NHS
Northumberland
Clinical Commissioning Group

Minutes of the Governing Body
20 April 2016

Members Present:

Mrs Janet Guy	Lay Chair (Chair)
Dr Alistair Blair	Chief Clinical Officer
Mrs Karen Bower	Lay Governor
Mr Steve Brazier	Lay Governor
Dr Paul Crook	Governing Body Secondary Care Doctor
Dr David Shovlin	Locality Director
Mr Rob Robertson	Chief Finance Officer
Mrs Julie Ross	Chief Operating Officer

In attendance:

Mr Stephen Young	Strategic Head of Corporate Affairs
Mrs Rachael Long	Corporate Affairs Manager
Ms Siobhan Brown	Transformation Director (for item 8)

NCCGB/16/14 – 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.

Members of the public did not raise any issues.

NCCGB/16/15 – Agenda item 2 – Apologies for absence

Apologies for absence were received from Dr John Unsworth.

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

Governing body members approved the minutes as a correct record.

Matters arising

Page 3 – Rob Robertson has circulated figures on the number of people in Northumberland with learning disabilities.

Julie Ross informed Governing Body members that as the CCG has now begun delegated commissioning, the Chief Officer Report will no longer cover practice specific information as this will be discussed in the Primary Care Committee, which is also being held in public.

Page 3 – Northumberland Safeguarding Children Board – Paul Crook queried the £10K that the Safeguarding Board consider to be insufficient as a contribution from the CCG. Julie Ross explained that the CCG had not been in a position to change the amount. The CCG believes that the contribution the designated nurse makes needs to be recognised and that putting her salary together with the £10K makes the CCG's contribution significant and equivalent to other bodies who do not employ a designated nurse. This is expected to be resolved at the next safeguarding board.

Page 3 – Alnwick maternity services – it was noted that the report was due to be circulated in February 2016. Julie Ross explained that as the Cumberledge report has now been published, the CCG has been looking at it and also at maternity in its entirety to make sure we have a service that is fit for purpose across Northumberland.

Page 4 – Action - Public Health update to be included in the Chief Officer Report – Alistair Blair would give a verbal report today and it was noted that this will be included in future reports.

Page 9 – Audit Committee Chair - Stephen Young explained that Steve Brazier must Chair the Audit Committee, as regulations state that it should be Chaired by a suitably qualified professional accountant.

NCCGB/16/17 – Agenda item 4 - Register of interests, review of conflicts of interest and quoracy

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

NCCGB/16/18 – Agenda item 5 – Patient story

Alistair Blair reported that across the North East there is a value based commissioning policy, which is a series of procedures the National Audit Office has said may be needed, but not routinely.

Alistair told the story of a young woman patient of his who was told by an orthopaedic surgeon that she needed to have surgery for carpal tunnel syndrome. The surgeon had asked for funding for the surgery, but the patient did not want to have the procedure. The value based commissioning policy is in place as other measures such as physiotherapy and steroid injections may be used for treatment in cases such as these before the need to resort to surgery. The patient has requested a conservative approach first, which demonstrates the importance of giving the patient a choice in her treatment plan. This method of treatment may also lead to a reduced cost to the NHS.

NCCGB/16/19 - Agenda item 6 - Chief Clinical Officer and Chief Operating Officer

assurance and key issues briefing

Alistair Blair provided an update on key issues:

Health and Wellbeing Board – The Board considered the annual report of the Director of Public Health, which is available on the Local Authority's website. The report reframes the public health challenge for Northumberland, concentrating on for example how many people do not smoke or do not drink to excess.

The Board also received feedback from the engagement conducted by NHS England and the CCG in advance of developing a new and sustainable model for primary care services at Harbottle, following the closure of the practice last year.

Northumberland Safeguarding Children's Board – The Northumberland Safeguarding Children's Board and Childrens Services inspection report was published on 14 April 2016, Northumberland County Council was rated as 'RI' (requires improvement) and Northumberland Safeguarding Children Board, which is the Board the CCG attends, was rated 'good'. This is the first 'good' rating for a local safeguarding children board in the region and the report highlights the strength of partnership working. The Local Authority has thanked Margaret Tench, the CCG's safeguarding children lead, for her contribution to the inspection.

Northumberland Safeguarding Adult's Board – The CCG has provided consistent senior level representation on all boards and sub-groups. The board has agreed sign off of the multi-agency Prevent Strategy and action plan and the North of Tyne Self Neglect Guidance.

CCG financial position –The CCG has overspent its allocation in 2015/16 by £5m. This has been reported to NHS England and the external auditors have written to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014.

The CCG has developed a financial recovery plan and has agreed a control total for 2016/17 with NHS England. The deficit position means the CCG will experience increased scrutiny from NHS England through the year and the deficit will be taken into account as part of their final 2015/16 assurance consideration.

