WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

A

Minutes of the Public Board Meeting
Tuesday 27 November 2018 at 13.30 – 16.30
WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ

Present:

Professor Mayur Lakhani	Chair
Ms Caroline Trevithick	Interim Accountable Officer
Mr Steve Churton	Deputy Chair Lay Member
Ms Gillian Adams	Lay Member
Mrs Wendy Kerr	Lay Member
Mr Ket Chudasama	Director of Performance and Corporate Affairs
Mr Spencer Gay	Chief Finance Officer
Dr Mike McHugh	Public Health Consultant
Dr Nick Pulman	Clinical Vice Chair
Dr James Ogle	Locality Lead, Hinckley & Bosworth
Dr G Hanlon	Locality Lead, North Charnwood
Ms Tamsin Hooton	Director of Urgent Care
Dr Nil Sanganee	Locality Lead, North West Leicestershire
Dr Umar Abdulmajid	Locality Lead, South Charnwood
Dr Ash Kothari	Locality Lead, Hinckley and Bosworth
Dr Rowan Sil	Locality Lead, North West Leicestershire
Mr Ian Potter	Director of Primary Care

In Attendance:

Ms Louise Guss	Interim Head of Governance
Mrs Michele Morton	Senior Committee Clerk (minutes)

Action

WL/18/188 Welcome and Apologies for Absence

Professor Lakhani welcomed all to the September meeting of WLCCG Board. Apologies for absence were received from Mrs Rita Patel who would be acting as the new Healthwatch Board representative.

The Chair noted that the meeting was quorate with 13 voting members. Two members of the public were present.

WL/18/189 Report from Conflicts of Interest Screening Panel held on 11 September 2018

Mr Churton gave a verbal update on the above that included:

- **WL/18/198 - Approved Referral Pathways** - All Board GPs, declaration only
- **WL/18/199 - Federation QIPP Update** - All Board GPs, declaration only. No delegation required to the Procurement and Investment Committee as a delegation was already in existence
- **WL/18/200 - Finance Report** - All Board GPs, declaration only
- **WL/18/209 - Report from Remuneration Committee 13th November 2018** - Caroline Trevithick declared an interest and absent for the item. CMT members declared an interest only.

It was RESOLVED to:

- **APPROVE** the update from the Conflict of Interest Screening Panel and

recommendations for how the conflicts of interest identified should be managed.

WL/18/190 To receive questions from the public in relation to items on the agenda

Professor Lakhani reported that two questions had been received for the Board as follows:

Question from Mr Paul Ackroyd, Voluntary Action Leicester - 'There was a firm evidence base for social prescribing. The voluntary and community sector across West Leicestershire were committed to working in partnership to develop social prescribing building on a successful pilot managed and delivered by Voluntary Action Leicestershire in 2015. What were the Board's short, medium and long term plans for social prescribing ?'

Answer: It was noted that the CCG had successfully piloted a social prescribing scheme that was discontinued for financial reasons, however that would be revisited should the opportunity arise. Dr Sil added that social prescribing benefitted patients hugely and ways should be sought on how to continue. Dr Abdulmajid added that integrated volunteering was a good way forward for encouraging people to become involved in progressing schemes and that should be actively signposted.

Some of the social prescribing ethos was being continued through signposting in practices, to signpost patients to appropriate community services and organisations.

Ms Hooton said that following a recent Public Health presentation it was realised that social prescribing was also being channelled through the prevention programme. She added the CCG should also look at better ways of the use of community resources. Some good examples had emerged from the King's Fund where PPG representatives were involved in engaging with local people via GP practices.

During 2018/19, the CCG had been working closely with member practices to support the development and rollout of Active Signposting, one of the ten High Impact Actions in the General Practice Forward View. Working to agreed protocols reception teams might direct patients to the most appropriate source of advice or help. The approach potentially had the dual benefit of freeing up GP time and helping patients to be signposted to the right help.

Going forward the CCG would continue to work with practices to support the development of active signposting and bring benefits to more patients and practices. The NHS England Ten year plan due to be published in December was likely to include a greater focus on prevention and might provide more opportunities to build on the progress made with Active Signposting and develop that model further.

