WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

A

Minutes of the Public Board Meeting
Tuesday 10 April 2018
WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ

Present:

Professor Mayur Lakhani	Chair
Mr Steve Churton	Deputy Chair Lay Member
Dr Chris Trzcinski	Clinical Vice-chair
Ms Gillian Adams	Lay Member
Dr Chris Barlow	Locality Lead, South Charnwood
Mr Ket Chudasama	Director of Performance and Corporate Affairs
Mr Simon Fogell	Healthwatch Representative
Mr Spencer Gay	Chief Finance Officer
Mr Ray Harding	Lay Member
Ms Nicky Harkness	Director of Service Redesign and Integration
Dr Mike McHugh	Public Health Consultant
Mrs Tamsin Hooton	Director of Urgent Care
Dr James Ogle	Locality Lead, Hinckley & Bosworth
Mr Ian Potter	Director of Primary Care
Dr Nick Pulman	Locality Lead, North West Leicestershire
Mr Toby Sanders	Managing Director (from item WL/18/031 onwards)
Dr Nil Sanganee	Locality Lead, North West Leicestershire
Dr Y B Shah	Locality Lead, South Charnwood
Mrs Caroline Trevithick	Chief Nurse and Quality Lead

In Attendance:

Mr Simon Fogell	Healthwatch Representative
Mr Wayne Rabin	Interim Communications and Engagement Lead
Ms Alison Moss	Committee Clerk (minutes)

Action

WL/18/059 Welcome and Apologies for Absence

Professor Lakhani welcomed Mr Simon Fogell, Healthwatch, to the Board meeting. Apologies for absence were received from Dr Peter Cannon and Dr Geoff Hanlon.

The Chair noted that the meeting was quorate with 13 voting members. There was one member of the public present.

The Chairman noted that there was an additional report to be considered on the Financial Plan 2018/19 and that Paper F, Board Assurance Framework, had been withdrawn.

WL/18/060 Declarations of Interest

The following declarations were noted:
WL/18/066 - Management of the UHL Pillar – All GPs, except Dr Trzcinski, Declaration Only
WL/18/067 – Composition of the Governing Body - All GPs and Lay Members Declaration Only
WL/18/071 – Finance Report - All GPs Declaration Only

WL/18/061 To receive questions from the public on relation to items from the agenda.

There were no questions from the public.

WL/18/062 Minutes of the meeting held on 13 March 2018

The minutes of the meeting held on 13 March 2018 were agreed as a correct record.

WL/18/063 Matters Arising/Action Log from the meeting held on 13 March 2018

Mrs Trevithick updated the Board regarding the waiting times for CAMHS Community Services referred to on page 4 on the Minutes of the meeting held on 13 March 2018. She confirmed that no children were waiting over two years and there had been an improvement in performance on the 30 day target. However, there was a significant number of patients waiting between one month and a year. This would be reviewed by PPAG. Mr Sanders said there was a need to understand the waiting time for patients as there was quite a difference in waiting for one month and waiting for one year. Dr Ogle asked whether there were any patients waiting between one and two years. Mrs Trevithick confirmed that no-one was waiting more than a year. He proposed that the contract terms be reviewed.

The Chairman noted that all the actions on the Action Log were complete.

It was RESOLVED to:

- **NOTE** the Action Log.

WL/18/064 Chairman's Announcements and Report

Professor Lakhani reported on the work he had been involved in since the last meeting. He had been working with CCG colleagues to support practices that were struggling, noting a number of general practices were vulnerable and the CCG had been very supportive. He had been involved in CCG governance and operational matters which had been challenging in light of the financial pressures. He thanked Mr Sanders and WLCCG staff for their response to the various challenges.

Professor Lakhani had provided clinical leadership in LLR and was organising a series of conferences. The next conference, to be held on 24 April, would consider the relationship between GPs and consultants. He hoped it would stimulate debate around the different pathways. Forty participants had already signed up.

Professor Lakhani continued to pursue system development and collaborative working. There would be a meeting with the local authority regarding the STP in 19 April.

Professor Lakhani reported on a meeting to be held at the end of May regarding End of Life Care. It would be attended by the national lead for Respect and involve LPT and UHL to look at the agreed documentation and ensuring it was enacted.

