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MEETING:	30th Meeting in Public of the NHS North Lincolnshire Clinical Commissioning Group Governing Body	NHS North Lincolnshire Clinical Commissioning Group **GOVERNING BODY**
MEETING DATE:	Thursday 8 December 2016	
VENUE:	Board Room, Health Place, Brigg	
TIME:	13:30	

PRESENT:		
NAME	**TITLE**	**SERVICE/AGENCY**
Dr Margaret Sanderson *(MS)*	CCG Chair/General Practitioner	NHS North Lincolnshire CCG
Ian Reekie *(IR)*	CCG Lay Member, Joint Commissioning/Vice CCG Chair	NHS North Lincolnshire CCG
Liane Langdon *(LL)*	Chief Officer	NHS North Lincolnshire CCG
Ian Holborn *(IH)*	Chief Finance Officer	NHS North Lincolnshire CCG
Catherine Wylie *(CW)*	Director of Nursing and Quality/ Nurse Member	NHS North Lincolnshire CCG
Richard Young *(RY)*	Interim Director of Commissioning	NHS North Lincolnshire CCG
Dr Andrew Lee *(AL)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr James Mbugua *(JMb)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Satpal Shekhawat *(SS)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Faisel Baig *(FB)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Paul Evans *(PE)*	CCG Lay Member, Governance	NHS North Lincolnshire CCG
Janice Keilthy *(JK)*	CCG Lay Member, Patient & Public Involvement	NHS North Lincolnshire CCG
Christine Nield *(CN)*	Consultant in Public Health	North Lincolnshire Council
Richard Shenderey *(RS)*	Secondary Care Doctor	NHS North Lincolnshire CCG
Heather McSharry *(HMc)*	Lay Member, Equality/Diversion & Inclusion	NHS North Lincolnshire CCG
IN ATTENDANCE:		
Amy Bahl *(AB)*	Project Officer/PA *(Note Taker)*	NHS North Lincolnshire CCG

APOLOGIES:		
NAME	**TITLE**	**SERVICE/AGENCY**
Dr Robert Jaggs-Fowler *(RJF)*	CCG Member/General Practitioner/Medical Director/Director of Primary Care	NHS North Lincolnshire CCG

SUMMARY OF DISCUSSION	**DECISION/ACTION** (including timescale for completion or update)	**LEAD**
1.0 WELCOME, ANNOUNCEMENTS, APOLOGIES AND QUORACY		
MS welcomed all attendees to the thirtieth meeting 'in public' of the Clinical Commissioning Group Governing Body. The Chair informed members and the public of the presence of a photographer at the meeting who would be capturing pictures during the meeting for updating the CCG Board. The public would not be captured in these photos. Richard Shenderey, Secondary Care Doctor and Heather McSharry, Lay Member, Equality/Diversion & Inclusion were welcomed to their first Clinical Commissioning Group Governing Body meeting. Apologies were noted, as detailed above.	**Decision:** Noted	Chair