CCG planning round for 2016/17 – Delays in the national timetable for agreeing contracts and for activity submissions have been enacted by NHS England. The CCG continues to work with its providers to finalise the contract for 2016/17 in line with the revised timetable.

Sustainability and transformation plan – The CCG is working with colleagues across the Northumberland, Tyne and Wear area to produce a Sustainability and Transformation Plan designed to secure the long term future of the health and care system across the patch. The full plan will be produced by June 2016 and will be presented to Governing Body in June.

Paul Crook asked how long the plans are for. Alistair Blair answered that they are for 5 years and will be enacted by the CCG and ACO. Alistair Blair commented that the summation of all

STPs in the country is approximately £22bn.

Rob Robertson noted there is a 5 year plan and 5 year forward view, but the CCG still need to be aware that every year new planning guidance is issued and the CCG need to make sure that this does not throw the planning off course. The one year plan is focussing on reducing hospital deficits.

Northumbria Specialist Emergency Care Hospital (NSECH) – The NSECH opened in June 2015 and the clinical model is showing the predicted benefits of fewer emergency admissions and shorter lengths of stay for patients, but operational difficulties with ambulance handover delays are compromising its overall performance. The CCG meets regularly with the Trust and ambulance service and has agreed a series of actions designed to improve handover delays.

Steve Brazier asked whether the CCG is confident that problems are just due to handover delays or whether there are any other factors involved. Alistair Blair answered that lower clinical acuity does affect the flow, and also the coming together of different teams from different hospitals has had an effect. The hospital has carried out several exercises to develop improvements.

Julie Ross noted that there are three parts to the problem. The first is demand, the second is estates and capability – the hospital was designed to take no more than 200 patients, and is regularly seeing up to 320. The third is the bringing together of two cultures from individual hospitals. A number of actions have been agreed to increase triage e.g. getting consultants to triage patients, and it was agreed that the CCG need to keep discussions going between NEAS and NHCFT.

NCCGB/16/20 – Agenda item 7 – Financial position update

Rob Robertson gave a presentation on the financial position.

In 2015/16 the CCG has overspent by just over £5m. The CCG has continued to improve the underlying position, but activity towards the end of the year means that the CCG has not met the duty not to overspend. The duty not to overspend on running costs has been met.

The CCG has spent a small amount of capital in-year on installing Wi-Fi into practices to enable mobile working in line with the PACS/Vanguard project.

The QIPP cost reduction plan is on track to deliver 85% of its savings, but other areas have overspent leading to a deficit.

The main reason for the overspend is acute contract performance. The CCG's main contract is with Northumbria Healthcare NHS Foundation Trust (NHCFT). During the course of the year from April to September activity was within the level that the CCG could afford. November saw significant increases in activity level, which had not been forecast. Reasons for the activity levels include a big increase in admissions to NSECH and significant increase in electives for

planned care. The CCG reported a risk of posting a £2.5m deficit in January 2016, and have been working with NHS England and partners to mitigate the risk.

February 2016 saw a further increase of £2m over performance, over and above the increased forecast. This increased the overspend to £5m. As this was so late in the year, it could not be easily recovered and because it is PbR activity the CCG are obliged to pay.

For a period of time during the year, patients from the west of the county were being taken by ambulance to the Royal Victoria Infirmary rather than using the agreed protocol of taking them to NSECH. Many of these patients were known to NHCFT and not Newcastle upon Tyne Hospitals Foundation Trust (NUTHFT), which led to full admission and investigations taking place rather than the patients being seen in an ambulatory care setting. This has now been corrected.

The consequences of the deficit were:

- External audit issued a Section 30 notice to the Secretary of State to report the deficit
- The CCG will not receive Quality Premium funding in 2016/17
- The CCG has agreed with NHS England to post a c£5m deficit in 2016/17

A financial recovery plan has been developed to deliver real savings, and is subject to close scrutiny by NHS England. It has been agreed that in 2016/17 the CCG will post a £5m deficit and will break even in-year. In 2017/18 the CCG will pay back the overspend from 2014/15. The financial recovery plan will need to save £20m as business rules have changed, there is now a tariff uplift, and an additional 1% of non-recurrent headroom is to be set aside and not committed.

Steve Brazier commented that £6m of the £20m requirement has come about due to a change in business rules about the 1% reserve etc. Rob Robertson agreed and said that previously CCGs needed to spend 1% of their allocation on non recurrent schemes, this year CCGs can't commit this money and need to have it set aside.

Steve Brazier commented that the amount of money the CCG spends on administration is very small compared to other CCGs so it has low running costs, this means the financial position cannot be attributed to running costs.