Professor Lakhani noted that work on Learning Lessons to Improve Care had been completed. This had repeated the exercise undertaken two years ago. The data was being collated and it was too early to discuss the findings. The scope had included primary care, community care and secondary care. In undertaking this task there had been many barriers to overcome and numerous issues to address. Professor Lakhani thanked Dr Pulman for his assistance.

It was RESOLVED to:

- **RECEIVE** the Chairman's Report.

WL/18/065 Managing Director's Communication

Mr Sanders presented the Managing Director's Communication, paper C and added his welcome to Simon Fogell from Healthwatch.

Mr Sanders reported that he had been engaged in the development of an operational plan and financial plan. His recent priorities had been the financial position of the CCG, planning for 2018/19 and the contracting process.

Mr Sanders noted the report on West Leicestershire CCG's 360° Stakeholder Survey 2017-18 which noted the findings of a survey of key stakeholders on working relationships with WLCCG. The report, Mr Sanders said, provided valuable insight and he commended it to members. Dr Ogle asked if the report could be circulated and Mr Sanders agreed to do so. **TS**

Mr Sanders reported that he and Ms Adams, had met with Edward Argar MP to discuss stem cell transplant services. The conversation was wide ranging and Mr Argar gave positive feedback about WLCCG noting how responsive it had been to MP enquiries.

It was RESOLVED to:

- **NOTE** the report from the Managing Director.

WL/18/065a 2017/18 Financial Update and Financial Plans for 2018/19 and beyond

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

Mr Gay gave a presentation to update the Board on the financial position 2017/18. The CCG forecasted failing the control total by £4.2 m. Pressures totalling £14.7 million had been felt in year with £10.5 m being mitigated through reserves, and the implementation of a recovery plan. QIPP savings of £16.4 m had been delivered in year (against £18.1 m target).

The final outturn position for WLCCG had been adjusted following instruction from NHSE in relation to two issues. The first was the Category M drugs rebate returned to CCG (£0.5 m) and release of national risk reserve (£2.1 m). The final outturn variance from initial CCG plan should be £1.6 m which meant the final variance from control total remained at £4.2 m.

Mr Gay noted the overspend of £4.2 m would create pressures on the 2018/19 budget. Whilst there had been some increase in funding. NHS England required WLCCG to plan for a level of acute activity which would create additional financial pressure.

The QIPP target for 2018/19 was £20.5 m. In 2016/17 WLCCG had delivered £10.8 m QIPP savings and in 2017/8 a total of £16.4 m. The current target, therefore, was higher than that achieved previously and the opportunities for savings reduced. Mr Gay noted that as a consequence the CCG would not be able to fund services it had done previously. It would be looking for savings in primary care and voluntary sector funding. He referred to making the 'least worst choices', noting that some decisions would be very difficult, with a need to understand the unintended consequences and impacts.

Mr Gay informed the Board that 2018/19 would be very difficult in financial terms for WLCCG.

Mrs Trevithick reported that she was, together with Professor Lakhani, planning to quality assure the existing QIPP schemes. She said it was important to engage with the public and key stakeholders on the financial position and the potential areas for savings. Mr Gay agreed but noted that there was a degree of urgency which meant the CCG would have to review previous feedback and experience. He added that 2018/19 would not be the end of the financial challenges and there was a need to ensure engagement was embedded. Ms Hooton said that the development of the plan should be a co-production with stakeholders and for it to consider carefully the impact on patients. Mr Fogell said that it was important to explain the choices to the public who would be able to contribute and offer alternatives. He said that Healthwatch was willing to assist the CCG in seeking feedback.

Mr Chudasama noted that having adopted the experience–led commissioning approach, there was an existing information and feedback that could be used to inform decision-making.

Mr Sanders noted that by the end of the week the CCG would have a clear picture of the financial position. He advised of the need to be consistent in the terminology used when engaging with the public as often terms were used interchangeably.

It was RESOLVED to:

- **NOTE** the presentation on 2017/18 Financial Update and Financial Plans for 2018/19

WL/18/066 Management of the UHL Pillar in the Alliance

It was noted that all GPs, with the exception that Dr Trzcinski, had declared a conflict of interest.