Across LLR there were a range of existing community based services, which were provided by agencies and voluntary sector groups and focus on prevention and wellbeing. Each integrated locality team would advise patients, carers and their families what was available in their area. This included referrals into First Contact Plus, delivered by Leicestershire County Council in partnership with GPs, the police, health organisations, social care departments, district and borough councils and voluntary groups. This would support people accessing support and information on housing, health, living independently, money advice, work, security

and a range of other topics to promote improved health and wellbeing.

Question from Kate Mocelutu – when would you allow prescribing/access to the Freestyle Libre sensor for Type 1 Diabetic patients in Leicestershire and end the discrimatory post code lottery that existed across England? Had due consideration been given with regard to the RMOC advice?

Answer: a policy decision had been made by NHS England that this was a product that should be made available to the public. Agreement had been reached in principle for implementation and this would be decided at the December Clinical Commissioning Board meeting.

WL/18/191 Minutes of the meeting held on 11 September 2018

The minutes of the meeting held on 11 September 2018 were approved as a correct record

It was RESOLVED to:

- **APPROVE** the minutes of the meeting held on 11 September 2018.

WL/18/192 Matters Arising from the meetings held on 11 September 2018 and action log

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

It was RESOLVED to:

- **RECEIVE** The Action Log

WL/18/193 Chairman's Announcements

Professor Lakhani reported that work continued:

- On collaborative working and weekly meetings were being held on the proposals for a single accountable officer and JMT. Documentation was currently under preparation for the Board meeting planned for 11th December 2018.
- Development of the WLCCG by team building and development of a strategy.
- With the SLT, UHL and LPT on clinical leadership and attendance at a 'making things happen' conference looking at an approach on positive risk and learning from patient stories.

It was RESOLVED to:

- **NOTE** the above

WL/18/194 Interim Accountable Officer's Report

Ms Trevithick presented paper C that summarised the latest CCG news, developments, upcoming events, national guidance and policy updates. The following highlights were noted:

Staff Engagement – development of a programme in response to feedback received from staff on a range of issues impacting on working at the CCG
BCT events – LLR partners had held seven of nine public events in Leicester, Leicestershire and Rutland to talk about the proposed improvements to NHS services and shared the plans for the hospitals and maternity services in

Leicester. Ms Trevithick thanked Board members who attended and contributed to the events.

Supporting doctors mental health - NHS chief Simon Stevens recently announced a new mental health support scheme to cover all doctors working in the NHS.

Extra support for GPs this winter - The Winter Indemnity Scheme would be used to cover the costs of professional indemnity for the extra services provided by GPs, giving them the freedom to work extra sessions securely and without extra costs

Practitioners health programme – now extended to all doctors and nurses

It was RESOLVED TO:

- **RECEIVE** the Managing Director's Report

WL/18/195 WLCCG Governing Body Development Session Summary Report

Ms Trevithick presented paper D which summarised the discussions and actions following the WLCCG Governing Body Development session held on the 13th November 2018. One of the aims of the session was to acknowledge the new membership of the Board to agree a number of objectives. The agenda also included time to focus on the planning requirements, primary care delivery, future governance arrangements and the CCG values.

It was agreed to add to the action list:

- Financial Efficiency
- Support Staff Engagement and OD
- Empowerment of neighbourhoods **CT**

The CCG would then be tested against the actions for next year. Ms Trevithick said the actions would be shared at the next staff briefing on 5th December 2018. **CT**

Board members noted that Mr Chudasama would be taking forward the development of future governance arrangements. Work was required to determine what that included and what would be communicated more widely. Dr Pulman asked for specific reference around engagement with neighbourhoods and engagement with federations and localities be included in future governance arrangements. **KC**

Ms Trevithick reported that the CCG had a robust engagement plan and it would be important to factor in to that, aspects of patient centred care, work happening in primary care and the digital patient function. The agreed priorities would then shape future CMT discussions and clinical lead meetings.

Dr Sanganee proposed the nomination of a 'Self-Care Lead' in each locality and asked that the word engagement be added into the planning section. Mr Chudasama agreed and added self-care and improved use of IMT should be part of each of the STP workstreams, particularly the use of APPS as part of that process. **CT/KC**

It was RESOLVED to:

- **APPROVE** the WLCCG Governing Body Development Session Summary Report subject to the above amendments.

WL/18/196 LLR System Resilience in Winter 2018/19

A presentation was given by Mr Mike Ryan, Director of Emergency Care with the following points.

