Minutes of NHS Norwich CCG
Governing Body
Tuesday 27th March 2018

NHS Norwich Clinical Commissioning Group

	Present: Tracy Williams (TW) – Nurse Practitioner/Chair Dr Jeanine Smirl (JeS) – GP / Elected Member John Isherwood (JIs) – Practice Manager / Elected Manager Dr Chris Dent (CD) – GP / Elected Member Dr Andy Douglass (AD) – GP / Elected Member Paul Fisher (PFi) – Lay Member – Governance & Audit Rob Bennett (RB) – Lay Member Dr Neil Ashford (NA) – Secondary Care Doctor Irene Macdonald (IM) – Lay Member – PPI Pam Fenner (PFe) – Non Executive Nurse Jo Smithson (JoS) – Chief Officer John Ingham (JIn) – Chief Finance Officer **In attendance:** Frank Hume (FH) – Deputy POD Director, NELCSU (on behalf of Nikki Cocks) James Elliott (JE) – Director of Clinical Transformation Karen Watts (KW) – Director of Quality Joan Maughan (JM) – Independent Chair, NSAB (Agenda Item 9) **Attending to support meeting:** Jean Clark (JC) – Head of Governance Tim Curtis (TC) – Head of Comms Laura McCartney-Gray (LMG) – Head of Engagement Lynette Dagless (LD) – Executive Assistant (Minute taker)	
1.	**Welcome and apologies**	
	TW welcomed everyone to the meeting. Apologies were received from; Nikki Cocks (NC) – Director of Operations and Delivery Dr Victoria Stanley (VS) – GP / Elected Member	
2.	**Declaration of Conflicts of Interest**	
	The Chair reminded the group that any declarations of conflicts of interest should be disclosed as soon as possible for a decision as to whether it is appropriate for the member to participate in discussion and voting for decision making. <u>Item 21 – Primary Care Committee Chair's Report</u> – All those working in Primary Care have a CoI. These are TW, CD, JeS, AD and JIs. <u>Item 24 – Remuneration Committee Chair's Report</u> – This paper is for information only and does not require any decisions to be made, other than approval of ToR. It mentions KW post and GB members terms of office.	
3.	**Items Exempt Under Freedom of Information Act (FOI)**	
	Part 2 – members of the public will be asked to leave the meeting at this time.	
4.	**Minutes of the meeting held on Tuesday 23rd January 2018**	
	The minutes were signed off as accurate	

	Action Log	
	STP Report – JoS provided a further update. The report in today's papers remains in the old format therefore expectations are unlikely to be met at today's meeting. However, JoS has received the first draft of the new format which needs further work but expects reports to be provided in the new format from May. Although not a specific action, at the last meeting there were two presentations on the Mental Health Crisis Hub. EW was expecting to know the outcome of funding bid early April. The question was raised as to whether there has been a response to these bids. It was confirmed that no response has been received to date but JoS agreed to share any updates via email. **ACTION: JoS to share any updates regarding Mental Health Crisis Hub funding bids via email**	**JoS**
5.	**Chair's Actions**	
	None	
6.	**Questions from the Public**	
	None	
7.	**Commissioning Case Study**	
	A video was provided around leadership development in the NHS, specifically around training and practice development using new approaches. It is part of an equality delivery system. Observations raised were the need for the different organisations to understand the need to progress and understand culture as well as systems in order to integrate. For the member of the quality team who has attended the training, it has given confidence in a Systemwide project and has been a huge learning opportunity. There is an ongoing roll out of courses.	
8.	**Consolidated Quality Committee Report & Chair's Report**	
	PFe and KW presented the Consolidated Quality Committee Report and Chairs Report. Each section was presented and further details provided as requested. The Quality Committee spent a significant amount of time considering systemwide pressures and interdependencies of organisation pressures with others and knock-on effects across the whole system during especially the winter pressure period. NNUH QIRs have increased significantly specifically with issues around communications relating to discharge letters. KW confirmed that specific work is taking place to address this issue. Looking at A&E performance statistics in the Performance Report, over the past 12 months, performance has reduced, have the comments in the Quality Report reflected the way A&E have performed and impacted on care quality and patient safety? The Consultant vacancies are impacting on A&E performance. Also, the acuity of	

