**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP PARTNERSHIP BOARD**

**MINUTES OF THE MEETING HELD ON THURSDAY 15 JANUARY 2015 AT 2PM**

**SOCIAL ENTERPRISE CENTRE, 84 WELLINGTON STREET, GRIMSBY DN32 7DZ**

**PRESENT:**

Mark Webb Chair

Philip Bond Lay Member Public Involvement

Dr Derek Hopper Vice Chair/Chair of CoM

Juliette Cosgrove Strategic Nurse

Cathy Kennedy Chief Financial Officer/Deputy Chief Executive

Helen Kenyon Deputy Chief Executive

Dr Thomas Maliyil GP Representative/Vice Chair Council of Members

Dr Peter Melton Clinical Chief Officer

Dr Arun Nayyar GP Representative

Sue Whitehouse Lay Member Governance and Audit

Stephen Pintus Director of Public Health

**IN ATTENDANCE:**

Jeanette Harris PA to Executive Office (Minutes Secretary)

Joanne Hewson NELC Deputy Chief Executive (Communities)

Lisa Hilder *(Item 7)* Assistant Director Strategic Planning

Laura Whitton Deputy Chief Finance Officer

**APOLOGIES:**

Cllr Mick Burnett Portfolio Holder for Tourism and Culture – NELC

Mr Perviz Iqbal Secondary Care Doctor

Dr Rakesh Pathak GP Representative

Joe Warner Managing Director – Focus independent adult social care work

**1. APOLOGIES**

Apologies were noted as above.

**2. CONFLICTS OF INTEREST**

No conflicts of interest were declared.

**3. APPROVAL OF THE MINUTES OF PREVIOUS MEETING:**

The minutes of the Partnership Board meeting held on 15 January 2015 were agreed to be a true and accurate record.

**4. MATTERS ARISING**

The actions outlined on the action summary sheet were noted.

**5. UPDATE ON LENGTH OF TENURE FOR THE CLINICAL CHIEF OFFICER**

At their last meeting the Council of Members (CoM) discussed the length of tenure for the Clinical Chief Officer role as this is due to end in April 2015, following an election process three years ago. The role has been put out to GPs but apart from the current post holder no applications were received. CoM discussed the appointment process for the role of Clinical Chief Officer together with how to best serve the community and the CCG. Following discussions with Dr Melton and the Remuneration Committee it has been agreed that in future this post will be a permanent appointment and no longer subject to a three yearly election cycle.

**6. BOARD ASSURANCE FRAMEWORK**

The Board Assurance Framework (BAF) is a tool that serves the organisation as a strategic level risk identification system that notes positive assurance to date and flags gaps in control and assurance processes and details the remedial action to be taken.  The BAF is scrutinised and monitored on a regular basis throughout the year, on behalf of the Board, by the Integrated Governance and Audit Committee who escalate any issues they may identify to the Board on an as required basis. Notwithstanding this the BAF is also brought to the Board on an annual basis to provide assurance and an opportunity to monitor the assurance received and identification of gaps to be addressed.

The BAF has undergone some key areas of development since March 2014 which include:

* grouping the risks into a top ten risk themes
* holding two risk awareness sessions to assess the risks facing the CCG and ensuring that identified risks have steps in place to control or reduce the risk to the organisation
* risk managers within the CCG had individual meetings to enable them to review their risks, explore further ways of mitigating them and to raise awareness of new risks
* on-going refinement of the BAF template and narrative to provide a more effective and efficient document

Following consideration of the document it was queried whether co-commissioning should be included due to the possible risks it posed.  It was noted that co-commissioning would need to be added to the BAF in the coming months and that the BAF needs to be a living document that can be flexed as required to include new risks as they arise.

**The Partnership Board noted the amendments made to the BAF template and the level of assurance received by the CCG, in relation to its strategic risks.**

**7.   LOCAL IMPLEMENTATION PLAN (LIP) AND FIVE YEAR FORWARD VIEW**

The paper before the Board provides an update on the one year Local Implementation Plan (LIP) together with the CCG’s five year strategic plan which has been updated to reflect the 5 Year Forward View published in October last year.

The organisation’s vision and direction of travel continues as set out last year, incorporating elements from the 5 Year Forward View and the Healthy Lives Healthy Futures transformational programme.  In particular the renewed emphasis on prevention of ill health and promotion of health and wellbeing was described. It was highlighted that the key themes within the CCG’s vision were in line with much of the content of the 5 Year Forward View but were strengthened further to more fully reflect this.

