):** The Local A&E Delivery Board has now been established and is working well. Task and Finish (T&F) groups will be established to enable workstreams to be taken forward. The key focus will be on implementing the recommendations of the Emergency Care Improvement Programme (ECIP) report.
- **Winter funding:** Funding received from NHS England to increase the availability of primary care appointments over the winter period resulted in some successful initiatives. 50 additional slots were created, with a 75% uptake. This compares well to other areas in the region.
- **Sustainable Transformation Plan (STP):** Four STP engagement events (one in each locality) were held and attendance levels were good. The sessions focused on describing how the STP, Accountable Care Organisation (ACO), the Five year Forward View and broader vanguard work fit together to improve the healthcare system in the county.
- **Talking Matters Northumberland (TMN):** The TMN contract remains in escalation and is being closely monitored. The escalation arose due to failure to meet a specific target, which has now been rectified. However, during the escalation period other targets have been missed. Process dictates that escalation must been removed as the original issue has been addressed. However VB has requested a review of other areas of underperformance.
- **Children and Young People's Services (CYPS):** AB and VB recently met with John Lawlor, Chief Executive of the Northumberland, Tyne and Wear Trust (NTW) to discuss current areas of concern. The NTW Board has discussed ongoing areas of risk and agreed to bring in agency staff in the interim. A system wide meeting has identified operational process issues which NTW and other organisations need to address; an action plan is in development. Contract escalation will be considered if waiting times do not improve.

FN asked for further clarity regarding the underperforming areas of TMN and how these differ from the original escalation issue. SY to include further detail in the director's brief.

SBr noted that the TMN contract is one of very few that has been re-let by the CCG and asked if lessons learned should be reviewed. VB said that there had been a clear award process for the contract and the issues have subsequently arisen due to internal TMN issues. JG noted that the Resources and Performance Committee (R&P) had recently received a report regarding TMN contract performance and were assured that sufficient work is underway to address the current issues.

Actions:

JLEB/17/07/01: SY to include further detail of TMN underperforming areas in the director's brief.

JLEB/17/08 Agenda Item 4 Locality Meeting Feedback

The Blyth Valley and central localities did not meet in January. There were no specific strategic items for consideration. Common themes were:

- The north locality request that Quality Impact Assessments (QIAs) are completed in relation to Consultant First in order to understand rejection rates, conversion rates and costs. JW said that these things would not be addressed in a QIA and requested that the locality clarifies the specific quality concerns for further consideration.
- West locality showed strong support for pharmacists in practices. There was also a great deal of discussion regarding the primary care voice within the ACO and concerns that secondary care activity is creeping into primary care, without the resources available to address this.

AB noted that a care home had attended the west locality meeting regarding respite beds and advised caution as this could be seen as preferential treatment due to the number of other care home operators in the county. DS assured JLEB that the care home in question was invited to speak as they are a charitable organisation which provides free beds.

Actions:

JLEB/17/08/01: HB to clarify north locality quality concerns in relation to Consultant First.

JLEB/17/09 Agenda Item 5.1 Quality Report

AT presented the report, outlining the performance exception areas as of December 2016:

- **Healthcare Associated Infections (HCAI):** Newcastle Hospitals (NUTH) has breached its Year to Date (YTD) c.difficile target.
- **Serious Incidents (SIs):** There has been an increased volume of SI reporting, which mirrors reporting levels for the same period in the previous year. NUTH has reported more slips, trips and falls and has also reported a 'never event', bringing the YTD total to nine. The Quality Surveillance Group (QSG) received assurance from Newcastle Gateshead CCG that they are content that appropriate actions have been carried out in response to never events.