Mr Gay introduced the report which updated the Board on changes agreed by the Alliance Management Team. He noted there were three contract or pillars under the LLR Alliance Agreement.

The Alliance Leadership Board, in conjunction with the LLR Chief Officers, had decided to change the management of the UHL pillar and adopt the same approach as the other two pillars and for it to be directly managed by the UHL Management Team.

Mr Gay said the change would free up the Alliance Management Team to focus on what the Alliance was established to do. The report was presented to the Board to ensure it was sighted on the change.

Ms Hooton said the paper implied that the freed up management resource would be redirected towards transformation work. She asked if that was confirmed or whether it would be seen as opportunity for corporate savings. She asked what the impact would be on planned care. Mr Gay said he was unsure whether it was confirmed and said it needed to be reviewed.

Mr Sanders welcomed the change believing it was in the spirit of what was originally intended. He said there was a perception that the pillar had created a silo which UHL considered to be a separate and competitive service.

Dr Trzcinski said it would be important for UHL to take responsibility to staff the clinics appropriately.

Mr Harding asked about the role of the Alliance and it was noted that it sought to deliver patient care using community hospitals and provide local service. Dr Shah questioned the value of the Alliance and noted that the clinics were not at full capacity. He thought it created an artificial waiting list and the contract needed monitoring more closely. Mr Chudasama thought the contract was important and there was the need to prioritise clinics held in community settings. He thought the data would show a reduction in the number of clinics cancelled. There was a need to review the data.

Dr Trzcinski thought the Alliance was a way of encouraging other providers to deliver services and diversification of what GPs could do. Mr Gay noted that the contract had been procured and it had a further three years to run.

Dr Pulman said the purpose of the Alliance was to allow for innovation and there was the need to make sure it was an enabler.

Ms Hooton noted that when she was the Director at the Alliance the key issue was getting UHL to take ownership of the activity and thought the proposed change should address that. She said that taking activity back into UHL could be one solution but there was a need to drive integrated out-of-hospital pathways. She thought the Alliance had a role in delivering the planned care strategy.

Mr Gay thought it would be useful to ask the Alliance to do a presentation on its priorities on a few months' time.

It was RESOLVED to:

- **NOTE** the planned changes to the management of the UHL pillar in the Alliance.

WL/18/067 Composition of the Governing Body

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

Professor Lakhani vacated the chair and Mr Churton presided for the discussion of this item.

Mr Chudasama introduced the report which outlined the costs of governing body functions, the drivers for change and a set of options for reducing expenditure by between one and two thirds.

Mr Chudasama noted the drivers for change were increased collaborative working and the financial plan. Comparative data on the size of governing bodies for similar CCGs was presented at appendix A. It noted that the WLCCG was an outlier with regard to the number of GPs, although Mr Chudasama cautioned that as the GPs undertook different functions in the CCGs the headcount could be misleading. It was noted that WLCCG had 35 clinical sessions, ELRCCG had 33 and LCCCG had 32. ELRCCG was also reviewing the composition of its Board.

Mr Chudasama presented the four options outlined in the report.

Mr Churton asked whether the savings stated accounted for a reduction in the frequency of board meetings. Mr Chudasama said the intention was to move to bi-monthly meetings to enable Board GPs to support transformational programmes.

There would be a shift in their role from governance to clinical leadership.

It was suggested that the Board could chose Option 4 whilst considering more radical change.

Dr Pulman said that, at a previous meeting, information on the costs of GPs and the allocation of time had been requested. He noted that GP Board Members at LCCCG were paid at a higher rate and there was a backfill option. Mr Chudasama noted the comparative costs were broadly in line with the rates for other CCGs; the only difference was that LCCCG had an arrangement to backfill GP sessions. Dr Pulman noted that the expenditure was not personal income but was money put into the Board Member's practice.

Dr Pulman thought it would have been useful to quantify the commitment needed for governance/representation and that needed for transformational change.

Dr Ogle considered that Option 4 was very difficult to agree to as two sessions were not enough to undertake all the work required. Dr Ogle considered the Board GPs' representation on collaborative committees and work programmes should be reviewed and shared out across the three CCGs.