- Introduction: patients were living longer: intense pressure being experienced in 2018/18
- A reflection of 2017/18
- 2018/19 escalation, response and resilience – system approach for managing winter pressure – 5 key priorities
- What was different in the current year and connectivity for operational group
- Ambulance handovers – attendances/admission avoidance – UEC demand management/A&E trends
- Ensuring safe care- hospital flows, capacity planning, functionality
- Post hospital/discharge – integrated discharge model

Dr Pulman commended the presentation but felt it lacked content on the response of primary care, how primary care was affected by increased demand and how that demand was handled. He added the Transferring Care Safely Group work also did not align with work carried in ED, for example people discharged on a Sunday often tried to see their GP on a Monday which was the busiest day in any surgery. He said patient flow back into primary care should be more appropriately mapped.

Ms Trevithick said the presentation was helpful and asked from an A&E Delivery Board perspective how many of the initiatives were embedded and implemented and would make a difference in the forthcoming winter, or whether some initiatives were still being tested out. Mr Ryan replied initiatives were already in place for demand management (since May and June 2018) and it would be important to establish what impact they were having. An emergency dashboard had been developed to show what was working. Some of the initiatives yet to be embedded might help with Dr Pulman's comments on patient flow.

Dr Sanganee said the EMAS conveyancing issue was due for review and asked if GPs were notified if patients accessed other means of transport due to EMAS delays. Mr Ryan agreed one of the most important things was to ensure that messages were accurate. Ms Hooton added this would be linked in and explored further with the acute visiting service. Dr Abdulmajid said discussion on the acute visiting service had taken place at localities and the reason for de-utilisation was due partly to difficulty of access. Patients were waiting up to half an hour for a response so were gaining no benefit from the service.

Dr Abdulmajid said NHS 111 was under-staffed (partially due to recruitment difficulties) and waiting times stood at between 20 minutes and two hours for a call back. Patients were therefore accessing other services which created further pressure in primary care.

Mr Potter referred to the federation QIPP and the focus on non-elective care. He said one of the key issues was data triangulation and analysis of what the data was revealing within a clinical context. This would be an important piece of work going forward. He also said a presentation on self-care initiatives had been given to a recent PPG network meeting where the group were unaware of some of the initiatives and an action had been agreed to improve communications.

It was RESOLVED to:

- **RECEIVE** the presentation on Winter Resilience

WL/18/197 Emergency Preparedness, Resilience and Response Compliance with Core Standards

Mr Ryan presented paper F and explained that the NHS England Core Standards for emergency preparedness, resilience and response (EPRR) set out clearly the minimum EPRR standards which NHS Organisations and providers of NHS-funded care must meet. He added that the Core Standards would also enable agencies across the county to share a common purpose and to co-ordinate EPRR activities in proportion to the organisation's size and scope; and provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

Board members noted:

- the purpose of the EPRR Annual Assurance Process was to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards.
- the core standards had been submitted to a recent CCB meeting for a virtual sign off.

Mr Chudasama confirmed to Ms Trevithick that the CCG position was similar to the previous year.

It was RESOLVED to:

- **APPROVE** the EPRR

WL/18/198 Approved Referral Pathway Policy

All GPs declared an interest in WL/18/198.

Paper G, presented by Mr Chudasama provided WLCCG with an update on the development of the Leicester, Leicestershire and Rutland (LLR) Approved Referral Pathways Policy (ARP), formerly known as Procedures of Limited Clinical Value (PLCV). The paper specifically covered:

- Feedback from the public and clinical engagement undertaken in August and September 2018
- The next steps in the implementation of the Approved Referral Pathways
- Presentation of the final ARP policy document complete with EIA and QIA for approval by WLCCG Governing Body

The public and clinical engagement took place over a five week period, ending 26th September 2018. The purpose of the engagement was to gather opinions on the pathways. The feedback would help to:

- Educate people about planned care services and highlight the existing, new and proposed changes to 101 of the policies
- Listen to any concerns about any of the policies and make any amendments or adjustments where possible
- Allow the CCGs to determine whether people were generally in support of the policies before any changes were made
- Understand any impacts on the changes so that they could be addressed or mitigated

Feedback from patients, carer's and the public via the survey and the events had been broadly positive and none of the comments received had impacted on the

policies presented.