A planning event was held on 12 February 2015 which involved our local stakeholders from primary and secondary care, the Local Authority and key providers.  At its conclusion the participants endorsed the direction of travel being taken by the CCG and agreed a key action for a Single Prevention Strategy to be developed across North East Lincolnshire to ensure a cohesive and joined up approach.

It was highlighted that waiting time targets have been set for mental health services as part of the steps being taken to ensure parity of esteem between physical and mental health services.

A revised submission date for the LIP has been received and is now 7 April; it is anticipated that our LIP will be submitted just before Easter to meet this deadline.

Attention was drawn to the improvement trajectories outlined in the supporting paper for the LIP as well as the “plans on a page” which are comprised of the reviewed five year plan and the one year plan which formed part of the focus for the event held on 12 February.  It was noted that the organisation is now in year two of the five year plan and is building on the achievements made in year one.

A query was raised over the waiting time target for Mental Health patients as it stipulates access to a first appointment only and it was highlighted that the follow-up waiting time was also very important and should be monitored; a further concern was expressed that there are possibly not enough targets being monitored for the quality of on-going care provision.  It was also flagged that when provider clinics are cancelled there is no assessment made of clinical priority when replacement clinics are arranged.  **It was agreed that these issues should be investigated in detail by the Care Contracting Committee.**

**ACTION:  H Kenyon**

A final query was raised by the Board that the direction of travel undertaken by the CCG was in line with the contents of the 5 Year Forward Plan and it was confirmed that this is the case and there are no major changes required.

**The Partnership Board endorsed the updated strategic direction of travel for the CCG and approved the priorities for action (Plan on a Page) for 2015/16.**

**8. MEDIUM TERM FINANCIAL PLAN**

The paper before the Board has been submitted to provide an update on the CCG’s financial plan and to gain approval for the 2015/2016 budgets.

The meeting was informed that the financial position for the CCG is the tightest it has ever been over the last 14 years of the organisation’s history as a PCT, CTP and then CCG.  Over the past 12 months there have been significant pressures created by unexpectedly high levels of activity at Diana, Princess of Wales Hospital and the increasing costs associated with continuing health care.  These risks have been managed in the current financial year but this does cause a pressure going forward.  In addition to the risks outlined above the CCG has received the lowest level of uplift to our allocation due to the fact that in the past it has been receiving slightly more than its fair share of resources as set out by the national formula which is calculated on the demographic/size of our population.  Additionally there is a requirement for a further £7m savings from the Adult Social Services budget with no funding uplift being provided to meet increasing demands on the service or cost increases during the coming year.

The above scenarios mean that there will be less funding available than previously to cover risks and provide contingencies and in the coming year the CCG will not have the same resources in contingency funding to cover the same levels of pressures that we have faced in 2014/15. In addition the funding available for transformation and sustainability will be less than previously provided.  It was also highlighted that the QIPP plan currently does not have sufficient schemes to fully meet the savings we need to generate.

One of the key assumptions being made by the medium term financial plan is that the CCG will be able to draw down £2m of its historic surplus to support the Healthy Lives Healthy Futures (HLHF) transformational programme.  Formal confirmation of this has not yet been received but it has received support from our local area.  If this drawn down is not approved there will be an impact on our transformational schemes which could be delayed or unable to proceed.

The plan also currently assumes that there will be no additional funding for the impact of the 2015/16 enhanced tariff offer, there is some central funding available to assist with this but to date we have not received confirmation of the amount that could be available to us.

Following on from work previously undertaken on the HLHF Single Version of the Truth, to ensure that key planning assumptions and plans are aligned for North Lincolnshire, an open book approach has been adopted within Northern Lincolnshire (NLaG, NAViGO, Care Plus Group and the two CCGs).

The key risks outlined in the Financial Plan for both health and Adult Social Care relate to the non-delivery of savings plans, activity growth being higher than planned, pressures arising from decisions being made externally to North East Lincolnshire (such as specialised commissioning) and no additional funding being received for the impact of the 2015/2016 enhanced tariff offer.

Attention was drawn to the detailed budgets contained on the last page of the supporting paper; the figures include the latest offer positions to the three main local providers.  These may be subject to slight changes.  It was also highlighted that the planned surplus of £4.5m is £2m less than last year’s figure.

Cathy Kennedy highlighted the extreme difficulty faced by the CCG  in overcoming the perception held by providers and the public that the CCG was generating a surplus of £4.5m yet had significant pressure on its budgets and is facing increasing funding difficulties.  It was reiterated that the CCG has to operate under business rules set by NHS England and those rules stipulate that this surplus has to be made.  However the £4.5m surplus position is actually the CCG’s breakeven position and this money is held by the Treasury and is not released into the CCG’s accounts.  If this “paper” balance position is not achieved the CCG is deemed by NHS England to be in deficit and therefore failing.