Janet Guy noted that the overspend can be attributed to contracts with the Trusts, which gives some level of reassurance that it is being spent entirely on care for patients.

Karen Bower asked what the loss is to the CCG for not getting the quality premium in 2016/17. Rob Robertson replied that this year the quality premium received was £700K. The quality premium comes with a 25% adjustment for each of the key contract standards, so the CCG were not expecting as much in 2016/17.

Janet Guy asked whether the CCG is confident that it can manage its resources next year to try and avoid a deficit at the end of the year. Rob Robertson answered that it is possible that the savings could be achieved, the CCG is part of the development of an Accountable Care Organisation (ACO) and Sustainability Transformation Plan (STP) discussions which have signalled changes in the ways of working.

Julie Ross noted that for the STP and contracts round this year, as the trusts have control totals and so do the CCG, discussions are taking place with the trust about how we handle risk in the system and where the risks sit.

Alistair Blair informed Governing Body members that Northumberland has a balanced health economy. The CCG is in deficit, but the trust has a surplus. Strategic commissioners will have to allocate funding, look at where the risk is and action joint financial planning and joint risk. The full allocation will be given to the ACO, some partners will get capitated budgets and others could trade in Payment by Results (PbR).

NCCGB/16/21 – Agenda item 8 – PACS Vanguard progress and risks

Siobhan Brown, Transformation Director, presented this report.

The vision for the Northumberland Primary and Acute Care System (PACS) is articulated in the value proposition, submitted in February 2016. It is supported by removing barriers to care, changing incentives to promote health and wellbeing, releasing time and capacity in order to make the right thing to do the easiest thing to so, and asking our patients 'what matters to you?'. The vision is underpinned by a shared record with read and write access in real time.

The Northumberland PACS Vanguard will be evaluated at both national and local levels. At a national level a basket of six core metrics is being designed to cover the three gaps – health and wellbeing, care and quality and finance and efficiency.

At a local level, each Vanguard has been asked to prepare an evaluation tender to procure an evaluation partner to work with the Vanguard, measuring its effectiveness against the value proposition and logic model it submitted. At this point in time, no funding has been announced for this work and all Vanguards have been asked to put in break clauses to the evaluation contract, should the funding be withdrawn at a later stage. Given that Northumberland has two Vanguards – PACS and ACO (chains of hospitals), the direction of travel is to procure the evaluation together but in separate lots to save time and costs.

A further area of work which is underway is the pilot with the National Datalab and Health Foundation which will use the Northumberland Vanguard as a pilot site to measure the 'before and after' effects of the NSECH change and the base site changes.

The bid for PACS funding for 2016/17 was £12.7m. The National Investment Committee has approved a significantly reduced indicative amount with an emphasis on developing shared records, workforce and primary care hubs. This poses a significant risk to delivery at pace and

scale for the PACS Vanguard.

Work is ongoing in looking at NSECH and the base sites and partners are working hard to ensure whole system pathways are right. Partners are working with GP practices on primary care transformation and increased access. There is also a workstream looking at how the hospital sector and the mental health trust can help wrap around care at home, this is underpinned by the shared care record developments. The final part of the work is the ACO development.

Workforce development is taking place and a new nursing course has been developed locally, with 18 placements introduced for students to work in care homes and with primary care.

Steve Brazier noted that under the shared care record, if patient is in A&E, their doctor needs to ask permission to access their record. Alistair Blair explained that the summary care record, which lists allergies and medication, is an opt in or out scheme. To access the shared care record, patients need to give their individual permission. Alistair Blair noted that the results of recent surveys show that the vast majority of the public have a shared care record and that giving consent on an individual basis to access that record is necessary.

Paul Crook asked whether moving to seven day working priorities will make extra demands on the ACO. Siobhan Brown answered that partners need to be smart about how this is actioned, but agreed that there are risks.

Karen Bower asked whether the regulation environment including procurement regulations would have an adverse effect on setting up the ACO. Siobhan Brown explained that nationally health bodies are working to look at this. In terms of the bigger piece of work e.g. musculoskeletal services, the risk is that this could slow delivery.

Julie Ross noted that Northumberland had put in a bid for £12.7m, but will have a significantly reduced amount awarded this year. It is therefore imperative that funding goes into primary care as the model was premised on increasing capacity for primary care. There has been a significant decrease to the allocation the CCG was expecting, but the proportion allocated to primary care will be spent in primary care.

There is a fully worked up plan for the £12.7m bid. However, the CCG will now need to look at whether there is a need to reduce the plan to reflect the reduction in funds.

NCCGB/16/22 – Agenda item 9 - Resource and Performance

Karen Bower reported on the work of the Resources and Performance Committee.

