NHS
Northumberland
Clinical Commissioning Group

Meeting of the Governing Body

This meeting will be held at 10.00 on Wednesday 21 February 2018 in Morpeth Town 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
1045	6.	Buddying arrangements	✓	J Guy
1115	7.	Planning Guidance and CCG Way Forward - presentation	✓	S Brown/ I Cameron
1145	8.	Board and Committee Minutes 8.1 Financial regulation and Audit - Audit Committee Terms of References 8.2 Primary Care Commissioning 8.3 Joint Locality Executive Board	 ✓ ✓ ✓	 S Brazier J Guy V Bainbridge
	9.	Any other business		J Guy
1200	10.	Date of Next Meeting: TBC		J Guy

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Minutes of the Governing Body
18 October 2017

Members Present:

Mrs Janet Guy	Lay Chair (Chair)
Dr Alistair Blair	Clinical Chair
Mrs Karen Bower	Lay Governor
Mr Steve Brazier	Lay Governor
Mrs Siobhan Brown	Chief Operating Officer
Mr Ian Cameron	Chief Finance Officer
Dr Paul Crook	Governing Body Secondary Care Doctor
Dr David Shovlin	Locality Director
Dr John Unsworth	Governing Body Nurse

In attendance:

Mr Stephen Young	Strategic Head of Corporate Affairs
Mrs Rachael Long	Corporate Affairs Manager

NCCGB/17/30 – 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 NHS Northumberland Clinical Commissioning Group (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. There were no questions raised.

The members of the public in attendance introduced themselves and explained that they had an interest in Riversdale Surgery in Wylam, and had come to see how the CCG works.

Janet explained that Governing Body has an overarching assurance role. The CCG's decision making body is the Joint Locality Executive Board. Governing Body oversees what the Board is doing and gives assurance that it is following due process.

NCCGB/17/31 – Agenda item 2 – Apologies for absence

Apologies for absence were received from Mrs Vanessa Bainbridge, Accountable Officer.

NCCGB/17/32 - Agenda item 3 – Minutes of the previous meeting and matters arising

Page 3, Financial Recovery, the last sentence will be changed to read “quality and safety”.

Page 4, 2nd paragraph, the last sentence will be changed to read “from all providers” instead of “from the acute trusts”.

Page 5, 4th paragraph on falls will be rephrased.

Governing Body members approved the minutes as a correct record subject to the amendments noted above.

Matters arising

Steve Brazier asked if the winter planning presentation on the agenda would cover the reasons behind the longer length of stays in Northumberland. Siobhan Brown agreed to discuss this.

NCCGB/17/33 – Agenda item 4 - Register of interests, review of conflicts of interest and quoracy

No conflicts of interest were declared.

The meeting was quorate.

NCCGB/17/34 - Agenda item 5 - Chief Clinical Officer and Chief Operating Officer assurance and key issues briefing

Siobhan Brown provided an update on key issues:

Accountable Care Organisation (ACO)

The ACO business case continues to be considered by NHS England (NHSE) and NHS Improvement (NHSI). In the meantime the Northumberland system continues to work on the assumption that the current commissioning architecture remains.

Steve Brazier commented that NHSE and NHSI are setting up Accountable Care Systems (ACS) in ten areas of the country, and asked what the difference is between an ACS and an ACO? Alistair Blair said that the difference is a degree of scale, an ACS is broader, and also considers health education and research funding. It is not such a detailed way of working as an ACO. ACSs are also aligned to an element of local devolution.

Our STP area applied to be an ACS but was not selected as such. The ACO would have a more focused contractual and organisational lock-in than an ACS.

Clinical Strategy

The second event in a series of four, held on 10 October 2017, was well attended by primary and secondary care clinicians. The event concentrated on the next steps in developing a sustainable clinical strategy for Northumberland with a focus on out of hospital models of care.

Alistair Blair said that the requirement for a strong clinical strategy remained and that a meeting later today was to consider the next steps. Alistair said that it is clear that, despite the fact that the ACO business case continues to be considered there is a continued intent to look at the integration agenda and ways of working better together.

John Unsworth asked how far this has developed, he is aware that the CCG is involved in developing models e.g. Rightcare, which are trying to align us with the national average in terms of interventions and spend, and asked what impact this has. Alistair explained that the event was not specifically looking at Rightcare, as there are other groups looking at that. This group is looking at broader concepts, including the 'realistic medicine' approach used in NHS Scotland, where right care is a tool within that approach. The next session will focus on realistic medicine.

John Unsworth asked when the strategy will be finalised. Siobhan Brown replied that the session later today will also consider the operational issues associated with the delivery of the strategy. The CCG is currently writing commissioning intentions for the year ahead, which will include delivering some areas of the strategy such as community services, length of stay and bed utilisation models.

Paul Crook asked how the local strategy fits with the region's Sustainability and Transformation Plan (STP) strategy. Alistair Blair said that the CCG is hoping to use the workstreams for the STP, e.g. how to decrease avoidable emergency admissions and looking at improving performance on handover delays, in which we are seeing some improvements already. David Shovlin asked that consideration be given to inviting ambulance providers to future clinical strategy events.

Primary Care Federation

The Federation leads have now been appointed into their roles across the four localities. The leads will become key members of the collaborative System Delivery Board alongside the healthcare system's Chief Executives. They will represent the views of their localities and influence the county-wide development of models of care.

Alistair Blair said that there may be a need to revalidate the Federation's purpose as the CCG moves forward over the coming year. Karen Bower asked who the federation leads are, it was agreed that the CCG will email the details of the leads to lay governors.

Rothbury

The Joint Locality Executive Board considered the future of Rothbury Community Hospital's inpatient services at a meeting held in public on 27 September 2017. The Board unanimously voted to permanently close the 12 inpatient beds and shape existing services around a Health and Wellbeing Centre on the hospital site.

Northumberland County Council's Health and Wellbeing Overview and Scrutiny Committee considered the decision to close the beds at its meeting on 17 October, and agreed to refer the CCG's decision to the Secretary of State. The CCG is waiting for formal feedback on the final reasons for the referral. The timescales for the referral are not known yet, but it is thought that it will be a matter of months.

Extended Access

As part of the GP Five Year Forward View, primary care in Northumberland launched extended access on 2 October 2017. Access to primary care is now available in the evenings from Monday to Friday, 6.30pm to 8pm, and also at locally agreed times on Saturdays and Sundays. This is part of a national programme to enable patients to access the right care at the right time in the right place.

Karen Bower asked if the additional appointments would be used, and whether this is being monitored? Alistair Blair said that the target uptake rate for the new appointment was75%. These appointments are all additional capacity, the impact will be greatest in practices with poorer access. The availability of Saturday morning appointments and direct access to appointments through 111 should make a big difference.

Karen Bower said that Northumbria Healthcare NHS Foundation Trust (NHCFT) has sent a survey to members asking for views on the extended access service. The questionnaire is worded in such a way that it is not possible to answer that a person would not use the service. Alistair Blair agreed that the CCG will discuss this with NHCFT. It was noted that there has been minimal appetite from the public for Sunday opening. It must be understood that spreading appointments too thinly would mean that there would not be enough GPs available for regular appointments during normal weekly opening hours.

John Unsworth asked what the CCG is doing to inform members of the public and queried whether a press release should be issued; and also the use of the internet as not everyone attends their practice. Alistair Blair said that posters had been put up in every practice, and that monitoring shows Saturday appointments are being used. Receptionists should be offering the option of Saturday and evening appointments. Stephen Young said that the CCG had a prepared press release, and he will check whether it has been used. Siobhan Brown added that the CCG will carry out an independent evaluation of the scheme.

Paul Crook asked whether Patient Participation Groups (PPG) have been involved? Alistair Blair said that this would be on a practice by practice basis. The role of PPGs is to consider

the practice itself, hubs delivering extended access may be on a wider scale. Stephen Young said that the CCG have sent the information to practices in the weekly bulletin asking them to forward it to their PPGs.

Steve Brazier said that looking at the numbers, there are an additional five appointments per GP surgery, 35 per cluster. If we look at for example Blyth, how does this look for the patient? Alistair Blair said that the extended access appointments at Blyth are at Village Surgery in the evenings and at weekends, and that in some areas the appointments are rotated around two or three practices, on a fixed basis.

NCCGB/17/35 – Agenda item 6 – Finance Update

Ian Cameron gave a verbal update on the CCG's financial position. There is no formal paper included as the CCG has been in discussions with NHSE to confirm the reporting of a revised deficit. NHSE has now confirmed that it is content with the CCG reporting a forecast deficit of £20.3m.

The CCG had reported a forecast deficit of £4.5m throughout this financial year. This does not reflect a deterioration in financial performance, it is a change in the way the deficit is reported as amounts previously reported as risks have now been included in the financial position.

The CCG views this as a positive development and now has a clear and deliverable target to aim for, although it recognises that a substantial amount of work remains to be done. The CCG has a challenging £17.4m savings target for 2017/18 with the focus being on delivery and implementation. The Programme Management Office is now operational and the first Finance and Project Management Board meeting took place on 17 October 2017.

Janet Guy said that it is good news that the forecast deficit position has been formally revised and reflects an improvement to the in-year position reported in 2016/17.

Siobhan Brown said that in terms of process, the reported deficit position will be formally agreed by the Joint Locality Executive Board.

Paul Crook asked about the £17.4m required savings, and said that one of the problems the CCG has had in the past is involving the providers who spend the funds. He asked if we believe we are involving them now? Ian Cameron said that the CCG is engaging with providers; it is considering all commissioning and demand management options available.

Steve Brazier said that it is good news that the CCG has a clear target to work to. At the NHS Audit Chairs' meeting yesterday some tips were shared in terms of financial recovery. QIPP opportunities have been published, detailing approaches used in other CCGs. These contain some interesting benchmarking information about QIPP plans in the rest of the country.

Karen Bower attended a Sustainability and Transformation conference last week, and noted that East Sussex CCG is aiming for a system control total, she asked if that was something we

could pursue? Ian Cameron said that the ACO would probably bring these things together, but at present we are still in the traditional system architecture.

Steve Brazier asked, in terms of the CCG's special measures and directions, does this position reflect a revised control total. Ian Cameron answered that it is not a revised control total, it reflects agreement from NHS England to report a revised forecast outturn.

NCCGB/17/36 – Agenda Item 7 – Winter Preparedness

Siobhan Brown gave a presentation on winter preparedness. The plans for winter 2017/18 are a single system plan which have oversight and a view of all partners in the local health system.

Alistair Blair said that there had been a lot of discussion about sentinel practices giving early warning signals to the wider system and asked what the mechanics behind it are? Siobhan Brown said that the system would look at working with a number of practices in terms of a pilot, and Alistair will also be invited to be involved. The four major elements of managing winter are:

- Keeping people well wherever possible and managing people at home and in the community wherever possible to stop them coming to A&E or hospital inappropriately
- Once people do reach A&E or hospital, they are triaged and treated as effectively as possible and returned home
- Managing flow throughout the whole system and being able to actively predict demand and the capacity required to meet demand
- Strong discharge planning and community services

Stephen Young said that there is an extensive communication exercise being undertaken throughout the winter period. At times this will become more detailed and will include messaging about key areas of inappropriate attendances at A&E and the signposting of alternative points of care.

Janet Guy noted that the minutes of the previous meeting state that Daljit Lally has been looking at care home beds, how realistic is it that we will be able to make a difference this year? We hear commentary about bed blocking with the frail elderly who can't go back home, and there are problems finding somewhere for them to go. David Shovlin said that a lot of these issues are about commissioning, who pays for beds and also about clinical governance. Newcastle/Gateshead CCG commission some care home beds as step down facilities, and we will look at how they do that.

Paul Crook said that we hear Northumberland has too many beds, but the figures in the presentation show that we are potentially short of beds, how is this? Siobhan Brown said that the figures are predicated on current lengths of stay and that in some cases they are unnecessarily long. Once the length of stay period has been optimised the system will require fewer beds.

Alistair Blair said that the CCG needs to keep a close eye on flu. Australia was badly hit by flu this year, and had increased numbers but lower morbidity. Paul Crook agreed that we may see more people with flu this year which will have other knock on effects on the system.

NCCGB/17/37 – Agenda item 8 – Board and committee minutes

Agenda item 8.1 – Financial Regulation and Audit

Steve Brazier reported on the work of the Audit Committee. The main items discussed at the last meeting were:

- Siobhan Brown attended to give a presentation on the development of the ACO as internal and external auditors had requested more information.
- Primary care reporting, Audit Committee do not consider many reports on primary care, as most primary care business is discharged at the Northumberland Primary Care Commissioning Committee. Any issues regarding primary care will be raised by exception in future.
- A revision to the timetable, taking some items out of the May meeting which is busy with annual reports and auditor reports.

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

Agenda item 8.2 – Primary Care Commissioning

Janet Guy reported on the work of the Primary Care Commissioning Committee, the main items discussed at the last meeting were:

- Vanguard evaluation, the committee will receive a report to consider at a later stage.
- Blood glucose test strips, the use of which will be reviewed.
- GP patient survey, 87% rated primary care in Northumberland as good, which is higher than the national average.

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

Agenda item 8.3 Joint Locality Executive Board

Siobhan Brown reported on the work of the Joint Locality Executive Board, the main items discussed at the last meeting were:

- The meeting was held in public to make a decision on the future of the inpatient beds at Rothbury Community Hospital, as a board, the CCG interrogated the issues and came to a unanimous decision. The board members also heard the campaign group speak, those notes are included for completeness of record.

Governing Body members received the minutes for information.

NCCGB/17/38 – Agenda item 9 Any other business

There was no further business to discuss

NCCGB/17/39 – Agenda item 10 - Date of next meeting

20 December 2017 – timings to be confirmed

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Clinical Commissioning Group

Governing Body
21 February 2018
Agenda Item: 5
Accountable Officer and Chief Operating Officer Report
Sponsor: Chief Operating Officer

Members of the Governing Body are asked to:

1. Consider the Accountable Officer and Chief Operating Officer report.

Planning Guidance for 2018/19

In 2016, NHS England (NHSE) and NHS Improvement (NHSI) set out planning guidance, including contracts and improvement priorities, for the period from 2017 to 2019. *Refreshing NHS plans for 2018/19*, published on 2 February 2018, reflects on the changes that have been made in the period since. It provides updated guidance on how commissioners and providers should refresh their plans for 2018/19. The guidance is intended to allow organisations to continue working together through Sustainability and Transformation Plans to deliver system-wide plans, with additional freedoms and flexibilities offered to the most advanced systems.

The detail and potential implications for NHS Northumberland Clinical Commissioning Group (CCG) and the wider Northumberland system are outlined in a separate item in today's agenda.

Price Waterhouse Coopers (PwC) Capacity and Capability Review

The CCG, as part of having Legal Directions and being in Special Measures due to the financial deficit, has been independently reviewed by PwC (commissioned by NHS England) to identify any gaps and provide recommendations on creating a fit-for-purpose CCG for the future. The findings will inform the future capability and capacity of the CCG and will include:

- a revised governance framework which will begin subject to due process from 1 April 2018 – with Lay Governors and the board nurse and secondary care doctor as voting members of Governing Body
- a revised clinical leadership framework in the light of recent and imminent changes in the clinical leadership team
- increased capacity in essential areas such as finance, contracting, commissioning and business intelligence.

Financial Recovery and creating a sustainable system

The financial recovery programme of the CCG is now well underway and the CCG remains on course to post a £20.3M deficit at the end of 2017/18 – in line with its revised forecast outturn. The underpinning CCG programme management office, as well as embedding a rigorous approach to financial recovery, also checks that schemes do not have a detrimental impact on the quality or equality of care for the population. This work will be delivered side by side with the development of new models of care with the ambition of releasing the pressure on acute hospital care over the coming years. Consultation and engagement with the public will be a pivotal part of this work.

System Transformation Delivery Board

The System Transformation Delivery Board, which has membership from all of the providers across Northumberland as well as the Council and the CCG, has begun to gain traction on the difficult issues faced by the CCG in terms of delivering clinical and financially stable services moving forward.

The Refreshed NHS Planning Guidance for 18/19 is being reviewed as a system this month with the intention of creating a system-wide programme of efficiency. To support this, the Board will adopt a programme management approach to ensure all aspects of the transformation priorities are delivered on time and within scope clinically and financially.

Local A&E Delivery Board and managing through Winter

Performance has been challenging for all providers over winter. At one stage, for example, 40 beds were out of commission due to norovirus and flu. Given the pressures experienced across the system the Local A&E Delivery Board (LADB) performance has been commended regionally and nationally by NHS Improvement.

For the first time the newly implemented primary care extended access was active over the Winter period and significant additional capacity in primary care was offered. 111 call volumes saw a stepped increase on the key bank holidays and subsequently the activity across providers increased.

Ambulance turnaround times have been challenging and more analysis is underway to review “crew clear to respond” times from ambulance handover to the Emergency Department team in order to release more capacity into the system.

A refresh of the LADB has been agreed to move at pace with the top priorities for the system to be managed through an Executive Board and Operational Group.

NHS
Northumberland
Clinical Commissioning Group

Governing Body
21 February 2018
Agenda Item: 6
Buddying Arrangements
Sponsor: Lay Chair

Members of the Governing Body are asked to:

1. **Consider and comment on the benefits gained from buddying arrangements with other organisations.**

Purpose

Members are asked to consider the benefits to be gained from buddying arrangements with other organisations and how they can contribute to such arrangements.

Background

Within 12 months of the establishment of Clinical Commissioning Groups (CCGs) in 2013, the commissioning landscape was already changing to allow closer working between organisations. In 2014, legislation was amended to allow a number of CCGs to establish joint committees.

Since then we have seen a continuing movement towards collaborative working at a variety of different levels, from low level informal networking between individuals to, at the higher levels, CCGs sharing staff, establishing joint management arrangements or, in some cases, merging.

We have also seen the growth of collaborative working with other organisations such as Local Authorities, NHS Trusts and NHS England (NHSE) through Primary Care Commissioning, Sustainability and Transformation Partnerships and proposed Accountable Care Organisations and Accountable Care Systems.

In our recent discussions with NHSE it is being made clear that locally, regionally and nationally there is a growing appetite for encouraging CCGs to work together and with other partners to exchange learning and good practice. NHS Northumberland Clinical Commissioning Group (CCG) has always done this at an informal and individual level but to obtain best value from these arrangements it is suggested that we should establish a formal schedule of 'buddying' meetings or contacts with other organisations and provide regular feedback to the Governing Body.

Action

It is proposed that the CCG should contact other appropriate organisations to establish buddying arrangements. These could be one to one meetings by role, group meetings by area of focus, Board to Board meetings or other arrangements which members think would be helpful. Buddying does not have to be through face to face meetings, it could include, for example, telephone and online discussions.

Arrangements with other local CCGs would be particularly relevant but electronic communication would allow buddying arrangements with any other areas with similar profiles or issues as ours.

Members are therefore asked for their views on whether such arrangements could be beneficial, which organisations they believe we could benefit from approaching and how members individually could contribute to and benefit from such buddying arrangement.

NHS
Northumberland
Clinical Commissioning Group

Governing Body
21 February 2018
Agenda Item: 7
2018/19 NHS Planning Guidance
Sponsor: Chief Operating Officer

Members of the Governing Body are asked to:

1. **Review the contents of the report and consider the implications of the 2018/19 NHS planning guidance and NHS Northumberland Clinical Commissioning Group allocation.**

Purpose

This report provides Governing Body with a summary of the recently issued NHS planning guidance, and associated NHS Northumberland Clinical Commissioning (CCG) allocation changes.

Background

In 2016, NHS England (NHSE) and (NHSI) set out planning guidance, including contracts and improvement priorities, for the period from 2017 to 2019. *Refreshing NHS plans for 2018/19*, published on 2 February 2018, reflects on the changes that have been made in the period since. It provides updated guidance on how commissioners and providers should refresh their plans for 2018/19.

The guidance is intended to allow organisations to continue working together through STPs to deliver system-wide plans, with additional freedoms and flexibilities offered to the most advanced systems.

In framing refreshed planning guidance NHSE and NHSI, have therefore taken account of**:**

- this improved funding outlook
- the already agreed 2018/19 'deliverables' contained in the *Next Steps* document
- the priorities set by Government in the recent November Budget and the expected Mandate; and
- insight from ongoing public engagement, involvement and feedback including from Healthwatch.

NHS Planning Guidance Summary

Financial framework for commissioners

Resources available to Clinical Commissioning Groups will be increased by £1.4 billion, reflecting realistic levels of emergency activity, additional elective activity to tackle waiting lists, universal adherence to the Mental Health Investment Standard and a commitment to reaching standards set for cancer services and primary care.

Additional investment will be made through:

- removing the requirement for CCGs to underspend 0.5 per cent of their allocations for 2018/19, releasing £370 million, and removal of the requirement for a further 0.5 per cent to be spent non-recurrently
- an additional £600 million for CCG allocations in 2018/19, distributed in proportion to target allocations
- creation of a new £400 million Commissioner Sustainability Fund to enable CCGs to return to in-year financial balance.

Where a Clinical Commissioning Group is unable to operate within its allocation it must commit to a credible plan to deliver a deficit control total. It will then qualify to access the Commissioner Sustainability Fund.

