WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

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West Leicestershire Clinical Commissioning Group
Minutes of the Public Board Meeting
Tuesday 11 July 2017, 13.30 – 16.30
Council Chamber, Loughborough Town Hall, Market Pl, Loughborough LE11 3EB

Present:

Professor Mayur Lakhani	Chair
Mr Toby Sanders	Managing Director
Dr Chris Trzcinski	Deputy Chair
Ms Gillian Adams	Lay Member
Mrs Angela Bright	Chief Operating Officer
Mr Ket Chudasama	Director of Performance and Corporate Affairs
Mr Spencer Gay	Chief Finance Officer
Dr Geoff Hanlon	Locality Lead, North Charnwood
Mr Ray Harding	Lay Member
Dr James Ogle	Locality Lead, Hinckley & Bosworth
Dr Nick Pulman	Locality Lead, North West Leicestershire
Dr Y B Shah	Locality Lead, South Charnwood

In Attendance:

Mrs Fiona Barber	Healthwatch Representative
Mrs Ruth Brutnall	head of Corporate Governance
Ms Alison Cain	Senior Nurse Qulaity
Mr Sandy McMillian	Assistant Director, LCC
Ms Carmel O'Brien	Chief Nurse, ELRCCG
Ms Yasmin Sidyot	Deputy Director Ugent Care
Ms Alison Moss	Committee Clerk (minutes)

Action

WL/17/129 Welcome and Apologies for Absence

Professor Lakhani welcomed all to the public Board meeting including 3 members of the public. Apologies for absence were received from Dr Mike McHugh, Dr Nil Sanganee, Dr Chris Barlow, Dr Peter Cannon, Mrs Tamsin Hooton and Mrs Caroline Trevithick.

Professor Lakhani confirmed the Board meeting was quorate with 12 voting members present.

Professor Lakhani asked Mr Sanders to update the Board on the report, CHC Settings of Care. Mr Sanders noted that since the paper had been circulated there had been further discussion between the three CCGs. Following the consultation and further reflection it was proposed to submit a revised set of recommendations. The recommendation would be to defer implementation pending an assessment of the potential impact of the policy.

WL/17/130 Declarations of Interest on Agenda Topics

The following declarations of interest were recorded:

WL/17/138 - LRI Front Door– All GPs: Declaration Only

WL/17/141 - Finance Report and Key Financial Risks – All GPs Declaration only
WL/17/142 - QIPP Delivery – all GPs declaration only

WL/17/131 To receive questions from the public

The Chairman asked Mrs Brutnall to read the two questions received from the public prior to the meeting. A written response would be made.

WL/17/132 Minutes of the meeting held on 13 June 2017

The minutes of the meeting held on 13 June 2017 were approved and accepted as an accurate record.

WL/17/133 Actions Arising from the meeting held on 13 June 2017

Members noted that all actions were either completed, or ongoing and an updated action sheet would be appended to the minutes.

WL/17/134 Chairman's Announcements

Professor Lakhani reported that the conference 'Making Things Happen' would take place on Thursday 13 July the focus would be on the implementation of policies and clinical pathways. The main areas for discussion were Home First, Urgent Care, Mental Health and a debrief form the Tiger Team. East Midlands Leadership Academy was supporting the event and 125 delegates had registered.

It was RESOLVED to:

- **RECEIVE** the above update.

WL/17/135 Managing Director's Communication

Mr Sanders presented paper C and noted that his role as Lead for LLR STP had been confirmed. He reported that following Mrs Bright's notice of retirement, Nicky Harkness had been recruited to the post of Director of Service Redesign and Integration and Mr Ian Potter recruited to the post of Director of Primary Care. Mr Sanders was seeking expressions of interest for the role of Deputy Managing Director with the interview scheduled for 15 August.

Mr Sanders noted that Mrs Cathrina-Reed was retiring and Mrs Waddington was moving onto to a new role with a CSU. Noting the departure of key personnel.Mr Sanders reassured the Board that the management team was aware of the risk and the next team away day would focus on transition and stability.