The engagement document was presented and discussed at the Joint Health Oversight and Scrutiny Committee in September 2018. Feedback included comments on:

- How the policies affected people covered by the protected characteristics groups
- Consideration on how engagement included speaking to patients who were already on a treatment pathway and the impact they believed the relevant policy would have on them
- Review of the language used to describe certain clinical specialities

A paper was submitted to the CCB in October 2018, for noting. The paper provided an update on the engagement process. One comment had been received regarding the low public response rate.

Board members noted that NHS England had also undertaken consultation on 17 interventions. Timelines, conclusions and recommendations were still awaited from them.

Professor Lakhani commended Mr Chudasama and his team on the significant amount of work carried out surrounding the ARPs which had also had clinical engagement.

Mrs Kerr questioned why the policy name was changed from procedures of low clinical value as she felt people understood that term more clearly. Mr Chudasama replied that for the people who met the criteria and undertook treatments, low clinical value might be considera a derogatory term. To those patients the treatment would be considered high value.

Ms Trevithick said it would be important to use the agreed four tests to help strength the decision making process and assist with conversations with the public around how conclusions were reached. She confirmed to Professor Lakhani that patient choice would still apply if patients met the appropriate criteria.

A brief discussion was held on the volume and complexities of the procedures and the problems that might cause for GPs. Mr Chudasama explained that there were a number of mechanisms planned to help with access:

- If a Referral Support System was established that would help with compliance with the policies when patients were being referred.
- The policies would be placed on WLCCG Website which would provide a simple route via a link to each speciality where a policy existed.
- Policies would be placed on PRISM (ensuring PRISM templates adhered to the requirements), together with appropriate links. Dr Pulman felt there was a possible case for a separate PRISM form which would include all of the policies in one place.

Dr Hanlon asked if any communications were sent out that the term ‘formerly PLCV’ be added as this would help doctors to identify what they were looking for.

Once approved by all Governing Bodies, the pathways would go live” from 1st December 2018.

It was **RESOLVED** to:

- **APPROVE** the Referral Pathways

WL/18/199 Primary Care Implementation Plan Update (Federation QIPP Update)

All GPs declared an interest in WL/18/199.

Mr Potter presented paper H that provided an overview of and an update on the work undertaken to develop a Primary Medical Care Implementation Plan to support the effective commissioning of services in 2019/20. The paper had been informed by and included reference to the CCG Board time out that took place on 13th November 2018, namely:

- The challenges facing the NHS.
- The system vision of moving from hospital centric to primary and community care, and the importance of general practice to that vision.
- The challenges facing general practice and the associated impact.
- Gaps in commissioning and the actions general practice was required to implement as part of the system vision.

The report also looked at the priority areas and outcomes and all of the resources at the disposal of the CCG. Work continued on the 2018/19 QIPP scheme and Dr Sanganee added that work was also linking up to ensure a fit with the 2019/2020 QIPP scheme.

Ms Hooton said the approach to the plan in the report was very clear and helpful, and she stressed the importance of recognising the interdependencies and ensuring over the next six months the final scheme that WLCCG was the appropriate one. Mr Potter replied a mapping exercise had taken place to look at the system requests for the different areas and recognising work to be done around engagement and that interdependencies were established. This also linked with work being carried out to align the plans with other CCGs.

It was RESOLVED to:

- **RECEIVE** and **NOTE** the contents of the report.

WL/18/200 Finance Report

All Board GPs declared an interest in WL/18/200.

Mr Gay presented paper I and reported the financial position of the CCG was currently showing an overspend of £0.7 million at the end of month 7, with the possibility of facing a £3 million risk in terms of achievement of the financial targets at the year end. Further key points included:

- The CCG was still forecasting a break even position. Risks had been scrutinised at the recent Board Development Session and the Finance and Planning Committee and ongoing conversations were being held with NHS England.
- Should the CCG reach a point of projected non achievement of the financial targets, it would be declared as soon as possible.
- A local Finance Recovery Group and LLR group met regularly to identify ways of improving the financial situation.
- Confidence remained high on the forecast QIPP delivery.

Mr Gay reported that conversations had been held with the PPG group recently on how to most appropriately publish the challenging financial messages. Often huge injections of funding at national level were not realised at CCG level. If the CCG

received the same level of growth funding next year it would mean 0.5% more growth which would equate to approximately £2 million (a lack of growth had been experienced over the previous seven years).