Financial framework for providers

A further £650 million will be added to the Sustainability and Transformation Fund, to create a £2.45 billion Provider Sustainability Fund. This additional investment will be reflected in 2018/19 provider control totals; 30 per cent of the fund will be linked to A&E performance. Providers will plan on the basis of their 2018/19 control totals.

Providers who accept their control totals will continue to be exempt from the application of certain agreed performance sanctions. NHSE will be consulting on changes to the Standard Contract to extend this exemption to all national performance sanctions, except mixed-sex accommodation, cancelled operations, healthcare associated infections and duty of candour. This will be done on the basis that NHSI will continue to ensure performance at acceptable levels against all national standards.

Capital and estates

The government has committed to providing an additional £354 million capital for property and estates investment. Allocations for this funding have not yet been confirmed, so STPs and providers should not plan on the basis of receiving this additional funding.

STP capital will be contingent on the areas having an estates and capital plan that sets out how individual organisations will work together to deploy the funding to support integrated service models, share assets and dispose or unused- or under-used estate.

Underlying assumptions

The NHS allocations are issued based on the following assumptions:

- Local systems are expected to continue to implement the priority efficiency programmes within the ten-point efficiency plan
- CCGs will receive the remaining period of temporary benefit from changes made to Category M generic drug prices
- CCGs should consider how to locally implement guidance on the 18 ineffective and low clinical value medicines
- CCGs will continue to work with the NHSE Continuing Healthcare and QIPP programmes.

Emergency care

Clarity on control totals, as well as additional sustainability funding for providers and commissioners, are intended to enable health systems to plan for activity in a way that enables improved A&E performance. Allocations also allow for a 2.3 per cent growth in non-elective admissions and a 1.1 per cent growth in A&E attendances.

It is expected that the government will roll forward the goal of ensuring aggregate performance against the four-hour target of 90 per cent for September 2018, with the majority of providers achieving 95 per cent for March 2019 and a return to overall adherence to the 95 per cent standard during 2019.

Plans should demonstrate how commissioners and providers will complete the implementation of the integrated urgent care strategy. All providers and commissioners should work together to reduce length of stay.

Community providers will be invited to participate in a new local incentive scheme where savings from acute excess bed day costs can be reinvested to expand community and intermediate care. £210 million CCG Quality Premium incentive funding will be contingent on performance on moderating demand for emergency care.

Referral to treatment times

Allocations now allow for improvements in the volume of elective surgery and improvements in waits over 52 weeks. Commissioners and providers are asked to plan on the basis that their RTT waiting list will be no higher in March 2019 than March 2018, and should aim to reduce it. National numbers of patients waiting over 52 weeks should be halved by March 2019. Provider plans will need to consider the capacity required to deliver growth in elective and non-elective activity.

Integrated system working

All STPs are expected to take an increasingly prominent role in planning and managing system-wide improvement efforts. This should include: ensuring a system-wide approach to operating plans; implementing service improvements that require system-wide effort; identifying system-wide efficiency opportunities; undertaking a system-wide review of estates; and further steps to enhance the capability of the system including stronger governance and aligned decision making and greater engagement with communities and partners.

There will be a further, non-recurrent, allocation within each STP to support its leadership. Integrated care systems (previously known as accountable care systems) will continue to be rolled out voluntarily. The existing ICS areas should prepare a single system operating plan narrative, rather than individual organisational narratives, and NHSE and NHSI will focus their assurance on these system plans, not organisational ones.

All ICSs will work within a system control total, with flexibility to vary individual control totals. They are encouraged to adopt a fully system-based approach to the PSF and CSF. They will be required to operate under system control total incentive structures by 2019/20, but there will be some flexibility on this in 2018/19. Systems adopting this structure will have a more autonomous regulatory relationship with NHSE and NHSI.

STPs that wish to join the ICS programme should confirm expressions of interest with their regional team. NHSE will aim for applications to be reviewed by March 2018. All systems are expected to engage with patients, the public, their democratic representatives and other community partners.

Winter demand and capacity

There will be no additional winter funding in 2018/19. Systems will need to demonstrate that winter plans are embedded in both system and individual organisation operating plans.

There is a requirement for each system to produce a separate winter demand and capacity plan. Guidance for these plans will be available by March 2018.

Important implications for Northumberland CCG

2018/19 allocation, control total and commissioner sustainability fund (CSF)

The CCG has been given a £6m deficit control total and an indicative share of the CSF of £6m. The CSF will be earned if the following conditions are met:

- *Demonstrate commitment to delivering the control total* - deliver a financial plan consistent with the financial control total for 2018/19
- *Repayment of cumulative debt* - agreement of a milestone-based recovery plan with NHSE by the end of quarter 1 if not already in place

- *Delivery of the financial plan for the year* - hit the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3.

If the CSF is earned, the £6m will be paid to the CCG to enable a break-even position to be achieved.

The CCG has also been provided with a £3.698m share of the additional £600m CCG allocation outlined in the planning guidance and will also benefit by c £2.3m by the removal of the requirement for CCGs to underspend 0.5 per cent of their allocations for 2018/19.

Requirements for investment

The planning guidance indicates that increases in allocations should fund:

- 2.3% growth in non-elective admissions and ambulance activity and
- 1.1% growth in A&E attendances
- 4.9% growth in total outpatient attendances and up to 3.6% growth in elective admissions (2.7% per working day). It is also assumed increases in GP referrals by 0.8%
- Achievement of the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding.

Given Northumberland CCG's current deficit position which has put the CCG in Special Measures, the CCG will be seeking guidance on the application of the growth assumptions.

Performances standards and provider sustainability fund (PSF) requirements

The following table highlights the main changes to national standards for providers.

In some cases, as performance standards have been relaxed, the CCG is confirming with NHSE that these changes will be mirrored in the CCG quality premium requirements.

Area	**Planning assumption**	**CNE current Av**
A&E 4 hour standard	• >90% for month Sept 2018 • Min 95% month of March 2019 (majority) • Return to 95% overall during 2019	Sep17 95.7% Jan18 ≈ 88.8% Jan18 YTD ≈ 94.1%
Reducing proportion of beds occupied by DTOC patients	…to 3.5% (unchanged)	Dec17 3.1%

Stranded patients	New indicator >7 days (“stranded”) >21 days (“super-stranded”)	Jan18 >7 days 37% >21 days 13%
Elective RTT	No. of patients on incomplete pathway in 2018 no higher in March 2019	Apr17vs Dec17 Drop -3.4%
52w	Minimum of 50% reduction in 52ww	16 Dec17 YTD

Providers that accept their control totals and so have access to the Provider Sustainability Fund for 2018/19 will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in the existing NHS Standard Contract. The planning guidance indicates that the list of exemptions is likely to increase.

Planning submissions and timeline

The following table sets out the key milestones for the planning submissions and timeline:

Item	Date
ICS system control total changes and assurance statement submitted	By 1 March 2018
Local decision to enter into mediation for 2018/19 contract variations	2 March 2018
Draft 2018/19 Organisational Operating Plans submitted	**8 March 2018**
Draft 2018/19 STP Contract and Plan Alignment template submitted	8 March 2018
National deadline for signing 2018/19 contract variations and contracts	23 March 2018
2018/19 Expert Determination paperwork completed and shared by all parties	27 April 2018
Final Board or Governing Body approved Organisation Operating Plans submitted	**30 April 2018**
2018/19 Winter Demand & Capacity Plans submitted	30 April 2018
Final 2018/19 STP Contract and Plan Alignment template submitted	30 April 2018
Final date for experts to notify outcome of determinations for 2018/19 update	8 June 2018

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Northumberland
Clinical Commissioning Group

Minutes of the Audit Committee
23 November 2017, Belsay Meeting Room, County Hall

Members Present:

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

In Attendance:

Alyson Williams (AW)	Internal Audit Manager, Audit One
Paul Bevan (PB)	Local Counter Fraud Specialist, Internal Audit, Audit One
Cameron Waddell (CW)	External Audit, Mazars LLP
Jim Dafter (JD)	External Audit, Mazars LLP
Ian Cameron (IC)	Chief Finance Officer
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)

AC/17/78 Agenda Item 1 Apologies for absence

Apologies were received from Carl Best.

AC/17/79 Agenda Item 2 Declarations of interest

There were no declarations of interest.

AC/17/80 Agenda Item 3 Quoracy

The committee was quorate.

AC/17/81 Agenda Item 4.1 Minutes of the previous meeting

The minutes were agreed as a true and accurate record.

Matters arising

SBr asked for an update regarding the Deloitte's Cost Improvement Plan (CIP) report. IC stated that he had not seen a copy of the report and that he would follow up with NHS England (NHSE). He explained that he would also discuss the North East Commissioning Support (NECS) offer to update the Deloitte CIP report with Vanessa Bainbridge, Accountable Officer, NHS Northumberland Clinical Commissioning Group (CCG) as referenced in Action AC/17/65/01.

AC/17/82 Agenda Item 4.2 Action log

All actions were agreed as complete and will be removed from the log with the exception of the following:

Action AC/17/65/01: MR to discuss the offer from NECS to update the Deloitte CIP report with Vanessa Bainbridge. IC stated that he would try to obtain a copy of the report from NHSE and would discuss the offer from NECS to update the report with Vanessa Bainbridge, Accountable Officer, CCG.

Action AC/17/71/02: IC to contact Graham Niven, CFO, Darlington/Durham CCG to discuss issues and escalate issue to area team. IC explained an update regarding this action would be given under agenda item 10 of the meeting.

AC/17/83 Agenda Item 4.3 Revised Audit Committee timetable

The Audit Committee reviewed the committee timetable. No amendments.

AC/17/84 Agenda Item 5 Chief Finance Officer's Report

IC gave an overview of the CCG's financial performance in the seven months up to 31 October 2017. He stated that the in year forecast was now a £20,265k deficit with a brought forward deficit of £40,461k from 2016/17, totalling a cumulative deficit of £60,726k. IC stated that it reflected the mid-year review undertaken by the CCG in bringing previously reported risks into this year's financial position. He explained that the £20,265k deficit and the change in reporting had been agreed by NHSE.

SBr asked about the impact of any prior year adjustment on the CCG's financial position. IC explained that following discussions with NHSE, there would be a change in the CCG's annual accounts but that it would not affect in year performance. SBr stated on that basis he was satisfied that the prior year adjustment issue could be closed.

IC stated that the NHSE/NHS Improvement (NHSI) arbitration panel result for the 2016/17 financial year challenges was received on 8 November 2017, but had not been included in the report. The arbitration outcome resulted in a £1.2m loss of additional revenue in year versus plan. SBr stated that the committee needed to understand both the 2016/17 and current year implications and asked if the CCG was confident that these could be mitigated. IC explained that the CCG's contingency funding has now been fully deployed to offset £800k of the £1.2m pressure. IC explained that there was now added emphasis on the delivery of the 2017/18 savings programme.

IC explained that the letter received from the arbitration panel was helpful. The panel had directed that more evidence was sought via contractual mechanisms via clinical audit/case file audit and local joint investigation/working in respect of the contested charges that have continued into 2017/18. He explained that the CCG was taking steps to strengthen processes and the focus was now on the 2017/18 challenges/disputes. PC asked what areas needed to be compared in the clinical audit. IC stated that Terms of Reference for the clinical audit was currently being developed and deadline for completing the joint investigations was 15 December 2017.

IC stated that the running costs forecast under spend was £387k but more staff were needed. He explained that NHSE supported the recruiting of a more robust team to address the CCG's current financial position, and PWC's findings would feed into an overall review of CCG resources. SY asked for an explanation regarding the Governing Body

2017/18 forecast (£549k). IC explained that the running cost was for the whole Governing Body function i.e. salaries, administration support and any other associated costs.

IC stated that the CCG had ten invoices in excess of £5k that were outstanding past their payment due dates. He highlighted NHS Leeds North CCG and explained that the invoice related to a S117 recharge from 2016. IC explained that discussions were ongoing to resolve the issue.

IC stated that there had been no waiver requests of financial policies in the financial year 2017-18 as at 31 October 2017, although there could be a waiver request for GP Forward View (GPFV) Extended Access services in December 2017.

IC stated that seven urgent payments had been actioned that were technically non-compliant with the CCG's Detailed Financial Policies (DFPs). The payments were made on 3 November 2017 to primary care delivery clusters in respect of GPFV Extended Access services that had been provided during October 2017. He explained that the payments were non-compliant as they had been made in advance of Joint Locality Executive Board (JLEB) approval to ensure that clinical services remained open and accessible to patients. IC stated that DFPs require that JLEB approves new budgets before payments are made.

IC stated that the introduction of GPFV Extended Access services was set out within national guidance for 2017-2019. In Northumberland, CCG primary care providers formed clusters in order to meet the new requirement. He explained that there was national pressure to commence service provision during September 2017. Commissioning work continued throughout September to agree the service specification and delivery model. The service specification was finalised in late September 2017 and clusters began delivering the service from 2 October 2017, under an implied agreement.

IC stated that in October 2017, the Primary Care Commissioning Committee (PCCC) agreed in principle to support the GPFV Extended Access implementation proposal and specification, and had recommended that JLEB approve the establishment of the associated delivery budget, with payments to follow by the end of October. Under special measures arrangements, NHSE challenged the value for money aspects of the proposals and the paper was removed from the October JLEB agenda pending the outcome of the discussions. IC explained that he authorised emergency payments in order to maintain service provision.

PB requested copies of the GPFV Extended Access papers. He explained that he was looking at extended access payments mechanisms for assurance purposes. IC stated that the service was delivered in clusters via a lead practice delivery model. He explained that it was a national payment based on population and that the CCG did not pay individual practices. PB stated that funding was being given to each cluster to then manage payment through a claims system. IC stated that the CCG was paying for outcomes and that delivery will be monitored.

SBr stated that the committee needed to define and agree its responsibilities regarding primary care. AW suggested that internal audit could review the primary care extended access payment process to provide the CCG with assurance in this respect.

SBr thanked IC for the full disclosure, and felt under the circumstances the action taken was appropriate. The full committee confirmed that it was satisfied with the emergency GPFV Extended Access services payments made.

Action AC/17/84/01: PB/AW to deliver an awareness session on Primary Care at the January 2018 Audit Committee.

Action AC/17/84/02: PB to keep Audit Committee updated on primary care extended access payment issues should they materialise.

Action AC/17/84/03: IC to send GPFV Extended Access papers to PB.

SBr stated that NHSE might attend Audit Committee due to the CCG's special measures status. He requested that External Audit be sent copy of the Special Measures letter from Alison Slater, Director of Commissioning Operations, NHSE (6 November 2017). SBr stated that the CCG had a 15 month timescale to get out of special measures and that if there was no improvement in financial performance, further and more stringent special measures would be applied to the CCG by NHSE. IC explained that any new investment needed to be approved by NHSE and a budgetary approvals process protocol had been communicated to all CCG staff.

Action AC/17/84/04: SY to send a copy of the NHSE Special Measures letter to CW.

AC/17/85 Agenda Item 6 External Audit progress report

CW presented the External Audit progress report in respect of the 2017/18 audit year. He explained that planning had started for 2017/18 and that he had met with IC and Siobhan Brown, Chief Operating Officer, CCG. CW stated that walkthroughs of the key financial systems as well as early interim testing (to reduce the impact on the year-end) were planned for January 2018 (Month 9)

CW highlighted the following areas of work being undertaken in the coming quarter:

- Audit Strategy Memorandum: Meeting with officers ahead of drafting 2017/18 Audit Strategy Memorandum in order to agree the scope and timing of work as well as any significant risks relevant to both the opinion and VFM conclusion work
- Review of previous year: Discuss the previous year's audit and consider any areas for improvement – carry out early testing to mitigate the impact on the year end
- Walkthroughs and interim visits: Walkthroughs of the key financial systems as well as early interim testing (to reduce the impact on the year-end)
- Run annual accounts workshops
- NHSE accounts workshops
- Internal training
- Client satisfaction surveys

AC/17/86 Agenda Item 7 VFM Training

JD gave a Value of Money presentation outlining the auditors' requirements in respect of VfM, overall evaluation criterion, the three Es, provisional risk assessment, and overarching

potential risks.

SBr stated that there had been a number of discussions last year regarding the sub-criteria: Informed decision-making, Sustainable resource deployment, working with partners and other third parties. CW stated that External Audit relied on the work of other regulators and organisations such as PWC and AuditOne, and would not duplicate work.

SBr thanked JD for his presentation.

AC/17/87 Agenda Item 8.1 Internal Audit

AW presented an update on progress against the 2017/18 internal audit plan. AW stated that no issues had been identified to date that might adversely affect the annual Head of Internal Audit Opinion.

AW stated that AuditOne had issued the following two final reports since Audit Committee in September 2017:

- NOR 1718/01 Financial & Strategic Planning – Assurance rating: Good
- NOR 1718/02 Stakeholder Engagement – Assurance rating: Substantial

AW explained that two medium risks (Appendix A - 1.1 & 1.2) had been highlighted in the Financial & Strategic Planning report which potentially could have been avoidable. SY stated that JLEB had approved the operational plan and 2017/18 budget but the minutes did not specifically document the decisions. SY also explained that the number of changes in interim appointments at the CCG had contributed to the lack of evidence available to support sign off of key documents and the retention of records.

AW stated that she had attended a Continuing Health Care (CHC) Open Book Audit meeting yesterday (22 November 2017) and confirmed that the recharges for payments were in line with what had been paid out. AW stated that value for money could be a potential issue for CHC and explained that the CCG did not currently receive yearly assurance on the accuracy of payments from Northumberland County Council (NCC). IC stated that the national Service Improvement Team had contacted the CCG offering resources if a business case was developed. SBr stated that there was a potential conflict of interest with the CCG and NCC. He stated that the committee needed to be assured that robust governance was in place to ensure all conflicts were identified and recorded when decisions were made. AW indicated there was no root cause analysis of high cost packages and a review was needed. She explained that CHC could potential impact on the Head of Audit Opinion. SBr asked AW to give the Committee early insight into any emerging findings.

SBr asked if the Better Care Plan (BCF) needed to be included in the Internal Audit 2018/19 plan. AW explained that BCF was in the 2017/18 plan.

SBr asked if the conflicts of interest audit could cover touch points with NCC. AW explained that discussions were ongoing with SY regarding the overall plan. SBr asked the committee if there were any other NCC touch points to be included in the Internal Audit 2017/18 plan. A discussion was had on high awareness and take up of CHC in Northumberland making

the CCG an outlier. SBr explained that a previous report on CHC had provided only limited assurance and we need to ensure the CCG was only funding Health Care Packages. IC agreed to review the CHC report.

Action AC/17/87/01: IC to review CHC report.

Action AC/17/87/02: AW to discuss the possible inclusion of BCF and CHC conflicts of interest in the Internal Audit 2017/18 plan with SY

SY stated that the ongoing review of governance planned for Q4 was on hold until findings from PWC review were published.

AW stated that Internal Audit would like to see PWC's QIPP review as it could potential impact on the Head of Audit Opinion. Following further discussion, SY agreed to ask PWC if AuditOne could contact them directly to discuss the QIPP review.

Action AC/17/87/03: SY to ask PWC if AuditOne can contact them directly to discuss the QIPP review.

AW stated that the Mental Health Arrangements - S117 After Care for Children had changed from assurance to advisory work.

AC/17/88 Agenda Item 9 Internal Audit outstanding actions

SY presented the Internal Audit outstanding actions and gave the following updates:

- 10512 JLEB Terms of Reference: Awaiting findings from PWC review
- 10514 Committee Self-Assessment of Performance: Awaiting findings from PWC review
- 10515 Financial delegation limits: All held with JLEB and governance process in place. PCCC has no official financial delegation
- 11371 Utilisation of feedback from Ipsos Mori survey: Refreshed communications and engagement plan in February 2018. Ipsos Mori survey closed down

AC/17/89 Agenda Item 10 Fraud Case Update

PB gave an update on the fraud regarding a Personal Healthcare Budget (PHB) that had occurred. He stated that there was no burden of proof that a fraud had occurred and no criminal proceedings were being taken.

IC explained that he had contacted Graham Niven, CFO, Darlington/Durham CCG and Chair of CFOs meetings, regarding the fraud case. He explained that guidance had recently been received that covered the situation in which an individual in receipt of a PHB is an employer and therefore responsible for any staff employed. PB stated that he was attending a meeting on 27 November 2017 to review the national guidance.

The committee discussed the CCG's responsibilities in respect of PHB.

PB raised the issue of risk assessment and asked who was responsible for undertaking

Disclosure and Barring Service (DBS) checks.

SBr stated that clarification on PHB policy and regulation was needed.

AW stated that the Local Authority was the lead for PHB, as it was part of CHC.

The committee discussed the controls within NCC for monitoring PHB decisions made on the CCG's behalf. The committee agreed that AW would contact Paul Turner regarding NCC's controls and monitoring PHB decisions and funding flows. AW asked if PHBs were value for money and who was actually deciding on packages of care, as delegated to NCC. PB stated that it was a significant level of spend.

CW stated that he would ask a Local Authority client if they were willing to share their recent PHB fraud report with the CCG.

Action AC/17/89/01: AW to email Paul Turner regarding NCC's compliance to CHC and level of assurance currently provided.

Action AC/17/89/02: CW to contact Local Authority client to check if willing to share recent PHB fraud report.

AC/17/90 Agenda Item 11 Governance Group Minutes

The Audit Committee reviewed the Governance Group Minutes (October 2017).