It was RESOLVED to:

- **RECEIVE** the update from the Managing Director.

WL/17/136 CHC Settings of Care: Consultation outcome and next steps

The Chairman introduced Ms Carmel O'Brien, Chief Nurse, who together with Dr Hilary Fox from ELRCCG had led, on behalf of the three CCGs, the review of the policy for Continuing Health Care.

Mr Chudasama introduced the report noting the policy concerned patients with complex care needs. It enabled those who were eligible for fully funded NHS Continuing Care to choose where they would be cared for providing that the cost of their choice of setting was not more than 25% higher than the anticipated costs of

the most cost effective care provision.

Mr Chudasama noted that the policy had not been applied consistently across LLR. The LLR CCGs were outliers nationally in relation to both the number of CHC packages of care and the cost of those packages when benchmarked against other CCGs. In March 2016 the Board had agreed, in principle, the revised 10% threshold and exceptional circumstances that should be applied subject to final approval on the consultation. Further reports were made to the Board in September 2016 and March 2017 on the consultation and process for review.

The report presented described the consultation process and the key findings.

Ms O'Brien highlighted the salient points from the report highlighting the robust consultation process. This had included an informed discussion with the public using a range of media and formal correspondence with the current recipients of care. She noted that professional advice had been sought regarding the length of the consultation process and it was decided to run the exercise for seven weeks. However, since the formal consultation period had ended, ELRCCG had continued to take comments and meet with the CHC Alliance to clarify points and give further consideration to what the CCG's would consider to be exceptional circumstances.

Ms O'Brien outlined the changes made as a result of the consultation including the discretion for exceptional cases, the application to existing patients and the notice period for changing a setting of care. Ms O'Brien said that the aim of the policy was to provide safe clinical care to enable patients to live independently within the constraints of their condition. She added that the policy would extend to those who were in the terminal phase of illness.

The application of the policy for existing cases was considered and it was intended to apply prospectively. However, having considered legal advice it was considered to be inequitable for new patients and the agreement was to review the package of care at an annual review. If an existing patient's needs had changed at the annual review then the revised policy threshold would be applied. If at the annual review the patient's needs had not changed then there would be no change to the care setting/funding.

Ms O'Brien said the CCGs engaged with a range of care providers for a variety of support packages and there was already a tried procurement process in place to test that providers' ability to provide care at the right level of quality and safety.

Ms O'Brien said that the introduction of personalised health budgets meant there was more flexibility in how care was secured. There were national guidlines to support the process.

Ms O'Brien addressed the notice period for changing a setting of care. There was a view that the patient should be given 28 days' notice of a change to their setting of care. Ms O'Brien noted the duty of the CCG was to ensure that the setting of care provided the right level of safety and there would be occasions when the patient's change in condition meant s/he should be moved as soon as practicable. It was therefore proposed to state that a minimum of seven days' notice would be given.

Ms O'Brien said that the policy had been reviewed by a senior barrister which confirmed that it complied with all the relevant legislation.

Ms O'Brien noted that CCGs had a duty to act in certain circumstances which may

be contrary to the patient's wishes regarding a setting of care, for example, following the death of a carer or where there was CQC enforcement action.

Ms O'Brien noted that, in exceptional circumstances there the CCG could fund continuing health care over the 10% threshold. This would be judged in the complexity of the patient's needs, circumstances, quality and safety.

Ms O'Brien referred to the points raised in the public's questions to the Board. She said that the policy was not reducing the package of care and that funding would continue at 100%. She said it was impossible to predict how many existing patients would be assessed as having a change in needs to prompt, at the annual review, a change in setting. She recognised that the panel process needed to be strengthened but there would remain a level of clinical judgement in relation to safety.

Dr Trzcinski said the policy affected the most vulnerable patients in the community, those with complex and difficult care needs. He noted that it was the CCG's role to make the best use of limited resources and in making a decision it had to balance quality against inequality. He considered that the current policy did not achieve that balance. He thought that the revised policy was fair and did address equity. However, the Board should consider the impact of the policy.

