NHS
Northumberland
Clinical Commissioning Group

Meeting of the Governing Body

Held on 24 April 2014, Committee Room 1, County Hall

Present:	Mrs Jacqui Henderson	Lay Chair (Chair)
	Dr Alistair Blair	Chief Clinical Officer
	Mr Peter Atkinson	Lay Governor
	Dr Paul Crook	Governing Body Secondary Care Doctor
	Mrs Karen Bower	Lay Governor
	Mr Rob Robertson	Chief Finance Officer
	Mrs Julie Ross	Chief Operating Officer
	Dr John Unsworth	Governing Body Nurse
	Dr Eileen Higgins	Locality Manager

In attendance:

Ms Steph Edusei-Basra	Strategic Head of Corporate Affairs
Mrs Heather Boardman	Personal Assistant

NCCGB/14/22 – Agenda item 1 – Apologies for absence: None

Jacqui Henderson, the Chair, welcomed members of the public to the Governing Body meeting and hoped that they found the discussions interesting and informative. She explained that this was not a public meeting but that we were holding our meeting in public. She asked if members of the public who had any questions about the agenda could let her know at this stage and when the agenda item came up she would ask them to raise their question then. There were no questions to be raised.

Jacqui Henderson asked the Governing Body members to introduce themselves for the benefit of the members of public.

There were no apologies for absence but it was noted that Peter Atkinson had to leave the meeting mid-way to attend a funeral.

NCCGB/14/23 Register of interest
Jacqui Henderson explained that the Governing Body members had made their interests known which interests were on the website. She further confirmed that the Governing Body was quorate.

NCCGB/14/24 Patient's Story
Alistair Blair explained that the patient story actually came from a book written by Harry Marsh who was a neurosurgeon. Although it was not local it was a powerful story of life, death and brain surgery. He read an extract from the book in which the surgeon stated that although he had made mistakes he had documented these in order that others may learn from his mistakes.

In particular he referred to a visit to a high dependency ward where he noticed a number of patients were those he had operated on. Some of them were people who he was unable to help. One patient was pointed out by the junior doctors saying the surgeon had wrecked the patient's life.

This man had a tumour growing from the base of his skull. After 15 hours operating it looked like most of the tumour was out and the cranial nerves were not damaged. The surgeon admitted he should have stopped at this point but he wanted to be able to say that he had removed the entire tumour. When removing the last piece of tumour he tore a small perforating branch off the basilar artery, the artery that keeps your brain stem alive and the rest of the brain awake. The man never woke up.

The surgeon admitted that every day he would make several dozen decisions and if wrong would have terrible consequences. His patients desperately needed to believe in him and he in himself. The delicate tightrope walking act of brain surgery was made all the worse by the constant pressures to get patients in and out of hospital as quickly as possible. He went on to say when he was younger at the end of a successful days' operation he felt an immense exhilaration. Finally, the surgeon said that there had been too many disasters and unexpected tragedies over the years and he had made too many mistakes to experience those feelings now. However, he still felt pleased when an operation had gone well. It was a deep and profound feeling.

NCCGB/14/25 Minutes of the last meeting
Jacqui Henderson referred to the accuracy of the Minutes of 27th February 2014.

Karen Bower drew the Governing Body's attention to the audit section on page 8. She had mentioned external audit and the fact that information had been delayed so this could not be reported to the Audit Committee but this had not been minuted.

NCCGB/14/26 Matters Arising
Steve Brazier commented on page 6 under Agenda Item 8 - there was a request for a verbal update to be made at this meeting on healthcare acquired infections which was not on the agenda.

Jacqui asked Alistair Blair to give an update on this when presenting his report.

NCCGB/14/27 Report from the Chief Clinical Officer
Alistair Blair reported that the NHS Northumberland Clinical Commissioning Group (CCG) was not meeting the national targets set particularly around clostridium difficile (C.Diff). The CCG had six cases less than the previous year– the totals being 91 up to end of March and 97 in the previous year, however, that was higher than the trajectory set. Alistair Blair added that it would be difficult to claim that the CCG had reduced incidents as the level of reduction was relatively small.

Alistair Blair informed the Governing Body that the CCG is examining the interventions made for C.Diff and that there has been a large amount of work done particularly in community as the high incidence is from community acquired infections.