	patients going through A&E is fewer but more complex which is impacting on the ability to discharge at the other end. There has been high seasonal demand with a high rise in flu and respiratory infections. The information contained within the Performance Report is a month ahead of the Quality Report. The Quality Report is looking at January data and the Performance Report is looking at February data. NNUH are actively recruiting into the Consultant posts, they have Advanced Nurse Practitioners and alongside this have been struggling with a major redesign in the department at same time as being challenged in terms of capacity. Concerns were raised with regards to the number of patient falls which has increased. GB asked for assurance that the hospital is taking action to reduce the number of falls. KW provided assurance that this is being monitored closely and is discussed at CQRM. <u>NCH&C</u> With regards to Looked After Children (LAC) a number of initial health assessments were declined in January by carers. To offer greater choice and flexibility clinics are being offered most days. A Band 6 and Admin Post has been recruited to release additional clinical capacity to undertake assessments. The Quality Committee decided to include some additional information about other providers in the report; EoE Ambulance Service Trust, ERS Medical, Primary Care and Care Home and Domiciliary Care Providers. A lot of time was spent discussing the impact of delays at the front door and whether this needs to be RAG rated and included in future reports. The ambulance trust has been under increased support and scrutiny by both NHSI and NHSE who are working collectively to address issues. Work is taking place with IC24 and EEAST to look at how the two organisations can support each other. NCCG is participating in work across the five counties covered by the ambulance service to undertake learning from the winter. The piece of work is being led by Ipswich and East Suffolk CCG on behalf of 19 CCGs. The work includes looking into patients that came to harm from delays and actions taken, managing demand, a directory of service and alterative places to take patients. For Norwich in particular, to help reduce demand on NNUH a new process has been put in place, across the system, previously GPs called an ambulance to transport patients to hospital. NNUH are now taking responsibility for getting patients there. For example, supported by family where non-emergency transport is required, using an ambulance as a last resort. It is about reducing demand where appropriate. The Quality Committee are assured that a focused amount of work has taken place and the governance has been strengthened, the on call process has been	

	strengthened and there is an awareness of how to manage patients that are waiting and the escalation process to follow. Governing Body is being asked to decide whether EEAST are added to the Quality Report and RAG rated going forward. As it is reviewed and scrutinised at Quality Committee it was agreed that as an interim measure it would be included within the report but would not be RAG rated. JoS advised that EEAST have been subject to an independent service review which will be published and on the agenda for GB in May. Governing Body signed off the amendments to the Quality Committee ToR. It was acknowledged that it is PFe, the Registered Nurse, last meeting; she was thanked for her input and will be missed.	
9.	**Norfolk Safeguarding Adults Board**	
	Joan Maughan (JM), Independent Chair NSAB attended the meeting to provide an update on the work carried out by the Safeguarding Adults Board. Governing Body members will be receiving Safeguarding Adult training in August which covers 10 categories of abuse. The significant issues faced by the Board include the ageing population in Norfolk which presents significant challenges, such as older people living alone with dementia and Alzheimer's, social isolation, rural facilities, family members who are also elderly, additional issues within a family for example mental health or physical poor health. Financial scamming is also a significant issue in Norfolk as is self-neglect and hoarding. Within extended categories of abuse there are areas that don't feature in the Care Act lists such as modern slavery, female genital mutilation. The Board has responsibility for anybody over 18 who is in receipt of care and support and this includes anybody in the health care system and who would be in the care and support system should they be assessed. There is a growing dislocation between health and social care. For example, early discharge, vulnerable patients unable to access services, missed appointments, challenges around communication with parts of population. The Board feels that it has raised awareness over the past three years, running successful events. The public are aware of what they should do if they have any concerns. It was noted from the Annual Report that only one Rep from Acute Hospitals has attended Board meetings, is that issue for Safeguarding Adults? JM confirmed that the core membership represents the entire health sector.	
10.	**Provider and System Performance Report**	
	Frank Hume presented the Provider and System Performance Report.	

	NNUH With regards to the A&E figures, WIC figures can be shown separate to A&E if required although this is not included in this report. It was felt that it would be helpful to see performance of the WIC at NNUH alongside combined with A&E. JoS to share a week's snapshot of this information but this will show that by the WIC nature it meets its 100% 4hr standard and combined with A&E it generates an improved % **ACTION: JoS to share a week's snapshot.** **Ambulance Trust –** Feedback from an early draft is that both vehicles and staffing models need to change as it has become apparent that the service needs more double staffed ambulances rather than rapid response vehicles. The full report will be available at the next meeting. **IC24** IC24 have realised the importance of reducing no of abandoned calls and their focus is on reducing the number of abandoned calls. The individual calling has not had any kind of assessment so the risk is unknown and IC24 are working to encourage people to stay on the line. **NSFT** <u>Wellbeing Services</u> The question was raised as to whether we are confident that NSFT will meet the recovery target. It is felt that it will be a challenge. They are not currently hitting the trajectory and if they were then we would be more confident. However, they are still confident that they will meet the target so we will continue to monitor and hold the current target. They provide the service to all five CCGs, NCCG have set the trajectory later than the other four CCGs. Are they meeting the trajectories for the other four CCGs? It was confirmed that they are close to meet them. **NNUH** With regards to RTT, when triangulated with the Finance Report, the NNUH sums in the Contract have the capacity to deliver the trajectory by October 2018. How likely is that? It is acknowledged that the October target is exceptionally challenging. NNUH are working differently to relieve some pressure and this is being discussed with NHSE. Also, there has been a significant reduction in referrals from GPs, (nearly 3% overall) and additional resources therefore why is there continued pressure? This is acknowledged but the backlog already in the system continues to challenge them. NNUH have undertaken weekend work in order to reduce the backlog and the question was raised as to how long this is sustainable because of workforce issues.	**JoS**