Mrs Barber acknowledged that it was a challenging paper and recognised the financial pressures on the CCG. She reflected that it addressed the needs of the most vulnerable patients with complex needs in primary care. However, she felt that more time was needed to understand the policy and clarify certain points.

Mrs Barber asked whether the policy only applied to people over 18 years of age. Ms O'Brien confirmed that was the case. Mrs Barber thought that should be explicit.

Mrs Barber asked whether the policy would apply to those patients who were partially funded. Ms O'Brien said that if patients were eligible they would be funded at 100%.

Mrs Barber had read the policy from the community's perspective and said the paper gave great emphasis to clinical safety but should acknowledge, to a greater extent, the importance of patient choice.

Mrs Barber reflected on the statement that the policy had not been applied consistently and asked what work had been done to review the application of the policy and why it had not been implemented consistently. She asked what the difference would have been if it had been applied consistently. Ms O'Brien said that it was difficult to assess due the legacy of the previous arrangements. The CCGs had recently re-procured the service and now MLCSU provided an end to end process.

Mrs Barber asked about how the 'anticipated costs' would be determined and what transparency there would be for the process. She also thought it would be helpful to provide examples of what would constitute exceptional circumstances. Ms O'Brien said that there was no national guidance on the matter and it would not be possible to give examples of exceptional circumstances; it would all come down to a clinical judgement regarding safety.

Mrs Barber asked if there was room for a lay member on the panel. Ms O'Brien said that the panel was chaired by an independent lay member and that the

panel's remit was LLR-wide.

Mrs Barber asked whether the policy could demonstrate greater transparency and be more patient friendly. Mrs Barber said she would email specific points to Mr Chudasama.

Mr Gay considered the policy to be reasonable as there was a need to control the budget. Dr Pulman referring to the revised recommendations, that had been tabled, asked what further impact analysis would mean. He thought that it should consider the impact on GP workload. Dr Pulman referenced a patient who was cared for at home and had the equivalent of an intensive care bed facility with his mother co-ordaining care. Had the patient been in a nursing home, Dr Pulman considered there would be a greater call on the GP's time.

He also asked whether the impact on the providers had been assessed and was there sufficient capacity within care homes to enable the change. The impact analysis should also consider whether the change would lead to increased hospital admissions.

Ms O'Brien said there needed to be executive level and GP involvement in a task and finish group to oversee the implementation.

Mrs Barber asked how the transfer of CSU from Arden GEM to Midlands and Lancashire would affect the policy. It was acknowledged that there was an impact and the start date had been put back whilst the service transitioned.

Mr Sanders supported the revised recommendations and said that they enabled the CCG to sense check the impact of the policy before its final approval. He said the recommendations should not be seen as avoiding a decision. The Board was supportive of the direction of travel but in agreeing the policy wanted to understand the potential impact. He noted that it was very difficult to retrospectively to assess the impact. He said that the time taken to undertake a further impact analysis would allow time for further dialogue with the CHC Alliance, Healthwatch, Motor Neurone Society and other support groups. He felt it was key that the policy was accessible to patients.

It was suggested that paper at paragrapgh 12.4 (domiciliary care) should provide reassurance that family members would not be pressurised into caring for patients at home.

Mrs Bright said it would be useful to have an outline of what the impact analysis would cover. Mrs Bright noted Ms O'Brien's comments regarding the period of notice to be given when the setting of care was to change. She felt that should be reflected in the policy as Ms O'Brien had explained it more clearly in relation to patient safety. Professor Lakhani said it would be useful to distinguish in this instance between emergency moves and planned moves. Dr Pulman thought that an emergency or crisis move should not be subject to a notice period.