Alistair Blair explained that the CCG has run a series of workshops and training particularly around primary and community care. It will be difficult to determine if the interventions have made an impact until at least the end of the first quarter of 2014/15. The trajectory for 2014/15 is slightly higher than in the previous year.

Widening the focus to other healthcare acquired infections, Alistair Blair added that work had taken place earlier in the year on norovirus which can decimate hospital wards and care homes and can be very unpleasant for individuals. There is no national target for norovirus but it is important for the CCG to do the right thing for patient care as well as hitting targets. Jacqui Henderson added that there are targets that have to be met and there are other self-imposed targets that the CCG feels are essential for people in Northumberland which was rather assuring.

Alistair Blair informed the Governing Body that the Health & Wellbeing Board (H&WB) continues to work well. The H&WB has endorsed a physical activity strategy across Northumberland. There has been consideration of the care of people with learning disabilities affected by the Winterbourne concordat. This has been particularly focused on those patients who are the responsibility of NHS England.

There are 17 patients who are the responsibility of the CCG under Winterbourne who by June have plans in place to be rehoused in non-institutional settings with appropriate care packages. Those under the responsibility of NHS England are predominantly in care for forensic reasons. There was assurance at a previous H&WB meeting that those patients were not likely to be discharged within a 12 month period. One of those patients has since been discharged; they have become the responsibility of the CCG. The CCG is working through this person's case to ensure that they are in the same position as their peers. We understand that there are no other forensic cases which are likely to become the CCG's responsibility within the next 12 months.

Alistair Blair referred to the Members' meeting which was held on 26 March 2014. The meeting was well attended by member practices as well as by members of the Governing body. There was very good discussion and members had looked at issues particularly in planned care and unplanned care. There was a sense of engagement between the CCG officers and its members; making sure that there was ownership and membership of the organisation.

The members voted to re-appoint Karen Bower as Lay Governor for resources and performance for a term of three years.

The CCG had had a very successful assurance meeting with the Area Team of NHS England and they were assured of all CCG performance.

Alistair Blair informed the Governing Body that NHS England required us to contribute nationally to a continuing healthcare restitution risk share agreement. This had created significant issues as a substantial allocation had already been made by NHS North of Tyne primary care trust on the CCG's behalf before that organisation was disbanded. This is being discussed at a national level as it affects a large number of CCGs.

The Governing Body was informed that John Lawlor, who has been Area Team Director very successfully for the last year, is to become the Chief Executive of NHS Northumberland, Tyne and Wear NHS Foundation Trust (NTW). Chris Long, Area Team Director for North Yorkshire, is going to be the interim replacement.

Contracts for 2014/15 have all been signed and Alistair Blair commended the work done by the teams involved in the contract negotiations and informed the Governing Body that in other areas of the country not everyone was in this position.

The CCG had some ambitious targets to reduce non-elective (emergency) admissions and some of this was built on the introduction of an ambulatory care service. The CCG is looking to replicate the successes in parts of the county by expanding this to areas that have not had access to ambulatory care as yet.

Alistair Blair stated that the practice activity scheme outcomes were encouraging and that it appeared that referrals discussions within primary care teams are continuing and seem to be working well.

There are plans to expand community based testing and diagnostic based service, e.g. prostate specific antigen (PSA) monitoring and disease modifying agents for complex issues such as dermatology and rheumatoid arthritis. This would avoid patients travelling great distances and was a more economic model.

The CCG is to review musculoskeletal services. Alistair Blair informed the Governing Body that the CCG spends around £6m more than any comparable CCG's for size, population, age demographics etc. with no effect on improved outcomes. Work will be done to understand why the expenditure is so high and why this is not reflected in improved outcomes for patients.

The CCG had their first NHS Improving Quality (NHSIQ) event in March – a form of training workshop. The meeting was attended by GP's, practice nurses and practice managers across Northumberland and looked at primary medical care transformation. Alistair Blair noted that these events will create some thinking space for primary care to determine where it needs to be going in terms of improving quality. He added that people get a good standard of care and across all measures of quality Northumberland GPs generally do very well. There are issues around access to primary care.

John Unsworth said although it was not explicit in the Chief Clinical Officer report, where it was outlined that the CCG is managing to reduce A&E attendances and emergency admissions, money saved is being reinvested into providing care closer to home and in new services by both us and our partners.

Alistair Blair responded that there has been a significant reduction in non-elective admissions which had been invested in the community. There has been no reduction in the number of A&E attendances which have stayed roughly static.