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It was noted that the meeting was quorate to proceed.		
2.0 DECLARATION OF INTERESTS		
MS invited those with any Declarations of Interest, not previously declared, to make them known to the meeting. Richard Shenderey introduced himself and confirmed he was a Gastroenterologist in Leeds. Heather McSharry introduced herself and confirmed no declarations of interest.	**Decision:** Noted	Chair
3.0 MINUTES OF THE PREVIOUS MEETING HELD ON 11 AUGUST 2016		
JK brought to the attention of the members that on page 10, item 8.7 the initials of the presenter caused some confusion. Initial to be changed to JKi for Julie Killingbeck. The minutes were accepted as an accurate record of the meeting.	**Action:** AB to amend. **Decision:** Noted	Chair
4.0 ACTION LOG – ACTIONS UPDATE FROM 11 AUGUST 2016		
Actions from the meeting held on 11 August 2016: • **Item 7.7 (09.06.16): Individual Funding Requests Annual Report 2015/2016** o This is now a collaborative piece of work across the sustainability and transformation plan. There are a single set of policies that are agreed upon and these will return to Engine Room or Governing Body for discussion. It was confirmed that the process by which IFR are agreed or not, are still in dispute and this is still on-going.	**Decision:** Noted	Chair
5.0 MATTERS ARISING *(NOT COVERED ON THE AGENDA)*		
There were no matters arising to be discussed.	**Decision:** Noted	Chair
6.0 CHAIR/CHIEF OFFICER UPDATE		
<u>Co-commissioning</u> The Chair confirmed that the Council of Members had a discussion regarding whether the CCG should move to level 3 from level 2. It was decided to stay at level 2 at present. NHS England (NHSE) are changing their structure to reflect sub regional working so there are no hazards. NHSE have not concluded their process yet and the CCG are expecting to hear soon about the new configuration and how NHSE will work. <u>Contract Update</u> The CO confirmed that the CCG are normally in the preparatory stages for negotiation of new contracts at this time. However, the CCG are now in receipt of planning guidance and there is not a single challenge. The CCG are expected to have all contracts signed by 21st December, however it may be challenging, and many other colleagues are having similar difficulties. The CCG are in a better position than last year and as a result have proposed to NHSE that they don't move into formal process. The CCG are looking for a	**Decision:** Update noted	CO

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
shared solution for the overall cost, along with cost for providing and maintaining good care, can be reduced. The CO will update between now and the signature deadline as to where the CCG are. NHSE are comfortable with the position. RY confirmed the contract with the Mental Health provider (RDaSH) is likely to be signed.		
7.0 PATIENT STORY		
7.1 A Patient Story		
CW highlighted a patient's story in relation to a young patient being placed out of area for complex care. The story highlighted problems with processes, some disputes about funding and how the issues were resolved. This was a good news story with assurance for the board that both quality of care and finance are being considered to get a good outcome, not just finance. The patient was happy and content.	**Decision:** The CCG Governing Body: • Noted the patient story	DoN&Q
8.0 CORPORATE GOVERNANCE AND ASSURANCE		
8.1 Major Incident Plan		
CW presented item 8.1. The paper has been through Quality Committee and agreed. It now requires final sign off from the Governing Body. JK highlighted the following: o There is an airport in the region which has not been mentioned on the risk plan at all. o Coastal flooding is mentioned twice o The term 'military' had been used instead of armed forces CW will feed the information back. RS raised the issue of alarm codes for the building being listed in the public domain. MS stressed that this had already been raised and codes had been requested to be changed ASAP.	**Decision:** The CCG Governing Body: • Agreed the Major Incident Plan with the amendments to take place.	DoN&Q
8.2 Proposed Structure and Template for Committee Reports		
LL presented Item 8.2 in form of a presentation. The presentation highlighted the purpose, content and form of reports from sub committees. The following was discussed; o Maintaining the process that is currently in place was agreed o The appropriateness of decision making to enable reflectiveness on structures was discussed o Consistency was discussed so papers that had been taken to one committee were not being taken elsewhere o Certain things need to be challenged from a CQC perspective. We need to have challenged safeguarding and that needs to be documented within the minutes and not just the presentation. CW suggested this should be reflected in the front sheet. o RY suggested being assured that we are processing in	**Decision:** The CCG Governing Body: • Noted, discussed and commented on the proposed structure and template for committee reports.	CO