Dr Hanlon cautioned the need to balance safety when the patient had capacity or had made a prior decision. Professor Lakhani said he knew of patients who had chosen to stay in their own home even though it was not safe. Dr Trzcinski added that the carers needed protection and that they could not be expected to work in an unsafe environment.

Mr Sanders noted there was need to update the current policy and the Board was committed to doing so. There would be the perception that the revised

recommendations were delaying the matter but that was not the case. He felt the impact assessment to be important and whilst it was impossible to be specific there needed to be an idea of scale. He also thought the policy could be finessed and a document presented to be read from the patient's perspective. Mr Sanders noted that there would be impact from the change in policy but that the CCG had a duty to consider the equitable use of NHS resources. He added that it was not an easy decision to take and that was why the Board should be as informed as it could be.

It was RESOLVED to:

- **RECEIVE** the contents of this report
- **NOTE** the feedback received through the consultation process and the thematic overview of the queries received
- **SUPPORT** key principle of updating the policy to ensure quality, safety and effective use of resources;
- **DEFER** the decision to approve a final policy until early 2018
- **AGREE** to undertake an impact analysis of the amended policy for new packages of CHC and for those individuals who will undergo a 3 month or annual review of their care package between 1st September 2017 – 30th November 2017
- **AGREE** to identify key agencies to continue engagement regarding the proposed policy and its implementation.

WL/17/137 Help to Live at Home – Lessons Learned Report

Mr McMillan introduced the report which updated the Board on the implementation of HTLAH. The report also summarized the lessons learned report presented to Leicestershire County Council's Adults and Communities Overview and Scrutiny Committee on 20 June 2017.

Mr McMillan noted that Leicestershire County Council was leading the re-procurement process and the award of contracts for the three outstanding lots was expected to take place at the end of July 2017.

Mr McMillan reported that Help to Live at Home had been operational for 7 months and the delivery picture was improving after a difficult start and the waiting times have reduced significantly. It had had a positive impact on the number of people waiting for their care to be arranged, which peaked over 300 people after the new service started and reduced to 39 on 29 June.

Mr McMillan noted that the implementation of the service was always going to be difficult especially with regard to the availability of the workforce in rural areas.

The contract would be awarded in lots and three lots are restricted because the provider, Hales Group, was subject to conditions set by CQC. There had been an inspection in November 2016 and Hales was deemed to be inadequate. There will be a re-inspection shortly and a further report will be published.

Mr McMillan referred the Board to the key lessons learnt outlined in paragraph 12 of the report. He added that it had been a large and complex programme involving different commissioning bodies. There was an Integrated Board but it did not have delegated decision making powers. The question arose as to how much partner agencies would be willing to delegate to integrated project boards.

One of the major impacts was the high number of people who opted for personal

health budgets and direct payments which was unexpected. A consequence of that was the uncertainty it created for providers regarding the level of take-up and planning staff resources.

Mr McMillan said that a recurring issues was the quality of the data and the difficulty in obtaining data from Arden GEM. He added that some providers were better than others in establishing the service and had good plans and contingencies in place. There was a need to understand the level of preparedness.

Mr McMillan concluded that overall the initial problems had been managed and it had been a successful programme.

Mr Chudasama asked how the lessons learnt would be taken forward. He also asked for an idea of the size of the problem and how much delay there had been. Mr McMillan said that the each delay was not too long, possibly one or two weeks, but cumulatively over the timeline of the project there was a significant delay. It took nine months to agree the S.75 agreement the local authority had signed the contracts without the agreement in place. Whilst that was a risk it was considered to be an acceptable and low risk.

Mrs Bright asked for WLCCG to be involved in the post implementation review. She also asked how the change in the service and the new emphasis on reablement would be quantified. Mr McMillan confirmed that the CCG would be involved in the post implementation review.

Mrs Bright said that it was a difficult market and it was difficult to get the providers which could deliver quality services with the capacity and flexibility needed. There had been an additional allocation to the Adult Social Care Grant which would support initiatives to increase capacity of the providers. The problems with the market were national and were not local. The number of staff required to stand still would be considerable and it was estimated there would be an 18% increase in demand before 2023 and the workforce was not available. There was concern that if restrictions were on placed on non-nationals there would be further staff shortages.