Paul Crook asked whether there was an update on the problems that NHS England was

experiencing with commissioning specialist services. Alistair Blair advised there were a few issues to consider – one is the issue area of activity growth and which has seen an activity increase of 6% year on year on spending on specialist commissioning. The second issue was the disaggregation of budgets which had blurred lines between what was core secondary care and what was specialist care which was helped by the previous system.

Rob Robertson reminded the Governing Body that last year the CCG had been unhappy that some of the calculation of specialist commissioning budgets had been done at the centre. Therefore, another piece of work was undertaken at patient level detail to ensure the budgets were disaggregated correctly. In the North East and Cumbria most were satisfied that this had been done correctly although other parts of the country had been unable to do this due to lack of capacity or information access. Jacqui Henderson added that in her experience from being at the Care Trust, a lot of work had been done over a two year period which had helped the current position.

Jacqui Henderson asked whether all practices were part of the Practice Activity Scheme and it was confirmed they were.

Jacqui Henderson asked that the minutes formally record that Karen Bower has a three year tenure as the lay member leading on resources and performance and that she is also deputy CCG chair but in accordance with the CCG constitution this is for one year only.

NCCGB/14/28 End of Life Care – Management in 2014/15
Jacqui Henderson stated that the decision box heading should not be for “Members of Resource and Performance Committee” as this was a Governing Body paper.

Julie Ross introduced the paper on end of life care. She stressed that this is, perhaps, the most complex and sensitive time of your life. When the CCG was constituted, implementing a plan that made sense was one of the first things looked at. Members’ attention was brought to the key issues, namely that when end of life services in all parts of the country are examined, there is a combination of NHS standard services, e.g. district nursing and general practices, as well as myriad of very small part voluntary sector and part stated funded sectors like MacMillan, Marie Curie and St Oswald’s, North Northumberland Hospice and Charlotte Straker. In Northumberland there are a number of small organisations who provide really good care but one of the difficulties found when looking at the analysis was although there are a lot of services covering a wide range of needs, it is difficult to navigate through them all, particularly by a patient nearing the end of their life and their carers. The CCG therefore joined all the provider contracts into one prime provider arrangement which started in April 2013. Northumbria Healthcare NHS Foundation Trust holds all the main charity contracts in a subcontract arrangement and therefore navigates for the patient.

This was initially a trial to establish that it was a more effective pathway for patients and results are positive. The CCG has agreed to extend the contract for another year before reviewing the position and deciding if a full contract is appropriate

Julie Ross drew the members’ attention to the national debate about the Liverpool pathway and that resulted in that pathway being put out of use. She advised the members that the

CCG has worked with all providers and with North Tyneside CCG to ensure the approach was consistent. The CCG has continued to use the Liverpool Pathway primarily as a communication tool until there is a new pathway established nationally. Julie gave assurance that no incentive payments linked to the care pathway have been made. The focus was on making sure providers communicate well with all other parts of the system and Julie reported that this seems to be working well. Bruce Dickie and Hilary Brown have both led on this and are part of the North East Regional Team developing a new care pathway. Julie Ross informed the Governing Body that this will be reported on when there is a new pathway.

Julie Ross explained that commissioning of lymphoedema services had received some focus over the last six months. Services commissioned were for palliative care, however, non-palliative care services are also provided. These services are provided by charities and therefore funding had become an issue. The CCG is currently looking at these services with the possibility of setting up contracts for next year.

Julie Ross advised that the Charlotte Straker care home has a number of beds which were on the whole not occupied and were commissioned on a block arrangement. Discussions had been held with the care home over the last year as this was an unaffordable position for the CCG. Work has taken place to develop some of their services and an agreement reached to pay them on a cost per case basis.

Alistair Blair commented that the CCG is beginning to see real benefits from the work it is doing on end of life care. Looking nationally and locally around 70% of people on palliative care pathways would like to die at home. Nationally the actual level of people who die at home is around 30%. In West Northumberland there has been an improvement of around 20% to a level of 50%. He added that whilst this was still below where the CCG would want to be it showed that end of life care was improving.

John Unsworth drew Julie Ross' attention to item 3.3 which outlined what had been done in relation to the national standard contract with practices. He asked if Julie could assure the Governing Body as to whether the standards which are there for the practices are also the same standards for the prime contractor model. Julie confirmed they were the same but were described differently and they were on the same contract format which was helpful. John outlined his concerns that the patient would not be able to navigate the system but added that the paper had outlined things which would assist the patient.