AC/17/91 Agenda Item 12.1 Chair's Briefing

SBr stated that he would brief the CCG's Chair on the following:

- Financial prior adjustment update
- Presentation on VFM
- External Audit: Business as usual
- Internal Audit: CHC and QIPP reports could impact on Head of Audit Opinion
- Conflicts of Interest – pinch points
- PHB and BCF
- Governance of CCG regarding primary care fraud related issues

AC/17/92 Agenda Item 12.2 Any Other Business

There was no further business to discuss.

AC/17/93 Agenda Item 13 Date of next meeting

25 January 2018 - 09.20am to 11.30am.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Audit Committee
25 January 2018, Choppington B Meeting Room, County Hall

Members Present:

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

In Attendance:

Alyson Williams (AW)	Internal Audit Manager, AuditOne
Carl Best (CB)	Director of Internal Audit, Audit One
Paul Bevan (PB)	Local Counter Fraud Specialist, Internal Audit, Audit One
Cameron Waddell (CW)	External Audit, Mazars LLP
Ian Cameron (IC)	Chief Finance Officer
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)
Gary Walsh (GW)	Senior Finance Manager, NECS (Agenda item 9)

AC/18/01 Agenda Item 1 Apologies for absence

Apologies were received from Jim Dafter.

AC/18/02 Agenda Item 2 Declarations of interest

CW declared a general conflict of interest for all agenda items as he works with four other Clinical Commissioning Groups in the region. The committee noted the declaration and agreed that CW could remain in the meeting for all agenda items.

AC/18/03 Agenda Item 3 Quoracy

The committee was quorate.

AC/18/04 Agenda Item 4.1 Minutes of the previous meeting

The minutes were agreed as a true and accurate record. There were no matters arising.

AC/18/05 Agenda Item 4.2 Action log

The action log was reviewed and the following updates given:

AC/17/65/01: MR to discuss the offer from NECS to update the Deloitte CIP report with Vanessa Bainbridge. IC said he had obtained a copy of the Deloitte's Cost Improvement Plan (CIP) report issued in March 2017. Following a discussion with SBr, Janet Guy, Lay Chair and Vanessa Bainbridge, Accountable Officer it was agreed that the plan would be used as a reference document in light of the recent PWC review which superseded it. AW requested a copy of the report to ensure no duplication of work. IC

agreed to share the report. Action complete and to be removed from the log.

Action AC/18/05/01: IC to forward a copy of Deloitte's Cost Improvement Plan (CIP) report to AW.

AC/17/84/02: Paul Bevan to keep Audit Committee updated on primary care extended access payment issues should they materialise. PB said that an extended access investigation was currently being undertaken at another Clinical Commissioning Group and that the learnings would be shared with the committee when available.

AC/17/87/03: Stephen Young to ask PWC if AuditOne can contact them directly to discuss the QIPP review. SY said that he would follow up his request to PWC regarding discussing the QIPP review with AuditOne.

AC/17/89/02: Cameron Waddell to contact Local Authority client to check if it is willing to share recent PHB fraud report. CW stated that his Local Authority (LA) client was willing to discuss their recent PHB fraud report outcomes. CW to forward contact details to IC. Action complete and to be removed from the log.

Action AC/18/05/02: CW to forward Local Authority client details to IC.

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

AC/18/06 Agenda Item 4.3 Revised Audit Committee timetable

The Audit Committee reviewed the committee timetable and agreed the following amendment:

- Risk Register/ Assurance Framework to be moved from January 2018 to March 2018.

SBr asked if the annual accounts and report timetable for 2018/19 was available. SY said that the timetable has been issued, and that dates for the CCG's 2018/19 committee calendar were currently being confirmed. The full annual report 2017/18 will be presented at the Audit Committee meeting in May 2018. SBr requested that Vanessa Bainbridge, Accountable Officer, NHS Northumberland Clinical Commissioning Group (CCG) and Janet Guy the CCG's Governing Body Lay Chair be invited to the May 2018 Audit Committee meeting. SB asked for the May 2018 meeting date to be confirmed as soon as possible.

SBr asked if the draft annual accounts and report would be available to review at the Audit Committee meeting in March 2018. SY stated that it would be unlikely the draft annual accounts and report would be available. AW stated that the annual governance statement was due at the end of April 2018. SY proposed that the draft annual governance statement be presented at the Audit Committee meeting in March 2018. The committee agreed the proposal.

Action AC/18/06/01: MP to update the Audit Committee timetable with the amendment outlined in the January 2018 Audit Committee minutes.

Action AC/18/06/02: SY to invite Vanessa Bainbridge and Janet Guy to the May 2018 Audit Committee meeting and confirm the date of that meeting.

Action AC/18/06/03: SY to present the draft annual governance statement at the March 2018 Audit Committee meeting.

AC/18/07 Agenda Item 5 Chief Finance Officer's Report

IC gave an overview of the CCG's financial performance in the nine months up to 31 December 2017. He stated that there had no significant changes in financial performance and that the brought forward deficit £40.5m, in year forecast £20.3m and the planned cumulative deficit position £60.8m remained unchanged.

Pressures continued relating to increasing numbers of S117 high cost packages, prescribing, and other Primary Care Services. There is a considerable risk of over performance in acute contracts exacerbated by winter activity. There is growth in non-elective and ambulatory care admissions at Northumbria Healthcare NHS Foundation Trust (NHCFT). A joint investigation is underway to explain the changes. A clinical audit regarding ambulatory care has recently been concluded and the report is being finalised

The running costs forecast under spend is £348k against plan, with a forecast full year saving of £465k. This is mainly due to vacancies not being filled.

Elective activity is down due to winter pressures. This issue will be discussed at the NHCFT contract meeting, but additional elective activity it not expected before year end. IC said that the data was received two months in arrears.

PC asked why the year to date actual brought forward deficit was £30m (appendix 1). IC explained that the brought forward deficit was being phased in and profiling had been applied. SBr stated that the financial data had become more granular and the quality of financial reporting was better.

The CCG made an ex gratia payment of £600 in December 2017 following a complaint from an individual regarding the inadequate level of care given to their father at a Care Home. The complaint was been independently investigated and the report recommended some form of financial redress to the complainant. SBr said that this type of payment was unusual and that he was not aware of a similar payment being made by the CCG before. AW said that it was unusual for a CCG to make an ex gratia and it was more common place in the wider NHS.

A single tender action was approved at the CCG's Joint Locality Executive Board (JLEB) meeting in December 2017 regarding the provision of GP Forward View (GPFV) Extended Access services. The exception applied was '…where specialist expertise is required and is available from only one source' (Northumberland CCG Detailed Financial Policies, clause 10.4.3i). PB said that it was important to state 'to the benefit of your locality' when services were only available from one source and that this should be documented in future single tender actions where appropriate.

AC/18/08 Agenda Item 6 External Audit Strategy Memorandum and Fee Letter 2017/18

CW presented the External Audit External Audit Strategy Memorandum which set out the external plan in respect of the audit of the financial statements and of value for money (VfM) arrangements for the CCG for the year ending 31 March 2018. The memorandum is in a new format but there have been no changes in responsibilities. CW explained the audit approach and said that testing would start in February 2018.

The review of the SAR from Capita regarding the processing of primary care co-commissioning payments showed that the second 6 months of the year was better than first 6 months. The planned audit approach needs to be considered. IC circulated primary care assurance information to the committee and explained that it was proposed that the information would be available to external audit to provide assurance on the primary care expenditure reported in the CCG's accounts.

CW outlined the summary risk assessment which highlighted the risks deemed to be significant or enhanced. The Value for Money (VfM) conclusion could change due to possible changes in the requirements of Section 30 of the Local Audit and Accountability Act 2014. SBr stated that the QIPP saving figure (page 11) was incorrect and requested that it be amended to £17m.

CW explained that further work was needed to understand the revised footprint of the Sustainability and Transformation Plan (STP).

Materiality thresholds have remained the same as the previous year and CW asked if the committee wanted the same approach used for trivial threshold errors and specific materiality as the previous year. The committee agreed it should remain the same.

CW said that Mazars were holding a 'lessons learnt' workshop for all CCGs in Durham.

Action AC/18/08/01: CW to amend QIPP figure in External Audit Strategy Memorandum.

Action AC/18/08/02: CW to confirm invitations to the Mazars CCG workshop in Durham.

AC/18/09 Agenda Item 7.1 Internal Audit

AW presented an update on progress against the 2017/18 internal audit plan. There are ongoing changes regarding the Sustainability and Transformation Plan (STP). Audit Planning Memos (APM) and the draft Safeguarding Arrangements report have been issued.

AW reported that the CHC Open Book final report had been issued. The report is not an assurance report and did not provide an assurance rating. The review had not identified any significant issues with the amounts recharged by Northumberland County Council (NCC) to the CCG. A discussion document has been issued regarding the current assurance audit of CHC and funded nursing care.

IC said that the NHSE CHC team were currently on site carrying out a CHC deep dive exercise. SY said that he met with the team to discuss the flow of assurance from NCC,

initial feedback has been positive. The committee discussed the tightening up of controls, VfM and delegated limit issues. AW said that the CHC audit could potential impact on the Head of Audit Opinion.

SY reminded the committee that governance principles should be followed and that summaries of internal audit reviews should be included in the internal audit actions summary. He said that a full internal audit report should only be presented to the committee if assurance was rated 'reasonable' or 'limited'. SBr said that as there was always a potential conflict of interest on CHC between the CCG and NCC, the committee needed to be assured that robust governance was in place. SBr requested that the NHSE CHC report be sent to AW and the committee when available.

Action AC/18/09/01: IC to send NHSE CHC report to AW and Audit Committee when available.

AC/18/10 Agenda Item 7.2 Draft Strategic and Operational Internal Audit Plan 2018-2021

AW outlined the draft strategic and operational internal audit plan 2018-2021. The plan sets out all of the identified areas where assurance may be required and included the annual operational plan for 2018-19. The annual open book review is new.

CB said that the high level review of governance and assurance arrangements was planned for Q4 2019. CB asked the committee to consider bringing forward the review to Q3 2019. AW said that she attended the CCG's governance group. SY said that terms of reference were submitted to the governance group for review. The committee agreed that the high level review of governance and assurance arrangements should brought forward from Q4 2019 to Q3 2019.

Action AC/18/10/01: AW to bring forward the high level review of governance and assurance arrangements from Q4 2019 to Q3 2019.

AC/18/11 Agenda Item 8.1 Internal Audit outstanding actions

SY said that the CCG would not be reviewing the delegation of financial responsibilities to the Primary Care Commissioning Committee as that action was superseded by special measures.

AC/18/12 Agenda Item 8.2 Governance Group minutes

The committee reviewed the Governance Group Minutes (December 2017). SY said that the CCG's Conflicts of Interest (COI) register would be reviewed on a quarterly basis by the governance group.

AC/18/13 Agenda Item 9 NECS Service Auditor Report

SBr welcomed GW to the meeting. GW presented the letter from the North of England Commissioning Support Unit (NECS) that summarised the formulated actions relating to each exception identified in the Service Auditor Report (SAR) for finance and payroll for the

period 1 March 2017 to 31 August 2017. There were only a small number of exceptions, less than the previous audit, and each exception was outlined.

SBr asked if the sample size of 1 'user' supported the conclusion of control objective D6. GW said that extended sampling was not undertaken in the report and it was only by exception. SBr asked for further clarification regarding the sample size.

Action AC/18/13/01: GW to confirm how many staff control objective D6 related to.

GW stated that the next SAR would cover the period from 1 September 2017 to 31 March 2018 and would be issued in line with 2017/18 annual reporting deadlines.

SBr thanked GW for the update. GW left the meeting.

AC/18/14 Agenda Item 10 Counter Fraud Presentation

PB and AW gave a fraud risk presentation on the following areas:

- Key fraud risks in CCGs
- A summary of key risk areas - Higher level if claims based or provider
- An overview of CHC including Personal Healthcare Budgets (PHB)
- An update on the recent PHB investigation and findings

PB outlined the role and responsibilities of the NHS Counter Fraud Authority and said that a new risk assessment process was underway but controls were needed.

SBr thanked PB and AW for the presentation, saying that it had highlighted a number of touch points including national issues requiring further guidance. The committee discussed the CCG's responsibilities in respect of counter fraud. PB asked what NCC's counter fraud assurance arrangements were. SY said that he would confirm. IC said that he would discuss the recent PHB fraud report outcomes with the LA contact provided by CW and then further discuss with NCC. SBr asked if counter fraud was on the CCG's strategic assurance framework. SY said that he would confirm this.

Action AC/18/14/01: SY to check NCC's counter fraud assurance arrangements.

Action AC/18/14/02: IC to discuss PHB fraud report outcomes with Local Authority contact and then discuss with NCC.

Action AC/18/14/03: SY to confirm if counter fraud is on the CCG's strategic assurance framework.

AC/18/15 Agenda Item 11.1 Chair's Briefing

SBr said that he would brief the CCG's Chair on the following:

- SAR – no issues
- External Audit: 2018/19 plan agreed. Similar assessment to last year

- Internal Audit: Reviewed plan and process report. Potential CHC issue but unlikely to affect Head of Audit Opinion
- Outline plan for annual accounts and report
- Draft governance statement to be presented at the March 2018 Audit Committee meeting.

AC/18/15 Agenda Item 11.2 Any Other Business

There was no further business to discuss.

AC/18/16 Agenda Item 12 Date of next meeting

22 March 2018 - 09.20am to 11.30am.

NHS
Northumberland
Clinical Commissioning Group

Audit Committee

Terms of Reference

1. Introduction

The audit committee (the committee) is established as a sub-committee of the Governing Body of NHS Northumberland Clinical Commissioning Group (CCG~~the group~~) in accordance with constitution, standing orders and scheme of delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCG~~group~~'s constitution and standing orders.

2. Principal Function

The committee provides the Governing Body with an independent and objective view of the CCG~~group~~'s system control, financial information and compliance with laws, regulations and directions governing the CCG~~group~~ in so far as they relate to finance.

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objective.

3. Membership

The membership of the committee will consist of:

- The Lay Governor (leading on audit and conflict of interest matters)
- One other Lay Member

The committee will be chaired by the Lay Governor (leading on audit and conflict of interest matters).

The Chief Finance Officer will be the lead officer for the committee and will be invited to attend all meetings. The Accountable Officer should attend at least annually when the committee considers the annual accounts.

The External Auditor and Internal Audit will attend the committee as necessary. Regardless of attendance, external audit, internal audit, local counter fraud and NHS Protect providers will have full and unrestricted rights of access to the Audit Committee.

The CCG Lay Chair will not normally attend the Audit Committee.

The Strategic Head of Corporate Affairs may attend the committee.

At least once a year the Audit Committee will hold part of its meeting with the external and internal auditors with only the members present.

Other officers, employees, and practice representatives of the CCG~~group~~ may be invited to attend all or part of meetings of the committee to provide advice or support particular discussion from time to time.

Those invited to attend will not be entitled to vote.

Lay governor audit committee members will serve on the audit committee for a maximum period of three years, when tenure will be reviewed.

4. Secretarial support

Secretarial support to the committee will be provided from the office of the Strategic Head of Corporate Affairs.

5. Quorum

The committee meeting will be quorate when attended by at least two committee members, one of whom must be the committee chair.

6. Frequency of meetings

Meetings of the Audit Committee will normally be held bi-monthly, and not less than 5 times per financial year. There will be no more than 20 weeks between meetings. The External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary.

Members will be expected to attend each meeting.

In exceptional circumstances and where agreed in advance by the committee chair, members of the committee or others invited to attend may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

7. Agendas and papers

The agenda for meetings of the committee will be set by the committee chair.

The agenda and papers for meetings of the committee will be distributed 5 working days in advance of the meeting. Items for the agenda should be notified to the chair 10 days in advance of each meeting. The setting of agendas for, and minutes of, each meeting should identify where discussion should rightly be recorded as being of a confidential or commercially sensitive nature.

8. Remit and responsibilities of the committee

The committee shall critically review the ~~group~~CCG's financial reporting and internal control arrangements and ensure an appropriate relationship with both internal and external auditors is maintained.

The duties of the committee will be driven by the priorities identified by the CCG~~group~~, and the associated risks. It should operate to a programme of business, agreed by the CCG~~group~~, and will be flexible to new and emerging priorities and risks.

The key duties of the audit committee are set out in the audit committee handbook, and will be amended as required to reflect any changes. This covers:

- Integrated governance, risk management and internal control
- Internal audit
- External audit
- Other assurance functions
- Counter fraud
- Management
- Financial reporting
- Conflicts of Interest

Auditor Panel

Regulations have been laid under the Local Audit and Accountability Act 2014 that require CCGs to ensure there is sufficient scrutiny and oversight of the CCG's relationship with its external auditors by having an auditor panel chaired by an independent member, who is not part of the management structure, such as a lay member of the governing body.

In order to meet these requirements the Audit Committee shall also perform the role of the Auditor Panel for the CCG.

The Chair and members of the Audit Committee will also be the Chair and members of the Auditor Panel. The Lay Governor for ~~Resources and Performance and Engagement and~~ public and patient involvement will also be a member of the Auditor Panel.

The Auditor Panel shall:

- advise the CCG on the maintenance of an independent relationship with external auditors;
- advise the CCG on the selection and appointment of external auditors;
- if asked advise the CCG on any proposal to enter into a limited liability agreement.

To ensure the activities of the Auditor Panel are distinctive to the other activities of the Audit Committee the Chair of the Auditor Panel shall arrange separate Auditor Panel meetings as required, ensure minutes of meetings are formally recorded and submitted to the Governing Body and provide a separate annual report to the Governing Body of the panel's activities and decisions.

9. Reporting arrangements

The committee reports to the CCG~~group~~'s Governing Body.

The committee will provide a report to the meeting of the Governing Body following each meeting of the committee, unless that meeting is within 10 working days of the committee in which case the committee will provide a report to the following meeting of the Governing Body.

Minutes of the committee will be received formally at the same meeting of the Governing Body as the committee's report.

The Governing Body will hold the committee to account for the delivery of its remit and responsibilities.

The committee will report to the Governing Body annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

10. Policy and best practice

The committee will apply best practice in its decision making, and in particular it will:

- comply with current disclosure requirements for remuneration;
- ensure that decisions are based on clear and transparent criteria
- comply with the group's policy and procedures for the declaration of interests

The committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

11. Conduct of the committee

All members of the committee and participants in its meetings will comply with the Standards of Business Conduct for NHS Staff, the NHS Code of Conduct, and the Nolan principles.

The committee will review its performance, membership and these Terms of Reference at least once per financial year. It will make recommendations for any resulting changes to these Terms of Reference to the Governing Body for approval. No changes to these Terms of Reference will be effective unless and until they are agreed by the Governing Body.

Date agreed July 2017~~May 2016~~

Review date July 2018~~May 2017~~

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Public Meeting of the NHS Northumberland Primary Care Commissioning Committee
18 October 2017, Morpeth Town Hall

Members Present:

Janet Guy	Lay Chair, Northumberland CCG
Karen Bower	Lay Governor, Northumberland CCG
Siobhan Brown	Chief Operating Officer, Northumberland CCG
Ian Cameron	Chief Finance Officer, Northumberland CCG
Jane Lothian	Local Medical Committee

In attendance:

Fleur Carney	NHS England
Scott Dickinson	Northumberland County Council
Pamela Leveny	Head of Commissioning, Northumberland CCG
David Thompson	Chair, Healthwatch Northumberland
Stephen Young	Strategic Head of Corporate Affairs, Northumberland CCG
Melody Price	Business Support Team, Northumberland CCG (Minutes)

NPCCC/17/53 Agenda item 1 - Welcome and questions on agenda items from the public

Janet Guy welcomed all members to the meeting including the members of the public present.

NPCCC/17/54 Agenda item 2 – Apologies for absence

There were no apologies received.

NPCCC/17/55 Agenda item 3.1 – Declarations of conflicts of interest

There were no declarations of conflicts of interest.

NPCCC/17/56 Agenda item 3.2 – Quoracy

The meeting was quorate.

NPCCC/17/57 Agenda item 4.1 – Minutes of the previous meeting and matters arising

The minutes were accepted as a true and accurate record.

Matters Arising

Riversdale Surgery: Stephen Young stated that he, and a representative from NHS England (NHSE), had attended a public meeting about Riversdale Surgery called by the local Labour group on 13 September 2017. The meeting was attended by approximately 80 people and

had attracted press, local and political interest. Stephen explained that the meeting had highlighted confusion about the engagement process being undertaken by the practice, and the overall assurance process regarding the proposed closure of Riversdale Surgery. He stated that following the meeting he had drafted a communication outlining the comprehensive assurance and approval process which had been posted on the practice's website.

Stephen explained that the NHS Northumberland Clinical Commissioning Group (CCG) Chief Operating Officer's update to the NHS Northumberland Primary Care Commissioning Committee (PCCC) in September 2017 had stated that the formal application to NHSE would be considered in October 2017 by the PCCC. He stated that no formal application had been made by the practice to date and further work needed to be undertaken by the practice following the 12 week patient engagement period which had now ended.