Mr Sanders picked up the questions raised by Mr Chudasama about taking forward the lessons learnt. He wondered if there had been the right governance structures in place. He wondered if the arrangements for transition and mobilization were right and there was a need to pay more attention to these phases.

Professor Lakhani said that report had been helpful.

It was RESOLVED to:

- **RECEIVE** this update on the HTLAH service and the lessons learned report.

WL/17/138 LRI Front Door Progress Report

It was noted that all GPs had declared a conflict of interest.

Ms Sidyot introduced the report on LRI Front Door. The report noted that the Board received a report in September 2016 summarizing the Vanguard Integrated Urgent Care model, which included a description of an integrated, primary care led model of streaming and urgent care at the LRI ED. The paper had sought approval for UHL to procure a primary care partner to deliver this model under a sub-

contract with the Trust.

Since that time, there had been some changes to UHL's thinking about the operation of the integrated ED and the role of primary care within that model. This was outlined in the report.

The CCGs and UHL had agreed that deflection into primary care/self-care would be a core part of the ED service model. It was agreed that CCG clinical leads and UHL leads would meet to agree the clinical approach to deflection. To achieve this, work would be overseen as part of the Urgent and Emergency Care workstream, reporting into the A&E Delivery Board.

There was a commitment from UHL to agree contractual incentives recognizing that primary care treatment in ED needed to represent value for money and to dis-incentivise growth in simple, non-urgent treatments. This would l include payment mechanisms and Key Performance Indicators for deflection and patients who were discharged from the assessment zone.

The next steps would be to finalise a protocol. The immediate plan was to run 'test days' with CCG clinical leads and UHL clinicians, supported by the UEC team, trialling processes for active deflection and using the learning to develop the final deflection approach. This would include work in the children's ED as well as adult ED.

Further work would include increasing the ability for UHL to directly book into a wider range of urgent care services, including WLCCG and ELR sites, as well as increasing the time range of appointments that were available. Work would be done to develop communications and signage to reinforce deflection and training for staff. There was the potential for a dedicated primary care co-ordinator role to support patients in accessing other services.

Dr Shah asked whether there the procurement process was in train. Ms Sidyot said not, as it was still in the testing phase.

Dr Shah noted a significant delay in LRI sending letters to GPs and some of those letters requested that GPs ordered further tests.

Mrs Bright said that the work on deflection was important and would need to be aligned to the local approach extending GP access. Ms Sidyot noted that there were some draft standards from NHS England which would be relevant to that discussion.

Dr Pulman noted the need to work with the GP IT group as there would be efficiencies in doing so.

Dr Hanlon said that local services needed to be more attractive to stop patients attending the emergency department.

Mr Sanders referred to the contract arrangements and thought there was a need to develop more insight and be more specific about the conditions. The contract should consider 'never events'. The premise should be tested with GPs and reported back. Meetings would be convened to review the contract arrangements and it was thought that Dr Ogle was to represent WLCCG. Mrs Bright thought that David Muir and Dr Hanlon should also be on the group and it should consider local issues in light of the Urgent Care Centre at Loughborough. Ms Sidyot agreed to check to membership of the group. **YS**

It was RESOLVED to:

- **NOTE** the contents of this report in respect of the LRI Front Door model and next steps

WL/17/139 Report on Committee Effectiveness Review

Mr Chudasama introduced the report which reflected on the annual review of the effectiveness of the Board's committees.

He noted that the survey conducted for the Audit Committee indicated there were no areas of concern although it was suggested there was insufficient visibility of the Committee to the Board. As a result it had been agreed to have a standing item on the agenda to consider items that should be escalated.

In respect of Finance and Planning Committee the results showed that the meetings were chaired effectively and there was positive engagement. There were concerns expressed about the overall quality of papers and late papers. The Committee had recommended a change to the terms of reference to remove the requirement for three of the four localities to be present in order for meetings to be quorate.