John Unsworth also commented under section 3.5, under Lymphedema services, the issue about non-cancer patients receiving lymphedema services provided by a hospice. He asked if Julie Ross could assure the Governing Body that the patients' experiences of those services would be taken into account. He cited that if he were a non-cancer patient he may not be happy with a service provided by a hospice associated with end of life and cancer. Julie Ross confirmed that this was a valid point, that she had not considered this view and will make sure that this is in the review.

John Unsworth further added that although people would be happy to receive this service from hospice staff it could be provided in a health centre or community hospital rather than a hospice environment.

Jacqui Henderson gave an anecdote on an acquaintance whose husband was dying last year and wanted to stay at home and his wife was full of praise of the services provided, specialist support, key worker etc. It made a huge difference.

NCCGB/14/28 Draft Annual Report & accounts

Jacqui Henderson introduced the draft Annual report and accounts – she reinforced the fact that it was draft even though this was not shown on all pages due to technical issues.

Rob Robertson asked the members of the Governing Body to note that these are the draft annual reports and accounts. He explained they would go through a process of audit and would be presented to the Audit Committee in May and then to the Governing Body for approval subject to the CCG members delegating responsibility for approval. He confirmed that the draft accounts and reports had been submitted at noon the day before as stipulated in the national timetable.

Rob Robertson drew the Governing Body's attention to the back page of the accounts. He noted that the CCG has achieved a very small surplice and achieved the break even target of £300,000. He then drew members' attention to the primary statements of expenditure and income on page 1 of the accounts. This highlighted the net expenditure for the year, £426m – divided as £4.7m of management costs and £421m of programme costs. Rob explained that the two funds are separately allocated to the CCG and that running costs underspend can be used to offset programme cost overspend but not vice versa. The CCG had significantly underspent their running costs (by £3.2m).

On page 2 of the balance sheet, the statement of financial position, Rob Robertson drew attention to two main areas in which the CCG has £2m worth of debtors. He reported that this mainly related to invoices raised to NHS England which had all been paid. He noted that there was also £640k outstanding with North of England Commissioning Support for invoices raised in respect of recharges for properties and £620k raised with the local authority in respect of prescribing. This latter amount came about as Northumberland GP's prescribe in some areas which Public Health is responsible for, and these come under local authority. The balance relates to credit notes raised to the CCG.

Rob noted that the only other material balance is CCG payables as the amount owed to creditors to the end of the year was all accounted for against CCG budget but was not physically paid until the end of March. He informed the members that the biggest area for this is £8.5m worth of prescribing accruals because the prescribing data is two months behind. Rob explained that these will all be paid off before the final submission of accounts.

Rob asked the Governing Body to turn to page 11 to review the employee benefits and staff numbers. He pointed out that the CCG has £500k worth of other salaries and wages highlighted which are not paid through payroll. These relate to £250k in respect of clinical leads mainly GP leads for different domain areas. The other relates to the CHC panel representative and agency staff the CCG has employed during the course of the year.

Finally Rob drew the Board's attention to page 15, operating expenses note 5. He noted that

there were two lines which looked as if the accounts did not balance (total column and the programme column). He explained this was intentional as the total column is a manual entry which is correct and the programme column is fed from the ledger. He assured the Governing Body that this would be resolved by the national refresh and when done everything would balance.

Rob Robertson referred to the annual report under salaries and wages. This contained information received from the Pensions Agency and Rob noted that this was incorrect in that not everybody's pensions that been included. He added that correct information was awaited.

Steve Brazier commented that Rob was quite correct in pointing out the pension figures. He reiterated Rob's point regarding the running cost underspend. He added that the CCG had re-invested a lot of monies from running costs into health services.

Alistair Blair agreed saying that often the NHS gets criticised for "wasting money on management" but added that managers are needed to help run the system.

Jacqui Henderson did feel that it was important that people realise that the CCG is a very lean organisation and that it was important that this was re-examined to ensure that as much money as possible could be saved to go into patient care. She noted that this also meant the CCG needed to have the correct resource internally to monitor, come up with ideas and support people. She added that she did not wish to take away or detract from what a fantastic outcome this was.