Siobhan Brown asked Fleur Carney for clarification regarding the assurance process. Fleur explained that NHSE needed to receive a formal application from Riversdale Surgery. Once received, NHSE would prepare a detailed report including all options available. The report would then be formally submitted to PCCC for consideration. Fleur stated that the process fulfilled regulatory requirements and provided formal assurance to the PCCC. Stephen confirmed that the assurance process was very robust. Janet Guy asked if the report from NHSE would be available for consideration by PCCC in December 2017. Fleur stated that that timing of the report would depend on when the formal application was received by NHSE from Riversdale Surgery, and no application had been received to date.

A member of the public asked the Lay Chair if he could ask a question. Janet explained that questions from the public were not taken as PCCC was not a public meeting, but a meeting held in public. Janet stated that she would allow a question on this occasion only. The member of the public asked if the PCCC had seen the Wylam Surgery Users Group report. Stephen explained that he was fully aware of report and would make sure it was included as part of NHSE's report.

Janet Guy stated that no formal application had been received from Riversdale Surgery by NHSE and no further action would be taken by the CCG until a report regarding Riversdale Surgery was received from NHSE.

NPCCC/17/58 Agenda item 4.2 Action Log

Action NPCCC/17/46/01: Ian Cameron to report Northumberland PCCC's concerns about the impact of rent and service charge changes to regional NHSE. Ian Cameron explained that the issue of rent and service charge changes was ongoing and that the action would remain on the action log until resolved.

Action NPCCC/17/47/01: Pamela Leveny to check if Blood Glucose Test Strip payments are retrospective. Pamela Leveny confirmed that the Blood Glucose Test Strip payments were retrospective. Scott Dickinson stated that the September 2017 PCCC minutes had highlighted a supply chain issue with the Finetest Lite® meters and asked if it had been resolved. Pamela explained that the company representative had been on annual leave which had resulted in no deliveries being made to practices, but that this had now been addressed. The committee highlighted its concern about the supply chain being dependant on one individual and Pamela responded that this issue had been taken up with the company. The action was agreed as complete and will be removed from the log.

Agenda item 5 Operational

NPCCC/17/59 Agenda item 5.1 Finance Update

Ian Cameron presented the Finance Update report outlining the CCG's primary care services year to date position and the forecast outturn position as at 30 September 2017, highlighting the following:

- General practice GMS/PMS: Forecast movement of £195k relates to transfer back to reserves of unallocated budgets
- Enhanced services: Opening budgets were based on an assumption that all practices would sign up to all services. The forecast movement of £34k was due to transfer to reserves for practices which have declined the extended hours DES
- Premises Cost Reimbursement: FOT saving of £31k is due to in year movements across various practices for both rent and rates. Additional resource has been allocated from reserves to cover pressures highlighted relating to rent budgets. Other GP Services: Forecast pressure of £69k. The movement in forecast outturn takes account of the pressure regarding locum costs of £150k which is now included in the budget.

Siobhan Brown asked how the transformation funding for GP Forward View (GPFV) would be captured within primary care services financial position. Ian explained that once the GPFV budget has been approved by the CCG's Joint Locality Executive Board (JLEB) it would be incorporated into the primary care services budget.

Action NPCCC/17/59/01: Ian Cameron to add GP Forward View into primary care services financial position once budget formally approved by JLEB.

David Thompson stated that he was aware that £20k of national funding was available to rural GP practices. Pamela Leveny explained that funding was available to GP practices in rural and coastal areas in England, which had particular difficulty in recruiting GPs, but having reviewed the funding criteria the CCG did not qualify. Janet Guy said that the national shortage of GPs had not affected Northumberland until relatively recently compared with other areas of the country, which may be part of the reason why the area did not qualify for this funding. David explained that there was a general concern amongst CCGs, GPs and NHS Trusts regarding GP shortages. Karen Bower stated that she was concerned about GPs being attracted to other areas to work if incentives were being offered. Siobhan explained that the introduction of a number of roles, such as care navigators and pharmacists, were supporting primary care and that the Vanguard access model had created an additional 4000 primary care appointments. Siobhan explained that a Northumberland Workforce Summit was being held on 23 November 2017 to identify issues and that an update would be brought to a future PCCC.

Pamela stated that Health Education England were studying future population projections and housing needs in England. David explained that at the Northumberland Healthwatch AGM there had been two separate questions from the public about GP shortages and the impact of future housing provision on health services. Ian stated that the CCG was linked into Northumberland County Council (NCC) regarding these issues.

Siobhan asked if a thematic analysis of each element of the budget could be produced. Ian confirmed that he would include an explanation of each element of the budget in future finance reports.

Action NPCCC/17/59/02: Ian Cameron to add an explanation for each element of the primary care services budget in future finance reports.

NPCCC/17/60 Agenda Item 5.2 Terms of Reference

Stephen Young explained that the PCCC Terms of Reference (ToR) were reviewed yearly and asked the PCCC to consider them. Janet Guy stated that internal audit had asked if specific financial delegation should be included in the ToR. Stephen explained that specific financial delegation was not usually included in ToR. Ian Cameron stated the CCG's Detailed Financial Instructions predated delegated commissioning and required updating. Ian explained that it would be unusual for the PCCC to have specific financial delegation. He stated that the role of PCCC was to scrutinise proposals that included a financial element and once it is content with the principle, make recommendations to JLEB concerning allocating associated budgets. Fleur Carney stated that every CCG used the standard ToR provided by NHSE subject to a few minor local amendments.

Scott Dickinson stated that he thought he was eligible to vote as a member of PCCC (Item 19). Stephen explained that Healthwatch Northumberland, NCC's Health and Wellbeing Board and NHSE representatives attended PCCC in a non-voting capacity. Each were able to fully contribute to the debates but did not have a vote. Stephen stated that Scott's experience and knowledge was highly valued by PCCC.

Jane Lothian requested that Item 18 be amended to add in 'or a deputy' when referring to the Chair of the Local Medical Committee. The PCCC agreed the amendment.

Action NPCCC/17/60/01: Melody Price to amend item 18 of the ToR to the following 'The Chair of the Local Medical Committee (or a deputy).

Siobhan Brown asked if there was a reason why GPFV and out of hours primary care was not included in the ToR. She stated that it was fundamental that the ToR reflected the whole primary care picture in Northumberland. Fleur stated that PCCC needed to add what was specifically relevant to the CCG into the ToR. The PCCC agreed that added assurance was needed in the ToR regarding all primary care commissioning functions.

Action NPCCC/17/60/02: Pamela Leveny to review all primary care commissioning functions with a view to including in the PCCC ToR.

David Thompson asked if the duties listed in the ToR (pages 1&2) would sit with the Accountable Care Organisation (ACO) once established. Stephen explained that the CCG would remain a statutory body following the establishment of the ACO, so the duties would remain with the CCG. The CCG would focus on core primary care and the ACO would focus on enhanced care.

David asked if the PCCC committee minutes still had to be presented to the Cumbria and North East area team of NHSE (Item 36). Janet Guy explained that the PCCC reported to NHSE Cumbria and North East, so the minutes would continue to be presented.

Jane Lothian stated that there were multiple sources of primary care models and continuing developments such as GP Streaming. She asked where these models sat within the wider primary care strategy. Pamela Leveny acknowledged that there were a number of ongoing primary care developments that needed to be reviewed within the wider primary care strategy.

Action NPCCC/17/60/03: Pamela Leveny to review primary care models and developments within the wider primary care strategy.

Decision NPCCC/17/60/04: PCCC agreed to approve the ToR subject to the changes as discussed.

Action NPCCC/17/60/05: Stephen Young/ Melody Price to amend PCCC ToR and circulate with the PCCC October 2017 minutes.

NPCCC/17/61 Agenda Item 6 Any other business

Stephen Young explained that Cambois Branch Surgery was reopening from 23 October 2017. Services had been suspended since 30 June 2017 following NCC surveyors declaring the building unsafe. All work had now been completed.

NPCCC/17/62 Agenda item 7 Date and time of next meeting

1200 noon on Wednesday 20 December 2017, County Hall.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Public Meeting of NHS Northumberland Primary Care Commissioning Committee
20 December 2017, Committee Room 2, County Hall, Morpeth

Members Present:

Karen Bower	Deputy Lay Chair, Northumberland CCG
Ian Cameron	Chief Finance Officer, Northumberland CCG
Jane Lothian	Local Medical Committee

In attendance:

Jenny Long	NHS England
Pamela Leveny	Head of Commissioning, Northumberland CCG
David Thompson	Chair, Healthwatch Northumberland
Stephen Young	Strategic Head of Corporate Affairs, Northumberland CCG
Melody Price	Business Support Team, Northumberland CCG (Minutes)

NPCCC/17/72 Agenda item 1 - Welcome and questions on agenda items from the public

Karen Bower welcomed all members to the meeting. No members of the public were present.

NPCCC/17/73 Agenda item 2 – Apologies for absence

Apologies were received for Janet Guy, Siobhan Brown, Scott Dickinson and Denise Jones.

NPCCC/17/74 Agenda item 3.1 – Declarations of conflicts of interest

There were no conflicts of interest declared.

NPCCC/17/75 Agenda item 3.2 – Quoracy

The meeting was quorate.

NPCCC/17/76 Agenda item 4.1 – Minutes of the previous meeting and matters arising

The minutes were accepted as a true and accurate record.

Matters Arising

Stephen Young stated that the Rothbury Practice had relocated into purposely renovated facilities on the ground floor at Rothbury Community Hospital but further discussions were required with the practice before the final contract variation could be issued.

NPCCC/17/77 Agenda item 4.2 Action Log

Action NPCCC/17/46/01: Ian Cameron to report Northumberland PCCC's concerns about the impact of rent and service charge changes to regional NHSE. Ian Cameron stated that the issue of rent and service charge changes was ongoing. The Primary Care Commissioning Committee (PCCC) agreed that the situation should continue to be monitored by the Primary Care Commissioning Operational Group (PCCOG) and issues will be raised by exception to the PCCC. Action agreed as complete and to be removed from the action log.

NPCCC/17/78 Agenda item 5.1 Finance Update

Ian Cameron stated that in a response to a request from the PCCC, GP Forward View (GPFV) allocations and other NHS Northumberland Clinical Commissioning Group (CCG) funded services had now been added into the primary care services financial position. He explained that a narrative for each element of the budget had been added to the Primary Care Overview (Appendix 1 of the PCCC report).

Ian outlined the CCG's primary care services financial position for the period ending 30 November 2017, highlighting the following key variances and risks:

- **General Practice GMS / PMS:** Movement in forecast position of £25k due to the impact of Q3 list size changes. The variance between the GMS and PMS lines was due to the Greystoke practice changing contract type in month
- **Enhanced Services:** The opening budgets for Enhanced Services were based on an assumption that all practices would sign up to all services. The reported position includes slippage regarding practices that have declined to provide Enhanced Services. The forecast slippage moved by £10k (£39k to £29k) due to increased charges in Q2 for the learning disabilities DES. Further slippage may occur regarding the Extended Hours DES
- **Other GP Services:** Forecast pressure £92K. £23k movement in month based on the increased charges from GP Locums and Suspended GPs. The pressure on the area totals £208k. There has been an increase in claims for Locum reimbursement under the Statement of Financial Entitlements (SFEs) for Parental Leave and Sickness. This is in addition to the contract change in the SFEs at the beginning of 2017 in line with national guidance
- **GPIT:** Cost of provision is greater than the national allocation received and further funding must be provided by CCG. Spend managed by the North of England Commissioning Support Unit (NECS) on behalf of the CCG
- **GPFV:** Two allocations received in year for access funding and GP Clerical training

Karen Bower stated that the CCG Primary Care Overview was very comprehensive. Pamela Leveny requested that the GPFV Access funding narrative be amended to reflect actual national funding received by the CCG.

Action NPCCC/17/78/01: Ian Cameron to amend GPFV Access funding narrative to reflect actual national funding received.

David Thompson stated that the Primary Care budget was very close to the actual financial position apart from locum maternity costs which were very high. Ian explained that high

locum maternity costs were a national issue resulting from a change in the application of SFE. David asked if the 2017/18 allocation had more or less than the 2016/17 allocation. Ian stated that the 2017/18 allocation was higher but he did not have the exact figure available.

NPCCC/17/79 Agenda item 5.2 White Medical Group – Stamfordham Branch Closure

Jenny Long outlined White Medical Group's application to close its branch surgery at Stamfordham. She explained that White Medical Group's main site was located at Ponteland Primary Care Centre (5200 patients) with branch sites at Wylam (1600 patients) and Stamfordham (650 patients). The Stamfordham site currently delivers 27 hours of reception and dispensary services and 10 hours of GP appointments each week.

Jenny stated that the practice had applied to close the Stamfordham branch surgery as the majority of patients were from outside the local area, a Care Quality Commission (CQC) inspection had highlighted lone working issues, and that the current access and services were considered inadequate.

Jenny stated that White Medical Group had undertaken full practice engagement activity with limited feedback from patients and no formal responses received from stakeholders. She explained that key patient feedback concerned transport between Stamfordham and Ponteland and prescribing/dispensing services. Jenny stated that dispensing would continue from the Ponteland and Wylam sites and patients could also use community pharmacists.

Jenny stated that the branch surgery building at Stamfordham was owned by White Medical Group and if it closed it would provide an annual £11,600 rent reimbursement saving to the CCG. She explained that if all White Medical Group's Stamfordham branch patients registered with other practices, those practices would receive an enhanced payment for each new patient in the first 12 months resulting in a cost of £12,206 for the CCG, and a loss of income to White Medical Group.

Jenny stated that NHS England (NHSE) had received a formal application from Riversdale Surgery to close its main site in Wylam and relocate to Oaklands Medical Centre in Prudhoe. She explained that the application was currently being assessed.

Jenny explained that if the application was approved, White Medical Group would be required to submit action and communication plans to mitigate patient concerns as far as possible. A contract variation to remove the branch surgery at Stamfordham from the practice's contract would also be issued.

Ian Cameron stated that Scots Gap Medical Group had a branch surgery in Stamfordham but that NHSE had received no response from them, or any other local practices, regarding the proposed branch closure or their capacity to take patients from White Medical Group's Stamfordham branch. Pamela Leveny stated that one of the GPs at Scots Gap Medical Group was due to retire which could result in addition pressure for the practice. She explained Scots Gap Medical Group's registered list size was currently open to new patients. Jane Lothian asked what the opening hours of the Scots Gap Stamfordham branch surgery were.

Karen Bower asked what new housing developments were planned for the area. Pamela stated that new housing development had not been outlined in the business case.

David Thompson stated that there was an overlap in geographical coverage between White Medical Group, Riversdale Surgery and Scots Gap Medical Group. He questioned why the practices had not worked together and discussed where patients from White Medical Group's Stamfordham branch could move to. Jane stated that practices were under no obligation to undertake that work and did not have oversight. David asked who was responsible for patient safety/care. Stephen Young stated that NHSE and the CCG could encourage and facilitate discussions but did not have the remit to force practices to undertake discussions regarding site relocations or closures. David stated that he was disappointed and that it did not demonstrate putting patients first. Jane stated that there was a CCG Primary Care strategy in place but it did not cover the issues raised. She explained that she had previously requested a more proactive Primary Care strategic approach from the CCG.

Pamela stated that the consolidation of practices into one area resulted in reduced patient choice. She explained however that patients at White Medical Group's Stamfordham branch surgery still had a choice of another branch surgery in Stamfordham as well as other practices in the wider area. Ian stated that there would always be planned branch closures in primary care but also unplanned closures. Jenny explained that nationally a large number of practices were consolidating into a single site due to economies of scale and difficulties in recruiting GPs into partnerships with partner owned premises. Jane stated that only a small amount of branch surgeries were NHSE sites and that very few partner owned premises had been bought into during the last 10 years.

David stated that he was concerned about elderly patients and asked if the two branch surgeries in Stamfordham had discussed the possibility of transferring elderly patients between the practices. Jenny stated that discussions between practices could not be undertaken due to patient confidentially issues and that it was an individual patient's choice. Ian stated that patients could not be denied choice and that capacity at the Scots Gap Medical Group needed to be confirmed. Karen asked if elderly patients could be prioritised in the action and communication plans if the application was approved. Pamela stated that the Scots Gap Medical Group's list was currently open to new patients. Jenny stated that further information was needed regarding the replacement of the GP retiring at Scots Gap Medical Group.

Stephen stated that the Northumberland County Council (NCC) Primary Care Application Group had approved the application on behalf of NCC's Health and Wellbeing Overview and Scrutiny Committee. He explained that the group were surprised that the branch surgery had been sustainable due to the low patient numbers. Stephen stated that he had spoken to Veronica Jones, Councillor for Stamfordham Ward and Health and Wellbeing Portfolio Holder. She had raised concerns about bus services between Stamfordham and Ponteland and the flexibility of appointments for patients using these services.

Ian asked for clarification regarding prescribing/dispensing services. Jenny explained that the NHS Pharmaceutical Regulations stated that patients living in a rural area qualify for dispensing services from a practice if they live more than 1.6km from the nearest community pharmacy. She stated that all the patients living in the Stamfordham area and using the branch had dispensing status, and if the branch closed their status would not change. Jenny explained that patients would have to collect dispensed medication from

either White Medical Group's Ponteland or Wylam sites or could use a local community pharmacy, many of which offered a delivery service. She stated that White Medical Group did not offer prescription delivery. David asked if White Medical Group could offer a free delivery service. Jane stated that some practices offered the service as a 'loss leader' but that it was a business risk to the practice. She explained that patients could choose to use a community pharmacy. Ian stated that online pharmacy options were also available.

Ian questioned if the application was not approved, whether it would threaten the sustainability of the practice and highlighted the quality and workforce issues. Jane stated that partnership owned branch surgeries would continue to close unless the system invested in them. Pamela agreed to undertake a review of Northumberland branch surgery sustainability for forward planning purposes.

Action NPCCC/17/79/01: Pamela Leveny to undertake a review of Northumberland branch surgery sustainability.

David stated that the closure of White Medical Group's Stamfordham branch surgery would result in transport issues for patients and there was no guarantee that a request for a flexible appointment due to transport would be met. Stephen stated that the need for the practice to continue to consider flexible patient appointments around local bus times to and from Stamfordham would be made a condition of the approval.

Ian stated that he would support the closure of White Medical Group's Stamfordham branch surgery on the grounds of clinical safety, workforce and quality issues, and the sustainability of the practice overall. He stated that clarification was needed regarding Scots Gap Medical Group's current and future capacity.

The PCCC unanimously agreed to approve the application by White Medical Group to close permanently the branch surgery operating in Stamfordham on 31 March 2018, subject to the following conditions of the practice submitting:

- A communication plan for patients and stakeholders
- An action plan designed to ensure that current patient concerns are mitigated, including how patient appointments are flexibly arranged around local bus times to and from Stamfordham

Action NPCCC/17/79/02: Stephen Young to draft a letter to White Medical Group informing them of the approval to permanently close the branch surgery at Stamfordham and the conditions of the approval.

David highlighted the Equality Act 2012 and stated that the decision to approve the application disadvantaged older people, a specific group of the population. Pamela stated that patients at White Medical Group's Stamfordham branch surgery still had a choice of another branch surgery in Stamfordham as well as other practices in the wider area.

David asked if White Medical Group's action and communication plans would be reviewed by the PCCC. Jenny stated that the plans would first be submitted to NHSE. Karen explained that the plans would then be reviewed by PCCOG as part of normal operational business. She stated that the minutes from PCCOG are considered by the PCCC so

oversight would be maintained. Karen explained that the PCCC was a strategic decision making committee, not operational.

NPCCC/17/80 Agenda item 5.3 Northumberland Contract Baseline Report

Jenny Long presented the Contract Baseline Report outlining the current contracting status of primary medical care in Northumberland and explained that it was a new report. She stated that the report contained details of contract type and list size for Northumberland practices, information regarding mergers, branches, dispensing and provided a status update on Directed Enhanced Services (DES).

Ian Cameron stated that the report was very useful and should be refreshed and considered by the PCCC on a quarterly basis.

Karen Bower asked why four practices had not signed up for the Dispensing Services Quality Scheme (DSQS) in 2016/17. Jenny explained that it was a voluntary scheme providing enhanced provision and that more practices were signing up for 2017/18.

Pamela Leveny stated that the last review of NHSE regional pharmacy services was carried out 10 years previously. She explained that other CCGs in the region were considering a Dispensing Services Review and proposed that the CCG also consider being involved. The PCCC agreed that a paper should be presented at the February 2018 meeting.

Action NPCCC/17/80/01: Pamela Leveny to present a Dispensing Services Review paper at the February 2018 meeting.

Karen asked what the practice assurance status outlier points were. Jenny stated that outlier points were linked to CCG outcomes and exception reporting as part of the quality assurance framework data and NHSE quality dashboard.

Action NPCCC/17/80/02: Stephen Young to ask Annie Topping to include quarterly assurance framework data in a PCCC Quality Update Report.

NPCCC/17/81 Agenda Item 6 Any other business

David Thompson asked for an update regarding the proposed closure of Riversdale Surgery in Wylam and the relocation of services to newly converted premises at Oaklands Medical Centre in Prudhoe. Stephen Young stated that NHSE was currently assessing the formal application.