The Chair of Primary Care Commissioning Committee had instigated the review of that Committee and as a result key actions were agreed including standing items on the agenda.

In respect of the Quality and Performance Committee there had been a discussion regarding the overlap with PPAG and it was agreed to seek further clarity on the matter. The Quality and Performance Committee terms of reference were presented with a proposal to extend the remit to include Equality and Diversity.

The input of non-Board GPs on Quality and Performance Committee was valued and it was seen as a route for Board succession. Mr Chudasama proposed that the Board reconsider its decision to remove non-Board GPs from Quality and Performance Committee.

Dr Trzcinski said that he understood the suggestion regarding board succession but noted that the clinical leadership budget was under strain. Mrs Bright said that the money should be spent wisely and it was also used for clinical input into working groups. Mr Sanders noted that the budget had been trimmed in light of the decision made in February 2017 and if non-Board GPs were reinstated this would incur additional expenditure and mean removing clinical resources from other areas.

Dr Pulman noted the argument for succession planning did not hold when the non-Board GPs were locums as in the case of Dr Clode-Baker. The GP would need to be salaried or a partner if they were to join the Board.

In light of the budgetary constraints it was agreed not to reinstate the non-Board GPs to Q&P and PCCC. The non-Board GP role would remain on Finance and Planning Committee.

Mrs Bright noted that she had been tasked with providing clarity on NHSE/WLCCG performance management responsibility, the overlapping roles of Q & P with PCCC and PCCC's role moving forward with LLR changes in STP. She said that there was an important relationship between PCCC and IPCPB and that too

should be clarified.

It was noted that different approaches had evolved with regard to the committees reporting to the Board on their work. For some committees detailed reports were made whereas for other committees the minutes were presented for information only.

Mr Sanders said the paper had been useful in tidying up the current arrangements. However, there was an opportunity to consider joint arrangements for the future. He noted that there was the potential for a joint Q&P..

It was RESOLVED to:

- **RECEIVE** the report on the effectiveness reviews undertaken by the four committees.
- **NOTE** the actions in hand to address the findings
- **APPROVE** the changes to the Terms of Reference of the Finance and Planning Committee and the Quality and Performance Committee respectively.

WL/17/140 Board Assurance Framework

Mr Chudasama introduced the Board Assurance Framework which was updated at the end of July. The BAF delineated those collaborative risks which were managed by WLCCG and those managed by LCCCG and ELRCCG.

The principle for escalating risks from the risk registers to the BAF was that all risks with a net risk score of 12 or more were automatically recorded on the BAF. As a result further risks had been added and these were highlighted in paragraph 2 of the executive summary. Mr Chudasama asked it that was the right approach.

Mr Chudasama noted that other than the new risks, little had changed on the BAF and that some of the actions had been updated.

Mr Gay thought there was value in including the risks that scored 12 or more. He thought that the layout was not helpful and that risks managed by other CCGs should not be separated out as ultimately it was all the responsibility of WLCCG**.** Mr Harding agreed and said that all risks were pertinent to WLCCG and the difference would be in the mitigation of the risks.

Mr Gay said that the grid was a prominent way of recognising new risks and but where there was no change there should not be an arrow.

Dr Shah asked how WLCCG compared with other CCGs. Mr Chudasama said the risks were specific to WLCCG although there were commonalities across LLR CCGs. He added that he did not routinely look at other CCG's BAFs but there were some instances where there was collaboration, for example, the Information Governance Risk Register.

Mrs Bright said that when WLCCG considered benchmarking it thought of other health bodies and there was merit in looking at local authority practice.

Mr Sanders agreed with the principle of adding risks where the score was 12 or more but thought that some of them, including 037 and 039 needed more refinement. He thought the scope was too wide to assess the risk.