- **Retinal Screening:** A regional SI has been raised regarding a failure to carry out a quality failsafe check. NHS England has contacted practices to request further checking of the status of patients. AT will report back to JLEB following these checks. FN and AT to discuss the involvement/updating of the Diabetes Interest Group.
- **SIRMS:** 39 incidents were reported by GP practices in December 2016. The volume of red incidents has increased since October. The North East Commissioning Support Unit (NECS) is working to refresh training and encourage practices to use the system.
- **Safety Thermometer:** NUTH and NHCFT are outliers in relation to pressure sores. A deep dive will be carried out to look at themes and patterns.

HB noted that no patient harm has been highlighted as a result of never incidents and asked for clarity. AT explained that there is a specific definition of harm used for reporting purposes. JU felt it was important to understand the degree of harm in order to ensure incidents are not repeated. AT explained that there is a nationally prescribed process for dealing with never events and that a NHS England learning event is taking place in February 2017. AT will present information regarding types of harm and a summary of event outcomes in the February 2017 JLEB quality report.

SBr noted that Northumbria Health Care Foundation Trust (NHCFT) has not reported any never events in recent months and asked if this could be due to lack of monitoring. AB explained that the CCG would not expect never events to be regularly reported as they are very rare. They are not externally monitored and would be self-reported by NHCFT. AB felt that there were no clinical concerns with regard to NHCFT in this area. VB noted that the CQC comprehensively consider never events and would raise any concern during inspections.

JU asked what providers are doing to monitor and address ongoing issues. He felt that falls prevention and pressure sores evidence required review in order that the CCG can be assured that new approaches are being implemented. AT assured JLEB that there is continuing and constructive challenge, with evidence regularly reviewed by the Quality Resilience Group (QRG). Providers were recently asked to supply evidence as to how they perform against a national audit report on falls monitoring and fragility.

AB suggested that it may be useful to look at a site by site breakdown of pressure sore occurrences, as NHCFT has community beds whereas NUTH does not. This may demonstrate that patients are safer in their own beds.

DS noted that a major risk factor regarding falls is a clear line of sight between the nurse's station and patient beds and that the Northumbria Specialist Care Emergency Hospital (NSECH) is designed in such a way that this is not possible. AT noted that this issue has been flagged at QRG.

KB noted that there was an IT major system failure in December 2016 and asked if this had resulted in any patient harm. AB explained that the incident lasted two hours and had no catastrophic impacts. VB noted that the CCG was notified appropriately and backup systems and plans were employed by practices.

JLEB discussed the need to ensure that reports are strategic in nature and provide an overview of current issues, the significance of these, what is being done to address concerns and what the expected impact of those actions will be. SY to further discuss with VB.

Actions:

JLEB/17/09/01: AT to include further information regarding types of harm and a summary of outcomes from the NHS England never event learning event in the February 2017 quality report to JLEB.

JLEB/17/09/02: FN and AT to discuss involvement/updating of the Diabetes Interest Group regarding the retinal screening SI.

JLEB/17/09/03: SY to discuss future JLEB reporting with VB.

JLEB/17/10 Agenda Item 6.1 Financial Performance Report

MR presented the report, outlining key headlines:

- The forecast outturn remains broadly as previously reported.
- A busy November has resulted in the loss of headroom in the forecast outturns for acute trusts with significant variances in non-elective, elective and day cases.
- The CCG met with NHCFT in December 2016 to refresh outstanding contract and coding challenges. A further meeting will take place on 25 January 2017 to address specific points, for example coding related to changes in location and re-designation of wards for ambulatory care. The challenges are likely to result in arbitration.

JG expressed concern that challenges are still ongoing and noted that NHS England has been clear in its expectation that the CCG will pursue challenges. She asked what the timescale for collecting the required information and reaching arbitration (if required) will be. MR will compile a programme detailing the actions and likely timescales for challenges, up to and including arbitration.

SM asked if the CCG still expects to end the year with a c£41million deficit. MR confirmed this, noting that there is currently a £36million overspend in addition to the existing £5million deficit. SM noted that NHS England has suggested a number of peer reviews. MR said that discussions are ongoing with John Connelly to take this forward, particularly concerning prescribing and referral management.