NPCCC/17/82 Agenda item 7 Date and time of next meeting

Wednesday 21 February 2018, 12 noon. Morpeth Town Hall.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Joint Locality Executive Board Meeting
Wednesday 25 October 2017, 09.00am
Warkworth Meeting Room, County Hall

Present

Siobhan Brown (SB)	Chief Operating Officer (Chair)
Alistair Blair (AB)	Clinical Chair
Frances Naylor (FN)	Locality Director - Blyth
David Shovlin (DS)	Locality Director - West
John Warrington (JW)	Locality Director - Central
Ian Cameron (IC)	Chief Finance Officer
Annie Topping (AT)	Director of Nursing, Quality and Patient Safety
John Wicks (JWi)	Transformation Director

In Attendance

Janet Guy (JG)	Lay Member - Chair
Karen Bower (KB)	Lay Member - Patient and Public Involvement
Steve Brazier (SBr)	Lay Member - Audit Committee
Paul Crook (PC)	Governing Body Secondary Care Doctor
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)

JLEB/17/144 Agenda Item 1.1 Apologies

Apologies were received for Vanessa Bainbridge, Hilary Brown and John Unsworth.

JLEB/17/145 Agenda Item 1.2 Declarations of Conflicts of Interest

AB declared a general conflict of interest for all agenda items. He explained that he had recently accepted the role of Medical Director - GP with Northumbria Healthcare NHS Foundation Trust (NHCFT). Start date of the appointment to be confirmed. Joint Locality Executive Board (JLEB) reviewed the agenda. Given that decisions were required on the Value Based Commissioning Policy update (regionally agreed previously), the Northern CCG Joint Committee ToRs (previously considered by JLEB) and, potentially the agreed revised financial position (already formally reported to NHS England), JLEB agreed that AB would remain in the meeting for all agenda items. SY said that the normal Conflict of Interest policies would be continue to be adhered to for all JLEB agenda items until AB's departure from the CCG.

Agenda item 3.1 Urgent Care Update: JG declared that her husband worked in Urgent Care for NHCFT as a doctor. JLEB agreed that JG would remain in the meeting for agenda item 3.1 as it was a progress report and no decisions were being made.

JLEB/17/146 Agenda Item 1.3 Quoracy

The meeting was quorate.

JLEB/17/147 Agenda Item 1.4 Minutes of the Previous Meetings

The minutes of the previous JLEB meeting were agreed as a true and accurate record, pending the following amendments:

- **Page 4, JLEB/17/133 Agenda Item 2.3 Performance report:** Full stop to be added to the last sentence.
- **Page 5, JLEB/17/134 Agenda Item 2.4 Quality Report:** Second bullet point - the word 'for' to amended to 'with'.

The minutes of the public Rothbury Community Hospital JLEB meeting were agreed as a true and accurate record, pending the following amendments:

- **Page 3, JLEB/17/141 Rothbury Community Hospital**
  - **Paragraph 2, Sentence 1:** The following to be added to the end of the sentence 'and asked if JLEB was satisfied that all available information sources had been considered'.
  - **Paragraph 5, Sentence 4:** Delete the word 'only'.
  - **Paragraph 5, Sentence 7:** 'it would extremely difficult' to be amended to 'it would be extremely difficult'.
  - **Paragraph 6, Sentence 2:** NHSFT to be amended to NHCFT.

JLEB/17/148 Agenda Item 1.5 Action Log

The actions register was reviewed and the following updates given:

JLEB/17/74/02: VB/SB/AB/DS to meet to discuss ECIP workstream progress and DS to present an update to JLEB. DS to present ECIP paper at future JLEB.

JLEB/17/94/02: SY to arrange for a cyber attack 'lessons learnt' briefing to JLEB. SY stated that Mark Thomas, Director of Health Informatics, NHCFT would present a cyber attack update at either the November or December JLEB. SBr stated that all local NHS organisations, including Clinical Commissioning Groups (CCG), would now be required to proactively confirm that they have enacted CareCERT Critical/High alerts. He explained that NHSE/NHS Improvement (NHSI) would follow up within 48 hours on critical alerts to confirm that action had been taken. SY asked SBr to forward the NHSE CareCERT collect information for his review. AT advised that the impact of the cyber attack was also being reviewed in QRG meetings.

Action JLEB/17/148/01: SBr to send NHSE CareCERT information to SY for review.

JLEB/17/118/01: SB/DL to add ECIP outcomes and dementia face to face reviews into the performance report. FN reported that she had now obtained information regarding dementia face to face reviews and was working with David Lea to incorporate this into the JLEB performance report.

JLEB/17/131/02: SB to review the System Transformation Board meetings dates. SB stated that the Primary Care Federation Leads had been invited to the System

Transformation Board meetings. The 2018 meeting dates were currently being organised. Action agreed as completed and to be removed from the log.

Actions **JLEB/17/105/01, JLEB/17/117/03, JLEB/17/131/01, JLEB/17/133/01 and JLEB/17/133/02** were agreed as complete and will be removed from the log.

JLEB/17/149 Agenda Item 2.1 Finance report

IC stated that the CCG has previously reported a formal deficit of £4.5m and a total cumulative deficit of £44.9m (including the 2016/17 deficit). IC explained that NHSE had now agreed that the CCG reported an in year planned deficit of £20.3m and a total cumulative deficit of £60.7m at Month 6. He stated that this reflected a more accurate presentation in respect of the CCG's expected outturn by bringing anticipated in-year risks into the reported position. IC explained that it did not signify a deterioration in financial performance overall.

IC reported that the 2016/17 in-year deficit was £35.4m (£40.5m cumulative) and that the 2017/18 forecast outturn of £20.3m was an achievable yet challenging target. IC explained that the 2017/18 QIPP targets needed to be delivered in order to achieve the deficit figure. SBr stated that he was assured that NHSE had approved the in year planned deficit of £20.3m.

Action JLEB/17/149/01: SY to draft a Directors' brief to be shared at Locality meetings explaining the CCG's current financial position.

FN highlighted that Appendix 6 showed increased ambulatory care activity and an impact on A&E which appeared to be an improvement, whilst other categories appeared to be underperforming. JWi explained that all the savings for the different categories were shown in QIPP category and that analysis showed the largest variance to be a significant increase in ambulatory care. SBr stated that QIPP was showing a £20.2m outturn variance and that action was needed regarding ambulatory care. SB explained that a performance notice had been issued to NHCFT requesting an explanation regarding the changes to service which have caused the increase in ambulatory care.

FN asked for an update regarding the formal agreement of Local Authority pass through costs. SB stated that she would raise the issue with NHSE.

Action JLEB/17/149/02: SB to raise the issue of Local Authority pass through costs with NHSE.

KB asked what the challenges category consisted of. IC explained that is was monies held back due to ongoing challenges with NHCFT. SB explained that the NHSE/NHSI arbitration panel was meeting on 8 November 2017. IC stated that a considerable amount of work had been undertaken in the preparation of the papers submitted to the panel. SBr asked if the panel were considering all challenges. IC explained that only 2016/17 challenges were being considered.

Decision JLEB/17/149/03: JLEB formally accepted the revised financial position.

JLEB/17/150 Agenda Item 2.2 Performance report

SB presented the performance report for August 2017, summarising the following CCG year to date position against key performance indicators:

- Dementia screening target continues to be achieved
- Diagnostic wait time performance achieved
- CCG continues to over perform against a target of 50% for early intervention in psychosis
- The percentage of Improving Access to Psychological Therapies (IAPT) patients moving to recovery continues to improve

SB outlined the following areas of performance concern:

- Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTHFT) failed to achieve A&E 4 hour waiting time target
- Ambulance response times remain significantly below the performance standards and continue to deteriorate.
- Excessive handover delays at NHCFT continue to impact on ambulance response times
- NHCFT and NUTHFT failed to achieve the 62 day cancer target in month. The CCG is working very closely with both Trusts and performance should start to improve during November
- A further two 52 week wait breaches occurred at NHCFT and a number of patients are approaching the 52 week threshold. Weekly monitoring undertaken and meetings being held with the Trust
- NUTHFT failed to achieved the diagnostic waiting time target for the third month running
- Whilst the CCG and main acute providers achieved the overall 18 week referral to treatment time (RTT) 92% threshold, it was breached in a number of specialities
- CYPS performance continues to deteriorate and a performance notice will be issued to Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

AB stated that 92 patients were affected by the 62 day cancer wait and asked that the total number of patients affected be included in future performance reports.

Action JLEB/17/150/01: SB to ask David Lea to include the total number of patients affected by the 62 day cancer wait in future performance reports.

KB asked if there was any financial impact for the CCG if the Strategic Transformation Plan (STP) trajectory was not met. SB explained that the impact would be on the provider rather than the CCG but that the providers were on track to meet trajectories.

KB asked for explanation as to why the CCG's RTT performance for geriatric medicine was amber but the two main acute providers were green. FN stated that the CCG's performance for rheumatology and neurosurgery were red but the two main acute providers are either green or amber. SB stated that she would ask David Lea to investigate.

Action JLEB/17/150/02: SB to ask David Lea to investigate the CCG's red or amber RTT performance in specialisms where the two main acute providers have green or amber performance.

JLEB/17/151 Agenda Item 2.3 Quality report

AT presented the quality report for September 2017 highlighting the following strategic headlines:

- C.Difficile hospital rates within monthly and year to date (YTD) trajectories but Community C.Difficile rates rising
- CCG E.Coli rates now within YTD trajectories
- 8 serious incidents (Sis) reported relating to Northumberland patients, with Slips/Trips/Falls continuing to be the most reported type of incident
- SIRMS incident reporting has decreased monthly since July 2017. 49 incidents reported by Northumberland GP practices in September 2017. The number of internal incidents reported by GP practices has reduced significantly
- Friends and Family Tests (FTT) response rates remain low for inpatients and A&E for both acute Trusts, although NHCFT has improved performance in both areas
- NHS Safety Thermometer: Only two exceptions reported; an increase in pressure ulcers at NUTHFT and a slight increase in VTEs at NTW
- 1 never event reported by NUTHFT (Newcastle/Gateshead patient – medication incident)
- North East Ambulance Service (NEAS) sickness rates remain high and some recruiting difficulties are still being experienced. Estimated small shortfall in the full establishment figure by the end of the year
- NRLS Patient Safety Reports: NEAS have improved incident reporting

AT stated that an end of year projection column had been added to the full quality dashboard. She explained that not all areas on the dashboard had targets at present but that work was ongoing with the Business Intelligence team.

AT stated that a primary care dashboard was being developed (planned to be in place by Q4 2017) to assist the CCG in seeking assurance regarding safeguarding arrangements.

AT explained that the CCG's Quality and Safeguarding Team, Northumberland County Council's (NCC) Safeguarding and Contracts team, and the Care Quality Commission (CQC) were currently supporting three independent care homes in the Northumberland region where significant concerns have been identified.

SB asked for an explanation regarding the decrease in SIRMS incident reporting. AT explained that GP practice reporting was down due to a combination of issues. FN stated that at a recent clinical leads meeting with NHCFT, GP practices had requested a direct link person into the Trust to enable concerns to be raised and this was confirmed as Robin Hudson. AB stated that the current SIRMS feedback loop was not patient specific and of limited use to practices, resulting in SIRMS incident reports not being submitted. JLEB agreed that the SIRMS feedback loop needs further consideration and improvement. JWi said the Mid Staffs Hospital Public Inquiry identified fragmented reporting of serious untoward incidents as a cause of concerns and harm going unnoticed and stressed the importance of adherence to standardised systems. SB asked AT to investigate incident reporting in other CCG areas.

Action JLEB/17/151/01: AT to review SIRMS current process including the quality of feedback being provided by the North East Commissioning Support Unit (NECS).

Action JLEB/17/151/02: AT to investigate incident reporting systems in other CCG areas.

PC stated that the rate of Community C.Difficile cases had increased compared to 2016/17 and asked if there was a specific reason for the increase. AT explained that there was ongoing work regarding Community C.Difficile and that it would be discussed at the HCAI meeting. FN suggested refresher training on hand washing.

Action JLEB/17/151/03: AT to review increasing Community C.Difficile rates and consider actions required.

JLEB/17/152 Agenda Item 3.1 Urgent Care Update

SB gave a presentation on Urgent and Emergency Care highlighting the following:

- Ambulatory care levels are increasing
- A&E attendances have remained steady following the opening of the Northumbria Specialist Emergency Care Hospital (NSECH). This is against the national trend and reflects the good work of general practice in Northumberland
- Non elective activity decreasing include a drop in short stay admissions (<1day LOS)
- Cost of combined non elective admissions and ambulatory care higher year on year than 2016/17. Joint investigation planned with NHCFT
- System delivery lead appointed to the CCG
- NHSE and NHSI continue to meet with NEAS and NHCFT to review issues regarding ambulance performance, handover delays and A&E performance
- 'Alternative options to Transport Solutions in Northumberland and North Tyneside' Rapid Performance Improvement Workshop (RPIW) 5 day event held on October by NEAS, NHCFT and CCG and looked at:
    - Stocktake of alternative dispositions and how to use them better
    - How to reduce the number of unnecessary conveyances to NSECH
    - Pathways and processes examined
    - NEAS levels of Hear and Treat and See and Treat need to improve
    - Further reviews to be undertaken at 30, 60 and 90 days
- Winter system overview - system wide approach to pre-hospital care, front door, flow, discharge, and transport
- Directory of Ambulatory Emergency Care for Adults will be commissioned by the CCG for 2018/19

AT stated that A&E attendance has remained at a steady state but ambulances were still stacking up at NSECH and asked if the flow of patients was an issue. DS stated that handover performance at NSECH was very variable. He explained that there was an issue with the flow of patients both within NSECH and across NHCFT. DS highlighted that batching of ambulances had been a problem since NSECH opened. AB stated that length of stay was an ongoing concern and needed to be reduced. AB explained that focus was needed on the community as well. SB stated that there were a number of areas of work currently being undertaken to address these issues including bed utilisation and flow, ED streaming model and winter planning. She explained that a system delivery lead has been appointed reporting to both the CCG and Daljit Lally, Executive Director of Delivery, NHCFT to support all these areas of work. Jeremy Pease, ECIP Lead, has left the CCG.

JLEB/17/153 Agenda Item 3.2 Value Based Commissioning Policy Update

JW outlined the proposed changes to the North East Clinical Commissioning Group's Value Based Commissioning Policy (VBCP). JW explained that the regional group was developing the policy at pace and that it was likely that approval would be sought to refresh the VBCP on a 6 monthly basis. JW stated that the revised policy had been agreed by both the north and south Individual Funding Request (IFR) Panels. He asked JLEB to ratify the proposed amendments prior to implementation by 31 October 2017.

SB asked JW if he had a sense of how robust the policy was. JW explained that the policy needed to be robust and that there was a list of further procedures to be considered which were being prioritised. SBr asked if there was an opportunity for benchmarking and questioned how the CCG could be assured that the policy met NHSE requirements. JW explained that the policy only focused on high cost and high volume procedures. AB stated that the policy was welcomed. He stated that a benchmarking exercise would be useful and asked if NECS could carry out a review across the North of England.

Action JLEB/17/153/01: JW to ask NECS to undertake benchmarking exercise across North of England regarding the application of the VFM policy and establish what procedures are covered by other CCG's VFM policies.

FN asked if the new Prior Approval Ticket (PAT) system was having an impact on the number of referrals and whether a review could be undertaken. JW stated that there had been no increase in referrals to date but he would review the impact of the PAT system.

Action JLEB/17/153/02: JW to investigate the impact of the PAT system on referrals.

JW asked if the thresholds could be introduced into emergency care. DS stated that non elective procedures still needed to follow the IFR guidelines/rules. DS stated that he would carry out review of cholecystectomies and groin non elective procedures to check adherence to the IFR guidelines/rules.

Action JLEB/17/153/03: DS to undertake a review of cholecystectomies and groin non elective procedures to check adherence to the IFR guidelines/rules.

Decision JLEB/17/153/04: JLEB agreed the revised VFM policy.

JLEB/17/154 Agenda Item 3.3 Fragile Services

AB briefly outlined the clinical services identified as fragile/vulnerable at the NHSE System Wide Collaboration to Improve Vulnerable Services meeting in September 2017. He explained that further discussion was needed in the wider context and more work was to be undertaken regionally. AB and AT to attend the next regional meeting on 21 November 2017.

JLEB/17/155 Agenda Item 4.1 Northern CCG Joint Committee Terms of Reference

AB outlined the final CCG Joint Committee for Cumbria and the North East Terms of Reference (ToRs) and asked JLEB to consider. SY stated that an earlier draft of the ToRs was considered by JLEB in June 2017, where it was agreed that further discussions be delegated to the CCG's Accountable Officer and Clinical Chair ahead of a final decision being taken by JLEB. SY stated that discussions had continued and the ToRs had been circulated to participating CCG's for approval. He explained that the Joint Committee would only now be making decisions on specialist acute and 111 services. The CCG attended the inaugural meeting of the Joint Committee on 5 October 2017.

SY explained that he had asked about exit options/timescales for the CCG but had received no feedback; he suggested that this question be asked at the next Joint Committee meeting. JG stated that she had some reservations although felt that the CCG should be involved but needed the right to review decisions made. JLEB agreed the ToRs and to continued participation but reserved the right to veto issues it did not agree with and withdraw from the arrangement if considered appropriate.

Decision JLEB/17/155/01: JLEB agreed the Northern CCG Joint Committee Terms of Reference and to continued participation but reserved the right to veto issues it did not agree with and withdraw from the arrangement if considered appropriate.

KB stated that the JLEB and Northern CCG meeting schedules needed to be co-ordinated in order for JLEB to inform the Northern CCG meetings. KB asked if a governance structure diagram outlining how the CCG links into the Northern CCG Joint Committee could be produce.

Action JLEB/17/155/02: SY to co-ordinate the JLEB and quarterly Northern CCG meeting schedules in order for JLEB to inform the Northern CCG meetings.

Action JLEB/17/155/03: SY to produce governance structure diagram for the CCG/Northern CCG Joint Committee.

JLEB/17/156 Agenda Item 4.2 Governance Group minutes

The minutes were reviewed by exception. No exceptions raised.

JLEB/17/157 Agenda Item 4.3 Quality Intelligence Group minutes

The minutes were reviewed by exception. No exceptions raised.

JLEB/17/158 Agenda Item 5 Hospital Admission Avoidance in the Frail and Elderly (HAAFE)

Dr Rosie Dew, University of Sunderland and Helen Riding, Research Manager, NECS joined the meeting. Dr Dew gave a presentation on the findings of the Hospital Admission Avoidance in the Frail and Elderly (HAAFE) research commissioned by the CCG. She explained that the aim of the research had been to explore the attitudes and experiences of patients who were registered on the Northumberland High Risk Patient Programme (NHRPP) and their carer's. 21 patients were recruited from 7 GP practices across Northumberland and 30 participants were interviewed.

Dr Dew outlined the following key findings of implications for hospital admission avoidance:

- Physical enablers of avoiding hospitalisation
- Coping strategies
- Decision making
- Support networks
- Continuity of care and attitudes towards health professionals.

FN asked why mental health problems and cognitive impairments were not listed as an issue under coping strategies. Dr Dew explained that there were no patients in the cohort that had mental health problems or were cognitive impaired. She stated that coping strategies were identified as being used less by patients who had a number of admissions.

AT stated that the findings confirmed and reinforced what was already known and asked if the research had produced any surprising findings, whether positive or negative. Dr Dew explained that it has been interesting to learn how the patients coped with their conditions particularly the use of positive thinking.

JLEB further discussed the research and agreed that the findings should be shared and incorporated into the CCG's relevant ongoing initiatives

Dr Dew and Helen Riding left the meeting.

JLEB/17/159 Agenda Item 6 Locality meeting assurance/key points

2017/18 financial position briefing to be produced.

JLEB/17/160 Agenda Item 7 Any other business

IMATTs procurement

SB asked JLEB to consider allowing IMATTs procurement to explore working with a number of providers rather than just using one provider only. She highlighted MSK and procurement paper that was presented to JLEB in January 2016 and stated that any decision would be brought back to JLEB for consideration.

Decision JLEB/17/160/01: JLEB agreed for IMATTs procurement to explore working with a number of providers and any decision would be brought back to JLEB for consideration.

JLEB/17/161 Agenda Item 8 Date and time of next meeting

22 November 2017, 09.00, Warkworth Meeting Room, County Hall, Morpeth.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Joint Locality Executive Board Meeting
Wednesday 22 November 2017, 09.00am
Warkworth Meeting Room, County Hall

Present

Vanessa Bainbridge (VB)	Accountable Officer (Chair)
Siobhan Brown (SB)	Chief Operating Officer
Alistair Blair (AB)	Clinical Chair
Hilary Brown (HB)	Locality Director - North
David Shovlin (DS)	Locality Director - West
John Warrington (JW)	Locality Director - Central
Ian Cameron (IC)	Chief Finance Officer
Annie Topping (AT)	Director of Nursing, Quality and Patient Safety
John Wicks (JWi)	Transformation Director

In Attendance

Janet Guy (JG)	Lay Member - Chair
Karen Bower (KB)	Lay Member - Patient and Public Involvement
Steve Brazier (SBr)	Lay Member - Audit Committee
Paul Crook (PC)	Governing Body Secondary Care Doctor
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)
Mark Thomas (MT)	Director of Health Informatics, Northumbria Healthcare NHS Foundation Trust/Managing Director, Northumbria Digital Solutions (Agenda item 2.1 only)
Sarah Anderson	Senior Manager, PricewaterhouseCoopers LLP
Sam Rinaldi	Associate, PricewaterhouseCoopers LLP

JLEB/17/162 Agenda Item 1.1 Apologies

Apologies were received for Frances Naylor and John Unsworth.