It was RESOLVED to:

- **RECEIVE** and **NOTE** the contents of the report.

WL/18/201 Quality Report

Ms Adams presented paper J that updated Board members on key items that related to quality since the last committee meeting in September 2018 and that included:

- A deep dive of the Q and P risk register that focused on the EMAS risks and Safeguarding – the overall risk ratings were considered appropriate. Q&P members noted in particular the high risk around domestic abuse and violence due in part to lack of regular feedback at MARAC causing disappointment on the lack of progress.
- Focus on out of area trust performance – Q&P members were cited on some common themes.
- Approval of LLR Rebate Policy Review
- Approval of medication rebates Approval of Patient Group Directions (PGDs)
- A discussion on RTT A&E Cancer wait times took place and surprise was expressed at the difficulties the lack of one or two consultants made. The Committee also noted that there were 78 clinical oncology vacancies nationally.

Mr Gay referred to the ARP standards and investment by EMAS and asked if any discussion had been held around the vacancy issue and how it should be handled. Ms Trevithick replied conversations were held at PPAG where it was felt it would be beneficial to work with other East Midlands colleagues on what had improved or otherwise since the additional investment, with a recognition of the workforce challenges faced. Mr Gay agreed to pick the issue up with the contracting teams. **SG**

It was RESOLVED to:

- **RECEIVE** the Quality Report

WL/18/202 Provider Performance Assurance Group (PPAG) Summary Report for September 2018

Ms Trevithick presented paper K, a report from PPAG; a meeting held in common of the 3 Leicester, Leicestershire and Rutland CCGs. The report provided the Board with assurance about the arrangements in place to collaboratively monitor the contracts and performance of the CCG key providers. Key points of note:

EMAS – PPAG noted that activity had continued to fall since March 2018 but was consistent with pre-winter activity levels.
NEPTS – in respect of discharge there had been a significant increase in the number of aborted discharge journeys resulting in a financial implication for CCGs.

Dr Pulman felt the PPAG was a well-meaning group on the outcomes of performance but had little influence to enact any changes.

It was RESOLVED to:

- **RECEIVE** the PPAG Summary Report for September 2018

WL/18/202a PPAG Summary Report for October 2018

Ms Trevithick presented paper Ki, a report from PPAG; a meeting held in common of the 3 Leicester, Leicestershire and Rutland CCGs. The report provided the Board with assurance about the arrangements in place to collaboratively monitor the contracts and performance of the CCG key providers. Key points of note:

EMAS – had achieved two trajectories but those were based on a small number of patients. Overall EMAS was not meeting its targets.
Workforce Issues – PPAG noted that all LLR providers currently had some workforce challenges that needed to be addressed in order to be able to deliver the effective service across those areas.

It was RESOLVED to:

- **RECEIVE** the PPAG Summary Report for October 2018

WL/18/203 Performance Report

Mr Chudasama presented paper M that outlined all WLCCG performance indicators and the Provider Performance Assurance Group (PPAG) summary report for performance across the collaborative contracts, and the respective providers' performance. He reported that the CCG had met with NHS England to discuss the performance and recovery of those standards, which would have a significant impact upon the CCGs annual assurance statement (performance component). The key constitutional standards and targets under risk of non-achievement included:

- IAPT (also discussed at Q&P on 20th November 18 and PPAG on 25th Oct 18)
- Cancer waiting times (also discussed at Q&P on 20th November 18 and PPAG on 25th Oct 18)
- A&E 4 hour wait (also discussed at Q&P on 20th November 18 and PPAG on 25th Oct 18)
- Ambulance response times and handovers (also discussed at Q&P on 20th November 18 and PPAG on 25th Oct 18)
- Referral to Treatment times and Diagnostic Waits (also discussed at Q&P on 20th November 18 and PPAG on 25th Oct 18)
- Appendix A supported the requirement of NHS England & NHS Improvement to routinely report numbers of more than 62 days and more than 104 days breaches and outcomes, learning themes & harm reviews.

He referred Board members to the helpful diagram on page five that showed that the RTT position had started to reduce. Compared to the 2017 position, 2018 still remained significantly high and had not recovered from the elective pause earlier in the year. Engagement with the independent sector was ongoing to ensure appropriate deflection from UHL to help with capacity problems. The level of transfer was expected to be between 400 and 450 patients, and instead had been between 70 and 80. Reasons for that were being investigated through the contract route. The position was challenging for the CCG in delivery against the RTT target.