The open book policy being undertaken by the CCG was encouraged by the Board which felt that working together with key providers is essential in the current challenging financial environment.

A Board member queried what actions the CCG would take in the event that it didn’t look like it would achieve its planned surplus and it was clarified that a series of steps are being worked finalised to identify what actions will need to be taken in the event of any areas outlined in the budget going off plan.  These include what we would be able to stop doing, how quickly we could stop doing it and what the implications of halting it would be and what other areas of involvement could the CCG cut or withdraw from.  The finance report coming to the May meeting will outline the steps that will need to be taken to ensure the organisation makes does meet its statutory obligation to make the required surplus.

**9. DECLARATION OF INTERESTS REGISTER**

The document before the Board is the latest version of the Declaration of Interests Register which has been compiled following a recent data collection exercise; information has also been provided on the declarations of interests made at CCG meetings during the period from April 2014 to January 2015.

Attention was drawn to the implications individuals or Practices will face if they fail to return a completed declaration of interest form.  To date there are 13 forms outstanding; 4 of these relate to individuals who have left their positions with the CCG; in these cases there are no perceived implications for individuals concerned and these returns will not be chased any further. The remaining 9 outstanding declarations relate to members of the Council of Members and form 28% of the overall voting membership within the CCG.  A number of steps have been taken to encourage completion and return of these declarations including e-mails being sent to the individuals/practices concerned and the importance of completing these requests being raised at the 5 February meeting of CoM by the Chair. The Board was advised that where an individual, or their practice where that individual represents their practice at CoM, fails to complete a declaration, that individual/practice will be excluded from any decision making responsibilities, until such time as a completed declaration has been received; the register will also be amended to this effect.

A letter is to be sent by Cathy Kennedy to each of the outstanding individuals/practices outlining the implications of their non-completion and return of a declaration of interests.

**The Board noted the contents of the Declaration of Interest Register and the steps being taken for non-completion of a declaration of interest form.**

**10. QUALITY REPORT**

The Quality Report was taken as read and it was highlighted there was nothing of significance to report at the time of writing.  However in the last few days there has been some Press coverage over a Coroner’s Report relating to hip operations.  The Quality Committee and Quality Team are investigating this incident of three, apparently unrelated incidents, and monitoring will continue.  An update will be included in the next Quality Report to the Board.

**ACTION:  C Kennedy**

A recent external report and data on stroke suggests that there is some further work to do in this area and will be taken forward by the relevant Service lead.

It was noted that the NLaG figures given in the SUI section of the report were combined for both areas of the patch and it was requested that these be separated out in future reports.

**ACTION:  C Kennedy**

It was queried whether Core Care Links reporting should be included within this report and it was clarified that primary care comes under the remit of NHS England but that from 1 April this will form part of co-commissioning and their numbers will need to be included in future Quality Reports.

**ACTION:  C Kennedy**

**The Board noted the content of the report and endorsed the on-going monitoring of quality issues by the Quality Committee.**

**11. HEALTHY LIVES HEALTHY FUTURES UPDATE**

An update presentation on the Healthy Future Healthy Lives programme was given to the Partnership Board and covered:

* Clinical service planning framework
* Leads for clinical work streams
* Clinical groups
* Example output – key principles of LTC model; Long Term Conditions
* Monthly programme report
* Scheme tracker
* Project plans

It was noted by the meeting that the local hospital is ending this financial year with a deficit and that QiPP programmes will mean further reductions of funding for the hospital; it is imperative that forward progress needs to start happening now to reduce the impact of funding gaps.

The appointment of Karen Jackson, Chief Executive of NLaG to the role of Accountable Officer for the HLHF programme was raised together with the difficulties being faced by her organisation and it was queried whether she would continue to be able to support both roles.  The Board was advised that this question has been discussed by Monitor and the NLaG Board and the consensus of both parties was that the HLHF programme is critically linked to the future of Northern Lincolnshire and the secondary care sector and in light of this it was appropriate that Karen Jackson continue in her role of Accountable Officer and she has since been asked to continue for a further 12 months.

It was agreed that it is important that the Partnership Board receives assurance and exception reporting for the HLHF programme and it was decided that a brief written report will come to all future Board meetings.  The Programme Management Office will be charged with providing this.  Mark Webb agreed to liaise with Cathy Kennedy over format and content for this report.