JLEB/17/163 Agenda Item 1.2 Declarations of Conflicts of Interest

AB declared a general conflict of interest for all agenda items. AB has accepted the role of Medical Director - GP with Northumbria Healthcare NHS Foundation Trust (NHCFT). Start date of the appointment to be confirmed. The Joint Locality Executive Board (JLEB) reviewed the agenda and agreed that AB would remain in the meeting for all agenda items. SY said that the normal Conflict of Interest policies would continue to be adhered to for all JLEB agenda items until AB's departure from the Northumberland NHS Clinical Commissioning Group (CCG).

Agenda item 4.2 Better Care Fund (BCF) Update: VB stated that she was responsible for the BCF in both her role as Director of Adult Care, Northumberland Council County (NCC) and Accountable Officer for the CCG. VB stated that IC would present the BCF update. JLEB agreed that VB would remain in the meeting for the agenda item as it was a progress report and no decisions were being made.

JLEB/17/164 Agenda Item 1.3 Quoracy

The meeting was quorate.

JLEB/17/165 Agenda Item 1.4 Minutes of the Previous Meetings

The minutes of the previous JLEB meeting were agreed as a true and accurate record, pending the following amendment:

- **Page 5, JLEB/17/151 Agenda Item 2.3 Quality Report**
    - Paragraph 4, Sentence 4: The following to be added after the fourth sentence 'JWi said the Mid Staffs Hospital Public Inquiry identified fragmented reporting of serious untoward incidents as a cause of concerns and harm going unnoticed and stressed the importance of adherence to standardised systems'.

JLEB/17/166 Agenda Item 1.5 Action Log

The actions register was reviewed and the following updates given:

JLEB/17/74/02: VB/SB/AB/DS to meet to discuss ECIP workstream progress and DS to present an update to JLEB. DS explained that ECIP actions had all been incorporated into the Urgent Care Workplan, which will be reporting directly to the Northumberland and North Tyneside Local A&E Delivery Board. An urgent care update will be presented to JLEB in December 2017.

Actions **JLEB/17/94/01, JLEB/17/118/01, JLEB/17/148/01, JLEB/17/149/01, JLEB/17/149/02, JLEB/17/150/01, JLEB/17/150/02 and JLEB/17/151/03** were agreed as complete and will be removed from the log.

JLEB/17/167 Agenda Item 2.1 Cyber Attack – Lessons Learned & Actions

VB welcomed MT to the meeting. MT gave a presentation on the ransom ware attack (Wannacry) on 12 May 2017. He outlined NHCFT's initial response to the attack, the results from an external assessment by GE-Finnamore, the lessons learnt, subsequent actions taken and plans to ensure future service delivery.

DS stated that it had taken a long time for Community Services to get back online following the attack and asked what lessons had been learnt. MT stated that the transport method the virus had used was a port on the firewall. He explained that NHCFT had closed the port immediately but that establishing another method to reconnect Community Services had been challenging. MT stated that in the event of another attack, a new secure route was now in place.

AT asked how NHCFT could be assured that no patient data had been lost and that no harm had been done to patients as a result of the attack. MT stated that all NHCFT's hospitals had

remained open during the attack. He explained that each department had a business contingency plan and that staff undertook business contingency training exercises. During the attack, departments switched to using paper. Some clinics were cancelled but this decision had only been taken following an assessment that no harm would be caused to the patients. MT explained that Jeremy Rushmer, Executive Medical Director, NHCFT had subsequently undertaken a medical investigation and assured NHCFT's Board that no harm to patients had occurred. VB asked if the incident reporting system had been checked. MT confirmed that it had.

SBr asked which member of NHCFT's Board had overall responsibility for the response to the ransom ware attack. MT confirmed that he did.

JG stated that she had been previously involved in emergency planning and explained that when an actual incident occurred, real findings and learning happened. She stated that it was very important to have feedback at Board level. JG stated that the recovery time for performance data from NHCFT had been slow and asked what actions had been taken to mitigate this in the event of a future attack. MT explained that Wannacry had occurred at year end resulting in a significant impact on NHCFT's reporting ability. He explained that currently all data was held in one common area but would be split into three areas: clinical, financial and administrative systems. MT stated that this would provide more protection and the changes would be delivered within the next six to nine months.

JG stated that NHCFT had a significant amount of old PCs/servers that had not been protected by NHCFT's anti-virus system, resulting in them having to be patched. She asked what was being done to address this. MT stated that patches were released by IT security providers twice daily and PCs/servers were updated. He explained that a Day 0 virus was the worst type of virus and that NHS England (NHSE) CareCERT released patches within four to six hours of a Day 0 virus being detected. MT stated that these releases are being incorporated into NHCFT's new anti-malwear. JG asked if the old PCs/servers would be replaced by the end of January 2018. MT explained that there was a rolling programme to replace equipment using XP and Windows 2003. He stated that the servers currently operating on XP had been isolated and protected.

AB highlighted the findings of the external assessment undertake by GE-Finnamore. He stated that NHCFT had only been able to communicate with community staff and primary care via text messaging during the attack. AB explained that primary care used nhs.net email and NHCFT has its own email system, even though nhs.net was considered as the gold standard. He stated that NHCFT needed to consider the current communication systems in place with the community and primary care.

VB stated that JLEB wanted to support NHCFT but remained concerned. She explained that the CCG would write to NHCFT requesting assurance regarding progress against key milestones. AT stated that the national Wannacry report had been discussed at the regional Quality Review Meeting and requested that this information was included in the letter. VB requested quarterly progress updates from NHCFT to JLEB.

Action JLEB/17/167/01: VB/IC to write to NHCFT seeking assurance regarding IT service delivery including progress against key milestones and noting the national Wannacry report discussion at the regional Quality Review Meeting.

Action JLEB/17/167/02: MT to present a progress update to JLEB in Q1 2018.

VB thanked MT for his presentation and MT left the meeting. KB stated that JLEB needed to be continually updated and reassured regarding any future ransom ware attacks.

JLEB/17/168 Agenda Item 3.1 Finance report

IC stated that a new reporting format had been introduced for Month 7 to improve presentation in respect of the CCG's in year and cumulative performance against resource allocations. He explained that the total in-year resource allocation was shown in the top section. The middle section showed expenditure and budget variance as at Month 7 (£20.3m forecast outturn). The bottom section added back the brought forward deficit to show the cumulative deficit position of the CCG (£60.7m). IC stated that it reflected the mid-year review undertaken by the CCG in bringing previously reported risks into this year's financial position. He explained that the change in reporting had been agreed by NHSE. HB stated that the financial reporting was much clearer and thanked Ian and his team for their work.

IC outlined the following key areas from the Month 7 report:

- Only marginal changes in financial performance between Month 6 and Month 7
- £20.3m forecast outturn unchanged
- Main pressures remain:
    - Over performance in acute contracts
    - S117 mental health – increasing number of high cost packages
    - Prescribing - increased drugs pressure for No Cheaper Stock Obtainable (NCSO) risk but should correct in year
    - GPIT

IC stated that the NHSE/NHS Improvement (NHSI) arbitration panel result for the 2016/17 financial year challenges was received on 8 November 2017, but had not been included in the Month 7 report. The arbitration outcome resulted in a £1.2m loss of additional revenue in year versus plan. IC explained that the CCG's contingency funding has now been fully deployed offsetting £800k of this pressure. He stated that there was now added emphasis on the delivery of the 2017/18 savings programme.

VB stated that she was disappointed with the arbitration outcome but that the letter received from the panel was helpful. She explained that the panel had wanted more evidence of clinical audit/case file audit and local joint investigation/working. VB stated that she had asked NHSE for support in strengthening processes around 17/18 challenges/disputes. JG asked if there was any opportunity to appeal. IC explained that the dispute process had been committed to in the knowledge that outcomes were binding and the CCG should now focus on the 17/18 challenges/disputes. VB stated that formal responses were currently being drafted to both the special measures and arbitration letters.

IC stated that the QIPP target overall remained at £17.4M but this now needed to increase to cover the arbitration losses and some emerging risks in the current programme. He explained that new schemes had been identified and were being developed to assist the 2017/18 QIPP and the 2018/19 planning process. JG stated that she was encouraged by the new QIPP schemes being developed.

AB stated that the CCG needed to understand the year on year position for the forecast variance under/overspend figures in order to identify growth (Appendix 1). He explained that the percentages needed to be reviewed. IC explained that the percentages would vary depending on the size of the budget. He agreed to review.

Action JLEB/17/168/01: IC to review Forecast Variance under/overspend figures year on year position and percentages.

KB stated that it appeared that QIPP had not delivered any savings to date. IC explained that QIPP was spread across the Point of Delivery (POD) categories and had delivered £10m to date.

IC highlighted the risk of winter pressures as having a possible impact on the CCG's financial position.

VB explained that an in depth finance/QIPP analysis would be part of the next JLEB/Governing Body development day in January 2018.

Action JLEB/17/168/02: SY to add Finance/QIPP analysis to the JLEB/Governing Body development day agenda.

JLEB/17/169 Agenda Item 3.2 Performance report

SB presented the performance report for September 2017, highlighting the following key performance updates:

- Northumberland, Tyne and Wear NHS Foundation Trust (NTW) issued with a performance notice following the deterioration in CYPS 18 week waiting time performance
- National Ambulance Response Programme: Four new categories of call were introduced from 30 October 2017
- New to the performance report: Delayed transfers of care (DTOC) during 2017/18 compared with the performance during the same period last year. CCG is working with Newcastle upon Tyne NHS Foundation Trust (NUTHFT) to analyse a potential coding issue which is incorrectly classifying repatriations as DTOCs
- Total number of patients affected by the 62 day cancer wait now included in performance report
- 18 weeks RTT: Total number of patients affected now included in performance report
- The CCG failed to achieve the local indicators set in the Quality Premium for 2016/17

KB asked if the CCG would meet its Quality Premium for 2017/18. SB explained that different indicators were for 2017/18. AB stated that the Quality Premium indicators for 2016/17 had been unachievable. He stated that reducing the proportion of patients' attendances at A&E by treating in primary care was a complex issue. SB explained that whilst every effort was made to select indicators which were achievable, the 2016/17 indicators were chosen based upon information at the time and that outside influences beyond the direct control of the CCG could effect in year performance. AT asked what the Quality Premium figure would have been if the CCG had achieved it for 2016/17. IC stated that he would investigate.

Action JLEB/17/169/01: SB to confirm the 2017/18 Quality Premium indicators.

Action JLEB/17/169/02: IC to confirm what the 2016/17 Quality Premium figure would have been if it had been achieved by CCG.

JG stated that ambulance performance issues had remained ongoing over an extended period and highlighted her enduring concern on this issue. She proposed that a detailed update be provided at the JLEB/Governing Body development day in January 2018. VB

agreed that the ambulance performance issues were concerning and that other CCGs were in a similar position. VB explained that the National Ambulance Performance Programme was currently in shadow form until 1 April 2018. DS stated that there was a lot of work ongoing regarding ambulance performance.

Action JLEB/17/169/03: SY to add Ambulance Performance to the January 2018 JLEB/Governing Body development day agenda.

AT noted a decrease in Cancer 62 day performance in September 2017. She asked which specialisms it related to and if the CCG was confident that action plans were in place. HB stated that there had been underperformance in lung, upper gastro intestinal and urology and that NHCFT had developed a series of action plans for each specialty. She explained that NHCFT's major focus was on reducing the delays between each stage of diagnosis and treatment. The CCG are currently working with Debbie Edwards, Deputy Director, NHCFT and will continue to monitor performance against the action plans.

JLEB/17/170 Agenda Item 3.3 Quality report

AT presented the summary quality report for October 2017 highlighting the following key headlines:

- An MRSA case was provisionally attributed to NHS Northumberland Clinical Commissioning Group (CCG)
- Seven serious incidents (SIs) reported relating to Northumberland patients. SIs reported reduced in October 2017 for the CCG and all of the four main providers
- NUTHFT reported a further never event (medication)
- 42 SIRMS incidents reported by Northumberland GP practices - 10 related to internal GP practice incidents and 32 related to providers
- Review of SIRMS feedback quality - report currently being written up
- Investigating incident reporting systems in other CCG areas – contacted NHSE re CCG out of area to learn from
- NHS Safety Thermometer: NHCFT reported above the national average for both all and new pressure ulcers. A presentation on pressure ulcer care is due to be taken to the November NHCFT QRG

AT explained that community root cause analysis (RCAs) reports for all of the community C.Difficile cases reported in year to date had been analysed to assess whether there are any themes or trends. It had shown that 80% of patients were aged 65 years or over. AT explained that the West locality reported rate of C.Difficile cases was high and that further analysis would be undertaken with DS. DS stated that the reported rate could differ due to a different testing protocol in the West locality.

Action JLEB/17/170/01: AT to review Community C.Difficile testing protocol in West locality.

JLEB/17/171 Agenda Item 4.1 Special Measures Update

VB outlined the CCG's current position concerning Directions and Special Measures. She stated that primary care had expressed concern about the lack of clarity regarding the impact of both. VB explained that financial position and impact Q&As had been produced (Appendix 1) which outlined, and expanded upon, the NHSE guidance in an effort to provide a clear and easily understood, position statement to primary care on the current level of administrative

oversight experienced by the CCG. She stated that the Q&As would be circulated via the CCG Locality bulletin and included in the December locality meetings, following approval from JLEB.

PC asked what would happen to the CCG after 15 months if there was no improvement in financial performance. VB explained that further and more stringent Special Measures would be applied to the CCG by NHSE, ultimately reducing autonomy.

AB highlighted Q&As bullet point 2 (page 1) '16/17 in-year performance worsened to £35.5m' and stated that in year performance in 2016/17 has been good but the position was due to a crystallisation of different accounting treatments and issues over previous years.

Action JLEB/17/171/01: VB/SB/IC to discuss the wording of bullet point 2 (page 1) of the financial position and impact Q&As.

Decision JLEB/17/171/02: JLEB approved the financial position and impact Q&As subject to clarification regarding bullet point 2 (page 1).

JLEB/17/172 Agenda Item 4.2 Better Care Fund Update

IC stated that the CCG submitted the Better Care Fund (BCF) plan for 2017/19 on 11 September 2017 following approved from NCC's Health and Well Being Board (HWBB). He explained that the CCG received confirmation from NHSE that the plan had been approved on 30 October 2017. IC stated that the CCG was required to meet the agreed performance objectives, including the DTOC target, as set out in the BCF plan and any additional performance objectives specified by NHSE.

IC stated that the target to substantially reduce DTOCs in Northumberland was challenging. He explained that NHCFT's health and care related DTOC remained low and that the majority of reported Northumberland DTOC was from NUTHFT. IC stated that the CCG was working with NUTHFT following an increase in DTOCs to analyse a potential coding issue, which has resulted in the incorrect coding of acute to acute repatriation of care, and not in fact delays within the definition of this metric.

JWi asked how the BCF would be spent and which organisation was responsible for the commissioning intentions. VB explained that the HWBB had oversight of the BCF. IC stated that the BCF was a national mandatory minimum spend and that NHSE had given approval for the dual agreement. He explained that NHSE would provide strategic oversight and that as Director of Finance he was responsible for reporting BCF expenditure on behalf of the CCG.

JLEB/17/173 Agenda Item 4.3 Rapid Programme Improvement Workshop - NEAS

DS outlined the NEAS Rapid Programme Improvement Workshop (RPIW), held at the beginning of October 2017, to identify ways of reducing ambulance conveyances to the Emergency Department at Northumbria Specialist Emergency Care Hospital (NSECH). He explained that a number of actions were highlighted following the RPIW and that it had been agreed that respective organisational board approval would be sought to implement. DS stated that a meeting would be held on 7 December 2017 to prioritise the action plan and track progress to date.

JG stated that outcomes were needed as well as progress. HB explained that Northumberland was geographically challenged and NEAS did not seem to have awareness of this. AT asked what timescales/milestones were in place to review progress. DS stated that reviews of the plan would be conducted after 30, 60 and 90 days.

Decision JLEB/17/173/01: JLEB approved the RPIW report and action plan.

JLEB/17/174 Agenda Item 4.4 Vanguard Evaluation

SB highlighted findings from the latest two independent evaluation reports for the Primary and Acute Care System (PACS) Vanguard. The evaluations covered North East Vanguards Evaluation Programme (NEVE) and the EXPLAIN Vanguard Evaluation of Primary Care at Scale and Pharmacy. The findings and recommendations included:

- The economic evaluation of NSECH found that it added costs to the CCG due to the volume of A&E attendances and admissions
- Continue to work towards a fully interoperable clinical system across all practices
- Progress the use of telephone and video conferencing
- Consider roll out of the Primary Care at Scale initiatives (access and LTC). Review the frequent attender initiative.
- Consider roll out of the enhanced care team and pharmacists in primary care initiatives. Review the Acute Visiting Service initiative

SBr stated that the CCG needed to understand the cost of rolling out recommendations from pilot areas to the rest of Northumberland. AB stated that the PACS Vanguard had been very positive from a CCG perspective and the evaluation was strong.

JLEB/17/175 Agenda Item 4.5 Communications and Engagement Report

SY outlined the CCG's communications and engagement quarterly activity report. He highlighted the following key activities under stakeholder engagement:

- PACS Vanguard Evaluation: Independent market research company Explain carried out a full evaluation of the patient, carer and staff experience of new care models; Model One - New access models (Doctor First) and Model Three – Pharmacy teams in primary care settings under two key services, the Enhanced Care Team (complex patients) and Acute Visiting Service
- Rothbury Community Hospital: Referred to Secretary of State for Health in October 2017. The 12 in-patient beds remain closed while the CCG awaits the outcome of the referral. Freedom of Information (FOI) requests continue to be regularly received
- Northumberland CCG Communications and Engagement Strategy: Refresh of communications and engagement strategy being undertaken
- Empowering People and Communities (EPC): The CCG continues to attend monthly EPC meeting
- Riversdale: The CCG continues to support the practice's communications and engagement effort
- Patient Forum: Event held in Northumberland Hall in Alnwick on 31 October 2017. It was fairly well attended with 16 patients, 10 CCG staff and six service provider colleagues. The Patient Forum is engaging with young people through NCC's Children and Young People's Participation Group during November

- GP Access: Communications and engagement work completed concerning improved evening and weekend access across the GP bulletin, social media, CCG website, poster distribution and the county-wide Patient Forum.
- Patient Engagement: A review of patient engagement including patient locality groups will be undertaken as part of the strategy refresh. A gap identified and monthly patient newsletter being considered. VB requested that the monthly patient newsletter to put on hold and reviewed as part of the communications and engagement strategy refresh.

SY highlighted the following key activities under member engagement:

- Northumberland CCG 360 Stakeholder Survey: Annual survey findings will inform the refresh of the communications and engagement strategy but key findings were:
    - Overall respondents felt that the CCG was an effective local system leader with the necessary blend of skills and experience, and clear and visible leadership. However confidence had fallen in the leadership of the CCG to deliver its plans and priorities
    - Fall in the level of confidence stakeholders had about how effectively the CCG monitored the services it commissions, though the majority felt they could raise concerns around the quality of local services and that they would be acted on
    - A great deal was felt to be known about the CCG's plans and priorities and that they have been effectively communicated. Whilst more respondents agreed that the CCG was seeking their views, and that their comments were being taken on board compared to the previous year, there was still less satisfaction around opportunities to give their views on plans and priorities and whether they are the right ones
- Locality Bulletin: The weekly bulletin continues to be well received by practices and usage of GPTeamNet remains high

SY explained that Internal Audit's comprehensive review of stakeholder engagement (including member practices) resulted in substantial assurance. Results from NHSE's remote review of patient engagement had recently been received and the assessment was disappointing and consideration would be given to challenging the result.

JLEB/17/176 Agenda Item 5.1 Assurance Framework and Risk Register

SY presented the quarterly risk status of CCG and outlined the following:

- 40 risks overall (a decrease of one overall since August 2017)
- Top risks remain:
    - Risk 1178 System Resilience
    - Risk 945 Contract over performance
    - Risk 946 Financial balance
    - Risk 1390 NEAS performance
- All risk and associated actions in date.
- 16 strategic risks above the JLEB Risk Tolerance Line (RTL) – no overall change since May 2017 with the following movements:
    - Risk 403 CCG Member Engagement increased.
    - Risk 401 Stakeholder Engagement increased.
- 7 operational risks above the JLEB RTL (an overall decrease of four) with following key movements:
    - Risk 1802 ACO Soft Launch - staff uncertainty decreased
    - Risk 1504 PCCC - Conflicts of Interest (COI) decreased

    - Risk 1446 ACO – CCG providing insufficient information to member practises to make an informed decision decreased.
- No new strategic or operational risks above the JLEB RTL
- Operational risk 1444 NSECH had been closed

SY stated that the CCG's risk effort over the preceding quarter had been targeted on ensuring that the QIPP risks are fully articulated for PMO governance. Risk 1799 QIPP had a current risk score of 16.

VB stated that a member engagement communications plan needed to be developed. JG stated that member disengagement was as a result of the ACO decision not being imminent and a focus on member engagement communications was needed. SY explained that membership engagement would be reviewed as part of the communications and engagement strategy refresh.