In respect of BAF/041 'Lack of plans in place to address performance improvement

on key metrics for work streams and organisations', Mr Sanders considered that the risk was not the lack of plans but that performance standards were not met. He thought the risk should focus on the desired outcome.

It was clarified in respect of 044 that the reference to Lincolnshire CAS concerned the ability of DHU to resource the service and that the description of risk should be revised.

It was suggested that the Information Governance be the subject of a deep dive and it was becoming more prominent. The categories of risk were cyber security and loss of equipment, research and compliance.

Dr Pulman noted that Information Governance underpinned a lot of initiatives and needed to be considered as an enabler. To ensure that people's data was safe there needed to be early engagement from information governance professionals.

Professor Lakhani said that that big data would be useful for commissioning and that the Caldecott report was not being implemented.

It was suggested that the CSU clarify its offer.

Mr Churton asked how the Information Governance Risk Register was managed and Mr Chudasama noted that it was a corporate risk register managed by CMT and in effect the risks were split between himself and Mrs Trevithick as the Caldicott Guardian. He noted that some of those risks, which were scored 12 or more, were on the BAF, e.g. mortality review. Dr Pulman suggested it would be helpful to understand the risk appetite of the CSU and that there was a need to assess the IMT risks.

It was RESOLVED to:

- **APPROVE** the latest iteration of the 2017/18 Board Assurance Framework.

WL/17/141 Finance Report and Key Financial Risks

It was noted that all GPs had declared a conflict of interest.

Mr Gay introduced the Finance and Key Financial Risks Report adding that WLCCG had reported its position to NHS England as set to deliver a small surplus. This would create a cumulative surplus of £8.88M in line with the requirement which needed to be retained.

Over the last two months the finance and contracting teams had been working to ensure budgets were fully understood and reflective of actual costs anticipated. Each line within the budget had been reviewed against implementation plans or contracts, with any anticipated QIPP or investments noted as contracted or not.
This has led to a number of small changes and there were recommended changes to the budget.

Mr Gay outlined the risks which included £2M for CHC, £6M QIPP schemes that were RAG rated red and £1M unidentified QIPP. This meant that as it stood WLCCG was £1M off plan. This had not been reported to NHS England as it was too early to say whether the plan was unachievable.

Mr Gay reported that at Month 3 there was an overspend of £660k. There were savings planned to take affect later in the financial year. However, as at the year to date, WLCCG was an outlier. He said that on a positive note WLCCG had a better

handle of information on activity including GP referrals into acute services which were significantly down.

Mr Harding noted that the next meeting of Finance and Planning Committee would be looking at Month 3 results and that Mr Gay had said the challenge would be significant for 2017/18.

The report noted that a saving of £400k was required from Primary Care Commissioning budget As a large part of that budget was not discretionary it represented a challenge. However, Mr Gay noted that in setting the budget WLCCG had agreed to put more money into primary care than was allocated and that it was not possible to increase it. It was asked whether the review of community based services would help achieve savings and it was thought not.

It was noted that at some point the financial situation would be subject to an NHS England escalation process which would increase the level of scrutiny.

It was RESOLVED to:

- **APPROVE** the changes proposed to budgets
- **NOTE** the risks to financial balance.

WL/17/142 QIPP Delivery

It was noted that all GPs had declared a conflict of interest.

Mr Gay introduced the report on the QIPP programme for 2017/18 which had a target of £18.127M. He noted the likely performance was RAG rated as follows red £6.1M, amber £5.5M and green £6.6M. The actions were being taken to mitigate the risks were listed in the report.

Dr Pulman noted that the report was focused on the savings but asked what attention was being given to changes in pathways that could increase costs. There was potential for more pressure on the budget.

Professor Lakhani noted there used to be a pot of funding for investment and innovation but there was no such support.

Mrs Bright cautioned on the need to ensure that existing schemes delivered as there was danger the focus would be dissipated.

Mrs Bright outlined that the Integrated Team workstreams had four separate projects: end of life, falls, cardio-respiratory, and integrated locality teams. She said that each one represented a significant work programme for service redesign.