Steph Edusei also drew the Board's attention to the annual report saying that there had been an effort to keep it quite light and digestible for members, members of the public and the Governing Body whilst complying with regulations. She indicated that this was not the way the CCG would like to have done it and that there was still work required to ensure that the right balance was struck between making it something real and ensuring that all the necessary information was included. Steph stressed the report was still draft and that additions had already been made after submission.

Steph commented that when going through the report there was a lot of reference to the Governing Body and reminded the members that the CCG has a slightly different governance structure. Whilst the Governing Body is very important the executive board is equally as important and this is not stressed nationally in the guidelines. Steph advised that she would be strengthening information around the executive board as the organisational decision makers.

Jacqui Henderson confirmed that it was still in the early stages and asked whether it would be a good idea to have appendices. Steve Brazier commented that he had explored the possibility of having some of the more mundane data held in appendices but the response received from the CCG community was that it would be rejected by NHS England. He had therefore written to NHS England to clarify the position in respect of appendices and awaited a response. He commented that it was difficult that NHS England wanted the report to be concise and smart but then also wanted a lot of.

Jacqui Henderson did say the report was about four times as big as the NHS Care Trust Fund.

Steph Edusei said this may be a reflection on the CCG being a new organisation. Rob Robertson also commented that in the early years primary care trusts had a large template that included everything but across the years this was whittled down as they became more mature.

Julie Ross pointed out the hard work involved by both Rob Robertson and Steph Edusei in putting the report and three commissioning plans together. This had put a lot of stress on everyone and the Corporate Affairs team was very small. Jacqui Henderson wanted this noted in the minutes as the members had acknowledged how lean the organisation was and the related savings. It was clear that a small team of people were doing everything and had worked hard on this.

Karen Bower pointed out that integration had not come out as positively in the report although the Integration Board had achieved a lot. Similarly the work which had been carried out on finances and asked whether highlighting this was the right thing to do in this report.

Jacqui Henderson added that there was no summary within the report which would normally describe all the things the CCG had sought to do.

Karen Bower did comment that it was very readable as a document and was accessible to the public.

Steph Edusei explained that the final version will be submitted in June and will simply be text but will then come back to the Governing Body annual general meeting in September and that would be the full edited version.

NCCGB/14/29 Two year operational plan

Julie Ross presented the paper on the CCG commissioning plan for the next two years. In total three plans are being written this year, one of which is the two year operational plan that describes what the CCG will be buying for the population over the next couple of years and how the work will be shaped. The CCG has also had to write a Better Care Fund Plan which is a plan of how £25m of health system funding will be moved to a joint pot, our integration pot, with social care to do something different for the population of Northumberland. Then there is a five year system plan, not a CCG plan, and this describes what the vision for the system is in five years' time.

Julie explained that critically whilst there are three plans and they have different formats that they work to, the CCG is working to one story. There is a health and social care system across Northumberland and the CCG has worked really hard with partners to ensure stories are aligned. Compromises have been made but there is now have a single story. She assured the Board that all three plans were aligned around that story.

Jacqui Henderson stated that the good news relating to the Better Care Fund plan is referenced throughout which was good and gave further assurance.

Julie Ross recapped on the work done a few years ago, conducting a gap analysis. The gap analyses showed the CCG where things needed to change. This allowed us to put a commissioning plan together. The CCG had engaged on the original plan two years ago and

on the basis of this we created the 2013/16, three year plan. This new plan (2014/16) has not changed from the original.
Julie referred to page 2 which showed the same objectives seen year on year about safety, joining up and integration which have not changed. She noted that on the bottom of the page the clinical domains remained the same.

Julie confirmed we continue to do three things; care for our vulnerable population, make better use of the community hospital resources that we have, particularly in beds and make better use of the community services which cover everything. She highlighted that the paper was in four parts; part one was the story, the narrative of how it all fits together with the Better Care Fund with the National Voice with all of the engagement we had been through.

Part two goes through each of the domains and describes in headline terms what the aspirations are and the key prioritising narrative showing how things will be.

Part three (called Ambitions for Proving Outcomes) includes a number of fairly technical numbers based on nationally prescribed measures of success. This describes how the Government will hold us to account on whether or not the CCG has delivered what NHS England expects on behalf of the NHS. Effectively these are the CCG's targets which are mainly national with a few local ones.

Finally part four (called a Summary Plan on a Page), shows all the CCG plans for the year linked back to the Health and Wellbeing themes and to the strategic objectives identifying programmes.