**ACTION:  C Kennedy/HLHF PMO**

It was also agreed that presentations on future plans will also be provided when required.

**12. INTEGRATED ASSURANCE REPORT**

This report was taken as read but attention was drawn to the performance highlight which provides details of the significant progress being made towards improving access to psychological therapies (IAPT).

The key performance indicators were also highlighted and the Board was reminded that under the NHS Constitution the CCG has no choice over these indicators and has to sign up to them as part of the plans going into the NHS England assurance process.

The target range for C Diff for the coming year has been reset on recent performance from 23 to 35 and now feels like a target that the organisation can aspire to deliver.

The challenge to achieve the new targets for Mental Health waiting times for the coming year was flagged.

It was also noted that it is now statistically impossible for the CCG to achieve the target set A&E 4 hour waits, and there are serious challenges for 18 week referral to treatment times (notably ophthalmology) as the local hospital has been struggling to deliver better performance in these areas.

The performance dashboard now includes a number of new national measures and these are listed in full on page 6 of the supporting paper.  The inclusion of these measures has created more amber areas than usual on the dashboard and this is because the measures are new and the CCG has not yet been able to assess and address where its performance stands against them.

The lack of data on people who have had an acute stroke who receive thrombolysis was queried and it was clarified that this data is reported as an annual measure at the beginning of the new financial year.  However the Delivery Assurance Committee closely monitors the detailed measures underneath this headline to enable us to work out where we stand.

**13. FINANCE REPORT**

The report before the Board provides an update on the financial position at the end of January 2015 and details the financial risks that need to be managed to the end of the financial year; the finance forecast is still reflecting that the organisation will achieve its required planned surplus.

The Board was informed that the forecast surplus has increased by £0.5m to £6.53m owing to an under-spend from the National Risk Share funds for continuing healthcare retrospective claims.

Risks that continue to require close monitoring include continuing healthcare, prescribing and acute activity for out of areas hospitals; until the final figures are available there is some uncertainty re continuing healthcare and prescribing but these two areas are being rigorously monitored.

It was queried whether in future years the CCG could be required to contribute higher levels of funding than previously to the National Risk Share pot for continuing healthcare retrospective claims.  It was confirmed that the CCG has been asked to contribute to this pot for the coming year. All retrospective claims need to be settled in 2016.

It was noted that the required Adult Social Care (ASC) savings were on budget which reflects the overall ASC forecast breakeven position.

**The Board noted the financial position as at January 2015 and the financial risks that need to be managed during the remainder of the year.**

**14. COMMISSIONING AND CONTRACTING REPORT**

The report supporting this item was taken as read but the meeting was informed that the timetable for submitting the 2015/16 contract has been revised again and is now 31 March; we are still awaiting receipt of the national contracts that have to be used for this process; in addition the Acute Trust have been given until mid-April to get their contracts signed and these issues have been discussed at this morning’s Care Contracting Committee meeting.

Attention was drawn to the draft Memorandum of Understanding (MOU); this document has been developed in collaboration with North East Lincolnshire CCG, North Lincolnshire CCG, NLaG, Care Plus Group and NAViGO and reflects the common view of the sustainable system that commissioners and providers are seeking to achieve.  All interested parties have been involved in working through the financial requirements, activity figures and performance indicators for each organisation which reflects the collaborative working, openness and transparency ethos that underpins this concept. Whilst the organisations involved may need to make choices that could have a detrimental effect on others in the group, everyone will be aware of these situations beforehand and the reasons for the steps being taken, which will assist those being affected to alleviate the possible impact on their organisations.  It was highlighted that this is still a draft document and the schedules that will accompany it are under development.  If the Board agrees in principle to the proposed agreement it is being asked to delegate authority to the Clinical Chief Officer to sign off the final version of the MOU when it is completed.

It was noted that the MOU relates purely to health monies and it was suggested that it should be an aspiration to have a similar understanding with the Local Authorities at some point in the future.  This idea was supported in principle but it was acknowledged that considerable in-depth liaison and development work would need to be taken by the CCGs and Local Authorities to bring this to fruition.

It was queried whether the limited list of providers within the MOU could lead to challenge from others and it was also noted that primary care was not included.  In response Helen Kenyon advised that Monitor has been involved in the development of the MOU and did not raise any issues as this document relates purely to behaviours.  Primary Care has not yet been included as the CCG has not been responsible for their contracts during the current year but they, together with other providers, can be included and involved in the future as circumstances change.  It was stressed that the MOU does not seek to provide guarantees that organisations will be supported in perpetuity but rather is an outline of the approach being taken to deal with the contracting and financial challenges being experienced by the CCG and local providers, for the provision of acute care, mental health and community services.