The March meeting focussed on the financial position of the CCG as, since the last meeting of the committee, it had become apparent that the CCG was not going to make the planned in year savings and so would be ending the financial year with a deficit.

At the time of the meeting PWC were undertaking a review of the CCG's capacity and capability given the ongoing financial position. The brief included a particular focus on finance, including the forecast outturn, the underlying financial position and plans for 2016; the capability and capacity of the CCG's leadership to deliver the recovery plan and a review of the governance and reporting processes in place.

The actions relating to the end of year forecast and plans for 2016/17 were discussed, including the QIPP plan and the system wide financial recovery plan.

A review of the working of the committee had been conducted prior to the meeting and a summary report had been circulated with the papers. Four specific suggestions were made to improve effectiveness:

- A greater focus on outcomes
- Officers to provide the committee with a matrix of data sources and details about who provides assurance for reference
- More details required about the decision making processes
- Comparative data on resource allocation from similar CCGs to be used to better understand the use of our resources.

Steve Brazier noted that the committee also received a presentation on value based commissioning, which was illuminating and brought to life the cost systems work we need to be doing to eliminate the deficit. Karen Bower noted that there was also reassurance that the system focussed on improving care for patients too.

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

NCCGB/16/23 – Agenda item 10 – Financial Regulation and Audit

Steve Brazier reported on the work of the Audit Committee and reported that Peter Atkinson has now left the organisation and Karen Bower has stood down from the Audit Committee. Paul Crook has joined the Audit Committee and attending his first meeting in March.

The next Audit Committee will sign off the annual report and accounts. External audit outlined how they will be preparing the accounts review and section 30 letter.

Internal audit colleagues compile a workplan through the year and the head of internal audit opinion shows a clear position for this year that governance and controls in place are good. Committee members signed off the internal audit plan for the next three years.

Committee members conducted their annual review of conflicts of interest registers. The new NHS England regulations were discussed, in future the committee will conduct quarterly reviews, and internal audit will report on conflicts of interest handling.

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

NCCGB/16/24– Agenda item 11 – Engagement and Quality

Karen Bower reported on the work of the Engagement, Public Health and Quality Committee and noted that the latest meeting was her first as Chair of the Committee.

Engagement has focussed heavily on primary care at scale recently as part of the Vanguard developments. There has been an excellent response to the online survey, 3000 responses were received.

Public health budgets will be reducing over the next five years making it imperative that even more joined up working takes place to try and sustain the work.

The quality visit programme, as part of contract monitoring by the CCG, was outlined and there was much discussion about the nature of the visits and how the CCG respond when unplanned visits are needed. Some improvements to reporting were suggested.

When considering unannounced visits, it was agreed that the CCG need to be able to react quickly when they suddenly become aware there is a problem. A programme of pre planned, unannounced and reactive unannounced visits will be scheduled.

The Engagement, Public Health and Quality Committee will include the quality visits programme as a stand alone item on agendas in future.

Action – Julie Ross and Executive Officers to ensure the value of the visits is timely and right and the feedback processes are right, and make sure visits are in lay governor's diaries.

The quality report highlighted two continuing risks, healthcare acquired infections and NEAS. The committee was assured that the action plan to reduce CDiff is progressing well.

The review of the committee's effectiveness over the last year identified an ongoing problem with fully understanding the committee's assurance role with public health. After much discussion officers have been asked to help clarify the situation and provide a report outlining the way forward. To improve assurance some refinement of current reporting was requested so that members would be better assured that a range of issues had been considered in relation to the subject of reports received.

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

NCCGB/16/25 – Agenda item 12 – Primary Care Co Commissioning

Janet Guy reported on the work of the primary care co commissioning committee.

At their last meeting, the committee members noted that the Harbottle engagement was

delayed slightly so that it could be started after the Christmas period. The engagement has now been finalised.

NHS England has announced the availability of £10K funding to support vulnerable practices. This will be for use by practices who have been rated as 'inadequate' or 'requires improvement' by the Care Quality Commission, or those practices who are deemed to be in need of additional support.

Committee members discussed the draft estates strategy, which outlines how the CCG intends to use its estate footprint. It has been agreed that the CCG, the North East Ambulance Service and Northumberland Tyne and Wear Foundation Trust will review the capital estate with a view to reducing it by 40% over the next five years.

The committee members discussed the delegated agreement and noted that it is a legal document which is produced nationally, with no local variations. Some concerns were noted as the agreement looked biased towards NHS England in terms of making changes, having input and opting out. It was agreed that officers will check whether the CCG can suggest any amendments.

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

NCCGB/16/26 – Agenda item 13 Any other business

There was no further business to discuss.

NCCGB/16/13 – Agenda item 13 - Date of next meeting

15 June 2016