	This performance indicator is not a good indicator, during the period of clearing a backlog more and more patients wait over 18 weeks and therefore this indicator gets worse. However in the background the Demand Management RTT Board use a different indicator to look at the size of backlog and this is reducing because of positive measures that have been put in place. **ACTION: Extended information will be provided at the next meeting**	**FH**
11.	**Activity and Demand Management Report**	
	JIn presented the Activity and Demand Management Report as at Month 10. NCCG are performing well, the report details specific demand management schemes. These have been scrutinised by Finance Committee. A query was raised with regards to Clinical Thresholds as the mitigation within the Demand Management Report isn't consistent with the QIPP Report. **ACTION: JIn will look at the inconsistencies to ensure that they are corrected.** The Clinical Policy Development Group is improving and the process has become more streamlined so that clinical policies are consistent across the five CCGs. The question was raised as to why it is RAG rated it red. This is because it is not achieving the savings target. However, in terms of progress we are comfortable that things that can be done are being done but in terms of quality we are already performing well as a CCG. The Clinical Policy Development Group considers policies primarily on the basis of quality and good clinical practices although financial considerations do form part of the discussion. Some policies, for example hip and knee replacement increase rather than reduce costs.	**JIn**
12.	**2018/19 Operational Plan**	
	JIn two year planning cycle, an Operating Plan is not required for 2018-19 but it is good governance to set out key things and it is within the constitution for GB to approve the CCGs annual plan. A lot of the work has already been discussed and is ongoing. The focus is on the NMoC and developing primary care at scale. Mental Health services are a key focus. GB feels that it is very comprehensive and there are a lot of actions, the question was raised as to where they all get picked up and whether the objectives are allocated. The process is aligned to organisation objectives and monitoring plan. The work programme is a list of key things which has a project document behind it, status reports are provided monthly with regular reports to GB. There are processes in place for both SRO's and clinical leaders. The 2018/19 Operational Plan was approved.	
13.	**Finance Committee Chair's Report**	
	RB presented the Finance Committee Chairs Report. The financial position to date was highlighted. NCCG are expecting a higher	

	underspend than expected. There are a few things to be finalised before confirming the financial position. These are being monitored by JIn. RB drew the attention of the GB to the objectives set out in appendix A and asked for comments for the coming financial year, the work programme underlays the set of objectives. GB was asked to review the ToR in appendix C. There has been a minor change to reflect what we want to do going forward. GB was asked to review and approve the amendment if it was considered appropriate. Due to the unresolved issues being monitored by JIn it was suggested and agree that RB also oversees any significant issues before accounts are finalised and submitted to NHSE. The ToR were approved.	
14.	**Finance Report Month 11**	
	JIn presented the Finance Report which forecasts an underspend against plan. This is less than 1% of what we spend and is due to a number of investments that we have made throughout the year, there is a sample listed within the report. In additional to the surplus there are some technical things that NHSE expect at year end which are detailed within the report. NCCG are in a good position going into the next financial year and are investing in some transformational initiatives early in the year.	
15.	**QIPP Report Month 11**	
	JIn presented the QIPP reported outlining a positive position. 87% of what we set out to deliver has been delivered. The Finance Committee have focused on the initiatives that have not been performing and on understanding lessons learnt. This will be reported to the next meeting. As this is not a one year programme these initiatives will roll forward to the next financial year, so although there has been slippage this year where initiatives have not delivered savings as quickly as expected they will deliver the savings during the next financial year. Well done to all involved.	
16.	**2018/19 Financial Plan**	
	JIn presented the 2018/19 Financial Plan. This has been discussed at Finance Committee who recommend it for approval. Recently the Government announced pay rises for all NHS staff, the question was raised as to whether NHSE will provide the money to cover that or whether the providers or CCG's will have to fund it. Since the budget it was predicted that it would be no more than 1% and that if it was more than 1% then more money would be given to the NHS to fund it. At the moment we don't know any further details and any additional funding is not up to	