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
alignment within national guidance o For accountability purpose would like to see which risks are being assessed o Keeping a decision log would help to gain assurance through the subcommittee reports more effectively o The committee need to be confident that the decision pathways haven't missed any steps. This should be more robust. o What mitigation actions are being taken o Triggers that might want to be aware of It feels like a more rigorous standard and would help the receiving Governing Body. JK suggested if there has been an impact then it should say how. There should be a statement saying what mitigation actions are being taken. Front sheets are to be completed before each meeting and should be appropriately completed. If this does not happen the front sheets will be bounced and the paper will not be considered at the meeting.		
8.3 CCG Objectives & Values		
LL presented Item 8.3 in form of a presentation. The presentation highlighted draft objectives which were based on feedback provided by members of the team at the CCG Time Out on 30th June 2016 and reflect priorities for the CCG. Themes identified as part of this process were compassionate care, individual need, solutions based, empowerment and partnership working. The following was discussed; o The need to refresh the current objectives. Teams were given the opportunity to reflect on them and have been having conversations o The key themes and objectives are underpinned by ABC values. The last value is starting to change conversations with other regulatory bodies. It means that we are challenging NHSE and NHSI and changing the nature of conversations RS confirmed his support in terms of the values. However, the document needs to be clear to the public regarding the acronyms used. LL confirmed it is still a working document and these will be addressed before final publication. FB highlighted that the increased MH spending and parity of esteem are already getting feedback that they see a change in the CCG, which is very positive. In terms of reduction of incidents of smoking, smoking in pregnancy in North Lincolnshire is quite an outlier, so the message for this needs sending out. JM confirmed that the smoke cessation services are working on this. RY showed support for FB's point. There is an issue with smoking in pregnancy and need to work out why that is.	**Decision:** The CCG Governing Body: • Noted, discussed and commented on the CCG Objectives & Values	CO

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
The good news is there is some national money available which may help us with that and the CCG are in the process of applying for it. So there may be an opportunity to develop that. IR commented on Partnership Working and expressed his concern that the relationship with the voluntary sector is not progressing. LL confirmed she has been working her way around the voluntary sector and talking to them about the work they are doing and how the CCG might work with them and remove some of the barriers. There are conversations happening with Voluntary Action North Lincolnshire. CN stated that having good relationships with the voluntary sector can make a big difference. She confirmed that the objectives were really useful to see. She highlighted that the issue about maternal smoking will depend on where the young women are living. LL knows that historically screening programmes increase the gap. However, it is a reasonable challenge which maybe should be more specific. LL confirmed this is a piece of work in progress and it will be back to the Governing Body again as it evolves.		
8.4 Governing Body Assurance Framework		
CW presented the report which was taken as 'read'. The following issues were highlighted: ○ There are two later risks which need populating more, but these are still being assessed at the moment ○ IR suggested that strategic risk tend to be long term and tend to evolve changes. It was felt there was a real risk that it is not scrutinised as closely as it should ○ The scoring matrix and the representation of risk score were discussed. The detail of the criteria should be included in the report and the descriptions of severity are unhelpful. CW will speak with JPo to send out the descriptors with the minutes. The risk register should describe that better. ○ A first attempt was made at assessing risk appetite for overspending on medicines management and suggested in PC3 that we are only prepared to tolerate a score of 1 or rare for probability of overspending on prescribing budget. The CCG have never once failed to overspend on prescribing budget, so at most it ought to be a possibility of going to overspend. ○ It was agreed that the risk register should be seen at a greater level at intervals.	**Decision:** The CCG Governing Body: • Received, noted and approved the Governing Body Assurance Framework.	HoCG
8.5 Quality Report		
CW presented Item 8.5. There was agreement to move to an integrated report for Quality and Performance, which will be more comprehensive. This will be managed for the next board.	**Decision:** The CCG Governing Body: ○ Received and noted the Quality Report.	DoN&Q