Julie noted that this means that all 45 member practices, as well as members of the public, can pick this up and see what the CCG does. Clearly this is not enough for the CCG to operate in any detail so each head of commissioning and each director has a detailed work plan.

Julie described the monitoring and assurance processes used to ensure that all directors and heads of commissioning are held to account for delivery of their plan.

John Unsworth referred to page 9 regarding planned care, there seemed to be a mismatch between the outcome ambition and what the CCG is planning to do. The CCG is planning for care outside of hospitals and/or actually getting less people going to hospital. The message could be less positive from the patient's point of view regarding a wasted journey to outpatients because they were referred to the wrong place or because the procedure did not give them any quality of life or benefit. He advised if he were a member of the public looking at the report he would be thinking how could this be a more positive experience than hospital care. John felt it might be lost in translation.

Julie Ross advised that the CCG wanted people to have a positive experience of hospital care and of care out of hospital.

Steve Brazier commented on the terms of planning guidance under the nationally set outcomes one of the key principals was highlighting local initiatives and there are probably a lot contained within the report, we need to draw this out.

Julie Ross confirmed that all the initiatives related to local not national initiatives.
Steph Edusei commented that the annual report talked about what the CCG had done, this report talks about what the CCG is going to do. There may be possibly one example on a national initiative but the majority are the CCG's local ways of addressing issues and achieving outcomes which may be set nationally. Therefore the requirement to reduce unplanned admissions is a national drive but the CCG has said locally what is appropriate for Northumberland and how it is going to deal with it. She stressed it was important to remember that this is a plan of what the CCG is going to do and will eventually form part of the five year plan.

Rob Robertson concurred that some of the things the CCG has had to do to meet national targets are innovative and that things need to be drawn out it which is best for Northumberland and which may be very different from what people have seen before.

Jacqui Henderson confirmed that the annual report was a reflection but asked that the CCG should consider producing a shorter reflection for the benefit of the public which also reinforces what the CCG is doing and why. A lot of the information that the CCG wants the community to know about is lost within the 80 pages or so.

Rob Robertson highlighted the three key areas that have been delivered this year, namely our Continuing Health Care (CHC) with the Local Authority which was brand new. Throughout the country only a few CCG's are doing the same thing. The practice activity scheme and gainshare, which is moving money from non-elective admissions into the community.

Alistair Blair said this highlighted a broader plan about publicising the work of the CCG. He explained that there are other CCG's looking throughout the country at CHC. CCG leaders had been asked to go to Northern Ireland and there had been some interest from London on how the CCG did things.

Karen Bower pointed out under the three year initiative section on the plan there were some activities last year which were not shown this time, e.g. reviewing audiology provision along with a number of other items. She asked what had happened to these initiatives.

Julie Ross replied there were a number of things such as nasal cautery etc. originally within the plan and whilst they were still important they represented a tiny proportion of the CCG's work. She added that the work themselves had been retained and that these would still be shown in the work plans.

Jacqui Henderson suggested that Karen had raised the issue to what was accessible by members of the public who had a particular interest in a subject thinking the CCG had stopped supplying this service.

Steph Edusei advised that she was still thinking on how to give details of the work plans in a way that makes sense to the public. She explained that the work plans are very detailed but agreed that it would be useful if there she could say in easy speak what the CCG were doing in each of the domains.

Karen Bower replied that from the point of view of the Resources and Performance Committee it would be useful to have some idea as to how things were progressing but there were no specifics when things happen.

Julie Ross replied that the purpose of the report was to say that in two years' time this is what would be achieved and that a timetable (within the work plans) supports this and is reported to the Joint Locality Executive Board (JLEB).

Jacqui Henderson said it was a good report and shows how the CCG is to proceed in the next two years and the point that Karen has made is something she would like to develop, a programme of reports that come to the Governing Body.

NCCGB/14/30 Resources and performance

Karen Bower highlighted the minutes from the Resources and Performance Committee. She pointed out that some of things she would report about were a little out of date due to the changing position on finances etc.

At the last meeting there was a forecasted break even and this had been fantastically achieved. At that point the CCG had a £1.4m deficit. The CCG had a good record of paying all invoices by the due date and the committee commended the work of the financial team in achieving budget situation and considering our starting position members were happy to note that the CCG had achieved what it had.

There were no issues coming out in terms of performance but the Committee felt that the CCG continues to follow up any areas of weakness thoroughly to try and understand the reasons behind the data. Karen noted that figures tell you one thing but do not give you the detail.