SY explained that the strategic risk register was set against ACO landscape and proposed that the strategic risks should be updated to better reflect the maintenance of the traditional commissioning architecture, and align with the system transformation board overview. JLEB agreed that the relevant risks should be refreshed to reflect this.

Action JLEB/17/176/01: SY to co-ordinate a review of risks impacted by the ACO.

SBr stated that Risk 407 needs to be updated to reference that the CCG was in special measures and that agreement was needed from NHSE for any financial decisions.

Action JLEB/17/176/02: IC/SY to update Risk 407 to reference that the CCG is in special measures.

SBr stated that the consequence rating needed to be updated on the highest risks.

Action JLEB/17/176/03: SY to co-ordinate updating of consequences for risks.

Decision JLEB/17/176/03: JLEB agreed to official close risk 1444.

JLEB/17/177 Agenda Item 5.2 Governance Group minutes

The minutes were reviewed by exception. No exceptions raised.

SY confirmed that IC had been appointed as Senior Information Risk Owner (SIRO) for the CCG.

JLEB/17/178 Agenda Item 5.3 Medicines Optimisation Group minutes

The minutes were reviewed by exception. No exceptions raised.

JLEB/17/179 Agenda Item 6 Locality meeting assurance/key points

Q&As financial position deficit/special measures to be circulated via locality bulletin.

JLEB/17/180 Agenda Item 7 Any other business

There was no any other business.

JLEB/17/181 Agenda Item 8 Date and time of next meeting

20 December 2017, 09.00, Committee Room 1, County Hall, Morpeth.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Joint Locality Executive Board Meeting
Wednesday 20 December 2017, 09.00am
Committee Room 1, County Hall

Present

Vanessa Bainbridge (VB)	Accountable Officer (Chair)
Alistair Blair (AB)	Clinical Chair
Hilary Brown (HB)	Locality Director - North
Frances Naylor (FN)	Locality Director – Blyth Valley
Ian Cameron (IC)	Chief Finance Officer
Annie Topping (AT)	Director of Nursing, Quality and Patient Safety
John Wicks (JWi)	Transformation Director

In Attendance

Janet Guy (JG)	Lay Member - Chair
Karen Bower (KB)	Lay Member - Patient and Public Involvement
John Unsworth (JU)	Governing Body Nurse
Paul Crook (PC)	Governing Body Secondary Care Doctor
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)

JLEB/17/182 Agenda Item 1.1 Apologies

Apologies were received from David Shovlin, John Warrington, Steve Brazier and Siobhan Brown.

JLEB/17/183 Agenda Item 1.2 Declarations of Conflicts of Interest

Agenda item 3.1 Vanguard Evaluation: JU stated that he was employed by Sunderland University who could also be invited to undertake the Vanguard Evaluation work. SY explained that JLEB were not being asked to recommend a provider so there was no material conflict regarding the declaration of interest. JLEB agreed that JU would remain in the meeting for agenda item 3.1.

Agenda item 3.2 Cancer Strategy: KB stated that she was a cancer advocate for Age UK Northumberland. SY explained that there was no material conflict regarding the declaration of interest and JLEB agreed that KB would remain in the meeting for agenda item 3.2.

Agenda item 3.6 Winter and Urgent Care Update: JG declared that her husband worked in Urgent Care for Northumbria Healthcare NHS Foundation Trust (NHCFT) as a doctor. SY explained that there was no material conflict regarding the declaration of interest and JLEB agreed that JG would remain in the meeting for agenda item 3.6.

AB declared a general conflict of interest for all agenda items. AB has accepted the role of Medical Director - GP with NHCFT. The Joint Locality Executive Board (JLEB) reviewed the agenda and agreed that AB would remain in the meeting for all agenda items. SY said that the normal Conflict of Interest policies would continue to be adhered to for all JLEB agenda items until AB's departure from the Northumberland NHS Clinical Commissioning Group (CCG).

JLEB/17/184 Agenda Item 1.3 Quoracy

The meeting was quorate.

JLEB/17/185 Agenda Item 1.4 Minutes of the Previous Meeting

The minutes of the previous JLEB meeting were agreed as a true and accurate record, pending the following amendment:

- **Page 3, JLEB/17/167 Agenda Item 2.1 Cyber Attack - Lessons Learned & Actions**
    - Paragraph 3, Sentence 1: Amend to 'JG stated that she had been previously involved in emergency planning and explained that when an actual incident occurred real findings and good learning took place.'

FN stated that the Blyth Valley locality practices had found the Financial Position and Impact Q&As very useful and wanted to thank those involved in producing the Q&As.

JLEB/17/186 Agenda Item 1.5 Action Log

The actions register was reviewed and the following updates given:

JLEB/17/155/03: SY to produce governance structure diagram for the CCG/Northern CCG Joint Committee. SY explained that the governance regarding the CCG/Northern CCG Joint Committee would be incorporated in the overall constitutional work that would be undertaken in January 2018, following a review of the findings from the PWC report. It was agreed that the action would be removed from the log.

JLEB/17/167/02: Mark Thomas to present a progress update to JLEB in Q1 2018. VB stated that she had written to Mark Thomas requesting an update regarding Cyber Attack – Lessons Learnt in February 2018. The response will be considered by JLEB at the March 2018 meeting. Action complete and to be removed from the log.

JLEB/17/169/01: SB to confirm the 2017/18 Quality Premium indicators. IC to follow up action with David Lea. Action owner to change to IC.

JLEB/17/169/02: IC to confirm what the 2016/17 Quality Premium figure would have been if it had been achieved by CCG. IC confirmed that the CCG would have received £100k if it had achieved the 2016/17 Quality Premium targets. Action complete and to be removed from the log.

JLEB/17/170/01: AT to review Community C.Difficile testing protocol in West locality. AT stated that the same community C.Difficile testing protocol was used across the whole of Northumberland except those carried out by Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTHFT). In this case, the patients that tested positive in the West locality had been tested by NHCFT. She confirmed that the same testing protocol was used for all the patients

identified C.Difficile positive to date. AT explained that she had sent the community root cause analysis (RCAs) report for the patients concerned in the West locality to David Shovlin for information and action if required. Action complete and to be removed from the log.

HB asked if RCA was being undertaken for all C.Difficile cases and if so, whether learning from the analysis would be published. AT confirmed that RCA was carried out for all C.Difficile cases and any learning was published in the HCAI quarterly report as part of the Quality Report. AB stated that the analysis of lessons learnt needed to be linked with prescribing. AT confirmed that Susan Turner is a member of the HCAI workstream and the antimicrobial performance data is used to inform the analysis.

Actions **JLEB/17/74/02, JLEB/17/153/03, JLEB/17/155/02, JLEB/17/167/01, JLEB/17/168/02, JLEB/17/169/03** and **JLEB/17/171/01** were agreed as complete and will be removed from the log.

JLEB/17/187 Agenda Item 2.1 Finance report

IC highlighted the following key areas from the Month 8 Finance report:

- Only marginal changes in financial performance between Month 7 and Month 8
- Brought forward deficit £40.5m, forecast outturn £20.3m and cumulative deficit position £60.7m remain unchanged
- Main pressures remain:
    - Over performance in acute contracts
    - Increasing number of high cost packages
    - Prescribing - increased drugs pressure
    - Other Primary Care Services

IC stated that the current position now included the 2016/17 arbitration result. He explained that this had been mitigated by the release of the 0.5% contingency plus other reserves.

JU asked if the GPIT overspend was capital or revenue. IC stated that it was all revenue.

JU stated that overspend on all the smaller block contracts totalled over £100k and asked it if would be clawed back. IC explained that underspends in the report were budgetary underspends and therefore already in the CCG's position and not within the block contracts themselves, but that a review of every block contract would be undertaken. HB stated that Rachel Mitcheson was planning to review the Community Services lines.

FN asked what the Quality of Life Metric Pilot was as listed in the NHS England (NHSE) Allocation October 2017 (Appendix 2). IC stated that it was a non-recurrent allocation but that no further guidance had been received from NHSE as yet.

In the absence of Steve Brazier, Lay Member - Audit Committee, KB asked a question on his behalf regarding NHCFT Month 7 expenditure. IC agreed to respond to Steve Brazier directly.

IC highlighted that winter pressures could potentially negatively impact on the CCG's financial position and need to be rigorously monitored and managed.

JLEB/17/188 Agenda Item 2.2 Performance Update

IC presented the performance update and highlighted the following key performance achievements:

- The CCG, NHCFT and NUTHFT achieved the overall 18 weeks referral to treatment time (RTT) performance
- Dementia screening continues to be achieved with the highest rate of performance recorded to date of 73.4% against the 66.7% threshold
- Diagnostic waiting times' performance was achieved within the CCG
- The percentage of patients moving to recovery target continues to be achieved within the mental health Improving Access to Psychological Therapies (IAPT) service.

IC highlighted the following key performance concerns:

- A&E 4 hour waiting time target was not achieved by NHCFT (94.6%) and the CCG (94.7%). The year to date target not yet achieved by any of the local acute providers or the CCG
- Excessive and increasing handover delays at NHCFT - November 2017 delays accounted for over 203 hours compared with 195 hours in October 2017
- 62 day cancer target in month for October 2017 was failed by both the two main acute providers and the CCG. CCG performance 79.1% against the 85% target with a year to date performance of 82.6%. NHCFT plan to achieve the target in month by December 2017. Achieving the target overall for the year is now at considerable risk for both the CCG and NHCFT. CCG continues to monitor provider's recovery plans
- NUTHFT did not achieve the diagnostic waiting time target for the fifth month running with performance reported at 1.7% against the 1% threshold. Ongoing breaches continue relating to Sleep Studies, MRIs and Peripheral Neurophysiology
- Northumberland, Tyne and Wear NHS Foundation Trust's (NTW) remains in performance escalation due to 18 week waiting time performance for CYPS

AT stated that at the recent NHSE assurance meeting the CCG was asked about its confidence in the 62 day cancer action plan. VB requested an update regarding contract discussions. HB stated that contract discussions were continuing. JG asked if there was anything the CCG could do. HB stated that NHCFT had developed a series of action plans for each specialty and were focusing on reducing the delays between each stage of diagnosis and treatment.

JLEB discussed A&E refocusing plans and noted that clinical leads would be involved in the reset of the Northumbria Specialist Emergency Care Hospital (NSECH).

HB asked about the possibility of diverting patients from the west of Northumberland to the Royal Victoria Infirmary in Newcastle upon Tyne. VB stated that it was discussed at the LADB. AB stated that it would not be suitable for patients with long term conditions but short term conditions such as fractures could be diverted to Gateshead or Newcastle.

JU stated that he accepted that the CCG's had done all that it could do about the NHCFT handover issues. JU stated that he believed that NHCFT should invest in delivering demand management/flow and the issue needed to be highlighted at the contract meeting.

Action JLEB/17/188/01: JWi/IC to highlight demand management/ flow issue at NHCFT contract meeting.

JLEB/17/189 Agenda Item 2.3 Quality report

AT presented the summary quality report for November 2017 highlighting the following key headlines:

- One MRSA case attributed to the CCG - year to date
- Seven C.Difficile cases reported in November 2017 - over the monthly trajectory but CCG remains within the yearly trajectory with 42 cases
- 27 E.Coli cases were reported in November 2017 - over the monthly trajectory. 192 cases reported year to date - CCG will breach year to date trajectory
- Seven serious incidents (SIs) reported
- 53 SIRMS incidents reported by Northumberland GP practices - an increase from October 2017 (40). Incidents regarding NHCFT have doubled but no clear themes
- NUTHFT reported a Never Event in December 2017 (incorrect lens used in cataract surgery)
- NHS Safety Thermometer: NHCFT reported above the national average for both all and new pressure ulcers
- NHS Safety Thermometer: National average for Falls with Harm was 0.6 in November 2017. NTW slightly above national average at 0.8
- Staff Friends and Family Test (FFT) Q2 2017/18 data: National average 80%. NTW scored 77% (care indicator)
- FFT A&E Response rates continue to be below national average for both acute Trusts; national average is 12.7%, NHCFT 8.4% and NUTHFT 4.2%
- FFT A&E percentage recommended rates - NHCFT below the national average (87%) with 81%
- FFT inpatient response rates remain below national average for both acute Trusts; national average is 25.1%, NHCFT 18.2% and NUTHFT 16.7%

JLEB/17/190 Agenda Item 3.1 Allocated Budgets – Vanguard Evaluation

IC stated that the Northumberland Vanguard Programme had been nationally funded by NHSE through a delivery agreement with Northumberland CCG for three years. He explained that the programme ended in March 2018 and that the CCG had initially committed to undertake a baseline evaluation of the programme. IC stated that additional funding has been approved by NHSE to undertake the evaluation prior to 31 March 2018. He explained that JLEB were asked to consider the proposal to undertake an evaluation and approve the establishment of the associated delivery budget.

VB highlighted her concern regarding the potential cost of the proposed evaluation and suggested that the CCG should consider alternative options and discuss them with NHSE. JG stated that she was pleased regarding the proposed renegotiation and asked if such a robust baseline evaluation was needed.

FN stated that she was confused by the business case. She explained that the North Locality will be the first locality to work within the CATCH team model and will be the evaluation site for this work. FN stated that the evaluation would only cover four practices in Blyth and that there are 42 practices across Northumberland. HB stated that there was a risk that the pilot would not be big enough to effectively evaluate the programme.

JU highlighted the cost breakdown of activities and stated that it would be recycling data already available and could be undertaken as ‘desk based’ work. HB stated that in order to ensure primary care engagement, workshops were needed.

IC stated that an evaluation needed to be undertaken but the CCG also needed to drive value for money.

VB proposed that she and IC would further discuss the Vanguard Evaluation proposal and develop an alternative option for JLEB consideration.

Action JLEB/17/190/01: VB/IC to discuss the Vanguard Evaluation proposal and develop an alternative option for JLEB consideration.

JLEB/17/191 Agenda Item 3.2 Cancer Strategy & Action Plan

HB outlined the Northumberland Cancer Strategy 2018-23 and the associated Cancer Action Plan. She explained that it had been developed alongside public health colleagues, led by Dr Jim Brown, and was based on the following national cancer strategy's strategic priorities:

- A radical upgrade in prevention and public health
- Drive towards earlier diagnosis
- Put patient experience on the same level as clinical effectiveness and safety
- Transform the approach to people living with and beyond cancer
- Modern high quality services
- Review commissioning, accountability and provision processes

JU stated that both the strategy and action plan were very good and really focused on what was deliverable. JG stated that she was surprised by some of the Northumberland data and agreed that an action plan was needed. FN stated that that strategy and action plan were good and highlighted a current disconnect between NHCFT and NUTHFT regarding cancer waiting lists. AB welcomed the strategy and action plan. He explained that lung cancer was a key issue in Northumberland. AB asked if the CCG should consider mobile CT scanners in shopping centres. HB stated that the CCG was waiting for national guidance to be published regarding CT scanners but a clinical discussion could be arranged.

Action JLEB/17/191/01: HB to arrange a clinical discussion about mobile CT scanners with AB, FN and Stephen Doherty.

Decision JLEB/17/191/02: JLEB endorsed the recommendations of the Northumberland Cancer Strategy and approved the implementation of the Northumberland Cancer Action Plan.

Action JLEB/17/191/03: HB to write letter of thanks to Dr Jim Brown.

JLEB/17/192 Agenda Item 3.3 STP/ACS Work streams Update

VB stated that discussions concerning the three local Sustainability and Transformation Partnerships (STP) continued and that there a renewed national focus on Accountable Care Systems. Further information would be available in early 2018.

KB asked if the North of Tyne devolution covering three local authorities would be considering Manchester's devolution model. VB stated that the new authority for Newcastle, Northumberland and North Tyneside would start 1 April 2019 and would include an elected mayor. She explained that the authority would cover transport, housing and regeneration but not health at this stage.

JLEB/17/193 Agenda Item 3.4 Improvement Assurance Framework

VB outlined the changes to the 2017/18 Improvement and Assessment Framework (IAF) used by NHSE to assess CCG performance. She explained that there are 51 clinical indicators which represent an overall reduction of 12 from 2016/17. VB stated that David Lea would update dashboards and the monthly performance report to reflect the changes.

FN asked how the changes would be communicated. JLEB discussed and agreed the development of IAF Q&As for cascade to the localities.

JU asked if the changes would impact on the CCG's current rating for Quality of Leadership assessment. VB stated that the current Quality of Leadership rating was not based on that set of measures but the new 2017/18 indicators were more specific measurements than before.

Action JLEB/17/193/01: David Lea to produce Improvement Assurance Framework Q&As to be cascaded to the localities.

JLEB/17/194 Agenda Item 3.5 SEND Update

AT gave a Special Educational Needs and Disabilities (SEND) update which focused on the following five priority areas and activities the team undertake by the team:

- Training delivered by Sam Barron, Designated Clinical Officer (DCO) for SEND to health professionals on the Education, Health and Care Plan (EHCP) process
- Meetings with schools to discuss how to support pupils with physical needs within main stream schools and explore pathways into physiotherapy, occupational therapy and Community Children's Nursing (CCN) teams
- SEND strategic group held a health focused meeting with provider leads to discuss the local SEND consultation, quality of care plan reports provided and current data available. The group requested representation at the SEND panel to encourage greater partnership working with education colleagues and ensure health needs were being appropriately addressed
- The CCG continues to work in partnership with Northumberland County Council (NCC) on the SEND consultation, with Sam Barron attending five SEND events as the CCG's representative
- Meeting held with NCC's lead for performance to review health contribution within the Joint Strategic Needs Assessment (JSNA)
- Exploring the possibility of extra capacity to undertake specific work on post 16 transitions pathways

AT also highlighted learning from recent inspections:

- Oldham: Critical report - EHC needs assessment process, conversion of statements to plans, autism strategy took too long to develop, working with parents to improve understanding of the EHC assessment process
- Durham: SEND inspection at the beginning of December 2017. Awaiting feedback
- Sam Barron attended a NHSE 'Learning from Inspections' workshop on 13 December 2017 and gave a presentation on her DCO role in Northumberland

AT stated that a case file audit of EHCPs had been undertaken by the CCG to assess the quality of the health element of the plans. An issue with the quality of content held on

SystmOne and EHCPs was highlighted. AT explained that an action plan was in place to improve the EHCP assessment process. VB requested that Sam Barron be invited to present a further SEND update at JLEB in January 2018.

Action JLEB/17/194/01: AT to invite Sam Barron to present a SEND update to JLEB in January 2018.

JLEB/17/195 Agenda Item 3.6 Winter and Urgent Care Update

VB welcomed MT to the meeting.

MT stated that Winter preparedness and urgent care issues were managed through the LADB, a requirement of NHSE and chaired by Jim Mackey, Chief Executive, NHCFT. She explained that the CCG was actively involved in the programme of assurance and development at the LADB and specifically manage the system delivery work stream for non-elective care.

MT outlined the following Winter 2017/18 operational preparedness:

- Additional trigger testing prior to 24 December as a result of extra scrutiny by NHSE on all LADB systems
- Primary Care access, extended hours and GP Out of Hours (OOH) appointment availability mapping completed with intention of maximising capacity to reduce ED pressure
- System Pressures Task Group established to deliver quicker solutions to emerging issues. Starts on 27 December 2017 - MDT between Acute Trusts and CCG
- Alternatives to admission protocols being reviewed between NHCFT and NEAS to utilise MDT at Foundry House using single point of access - facilitated by CCG. Goes live 21 December 2017
- Review of NEAS Clinical Assessment Service for nursing home support to facilitate direct access by Northumberland Homes to avoid conveyance to hospital
- NHSE/I winter funding allocation held at regional level - some potential to increase earlier discharges from NHCFT using NEAS
- Expectation that activity and bed usage in acute setting will be as predicted in Trusts' winter plans
- Health and Wellbeing Overview and Scrutiny Committee whole system assurance provided in November 2017

MT stated that the additional primary care capacity has been very welcome but the system was experiencing real pressure with Norovirus compounding the issue at NHCFT. She explained that the LADB was focused on Winter and that the LADB needed to develop system wide solutions to emerging issues.

MT stated that the CCG delivery team for non-elective care has a system-wide programme of work which had a regional focus. She explained that the 2017/18 and 2018/19 work plan focussed on the A&E four hour wait and ambulance response times targets.

AT stated that there were big expectations outlined at the LADB and focus was needed in order for these to be delivered. MT explained that the LADB had oversight of the system issues and the System Pressures Task Group was operational and tasked with delivering solutions.

AB asked if the CCG was assured that it was doing enough. He stated that the CCG should acknowledge the possible impact of NTCCG on the Northumberland system and work with them. MT explained that NTCCG was part of the System Pressure Task Group and involved in the Winter teleconferences. JG stated that the CCG needed to be assured.

Action JLEB/17/195/01: VB to write to Mark Adams, Chief Officer, North Tyneside CCG regarding closer working.

PC asked for further information regarding Consultant Connect. MT explained that Consultant Connect was currently being developed across Northumberland and North Tyneside and would be launched in February 2018. GPs will be able to contact consultants directly for all non-elective care via a dedicated phone number. Each call will be recorded and audits undertaken. AB stated that Consultant Connect would require good primacy care engagement to ensure no patients were admitted unless via Consultant Connect. He stated that it would empower GPs and patients but needed to be the only route for non-elective care.

Action JLEB/17/195/02: MT to present Consultant Connect overview at future JLEB.