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
Specific areas highlighted: ○ In terms of provider assurance, NLaG are going through CQC inspection and RDaSH just had theirs. They are awaiting outcomes. ○ There is a new National process around any LD deaths. A template is to be completed. CW to lead for NL and set up with leads and provider services. IR confirmed that when the revised template is produced, it would be helpful to track how many clients we currently have on Continuing Health Care (CHC) and how that is growing. It would be helpful to develop a value for money metric. CW will take the feedback forward. A procurement manager has now been appointed in the CHC team. There was mention about focusing a governing body workshop on CHC, so lots more data can be made available. There is a transformation plan in place which involves some significant developments within funding stream. The aim to have a CHC discussion at the workshop may have to be the meeting after the next as there is a good governance review to discuss. CW is keen to get a good report coming to the board which reflects the assurance and can be developed further.		
8.6 Corporate Performance Executive Summary		
IH presented Item 8.6 and the report was taken as 'read'. The report briefed the CCG Governing Body on Corporate Performance. Specific areas highlighted/discussed: ○ There is now a contract report and embedded documents which are within the performance report. There is still some work to do on reporting and actions are being drafted. This is in the process of receiving responses from Executive team and managers and is moving forward. ○ <u>Performance report</u> There has been some deterioration from NLaG with a problem with referral to treatment (RTT) time. There has been a recovery plan from NLaG but nowhere near the 92%. The news is not good news and there is a gloomy prognosis. ○ A&E 4 hour wait is now at 90% and has reduced slightly. A recovery plan and some resources have been put in that. ○ There has been one breach on 62 day cancer. ○ The ambulance service is not good across whole patch but ok for this area. ○ Outpatients do have a capped contract but are not a great position. ○ <u>Section 4 contract update</u> It was highlighted that IAPT doesn't describe the current situation in that they have made the change irrespective of	**Decision:** The CCG Governing Body: • Received and noted the Corporate Performance Executive Summary.	CFO

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
the fact the proposal was rejected. IH will get that reflected. ○ RTT (page 3) There is a breach but the patient chose to wait. However, this still needs to be reported as a breach but the dialogue explains it. ○ Local measures There has been reduction in elective gastroscopies. The number being done was far more than should be expected. AL suggested that this is a very marked outlier compared to national and local rates which needs to be explained better. ○ Section 10 of contract report RY explained that there is a suggested drive which we should be looking at in terms of a different way of pulling available resources for paying for the provided services. In some specialities we have been proactively diverting to help with RTT issues. The intention at this moment in time is to have a block contract with NLaG for 17/18 and as a result will not be adversely impacted upon with cost somewhere else. It is very unlikely this will be in place for 17/18. Inequalities for deprived areas were highlighted. It is possibly building increase in equality because there is no provision for funding for people to get to appointments elsewhere. It was mentioned that there may be scope to bring more capacity into the area and outpatients are being looked into. LL explained she was having a conversation with counsellors regarding this. There needs to be the opportunity, where it is appropriate, to have face to face appointments. However, choice should still apply. By offering alternatives it creates more capacity and less waiting. There was a discussion surrounding the lack of clinical information provided when someone is required to be seen in a follow up clinic in 6 months. There are a significant number of patients in the system and doctors are unaware why they need the follow up, which is why there is an issue. There is a need to identify the ones who don't need the follow ups to save space in clinics.		
8.7 Finance Report: Month 7 (October) 2016/2017		
IH presented Item 8.7 and the report was taken as 'read'. Specific areas highlighted: ○ End of month 7 we are £2.6 million adverse to plan and £2.3 deficit. Plan would vary by 4 million as an adverse. Total deficit of £1.7 million. Need to recover from £2.3 to £1.7. It was confirmed that all workstreams have made some contribution in the last 5-6 weeks. There is now a formal arbitration position on the BCF income issues. This should be concluded after Christmas. The CCG are robust. There is cash available to pay providers and	**Decision:** The CCG Governing Body: • Received and noted the Finance Report.	CFO