SBr noted that the finance report continues to show the expected deficit at £5million (as requested by NHS England), which does not give a correct view of the deficit. He raised concerns from an audit and governance perspective. SM explained that due diligence was undertaken on CCG finances as part of his appointment to the AO role. NHS England recognise that the true overspend is not reflected in the monthly reporting figures and the deficit will be considerably larger than previously expected. More guidance is needed from NHS England as to how the true deficit amount will impact on the cash position at year end.

MR noted that a hard close took place on the accounts at month nine and that the difference between the reported deficit and the actual position is shown as a debtor on the balance sheet. The cash forecast shows a requirement for £40million.

PC noted that a great deal of work was undertaken to compile a comprehensive Financial Recovery Plan (FRP), as requested by NHS England, however this does not seem to have improved the financial position. MR said that the FRP helped to clarify the deficit and identify challenges. However, it has not had an impact on improving the final position for 2016/17.

VB noted that the CCG requires confirmation in writing from NHS England that the financial position will not impact on the ability to become part of the ACO. NHS England has not given a decision on any of the 'unpalatable' proposals. JLEB noted the importance of ensuring meetings with NHS England are minuted and that formal letters are sent to agree actions where necessary.

AB noted that the NHCFT control total imposed by NHS England is competing directly with CCG spend. SM suggested that Board member briefing sessions are organised regarding CCG finances and how information could be better presented to JLEB.

FN noted that Right Care, as detailed on the QIPP tracker, will not release savings as a separate line as it is made up of a combination of schemes covered in the lines above. MR noted that there are definitions regarding which lines are cash releasing and which are reducing demand. FN and SB to discuss GP reception and clerical training.

Actions:

JLEB/17/10/01: MR to develop a programme detailing the actions and likely timescales for financial challenges, up to and including arbitration.

JLEB/17/10/02: MR to arrange a JLEB financial briefing session.

JLEB/17/10/03: FN and SB to discuss GP reception and clerical training.

JLEB/17/11 Agenda Item 6.2 Performance Report

MR presented the report, which outlined the CCG's performance position to the end of November 2016, and noted key headlines:

- The dementia screening standard has been met for three consecutive months.
- 18 week waiting times are on target for all specialties except trauma and orthopaedics where the 92% threshold has been consistently breached.
- Diagnostic waiting time performance targets were met.
- The target for early intervention in psychosis was achieved.

JU noted the outstanding work undertaken by David Lea (DL) in relation to patient choice for cancer waiting times and asked how this would be continuously monitored. SB explained that a pilot will be implemented to continue this work.

SBr noted the difficulty in providing assurance regarding CYPS referrals based on the information table provided on page 11 of the report, as there is no indication of the relationship between the numbers. AB explained that a longer trajectory is being considered to improve the clarity of correlation between data.

FN asked for clarity regarding ECG referral rates and whether this related to GMS or PMS contracts. Clinical directors to review this with DL.

Actions:

JLEB/17/11/01: Clinical directors to clarify ECG referral rates and contract types with DL.

JLEB/17/12 Agenda item 6.3 GP Forward View (GPFV)

SB presented the report for information ahead of approval by the Primary Care Commissioning Committee (PCCC). SB explained that the GPFV is a major piece of work which collates all primary care funding streams work and details action plans.

FN noted concern regarding the use of the term 'primary care' as this can have different meanings to acute providers and practices. It was suggested that the term 'GP practices' or 'primary medical care' could be used instead.

AB noted that the GPFV is not a tool to increase profits for GP practices and cannot be used for consultants in the community or hospital services.

JLEB/17/13 Agenda Item 6.4 Referral Management

SY noted a potential conflict of interest in relation to JLEB's clinical directors as they are also GP providers and may be affected by the outcome of discussion. It was agreed that clinical directors would take part in discussion but would not vote on this item.