The Integrated Locality Teams workstream had established a savings target which had been a guestimate. The schemes were judged to be amber. Mrs Bright noted the risk of double counting. The falls programme had identified savings and the end of life was reported to be on track. However, the cardio-respiratory programme was more complex and it was proving difficult to realize investment funding. Mrs Bright said it was a good example of a system deciding on change and supporting a clinical model but not being able to realize the funding for investment to affect change. What improvements could be made without investment funding were being considered. Mrs Bright said there was a need to review how savings can be made within the health system on joint initiatives.

Dr Pulman noted that the cardiologists were asking GPs to work outside their

contract and that it was reliant on the goodwill of GPs.

Mr Sanders said that the report was helpful but the position was concerning. He felt that the CCG had a better handle on QIPP schemes but it revealed a significant gap in achievements

It was agreed that the Board meeting in September should give more focus the QIPP deliver and financial position.

It was RESOLVED to:

- **RECEIVE** the QIPP report

WL/17/143 Arriva – Quality Report

Mrs Cain introduced the report on Arriva, the provider of Non-Emergency Patient Transport for LLR, which was inspected by CQC on 13 and 15 March 2017. Following a further unannounced visit on 27 March 2017 a Section 29 Warning Notice was issued under Regulations 13 (Safeguarding) and 17 (Good Governance). The full report was presented with a summary of the findings. Arriva had until 9 August to submit an action plan.

Arriva's contract would end on 30 September so WLCCG was working with Mid Nottinghamshire CCGs which had a contract with Arriva until 2019. The intention was to establish a joint oversight group which mid Nottinghamshire CCG would lead.

It was noted that there was of outstanding practice in relation to the approach of the staff towards patients. Mrs Bright said that it was positive that the staff would transfer to the new provider but that care should be taken to ensure the culture remained patient-centered It was noted that mobilisation meetings had already been held and the findings were useful to identify priorities and expectations.

Mrs Cain reported that the Quality Team would undertake a quality visit and the focus would be on the actions required.

It was RESOLVED TO:

- **RECEIVE** the Quality report.

WL/17/144 Assurance report from PPAG meeting on 15 June 2017

Mr Harding introduced the report of the PPAG meeting. He noted that Ambulance delays had risen when the new Emergency Department (ED) had opened and the 4 hours A and E performance had also deteriorated, to 80% in April.

There were issues relating to the financial performance and coding. The on-going dispute had been settled however the underlying issue relating to coding was unresolved.

PPAG had noted some improvements in the performance for cancer standards.

A Board to Board meeting referred to as 'Commissioner Quality Review' meeting had been arranged for 18 July 2017. The CCGs would be present together with representatives of NHS England, NHS Improvement and Health Education. A request had been made for a senior representative from UHL to attend.

A detailed review of PPAG would take place in August and recommendations

would be presented to the Board.

Mr Harding noted the continued performance failings on the part of IAPT and UHL which were of concern. There had been a contract performance meeting for IAPT and different options were being considered.

It was RESOLVED to:
• **RECEIVE** the assurance report from the Provider Performance Assurance Group.

WL/17/145 Performance Report

The report was deferred and Board members requested to provide any comments to Mr Chudasama.

WL/17/146 Areas of Focus for Future Board Meetings

Professor Lakhani advised that any suggested areas of focus for future Board meetings should be directed to Mr Chudasama, with a draft iteration of the agenda for the next circulated to members to review.

WL/17/147 Minutes of the Primary Care Commissioning Committee held on 18 May 2017

Members received for information, Paper N, the minutes of the Primary Care Commissioning Committee held on 18 May 2017.

WL/17/148 Minutes of the SLT meeting held on 18 May 2017

Members received for information, Paper O, the minutes of the SLT held on 18 May 2017.

WL/17/149 Any Other Business

No other business.

WL/17/150 Date and Time of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group will be Held on Tuesday 8 August 2017, 13.30 at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.