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
creditors. The balance sheet is solid and accounts are solid. The headroom is an element of discretionary, the ability to release or not release by NHSE. If headroom is released the CCG will break even.		
8.8 CCG Audit Group: Summary Report		
PE presented Item 8.8 with a verbal update. Specific areas highlighted: ○ It was confirmed that there had been changes to membership of the group. The Audit Group have received a new Lay member and Ian Reekie has left. Satpal Shekhawat has left and the committee will welcome Hardik Ghandi and Sami Ahmed as the GP representatives. ○ The Audit Group approved the Conflict of Interest Policy. The proposal for administration processes were reviewed and internal audit role agreed. The members are going to support the training for conflict of interest and also recommended that the whistleblowing policy is reviewed. ○ The board assurance framework had been challenged in terms of its presentation. It is now more understandable and easy to interpret. ○ The internal audit team reported on the clarity of governance and BCF. IH is investigating some issues around the governance which is more about quoracy at meetings. ○ PE confirmed that the CCG were obliged to retender with external auditors. There is a bid for a new auditor but it is not in the public domain as yet.	**Decision:** The CCG Governing Body: • Received and noted the verbal CCG Audit Group Summary Report.	Chair of Audit
8.9 Joint Commissioning Committee: Summary Report		
IR presented Item 8.9 and the report was taken as 'read'. The report updated CCG Governing Body members on decisions taken by the Joint Commissioning Committee (JCC). Specific areas highlighted: ○ <u>Market Hill re-procurement</u> NHS England wanted to let that contract for 5 years and wasn't happy with that proposition. There wasn't sufficient time to see what a better offer looked like. It is going out for a further year to enable to make changes with expectation proposition for 16/17. The tender says 3 years but it should say 12 months so IR and LL will investigate.	**Decision:** The CCG Governing Body: • Received and noted the Joint Commissioning Committee Summary Report	Chair of the JCC
8.10 CCG Executive Team Meeting: Summary Report		
LL presented Item 8.10 and the report was taken as 'read'. The report highlighted to the CCG Governing Body the issues that had recently been considered, or were currently being considered by the CCG Executive Team. The report was for information and noting.	**Decision:** The CCG Governing Body: • Received and noted the CCG Executive Team Summary Report	CO
8.11 CCG Quality Group: Minutes dated 24 August & 26 October 2016		
CW presented Item 8.11 and the report was taken as 'read'.	**Decision:** The CCG Governing	DoR&QA

SUMMARY OF DISCUSSION	DECISION/ACTION (including timescale for completion or update)	LEAD
The CCG Quality Group minutes were for information only.	Body: • Received and noted the CCG Quality Group minutes	
8.12 CCG Engine Room – Agenda Item Log: October and November 2016		
MS presented Item 8.12 and the report was taken as 'read'. The CCG Engine Room: Agenda Item Log for October and November 2016 was for information only.	**Decision:** The CCG Governing Body: • Received and noted the CCG Engine Room Agenda Item Log	Chair
9 HEALTHY LIVES, HEALTHY FUTURES		
9.1 Update: Healthy Lives, Healthy Futures (HLHF) Programme		
LL provided an update in relation to the Healthy Lives, Healthy Futures (HLHF) programme. Specific areas highlighted/discussed: o Since the paper was complied, things have progressed. o The Local Accountable Care Partnership (ACP) has a workshop to develop their thinking around what the future might look like and what a population health management contract would look like. o HLHF are on track	**Decision:** The CCG Governing Body: • Received and noted the update	CO
10 PUBLIC QUESTION TIME		
10.1 An opportunity for members of the public to ask questions linked to the agenda or the CCG		
John Whitelam, Healthcare Partnership Manager, introduced himself to the members of the Governing Body. He was particularly interested in objectives 2 and 4 around partnership working. He confirmed that part of his role is to look at opportunities within community pharmacy. He highlighted that the NHS innovation accelerator is in the second year and there are some new schemes within that. He gave some examples of sore throat tests and treat service within Boots, being linked to commissioning and medicines management. He questioned whether there would be an appetite to engage in conversations. LL confirmed that RJF has a date in the diary with the LPC which is Humber. She asked Mr Whitelam to leave a card and RJF would be in touch. AL added that pharmacy has a huge role to play in all this. There are some very good national resources. However, one common frustration is those pharmacists are not using those recognised resources to assist people. He suggested that pharmacy should be more consistent and that would help. Mr Whitelam took the comment on board and will take forward to colleagues. No other questions were asked.	**Decision:** Noted.	Chair
11 ANY OTHER BUSINESS (Urgent Items by Prior Notice)		
There was no other business.	**Decision:** Noted	Chair
12 DATE AND TIME OF NEXT PUBLIC MEETING		
Thursday 9 February 2017 13:30	**Decision:** Noted	Chair

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Board Room, Health Place, Brigg		