JW explained that Northumberland has the 15th lowest referral rate out of 209 CCGs nationally and the lowest rate in the north east. The Practice Activity Scheme (PAS) has been successful, with a 10% reduction in GP referrals in the last four years.

Consultant First allows GPs to submit cases for review by a consultant before referring to the outpatient department at NHCFT. The rejection rate is currently 6%. PC asked JW to consider changing the terminology away from 'rejection rate' as this is a negative term to describe a positive outcome for avoiding unnecessary referrals.

JW asked JLEB to consider work undertaken to date and approve continuation of the Practice Activity Scheme (PAS) and Consultant First in 2017/18. He explained that an alternative to continuing with Consultant First would be to buy into a Referral Management System (RMS) at a cost of approximately £520k (£90k more than current spend). There are risks that, while the referral rate may drop, there will be a cost to procuring the system which could lead to no advantages and negative publicity.

JW outlined three options:

- Stop all referral management activity and invest the saving elsewhere.
- Stop current initiatives and procure a RMS.
- Continue with current arrangements – Recommended option.

JU asked if there are any potential savings from moving to RMS, noting that the CCG needs to consider all possible options for reducing the deficit. JW said that North Tyneside CCG implemented RMS, which brought performance to a similar level of Northumberland CCG which would not suggest any benefit to changing systems.

MR asked whether there has been any analysis of the 6% rejection rate to determine the types of referrals and any individual impacts. JW said that this has not taken place as the scheme is still in the early stages. MR suggested including referral management within the NHS England peer review.

AB noted that the Northumberland referral position is good and that there is a risk that moving to RMS could be detrimental. He said that paying an external company c£520k could be seen as a c£400k dis-investment in primary care.

JLEB discussed how poor performing practices could improve referral management for example through direct incentives, auditing referrals or shadowing higher performing practices. It was agreed that incentives were not possible but that more consideration of the wider approach is required. JLEB requested further information detailing the rejection rate by practice.

SBr suggested a pilot of an RMS system to test effectiveness. It was agreed that this would not be appropriate as Consultant First is already demonstrating the benefits of referral management.

JLEB discussed the need to maintain current good levels of referral management performance but to balance this with the CCG's responsibility to move closer to financial balance. SM suggested that further work is undertaken through the system-wide transformation programme, led by Daljit Lally, to explore the potential benefits of moving to RMS and understand conversion rates once patients are within the secondary care system.

Decision: JLEB members (excluding clinical directors who did not vote due to conflicts of interest) agreed to continue PAS and Consultant First for 2017/18 and undertake further work in the system transformation programme to ensure that the schemes were working optimally.

Actions:

JLEB/17/13/01: JW to consider changing the Consultant First 'rejection rate' terminology.

JLEB/17/13/02: JW to provide the Consult First rejection rate by practice.

JLEB/17/14 Agenda Item 6.5 Lymphoedema

HB presented the report, explaining the SOH hold the existing contract for chronic oedema. This began as an arrangement for SOH to deal with complex cases, however all oedema cases are now being referred. As a result, SOH has requested that the contract is reviewed as there is too much activity and costs are increasing.

The CCG agreed a block contract with SOH for 2016/17 and is now working with SOH and NHCFT to look at increasing use of the tissue viability clinic at NSECH. Analysis was undertaken to understand the types of cases being referred and how these are treated. Patient referrals were categorised in four groups based on the complexity of the case.

HB outlined the proposed new approach, which would re-model the service to be more community based, utilising practice and community nurses. SOH would be encouraged to discharge patients where appropriate to primary, community or self-care, creating a more sustainable service and reducing costs. The CCG is working with 3M Healthcare to undertake a two year pilot of the proposed model, with buy in from NHCFT and SOH.