Karen Bower informed the members that the committee had looked at the commissioning plan and was taken through a presentation of the Five Year Plan, the Two Year Plan and the Better Care Fund which was interesting and commended the CCG in trying to link these up and make it a coherent approach although nationally they had to produce these individual plans.

She then explained that there was a review of the Resources and Performance Committee and she circulated a questionnaire to members in which they discussed some of the issues which came out of it. The main thing to come out of it was they would focus more on the exceptions in the Performance Report as against looking at it as a whole as it does not change a lot from each meeting.

Julie Ross informed the committee that JLEB would receive a full performance report on alternate months with an exception update in the intervening month.

Steph Edusei stressed despite the change in reporting the CCG staff were still keeping an eye on performance and concentrating on the areas of concern. The change in reporting was to give time to take action on performance concerns rather than spend a lot of time preparing reports.

NCCGB/14/31 Engagement and quality

John Unsworth reported on Engagement and Public health policy committee on behalf of Peter Atkinson who had to leave early. The meeting was held on the 20th March and the committee received a comprehensive update from Cynthia Atkin on progress within Healthwatch. In particular the committee was heartened to hear that Health Watch was proactively seeking to see greater involvement and engagement with younger people. There was also a presentation from Liz Linguard who is part of the Public Health Team around cancer and variations across localities in terms of different types of cancer and survival rates and what initiatives are planned nationally trying to get patients to seek earlier assessment if they suspect they have problems.

John noted that the members had a very useful discussion and presentation around engagement and that an update of the engagement strategy action plan was received. He added that this was a living plan which plots the progress of various initiatives which unfold throughout the year.

The committee felt assured that the engagement was being handled in a very proactive way by the CCG.

The committee received an update with relation to facedown restraint within Northumberland Tyne and Wear Health Trust. This was an issue about which the CCG had very tenaciously and proactively sought explanations and assurances from the provider. The Committee felt that the CCG had done lots of excellent work and a number of outcomes which would specifically benefit patients to reduce the use of facedown restraint if it was regarded as inappropriate by the providers.

The committee had also received an update on Commissioning for Quality and Innovation which is known within the NHS as CQIN and we were brought up to date with the developments from the friends and families tests and initiatives to try and reduce pressure ulcers and falls amongst CCG providers. Members were assured again that CQIN was being effectively well managed and handled by the CCG.

Finally John Unsworth invited the Governing Body to receive the Minutes of the Committee and note these points.

Karen Bower commented on an issue that they had with Northumberland, Tyne and Wear NHS Foundation Trust (NTW) regarding serious incidents and noted that the CCG had been asking for information on serious incidents but that this had not been supplied in due time.

Steph Edusei answered saying this was on the restraint issue and that the CCG had a presentation which came to JLEB in February. There was an opportunity to ask a lot of questions of senior Trust leadership and clinicians. The executive directors were now happy we had a way forward to monitor that the level of restraint is appropriate.

Jacqui Henderson commented that the committee had a very good presentation which received a lot of discussion within the Committee. It was felt that the CCG had achieved a

very good outcome on restraint issues due to the probing questions asked.

NCCGB/14/32 Audit Committee
Steve Brazier introduced the paper on the Audit Committee commenting on the presentation from Mazars, the external auditors, around their audit approach. As it is the first year of operation there were a few gaps by way of third party assurances which meant that Mazars had to do a bit more work than had been expected.

The second theme he wanted to highlight was around risk. This completed a circle as this item came to the last Governing Body meeting which he did not attend. Committee members went through the risk register which had been to JLEB and the other groups. The Audit committee was happy about the discussion that had taken place to establish the risk appetite reflecting that it was a clinically led organisation, and happy around the approach to provider risk. At the March committee members were assured that the CCG had a robust approach to risk. The only outstanding item is under the contract with North East Commissioning Support Service (NECS) who host the system that most of the CCG's in the north east use for their risk registers.

Steve noted that whilst neighbouring CCG's risks may not be applicable to Northumberland, it would useful to know what they are and at what level they've been assessed as this would provide a further level of assurance. As a result of the meeting he took an action as Audit Chair to ask NECS to obtain this information as he believed that Steph Edusei had great difficulty over the last couple of months trying to obtain this. The Committee was assured by what the CCG had done.