	the providers or CCGs to fund. Concerns were raised with regards to the surplus from the past few years and PMS monies and whether these will be given back to NCCG. The financial regime is that any surplus will be given back to the CCG in the future at the discretion of NHSE. It is banked against the NCCG official documents. However, we don't know when we will see it coming back to us, they can decide when or if. PMS monies is different, there has been some slippage this year which the Primary Care Committee will oversee are allocated and spent next year. The money won't disappear. Some good proposals have been approved and NCCG will make good that funding in 2018/19. The STP and ICS footprint is in deficit. Can the NCCG surplus be counted towards the overall footprint to bridge the gap? It was confirmed that is up the NCCG as it is our money, if we were to become an Integrated Care System as part of governance in the future. There is nothing to say it will be taken away from us. GB approved the plan and budgets.	
17.	**STP Report**	
	TW presented the STP report. Further to discussions at the last GB meeting it was confirmed that the paper will be RAG rated for the next meeting. JoS has seen the first draft incorporating assurance and has asked for finances to be included. The question was raised around how safety, quality, risk and safeguarding are being captured within the report. It was confirmed that there is a Clinical Care and Reference Group which TW attends and can feedback any comments and concerns. It is jointly chaired by a CCG Chair Anoop Dhesi and NNUH Associate Medical Director Eric Denton. JoS confirmed that a Chief Nurse Anna Morgan from NCH&C has recently been appointed to the STP. With regards to the development of digital maturity across Norfolk and Waveney. A Chief Information Officer is now in post. This is shared post between NNUH and the STP and has the responsibility for driving forward the digital agenda. Every organisation has a multitude of different systems which need to join up. The key focus is to join up information between all providers. GB reiterated that they would like an assurance report at future meetings. At the recent STP Urgent and Emergency Care Workstream meeting there was a talk from Julie Thallon (who is cover for Nikki Cocks role) on the Urgent Care Specification. There is a need to review the priorities and this piece of work needs to be included. Work is taking place with Jane Harper-Smith to incorporate it into the priorities.	

18.	**Integrated Care System Expression of Interest**	
	JoS presented the ICS expression of interest paper seeking GB support to submit an expression of interest. Norfolk and Waveney Sustainability and Transformation Programme has been invited to submit an expression of interest to become one of eight STPs in a 'second wave' of Integrated Care Systems (CS). This would mean working in shadow form, whilst we explore what becoming an ICS for Norfolk and Waveney would mean for our population GB felt very strongly that they have been taken along this journey without due consultation and thus questioned the governance in the way the process has been handled. At the last meeting GB were asked to support the submission of the expression of interest once it had already been submitted due to timescales. Concerns were raised with regards to governance about going forward with a plan which does not have a financial Business Case. No other organisation would commit all of its resource into something with no understanding of potential financial benefits. As a CCG are we willing to commit to an open ended arrangement? Part of the one of the perceived benefits of an ICS is having access to NHSE resources such as their expertise and understanding which will help us to develop and strength across the system. It is seen as an opportunity and a way to achieve something that we will need to achieve anyway. The question was raised as to why it was not explored at a formal meeting before the submission of the expression of interest? TW confirmed that the timescales didn't allow for this and there is currently no commitment to go ahead with becoming an ICS. GB are being asked to support it as direction of travel but it is recognised that due to the timescales this didn't allow for normal governance process to be followed and therefore discussions only took place between Chairs and Chief Officers at that point with a recognition that it needed to be followed up with appropriate governance afterwards. GB recognise the inevitability of this kind of thing happening but feel that there needs to be a process put in place about how to record and communicate any action that takes place in-between meetings. There also needs to be a system that allows for robust discussions in between GB meetings allowing Chairs Action with a degree of assurance to be passed back to GB for ratification. The GB raised the question as to whether we have to approve it or whether we can respond to say that it was not approved due to the lack of time to discuss it fully. We were not able to formally approve it at developmental meeting as it had already been written and pragmatically Chairs Action was taken. It was felt that this is a piece of learning for NCCG as it could have been shared while it was being worked up rather than waiting until the GB development meeting. **ACTION: TW to work with JC to develop a checklist of what is coming up and a framework for making decisions.** It was agreed that extraordinary GB meetings should take place as appropriate.	**TW / JC**