Mr Chudasama explained to Mrs Kerr that decisions would need to be made around the cost of achieving the RTT target of 92%. The CCG was currently looking at the size of the waiting list and the cost of delivering the backlog and that information would inform discussions as part of the planning process. Ms Hooton added that discussions between the three CCGs had taken place on how to treat

waiting times as part of next years planning round. Mr Gay said because of the scale of the financial and activity gap a more strategic debate would be necessary to determine what was possible. Mrs Kerr agreed discussion needed to be collective to avoid postcode treatment. RTT was currently a bigger problem for WLCCG than the other two CCGs.

It was RESOLVED to:

- **RECEIVE** the Performance Report.

WL/18/204 Board Assurance Framework (BAF)

Mr Chudasama presented paper M and reported that the BAF had been reviewed and updated to show the latest position as at the end of quarter 2 2018/19. The BAF contained risks to the achievement of strategic objectives for the year, plus other risks escalated from the constituent risk registers where there was an inherent risk rating of 12 or more. Further key points:

- Despite a small reduction in the number of risks appearing on the BAF, Q2 had seen an increase in the number of risks relating to quality/service specific concerns and system provision. While there had been a small reduction in the number of BAF risks relating to finance, resulting predominantly from combining some existing risks as opposed to a reduction in overall risk.
- Consideration of the recent 360 Assurance Benchmarking report *'Governing Body Assurance Frameworks: Benchmarking Exercise – Clinical Commissioning Groups'* across 29 CCGs in the Midlands and Yorkshire demonstrated that the risks appearing on the West Leicestershire BAF were not uncommon in both subject and average score.

In relation to the quarterly deep dive Ms Trevithick said that function was currently delegated to the Quality and Performance Committee and she asked if the Board was confident of that process. She welcomed suggestions from Board members on future areas of focus.

Mr Chudasama said the results from the survey last year on the effectiveness of the BAF were quite positive and he was aware there had since been some new GP members. Mrs Kerr the new Finance Lay Member said she had compared the BAF with the content of the Board agenda items and the two appeared to be consistent. Mr Churton added if both the Quality and Performance and Audit Committees were scrutinising relevant risk areas then that was an appropriate delegation and should not be duplicated by the Board.

Dr Sanganee pointed out one recurring theme through Board discussion was the issue with workforce and he asked if that was being taken any further by the whole Health economy. Mr Chudasama replied that issue would evolve at the same pace as collective working arrangements and would form an integral part of strategic priorities.

A discussion was held on the correlation between workforce and early cancer diagnosis. A recent report gave evidence that Leicestershire was performing less well in capturing 30 – 40% of patients with vague symptoms that needed a confirmed diagnosis. Dr Pulman also emphasised the importance of cross referencing the different workforce issues, for example the IMT group were looking at the ability to order tests and that required the support of a Q&P deep dive. Ms Trevithick agreed it would be beneficial to reflect the issue between workforce and cancer targets and within that context it was agreed to invite local cancer lead Dr Ben Noble to a future Q&P meeting to see how that might fit with the planning process. Mr Gay also reminded Board members of the importance of feedback to **CT**

the cancer workstream.

Professor Lakhani suggested practice profiles should be reintroduced to support early cancer diagnosis. Mr Potter agreed and added practice profile data and how it was being used for clinical discussion was currently under review. Dr McHugh reminded Board members that could be quite labour intensive and one area of value would be to include late diagnosis as part of SI reporting in primary care.

It was RESOLVED to:

- **APPROVE** the Board Assurance Framework

WL/18/205 Conflict of Interest Policy

Mr Chudasama presented paper N and reported that 360 Assurance had reviewed the CCG's Conflict of Interest Policy as part of their annual review of the CCG's arrangements for the management of conflicts of interest. He added the review identified that a number of areas outlined within NHS England's statutory guidance document required inclusion, and these had been addressed.

Subject to members' approval of the amendments outlined in the main paper, the revised Conflict of Interest policy would be published on the CCG's website and would be issued to all staff members via internal communications.