AT stated that handover delays were a high risk area for quality and were a long term pressure on the system. MT explained that work was being undertaken with NHCFT regarding handover delays including conversations with paramedics before unplanned arrivals. She stated that handover delays were the focus of both the LADB and the System Transformation Delivery Board (STDB), and on the list of issues/concerns to be discussed at the NHCFT contract meeting in January 2018.

JLEB/17/196 Agenda Item 3.7 System Transformation Update

MT outlined the revised format of the STDB including the priority work plan and engagement issues. She explained that the STDB had met three times and was attended by system wide Chief Executives. MT stated that the new model of operations was in the early stages of development, and the process would be tested over the coming months.

MT explained that the STDB had no independent decision making powers and reported to NCC's Health and Wellbeing Board. All commissioning decisions would need to be approved by JLEB.

MT left the meeting.

JLEB/17/197 Agenda Item 4.1 Northern CCG Forum/ Joint CCG Committee CNE Feedback

VB stated that due to timescales, a decision was needed prior to the next Joint CCG Committee CNE on 4 January 2018 regarding the regional procurement process for the 111 and clinical advisory service (CAS) contracts. She explained that the CCG Accountable Officers had agreed to start the procurement process which will be managed by NECS. VB stated that further information regarding the contracts would follow.

JLEB/17/198 Agenda Item 4.2 JLEB Forward Plan

SY stated that a JLEB Forward Plan had been developed and asked that any items for future JLEB agendas be sent to him directly.

JLEB/17/199 Agenda Item 5 Locality meeting assurance/key points

Improvement Assurance Framework Q&As

VB stated that GP Extended Access needed to be communicated to practices. SY explained that an out of committee approval had been given by JLEB for establishment of budget and single tender waiver action. He explained that a separate communication would be issued to practices.

JLEB/17/200 Agenda Item 6 Any other business

A question was raised on behalf of Steve Brazier regarding the Better Care Fund (BCF. IC agreed to response to Steve Brazier direct.

Action JLEB/17/200/01: IC to respond directly to Steve Brazier question regarding the Better Care Fund.

JLEB/17/201 Agenda Item 7 Date and time of next meeting

24 January 2018, 09.00, Committee Room 1, County Hall, Morpeth.

NHS
Northumberland
Clinical Commissioning Group

Minutes of the Joint Locality Executive Board Meeting
Wednesday 24 January 2018, 09.00am
Committee Room 1, County Hall

Present

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

In Attendance

Janet Guy (JG)	Lay Chair
Karen Bower (KB)	Lay Member - Patient and Public Involvement
Paul Crook (PC)	Governing Body Secondary Care Doctor
Steve Brazier (SBr)	Lay Member - Audit Chair
Stephen Young (SY)	Strategic Head of Corporate Affairs
Melody Price (MP)	Business Support (minutes)
Sam Barron (SBa)	Designated Clinical Officer, CCG & Head of SEND Strategy, Northumberland County Council (Agenda Item 3.4)

JLEB/18/01 Agenda Item 1.1 Apologies

Apologies were received from Frances Naylor and John Unsworth.

JLEB/18/02 Agenda Item 1.2 Declarations of Conflicts of Interest

AB declared a general conflict of interest for all agenda items. AB has accepted the role of Medical Director - GP with Northumbria Healthcare NHS Foundation Trust (NHCFT). The Joint Locality Executive Board (JLEB) reviewed the agenda and agreed that AB would remain in the meeting for all agenda items. SY said that the normal Conflict of Interest policies would continue to be adhered to for all JLEB agenda items until AB's departure from NHS Northumberland Clinical Commissioning Group (CCG) on 31 January 2018.

JLEB/18/03 Agenda Item 1.3 Quoracy

The meeting was quorate.

JLEB/18/04 Agenda Item 1.4 Minutes of the Previous Meeting

The minutes of the previous JLEB meeting were agreed as a true and accurate record, pending the following amendment:

- **Page 7, JLEB/17/194 Agenda Item 3.5 SEND Update**
  - Bullet point 7: To be deleted as a repeat of the first sentence.
- **Page 9, JLEB/17/195 Agenda Item 3.6 Winter and Urgent Care Update**
  - Action JLEB/17/195/01: To be deleted as incorrect.

JLEB/18/05 Agenda Item 1.5 Action Log

The actions register was reviewed and the following updates given:

JLEB/17/153/01: JW to ask NECS to undertake benchmarking exercise across North of England regarding the application of the VBC policy and establish what procedures are covered by other CCG's VBC policies. JW stated that the number of procedures being covered by the VFM policy was substantial and growing. A six month review was carried out by the North East Clinical Commissioning Group's Value Based Commissioning Policy (VBCP) and any decisions will be brought to JLEB for consideration. Action complete and to be removed from the log.

JLEB/17/153/02: JW to investigate the impact of the Prior Approval Ticket (PAT) system on referrals. JW stated that the impact of the PAT system on referrals had not been significant and continued to be measured against a list of procedures. Action complete and to be removed from the log.

JLEB/17/168/01: IC to review Forecast Variance under/overspend figures year on year position and percentages with NHSE. IC stated that work had been undertaken and explained that more work would be required to ensure a direct 'like for like' comparison year on year. Further review is needed to confirm if the exercise would be of sufficient added value. AB and SBr agreed to be involved with the added value review.

Action JLEB/18/05/01: IC/AB/SBr to review Forecast Variance year-on-year figures for added value.

JLEB/17/191/01: HB to arrange a clinical discussion about mobile CT scanners with AB, FN and Stephen Doherty. HB stated that a teleconference was being held today. Action complete and to be removed from the log.

JLEB/17/195/01: JG to write to North Tyneside CCG's Lay Chair regarding assurance. To be removed from the log as incorrect. Letter sent from VB to Mark Adams, Chief Officer, NHS North Tyneside CCG regarding closer working.

Actions **JLEB/17/188/01, JLEB/17/195/02 and JLEB/17/200/01** were agreed as complete and will be removed from the log.

JLEB/18/06 Agenda Item 2.1 Finance report

IC highlighted the following key areas from the Month 9 Finance report:

- No significant changes in financial performance since Month 8

- Brought forward deficit £40.5m, forecast outturn £20.3m and cumulative deficit position remains unchanged
- Some increase in NHCFT activity being offset by expected Value Based Commissioning (VBC) savings
- Significant variance in non elective and ambulatory care admissions at NHCFT. A joint investigation is underway to explain the changes in the non elective service. A clinical audit regarding ambulatory care recently concluded and the report is being finalised
- Main pressures remain:
    - Over performance in acute contracts exacerbated by winter activity
    - Increasing number of S117 high cost packages
    - Prescribing - increased drugs pressure although starting to plateau
    - Other Primary Care Services

KB asked if the Northumberland Tyne and Wear NHS Foundation Trust (NTWFT) reported £0.2m overspend would decrease or increase. IC stated that it was likely to remain the same.

SBr questioned the difference between the year to date and outturn figures for NHCFT. IC explained that NECS apply straight line profiling to the plan for purposes of SLAM reporting, whereas actuals will fluctuate with factors such as seasonality. IC explained that the forecast challenge figures represent the full values currently being investigated.

Action JLEB/18/06/01: IC to produce a brief to JLEB regarding the reporting of the NHCFT challenges figures.

SB said that the Month 9 forecast demonstrated that demand management was working. Monthly finance meetings were taking place with the teams in the CCG and these provide budget assurance and financial grip.

VB stated that some elective procedures had been stood down at NHCFT due to winter pressures and asked what impact this would have on the activity profile. JW asked if elective activity would be increased before the end of the March 2018. JG said that there should be an agreed annual profile of activity with NHCFT. AB stated that the directive to cancel elective procedures from NHSE via the Local A&E Delivery Board due to winter pressures had resulted in limited impact locally. IC said that activity profiling before year end would be discussed at the NHCFT contract meeting and explained that some in year variations would be expected.

JLEB/18/07 Agenda Item 2.2 Performance Update

IC presented the performance update and highlighted the following key performance achievements:

- The CCG achieved the 62 day cancer target for the month – a marked improvement on previous months
- NHS Constitution standard for the dementia screening continues to be achieved
- Diagnostic waiting times performance was achieved within the CCG and NHCFT
- Continued to over perform against the 50% NHS Constitution target for early intervention in psychosis (EIP).
- 18 weeks referral to treatment (RTT) – significant improvement compared to recent months.

IC highlighted the following key performance concerns:

- CCG, NHCFT and Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTHFT) failed to achieve the A&E 4 hour waiting time target along with the year to date target
- Excessive handover delays at NHCFT continue to impact upon ambulance response times
- 18 weeks RTT threshold breached within the trauma and orthopaedics specialty
- NHCFT and NUTHFT failed to achieve the 62 day cancer target in month
- NUTHFT failed to achieve the diagnostic waiting time target for the sixth month running
- Children and Young People's Service (CYPS) - deterioration in waiting time performance
- Improving Access to Psychological Therapies (IAPT) service - performance has deteriorated compared to the start of the year. This poses a risk to achieving the 2017/18 CCG locally set Quality Premium indicator
- The CCG failed to achieve many of the national indicators set in the Quality Premium for 2016/17.

IC reported that the CCG were continuing to work with NUTHFT to analyse a potential coding issue which is incorrectly classifying repatriations as delayed transfers of care (DTOC). VB said that the issue needs to be resolved.

Action JLEB/18/07/01: IC to follow up on progress regarding a potential coding issue with NUTHFT related to DTOCs.

SB asked for an update regarding 'handover to clear' performance. DS stated that he would follow this up. VB explained that Jo Dobson, Head of Customer Programme, North East Commissioning Support Unit (NECS) was focusing on the issue at a regional level. AT said that the North East Ambulance Service NHS Foundation Trust (NEAS) QRG and NEAS contract meeting were both being held this week.

Action JLEB/18/07/02: DS to follow up 'handover to clear' issue.

SB stated that the Quality Premium 2016/17 targets were very challenging and the right focus for the CCG but that performance had been disappointing.

KB asked why accident and emergency performance had deteriorated when activity had remained the same as 2016/17. DS said that a clear focus was needed on the flow of patients within the emergency department and throughout the whole hospital system. JLEB discussed the patient flow issues. VB said that the reset of the Northumbria Specialist Emergency Care Hospital (NSECH) is in progress. HB said that the concerns raised by JLEB about NEAS also needed to be included in the CCG's performance report going forward. VB said that she and JG would discuss the concerns raised by JLEB with NHCFT.

Action JLEB/18/07/03: VB/JG to discuss NSECH reset and flow issues with NHCFT.

Action JLEB/18/07/04: SB to discuss the concerns raised by JLEB regarding NHCFT patient flow and NEAS performance with D Lea for inclusion in future performance reports.

AB explained that all admissions go through accident and emergency at NHCFT and although focus was needed on this, performance was not directly comparable with NUTHFT

who had various admissions access points including a medical admissions suite. VB said that further information regarding NUTHFT admissions was needed.

Action JLEB/18/07/05: SB to ask D Lea to investigate NUTHFT admission figures including the GP admissions unit.

JLEB/18/08 Agenda Item 2.3 Full Quality Report

AT presented the quality report for December 2017 highlighting the following key headlines:

- 2 C.Difficile cases reported in December 2017 - CCG remains within the annual trajectory
- 37 community C.Difficile cases reported in the year to date - increase on last year
- 28 E.Coli cases were reported in November 2017 - over the monthly trajectory. 193 cases reported year to date. CCG has breached year to date trajectory. CCG action plan in place and working with other CCGs to develop a North of Tyne plan
- 11 serious incidents (SIs) were reported in December 2017 - Slips/Trips/Falls continuing to be the most reported type of incident. NHCFT attended the most recent SI panel and will provide a representative for panels
- 32 SIRMS incidents reported by Northumberland GP practices - a decrease from November 2017 (53). Most common theme was discharge issues was practices receiving duplicate discharge summaries
- NHS Safety Thermometer: NHCFT reported above the national average for all pressure ulcers. NUTHFT remained above the national average for all pressure ulcers
- NHS Safety Thermometer: NWTFT slightly above national average for falls with harm
- Friends & Family Test (FFT) A&E and inpatients response rates continue to be below regional and national average
- NHCFT's FFT A&E and inpatients recommended rates percentage have fallen slightly below the recommended national average

A review of the SIRMS process has been undertaken by the CCG and NECS to investigate the potential reasons for the reduction in SIRMS reporting. NHSE and NECS were unable to find any other reporting systems that were being used elsewhere in England.

A SIRMS survey had been sent to all GP Practice Managers in December 2017 and had now closed. Further work is being undertaken to analyse the responses and identify recommendations and a SIRMS User Group had been created.

Action JLEB/18/08/01: HB to provide support to SIRMS feedback exercise.

AT stated that NEAS continued to experience paramedic recruitment issues and was currently estimating a small shortfall in the full establishment figure. The NEAS sickness rate has fallen slightly. KB proposed that the NEAS workforce action plan and staffing levels should be incorporated into the CCG's monthly performance report.

The information sharing pilot with all GP practices regarding police domestic violence incidents where children were involved is working well.

The Olivia Serious Case Review (SCR) has just been published. An internal audit is underway looking at how learning from SCRs is shared. A Section 11 audit has been circulated to GP practices for completion.

The Looked After Children (LAC) designated nurse role is an interim arrangement and is held by the designated nurse safeguarding children. AT stated that the arrangement was to be reviewed and a paper would be developed for consideration regarding the options going forward.

Action JLEB/18/08/01: AT to develop Interim Designated LAC Nurse options paper for JLEB.

VB requested a status update on the current influenza and norovirus outbreaks and stated that assurance was needed.

Action JLEB/18/08/03: AT to produce influenza and norovirus update and circulate to JLEB.

JLEB/18/09 Agenda Item 3.1 Consultant Connect

DS outlined the proposal to implement the Consultant Connect telephony system in NHCFT. Consultant Connect would enable GPs to call a single number or click into a mobile app to immediately reach an ED consultant for quick access to advice and guidance for unplanned care. All calls would be recorded, enabling the CCG to monitor and address variation in practice between Consultants and GPs. Consultant Connect has been successfully implemented in Sunderland CCG and has resulted in a reduction in avoidable admissions. Implementing Consultant Connect in NHCFT would potentially generate cost savings as a result of reduced avoidable admissions. It would also make it more difficult for a patient to be admitted without being discussed first.

There is a risk that GPs might not use Consultant Connect and instead send patients directly to ED. There has been a dedicated Consultant telephone number in place since July 2017 at NHCFT. The service has not been greatly utilised as it was optional and many GPs had declined the offer of a clinical discussion. Delays in accessing the appropriate consultant had also been reported.

Ideally, NHS North Tyneside CCG would choose to commission Consultant Connect together with the CCG, but that is a decision for their local CCG Board.

The associated delivery budget (£53,019) has been approved by the CCG's Corporate Finance and QIPP Programme Board along with Option 1. NHSE had also approved Option 1 and the associated delivery budget. Audrey Pickstock, Director of Finance - North East and Cumbria, NHSE has suggested that ETTF funding may be available.

HB said that the Consultant Connect proposal was very good but assurance was needed regarding calls being answered with the specified timescale.

JW asked how calls for specialisms would be handled and said that specialism subsets were needed. Some patients would rather go to A&E than wait for an outpatient appointment. Initially Consultant Connect would focus on acute non elective, but the option to expand the service to include elective specialisms would be investigated.

JG asked if GPs would be able to feedback any concerns about the service including calls not being answered. DS said that an implementation group would be established and it would consider service delivery issues and feedback.

SBr said that the Sunderland CCG findings in the business case were positive. AB reported that Sunderland CCG had a number of ongoing schemes in place regarding avoidable admissions, of which Consultant Connect was an important part.

VB said that if approved, data and costs would be closely monitored post implementation and the expansion of the service would be investigated.

Decision JLEB/18/09/01: JLEB approved the proposal to implement the Consultant Connect telephony system in NHCFT and the associated delivery budget.

Action JLEB/18/09/02: IC to confirm if EFFT and NHSI funding was available for Consultant Connect.

JLEB/18/10 Agenda Item 3.2 Influenza Vaccine

IC outlined the proposal for the primary care influenza vaccine purchasing for 2018/19. The North East & Cumbria CCG Prescribing Forum (Forum) have developed guidance concerning the ordering of Quadrivalent versus Trivalent Influenza Vaccine for 2018. The Forum's recommendations applied to the 2018/19 influenza vaccination programme and primary care started to place orders for 2018/19 in September/October 2017.

Decision JLEB/18/10/01: JLEB approved the immediate promotion of the North East & Cumbria CCG Prescribing Forum guidance concerning the ordering of Quadrivalent v Trivalent Influenza Vaccine for 2018. JLEB requested that practices be asked to adhere to the guidance.

JLEB/18/11 Agenda Item 3.3 SEND Update

SBa joined the meeting. AT explained that SBa has a joint role as the Designated Clinical Officer (DCO) for the CCG and Head of SEND Strategy for Northumberland County Council (NCC).

SBa gave a presentation on Special Educational Needs and Disabilities (SEND) which outlined the following:

- The role of the DCO including key responsibilities - statutory, oversight, coordination and strategic input
- Governance
- Inspection Framework - 1 week inspection covering education, health and social care
- Northumberland SEND strengths including robust leadership and support from the CCG
- SEND Action Plan - areas for development.

SBa said that she had recently attended an LGA peer review in Bristol which had given her the opportunity to reflect on the SEND plans in place for Northumberland. She is confident that the Northumberland SEND action plan is robust but that further joint working will improve it further. VB said that SEND updates would continue to be brought to JLEB.

JG asked if it would be useful to have a Lay Member linked into SEND to provide support, strategic input, oversight and governance. AT said that she would consider the proposal.

Action JLEB/18/11/01: AT to consider Lay Member support for SEND.

SBr asked if the joint role was beneficial or had resulted in any conflicts from a governance perspective. SBa stated that the joint role was a real strength. PC asked why the role had not been joint before now. SBa explained that it was unusual for a healthcare profession to have in depth experience and knowledge in education.

DS stated that the Speech and Language Therapy (SALT) provision in Northumberland needed to be more efficiently delivered. SBa acknowledged that there was an overlap in services and a lack of understanding on what each service provided. A single pathway approach is needed so that parents/carers have a clearer understanding of the services available and how to access them. AB said that there could be a social economic bias resulting in some parents/carers being able to access more SEND provision and that a balanced approach was needed. SBa agreed that resources needed to be used appropriately. JG said that an equality impact assessment was needed.

AT asked if capacity was an issue regarding the delivery of the SEND action plan. SBa said that some substantial pieces of work were being undertaking and that the capacity felt right to deliver these at present.

Action JLEB/18/11/02: AT to circulate the updated SEND action plan to JLEB.

SBa left the meeting.

JLEB/18/12 Agenda Item 4.1 Governance Group Minutes (December 2017)

SY asked for any comments regarding the Governance minutes to be sent to him directly.

JLEB/18/13 Agenda Item 4.2 QIG Minutes (December 2017)

SY asked for any comments regarding the QIG minutes to be sent to him directly.

JLEB/18/14 Agenda Item 4.3 Northern CCG Forum/ Joint CCG Committee CNE Feedback

VB said that there were no updates from the Northern CCG Forum/ Joint CCG Committee CNE.

JLEB/18/15 Agenda Item 4.4 Statutory and Mandatory Training

SY highlighted the Data Security Awareness training completion rate as particularly important as it was a key element of the IG toolkit. He explained that the results were reported nationally and taken into account when NHSE assess suitability for programme eligibility such as delegated commissioning. SY stated that all staff needed to complete the Data Security Awareness training by 31 January 2018 and that the current completion rate required improvement to get to 100%. KB asked if Governing Body members needed to complete the training.

Action JLEB/18/15/01: SY to confirm if Governing Body members must complete Data Security Awareness training.

JLEB/18/16 Agenda Item 4.5 Revised Governance Proposals

SY outlined the revised governance proposals and implementation plan. Governing Body (GB) would become the strategic decision making body of the CCG and be supported by the Clinical Management Board (CMB), the tactical/operational decision making body of the CCG, both would have a clinical voting majority.

AT said that she wanted to understand how the Safeguarding Group (SG) would report into the CMB. VB answered that Terms of Reference needed to be developed for the SG.

KB said that the Primary Care Commissioning Committee was currently in line with GB on the governance structure diagram and proposed it be moved down. JLEB agreed the proposal.

Action JLEB/18/16/01: SY to update governance structure diagram.

VB said that if approved by JLEB, a staged communications approach would be needed with a general update to locality meetings and further details to follow. JG said that she supported the approach.

AT stated that she would abstain from voting.

Decision JLEB/18/16/02: JLEB approved the revised governance arrangements and implementation plan.

JLEB/18/17 Agenda Item 4.6 JLEB Forward Plan

SY asked for a review of governance to be added to the JLEB Forward Plan for October 2018. SY asked for future JLEB items to be sent to him directly.

JLEB/18/17/01: MP to add review of governance to JLEB Forward Plan for October 2018.

JLEB/18/18 Agenda Item 5 Locality meeting assurance/key points

Governance proposals update.
Consultant Connect.

JLEB/18/19 Agenda Item 6 Any other business

No any other business.

JLEB/18/20 Agenda Item 7 Date and time of next meeting

28 February 2018, 09.00, Committee Room 2, County Hall, Morpeth.