The third main theme was internal audit and the committee had received two internal audit reports both with significant assurance. One was that the CCG was involved proactively in the Health & Wellbeing Board's operation and the second that there were proper processes in place to canvas patient's and the public's views and to place them into plans.

He added that the CCG had now received five or six reports all with significant assurance and one of the debates the committee had was regarding the standards within internal audit. Internal Audit said that the CCG had been well prepared, operated in shadow form and were approved with no conditions. This, however, was not the same for all other CCG's, therefore, the CCG was in a better position. The important thing to note was not all CCGs receive significant assurances in respect their reports.

Internal Audit commented on the 2013/14 audit commenting the CCG had processes in place and had a system to capture patient and public involvement. The 2014/15 benchmark will be slightly higher in that it would check if the systems work effectively. This was an interesting dialogue for the Audit Committee to hear in terms of the CCG as an organisation and how it is progressing.

Jacqui Henderson thought that the clarification by Internal Audit was very helpful as a few times there has been some cynicism about their assessment.

Julie Ross stated that the internal audit team are the same people who were part of the audit

team for the primary care trust so there has been some consistency. She stated the CCG would have been disappointed if they had put the bar really low and given the organisation an easy ride for the first year.

Jacqui Henderson thanked everyone and confirmed that the Board noted the Minutes and highlighting the key items.

NCCGB/14/33 Any other business
There was no other business.

Due to their being time left Jacqui Henderson wanted to ask the Board whether they had any points or issues they wanted to raise about how they felt about the quality of discussion of this meeting or the content of Board papers.

John Unsworth said there was quite a volume of paper including the annual report and accounts and he found the two year operational plan of interest. He added that he quite liked the clinical based items, such as the operational plan and end of life care update. He though the quality of the documentation was very good and well-structured and useful in that the members are not taken through everything line by line.

Eileen Higgins said she was on the previous shadow Governing Body and felt that this had a very different feel. It was much more positive in some ways. She had not seen some of the documents before and found them interesting. She said she knew a lot about the operational side and it was nice to see how people actually challenged and looked at what is done and how it works in practice.

Karen Bower thought the members had plenty of chance to discuss and give views and ask questions. She felt that sometimes she was seeing the information twice particularly as she sat on all three committees last year. She felt that some more complex issues could just come to the Governing Body for discussion. Jacqui responded that it would be useful to develop a calendar of issues going through the next 12 months and that she felt the Governing Body was in a different place to where it was last April.

Steve Brazier found the reports interesting. Not being a clinician he found the clinical bits understandable. In terms of the meeting itself he thought the meeting was well run and within time. He also thought the papers and questions were concise.

Paul Crook commented that he found the views interesting as he comes from a clinical background. He did say he had to think about the finance side of things but thought it was a good balance.

Alistair Blair said he agreed with a lot of the comments. One of the things he highlighted was Governing Body assurances. He perceived that the organisation is doing well and that there was a risk of complacency. He said it would be important to recognise that if the organisation starts to fail this would change the focus of the meetings. He felt it was important to raise this as a Governing Body so members are always proactive in terms of challenge and debate.

John Unsworth said he himself would challenge the clinical performance if our performance deteriorated.

Jacqui Henderson added that she attended all the committees and confirmed there was a lot of challenging questions.

Julie Ross stated although she does not sit on all the committees she does read the papers and though it was necessary to think very carefully about what goes to the committees and what comes to the Governing Body. There had been comments made about duplication but her main worry was bringing something to the Governing Body without going to a committee could lose a bit of scrutiny.

Steph Edusei thought that the Governing Body meetings had been quite challenging over the past year and found them valuable.

Rob Robertson confirmed that the challenging questions were for the right reasons. He agreed with Alistair's observation of the Board being all assured and happy, however, he stressed that on the financial side he found that it had been a very difficult process to come back to the Governing Body with a level of assurance

Karen Bower agreed with the statement by John Unsworth that there was a need to be careful that over time, as she and Steve become more knowledgeable about the health service, they would become less 'lay' than they are now are.

Jacqui Henderson agreed and quoted Peter Atkinson's comment on how it was important to hang on to his naivety.

Jacqui Henderson stated that she felt the meeting had been a good one and thought the group had matured over the last year as a governing Body. She added that this meant that things had to be done in different ways to ensure that probing questions were asked in the right way. She thanked members of the public for attending and hoped they found the meeting interesting and informative.