JU asked whether proposals could be more ambitious, with the whole service being undertaken by NHCFT in order to reduce costs. HB explained that the forecast costs are based on patients currently in the SOH service and noted that she would expected a greatly reduced forecast for 2017/18 as a result of the proposed model. VB explained that NHCFT

was previously approached to run the service and declined due to the resource intensive nature of the work. JLEB discussed the need to ensure that there are appropriate resources available within primary and community care to support the proposed model.

Decision: JLEB approved the development of a new chronic oedema pathway.

JLEB/17/15 Agenda Item 6.6 ECIP Review

SB presented the report, and introduced JP, ECIP Improvement Manager and Chair of the system wide chief officers group, which is tasked with taking forward the actions identified during the ECIP review of the urgent and emergency care system. SB and JP presented the findings of the review and asked JLEB for comments and questions.

VB noted that the review has reinvigorated a number of system wide issues e.g. estimated dates of discharge and community services. Issues around conveyancing rates have been highlighted with the North East Ambulance Service (NEAS) and will be monitored by the Local A&E Delivery Board.

JU asked how the programme will ensure that recommendations are embedded and delivered on an ongoing basis. JP explained that test areas within the system will be monitored on an ongoing basis. Ownership will be identified, actions agreed and those responsible for delivery fully held to account. JU asked if recommendations could be tied into QIPP to ensure they are monitored. JP said that data would be required to see evidence of shifts; key metrics would need to be developed as these do not currently exist.

DS noted the importance of embedding a culture change at NHCFT, with a focus on ‘home first’ and away from automatic transfers.

AT asked whether the focus for recommended actions is NSECH specific or system wide. JP said that the whole system needs to be addressed rather than specific facilities and noted the importance of improving normal practice in order to achieve the best possible treatment for patients. Issues need to be handled head on rather than implementing a series of workarounds.

FN noted the importance of ensuring consistent communications messages across the system.

AB welcomed the report, noting that an external view of issues within the system in invaluable to unlocking the current problems. JG thanked ECIP for the work undertaken to date and was confident that productive actions have been identified.

JLEB/17/16 Agenda Item 7.1 ACO Update

VB presented an ACO update and asked JLEB for comments and questions.

JLEB discussed the need to clearly articulate the requirement for behaviour changes in the system. The focus needs to be on transformation of the system as a whole, rather than merely Payment by Results (PBR).

SBr asked whether there was inference from NHS England that the CCG should consider alternative options to the ACO. VB said that NHS England may suggest other options are considered due to the financial deficit however there is no indication that the ACO is not the preferred option.

VB noted that the ACO will not go live on 1 April 2017. A number of milestones need to be achieved before this can happen. The NHCFT Board are due to consider a report regarding whether they will enter into a PBR or block contract with the CCG from 1 April. AT asked if ACO transition will still happen if the NHCFT Board decide to remain on PBR. VB confirmed that it would.

HB felt that remaining on a PBR contract would not incentivise NHCFT to adapt ways of working. DS said that NHCFT would still be required to manage its budget and the activity within that. JLEB discussed the need to plan for the potential decision for NHCFT to remain on a PBR contract.

JLEB/17/17 Agenda Item 8.1 Assurance Framework

An additional JLEB meeting date will be scheduled for February 2017 to discuss the assurance framework and further updates regarding the ACO Outline Business Case (OBC).

Action:

JLEB/17/17/01: Additional JLEB meeting date to be scheduled for February 2017.

JLEB/17/18 Agenda Item 8.2 Governance Group Minutes

Received for information.

JLEB/17/19 Agenda Item 8.3 Medicines Optimisation Group Minutes

Received for information.

JLEB/17/20 Agenda Item 8.3 Quality Intelligence Group Minutes

Received for information.

JLEB/17/21 Agenda Item 9 Locality Meeting Assurance Points

SY to circulate.

JLEB/17/22 Agenda Item 9 Any other business

There was no further business to discuss.

JLEB/17/23 Agenda Item 10 Date and time of next meeting

22 February 2017, 9am; Warkworth Meeting Room, County Hall