A concern was raised by Dr Maliyil over the shared financial risk strategy and clarification was sought on exactly what this means as he was concerned that the MOU may tie the CCG into providing financial assistance to a struggling provider and that providers may use it as a tool to call on the CCG if they find their risks are escalating or materialising.

In response it was reiterated that provider organisations will have to deal with their own risks and that these are not a jointly held responsibility and will only reach escalation point if it is identified that there will be a collective impact across others.  One of the benefits of the MOU is that the providers are now fully aware that the CCG does not have extra monies that can be called upon to mitigate their risks; it is rather an approach towards contracting and provides a process whereby if a risk is realised, all interested parties are aware of it in advance and are therefore able to take steps to minimise the impact that may arise from it.

Dr Maliyil reiterated the need for the MOU to be explicit on the points above to ensure that it could not be used as a tool by struggling organisations to call on extra funding.

**The Partnership Board noted the contents of the Contracting Report and subject to the above concerns approved the Memorandum of Understanding in principle and agreed that signing up to the completed version of this document will be delegated to the Clinical Chief Officer.**

**15. UPDATES**

a) Community Forum Update

Last December the Community Forum put together a small working group to look at mitigating the risk posed by all the Community Forum appointments coming to the end of their term of appointment in April 2016. As a result, to ensure succession planning for the Forum, five members have volunteered to go to election this year; between them they hold positions on three Service Triangles and two community posts. Effectively these members will resign from the Community Forum and the recruitment process for these positions will come into play. This process will most likely take place at the end of summer and the new term of office will run to 1 April 2018.

The recently formed ACCORD steering group has met three times now and taken on responsibility for the ACCORD annual members meeting. Following discussion and to ensure the meeting is as effective as possible it has been agreed that it will take place in September immediately prior to the start of the CCG AGM and at the same venue.

b) Council of Members (CoM) Update

The Terms of Reference (TOR) for the Remuneration Committee were submitted to the last meeting for approval.  Following discussion it was felt that the membership of the Remuneration Committee should be amended slightly to avoid any perceived conflict as all Remuneration Committee decisions need to be ratified by the Governing Body and currently the Remuneration Committee is comprised of members from the Governing Body.  It was therefore agreed that the second GP position on the Remuneration Committee will be filled by a voting GP member of CoM and not a GP member of the Governing Body.  The TOR have been amended to reflect this.

An update was also given to CoM on the review and draft service specification for the Rapid Response service.

**16. ITEMS FOR INFORMATION**

a) Retrospective Use of CCG Seal

The paper outlining the use of the CCG Seal on 13 February 2015 was noted.

b) Care Contracting Committee Draft Minutes 15 January 2015

The Minutes from the Care Contracting Committee meeting were noted by the Board

b) CMM Action Notes 20 January 2015

The Action Notes from the CMM meeting on 20 January 2015 were noted.

c) Delivery Assurance Committee Minutes 17 December 2014

The Minutes from the Delivery Assurance Committee meeting held on 17 December 2014 were noted.

d) Draft Integrated Governance & Audit Committee Minutes 2 December 2014

Minutes from the Integrated Governance & Audit Committee meeting were noted.

e) Quality Committee Minutes 11 December 2014

The minutes of the Quality Committee were noted.

**17. QUESTIONS FROM THE PUBLIC**

The Board was asked when members of the public will be able to have a say in the redesign of the different care pathways being considered under the Healthy Lives Healthy Futures programme.

In response it was explained that public opinion has been informing all levels of this programme through the Community Forum and that during Phase 1 a series on going dialogues was held with the public at supermarkets, local interest groups and public meetings.  There has also been a lot of involvement from individuals who use the services and care pathways and their information and feedback is incorporated from the beginning of any service redesign.

A second query was raised over how the CCG are addressing the use of technology to improve services.  In response Dr Nayyar explained that following investigation it has become apparent that the majority of patients prefer a medical consultation but trials have taken place using video consultations and consideration is currently being given to placing cameras into each Primary Care Centre.  It was acknowledged by the Board that the NHS lags behind other sectors when it comes to using technology but the CCG is exploring other technology options that may be of benefit in the future.

**18. DATE AND TIME OF NEXT MEETING**

Thursday 14 May 2015 from 2pm to 4pm at the Social Enterprise Centre, 84 Wellington Street, Grimsby DN32 7DZ