	With regards to the earlier comment about support from NHSE, NCCG are good at managing our money so it is felt that this support is not required and we are unique in the local system in terms of our financial performance. With regards to the Expression of interest, there is a lot of detail and uncertainties to be worked through before the Governing Body feels comfortable with becoming an ICS. This paper seems to be saying that the bid is to become an ICS in shadow form from April 2018 – that is next week. JoS confirmed that if GB supports the expression of interest she would expect a full robust governance process to take place through the Statutory Bodies before any further steps are taken. GB are very uncomfortable about lack of governance so far and need to know further details and the governance process that follows before being able to commit. It was agreed that it makes sense to do things once rather than five times, but the ICS has confused some of the local things and does not provide any assurance on how we protect the local elements and we need to understand how the ICS supports that. GB recognise that this is the way that the NHS is going but the process is lacking and there are significant concerns around finances and governance that need to be addressed. **ACTION: TW to feedback via a formal letter to Patricia Hewitt**	**TW**
19.	**Strategic Commissioning**	
	JoS presented the Strategic Commissioning Report. GB agreed the proposed delegations to the JSCC and agreed to take these to the CoM for approval. JSCC outlined discussions that took place at the February JSCC meeting. JSCC will now take place in public bi-monthly and will report to Governing Bodies. There will be a further development session in May and the first meeting in public will be in June. The public meetings will rotate between each CCG area. Antek Lejk feels that he has significant CoI's so has not been attending the meetings. NNCCG and SNCCG are discussing at their GB meetings today so we are waiting to hear his departure date. Helen Stratton is Interim Accountable Officer until they appoint a joint Accountable Officer.	
20.	**New Models of Care Commissioning**	
	NA presented the New Models of Care Commissioning Report and outlined discussions that took place at the first two meetings. The newly established *Your*Norwich Local Delivery Group (YNLDG) has met twice and has evolved from the *Your*Norwich Programme Board. Both the membership and role have changed to include STP reports and representation. **ACTION: The revised ToR will be on the agenda for the next GB meeting for**	**NA**

	approval. GB are asked to sign up to the Smokefree Pledge. It is one of the key themes of Healthy Norwich. It is an embedded document and GB were unable to open it before the meeting. **ACTION: Smokefree Pledge to be circulated via email following the meeting. GB members to sign off the pledge via email if they are happy to support it.** The question was raised with regards to becoming a Virtual MCP rather than a partially integrated MCP. It was confirmed that this was discussed at the February Development meeting and as it was signed off by the Primary Care Committee where there were no Conflicts of Interest. The recommendation will be agreed formally at the end of April, CoM and OneNorwich are aware and all parties are supportive of it.	**ALL**
21.	**Primary Care Committee Chair's Report**	
	IM presented the Primary Care Committee Chair's Report. GB noted the report.	
22.	**SIRO Report**	
	JIn presented the SIRO report to provide assurance in relation to the effectiveness of controls for Information Governance and progress of the CCG's IG Toolkit submission for 2017/18. The latest and target scores are outlined in the paper. The working group met just before GB and all targets have now been met and in some areas we have exceeded the targets. GB are asked to approve the embedded document. As members are unable to view the document it was suggested and agreed that GB delegated authority to the Audit Committee to approve this document at their April meeting. Governing Body agreed this suggestion. GB acknowledged Chrissy Jackson's hard work and the enormous amount of work that goes into this.	
23.	**Audit Committee Chair's Report**	
	PFi presented the Audit Committee Chair's Report, updated ToR and Risk Management Strategy Policy and Framework. GB were asked to approve both documents. GB approved both the ToR and Policy.	
24.	**Remuneration Committee Chair's Report**	
	PFi presented the Remuneration Committee Chair's Report and updated ToR. GB were asked to approve the ToR. The updated ToR were approved	
25.	**Conflicts of Interest Chair's Report**	
	PFi presented the CoI Chair's Report. CoI Mandatory Training is now available and should be completed by 31st May	

	2018. JC has trialled the three modules and made a recommendation to SMT who have agreed which staff groups need to complete modules two and three as essential to role as well as mandatory training. **ACTION: Links to be shared with staff and GB members**	**LD**
26.	**Governing Body Assurance Framework (GBAF)**	
	JC presented the GBAF, although this was not scrutinised at Exec Committee as the meeting was cancelled all risks have been updated by risk owners.	
FOR INFORMATION ONLY		
	Health & Wellbeing Board	
	The link to the Health & Wellbeing Board papers was shared for information.	

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair (on behalf of NHS Norwich CCG Governing Body)