Mr Chudasma reported that the Conflict of Interest policy had been received at the Audit Committee on the 27th November where minor changes to the contact details had been suggested and would read 'The CCG's Conflict of Interest Guardian could be contacted direct at any time in person at the CCG's office or via the following email address: enquiries@westleicestershireccg.nhs.uk '

It was RESOLVED to:

- **APPROVE** the Conflict of Interest Policy and the Audit Committee suggestion on contact details.

WL/18/206 Risk Management Strategy and Policy

Mr Chudasama presented paper O that set out how the CCG would identify, assess, quantify and manage risks in relation to its own operations. The strategy had been reviewed as part of the routine cycle of policy review, and the revised strategy was presented to the Board for approval.

While the fundamental principles of the policy remained unchanged, the strategy reflected a number of changes made to ensure it continued to reflect updated legislation, good practice, post changes and to incorporate recommendations which had arisen from the internal audit and assurance work. The key changes included:

- Amendment to reference the Data Protection Act 2018 and GDPR.
- Changes to replace 'sub-group' references to 'Committees'.
- Amendment of the job title of the Director of Performance and Corporate Affairs (throughout) and to the change of CSU support in Information Governance

The Audit Committee had reviewed the Risk Management Strategy and Policy and at that meeting Ms Guss had assured members the review date could be reconsidered should there be an earlier move towards collaborative working.

It was RESOLVED to:

- **APPROVE** the Risk Strategy for 2018-20

WL/18/207 Committee Terms of Reference Review

Mr Chudasama presented paper P and reported that NHS England had recently reviewed and approved the CCG's revised constitution. As part of that review they identified areas for consideration in some Terms of Reference, as follows:

- Audit Committee
- Quality and Performance Committee
- Primary Care Commissioning Committee

In addition, additional Terms of Reference had been reviewed for operational purposes. Changes had been approved by the affected committees and Board approval of those changes was required.

Ms Trevithick clarified for the Quality and Performance terms of reference that the membership list should include 2 Locality Leads and not 1 as stated.

It was RESOLVED to:

- **APPROVE** the amendments to the Audit Committee Terms of Reference
- **APPROVE** the amendments to the Quality and Performance Committee Terms of Reference
- **APPROVE** the amendments to the Primary Care Commissioning Committee Terms of Reference

WL/18/208 Amendment to the Financial Scheme of Delegation

Mr Gay presented paper Q and reported that following the appointment of Caroline Trevithick as the CCG's Managing Director, taking over from Toby Sanders, the number of people who could approve invoices up to values of £5 million had now fallen to just one (Tamsin Hooton). This was because the post of Chief Nurse & Quality Lead had fallen vacant, and that of Director of Service Redesign & Integration remained vacant since the departure of Nicky Harkness. It was therefore proposed that the post of Director of Primary Care be added to the relevant line in the Financial Scheme of Delegation (s.8), so that part (d) read as follows:

Up to £4,999,999 - DSRI or DUEC or CNQL or DPC

The change would provide additional flexibility in invoice approval so that no payments were 'held up' in times of the unavailability of senior staff.

It was RESOLVED to:

- **APPROVE** the proposed change to the Financial Scheme of Delegation

WL/18/209 Report from Remuneration Committee Meeting held on 13th November 2018

Ms Trevithick left the room for item WL/18/29.
Mr Chudasama, Ms Hooton, Mr Potter, Mr Gay all declared an interest in item WL/18/29.

Mr Churton presented paper R and informed the Board that on the 13th November 2018, the Remuneration Committee met in order to consider proposals for the remuneration of Caroline Trevithick, the new Interim Accountable Officer. He added that discussions took into account NHSE/NHSI advice, CCG remuneration guidance, the Hutton Fair Pay Review, benchmarking data, the process for offering

a salary in excess of the cap set by NHS England (currently £150,000) and the salaries of ELRCCG and LCCCC AOs.

Following discussion, the Remuneration Committee had agreed a recommendation upon remuneration for the Board's consideration.

It was RESOLVED to:

- **APPROVE** the recommended remuneration level is proposed to fall within the band £110,000-£115,000 per annum (inclusive of on-call payment) with a notice period of 6 months.

Ms Trevithick rejoined the meeting.

WL/18/210 Report from the Audit Committee held on 25 September 2018

Mr Churton presented paper S and informed Board members that the CCG's Audit Committee had met on the 25th September 2018 and received a paper proposing removal of the Joint LLR STP Governance Audit from the Audit Plan 2018/19. Following discussion it was agreed to escalate a specific issue to WLCCG Board regarding the timescales around that audit.

Mr Churton explained that an internal audit plan was received by the Audit Committee at its March 2018 meeting. The plan included a joint audit for LLR on STP Governance arrangements, which was deferred to Q1 2018/19 as the scope had not yet been agreed. Each CCG had allocated approximately 10 days in their internal audit plans for a two stage audit. The following two points were noted:

- Following discussions at its meetings in April, May and June 2018 the SLT discussed and agreed to commence its own STP governance review. However, following receipt of a paper proposing a timescale for the work in July 2018, it was agreed that the review would not commence until the conclusion of an SLT away-day, to take place during September 2018 or shortly thereafter. As a consequence of that, the heads of governance from WLCCG, ELRCCG and LCCCGs were of the view that the joint LLR STP audit should be removed from the audit plans in order to avoid duplication of activity and that the surplus days in the CCG individual 2018/19 plans be used for other pieces of work.
- The Committee acknowledged that forthcoming changes in the STP leadership might create delays however Audit Committee members were informed that the review had not yet commenced which they felt posed a risk that it might not happen at all. Audit Committee members noted that STP governance arrangements were established and that the governance system was rated as 'advanced' last year by NHS England and NHS Improvement but noted that it had not been tested which was important in order to identify any fundamental flaws or risks.
- Audit Committee members agreed that the joint LLR audit be removed from the audit plan however due to their concerns regarding the timely completion on the STP's own review requested that the issue be raised at Board level in order that Board members were made aware of the situation.

Ms Trevithick referred to the SLT away day held in September 2018 where it was felt an audit review might not be necessary. Following a conversation at the last SLT meeting it had been agreed that a review in some form would still take place, possibly with a broader number of people such as the inclusion of lay members from provider organisations. Mr Gay emphasised the importance that collective governance arrangements were correct and that the SLT was carrying out their

responsibilities as expected. Mr Churton said the original audit should be added to the Audit Plan for next year following the possibility of an internal audit prior to that. **KC**

Professor Lakhani asked what the opinion of the other two CCGs were and Ms Trevithick replied the fact that a development session had been held on how the SLT worked was an admission of the need for improvement. She added that a plan had been established, together with a review process going forward.

It was RESOLVED to:

- **NOTE** the report of the Audit Committee on the meeting held on 25th September 2018

WL/18/211 CCB Summary Report, September 2018

Paper T, the CCB summary report for September 2018 was received for information.

WL/18/211a CCB Summary Report, October 2018

Paper Ti, the CCB summary report for October 2018 was received for information.

WL/18/212 Minutes of the SLT meeting held on 16th August 2018

Paper U, the minutes of the SLT meeting held on 16th August 2018 were received for information.

WL/18/212a Minutes of the SLT meeting held on 18th October 2018

Paper Ui, the minutes of the SLT meeting held on 18th October 2018 were received for information.

WL/18/213 Minutes of the Collaborative Commissioning Board meeting held on 16th August 2018

Paper V, the minutes of the Collaborative Commissioning Board meeting held on 16th August 2018 were received for information.

WL/18/214 Minutes of the PPAG meeting held on 30th August 2018

Paper W, the minutes of the PPAG meeting held on 30th August 2018 were received for information.

WL/18/214a Minutes of the PPAG meeting held on 27th September 2018

Paper Wi, the minutes of the PPAG meeting held on 27th September 2018 were received for information.

WL/18/215 Minutes of the Quality and Performance Committee meeting held on 21st August 2018

Paper X, the minutes of the Quality and Performance Committee held on 21st August 2018 were received for information.

WL/18/216 Minutes of the PCCC meeting held on 10th July 2018

Paper Y, the minutes of the PCCC meeting held on 10th July 2018 were received

for information.

WL/18/216a Minutes of the PCCC meeting held on 18th September 2018

Paper Yi, the minutes of the PCCC meeting held on 18th September 2018 were received for information.

WL/18/217 Minutes of the Audit Committee meeting held on 22nd May 2018

Paper Z, the minutes of the Audit Committee meeting held on 22nd May 2018 were received for information.

WL/18/218 Any Other Business

No other business.

WL/18/219 Date of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group would be held on Tuesday 11 December 2018, 13.30 – 14.00, at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.