Mr Sanders said there was a strategic question as to what level of clinical input was required, that is, what was the quantum number of sessions rather than headcount. He added there was a need to reduce the CCG's running costs and in reducing the number of clinical sessions there would need to be a reduction in the frequency of meetings and consider LLR-wide committees.

It was suggested there could be a hybrid option to lessen the reduction in clinical sessions to ensure sufficient capacity to deliver transformational change.

Dr Barlow said that he agreed with Mr Sanders about identifying the number of sessions needed and how they were used. He welcomed the lesser frequency of Board meetings but noted that at the same time there had been discussions about additional tasks. He noted that in ELRCCG and LCCCG the prescribing lead was not performed by a Board GP. He asked whether that was reflected in the overall totals. He wondered whether the role of locality lead should be separated from other roles.

Mr Sanders noted the example given and asked whether it was necessary for a GP from the three LLR CCGs to lead on medicines management and whether the CCG could trust its peers to undertake the role on an LLR-wide basis. He said there would be a discussion in the Autumn about joint clinical roles.

Mr Sanders said the immediate question for the Board was what option was feasible. Mr Harding said it was imperative for the Board to take action and that it was about leadership at a time when the CCG was cutting services. There was a need to lead from the front and to demonstrate that the Board was prepared to review the Governing Body.

Dr Trzcinski said there was a need to understand what ELRCCG and LCCCG was planning and for an incremental approach.

Dr Shah referred to Dr Pulman's point and asked why there were no comparative costs for GP roles as there was no national rate. He asked whether there were other GPs engaged on a sessional rate. It was noted that these roles had been reviewed and pared to the minimum.

Dr Shah said that there was a danger of losing locality input which would affect delivery of the QIPP and the right people might not come forward for the roles.

Dr Sanganee said that from a financial perspective the lack of clinical drive on pathways affected delivery. He asked what the priority was for Board GPs. He thought that to drive QIPP there was a need for clinical leadership to ensure engagement from practices. He noted that there was a proposal for locality leads to assist with practice appraisals and reviewing QIPP schemes.

Dr Sanganee proposed that the board structure be reviewed with a view to redeploy Board GPs to work on transformational change. It was agreed that with the increase in collaborative working it was imperative to ensure GPs worked together across LLR. There was a balance to be struck between the Board role and the clinical role.

Professor Lakhani said the principle had been established that when representatives undertook work on behalf of the system that the host organisation paid. WLCCG led on a number of committees and there was not an even distribution of the work. He said that meant the WLCCG was essentially funding clinical time for the system.

Dr Shah asked who else was leading on clinical work for the GP and it was noted that consultancy had been agreed for anti-coagulation, maternity and cancer maps. It was suggested that it could be redistributed to Board GPs. Professor Lakhani pointed out that if the number of Board GPs was reduced to 8 there was a need to consider how they were selected and for all posts to be up for re-election.

Professor Lakhani asked whether the savings could by hypothecated and allocated to the Primary Care QIPP. Mr Gay said the savings had already been included in the corporate savings plan. He added that the CCG, in his view, could not disinvest in patient care without cutting corporate costs.

Mr Gay agreed that clinical leadership was needed for transformational change but the CCG had to make financial savings. He said that no-one was questioning the value of Board members but there was a need to work differently. If the number of sessions were reduced it should be clearer which GPs were leading on which programmes.

Dr Ogle commented that, as the sole representative of Hinckley and Bosworth locality, it was difficult to maintain links with the locality and that he preferred Option 3 with some amendment.

Dr Pulman considered that Option 4 was the best solution. He said it was difficult to recruit Board GPs and it gave the option to expand if there was a need. The option reflected the views of the member practices.

Mr Sanders noted that the CCG had provided funding for the federations and when the Board was established that infrastructure was not in place.

It was suggested there was no reason, for option four, why all locality leads had to do the same work; four could be Board members and four could lead on clinical programmes.

Dr McHugh thought that doing nothing was not an option and Option 4 seemed the most sensible. He proposed that who was leading on what work should be

reviewed noting that three GPs were working on cancer and that as it was the biggest cause of premature mortality there was a need for a focussed resource. There was a need to deploy expertise in a targeted way.

Dr Barlow said that Option 4 was the most sensible and locality leads could be used in different ways. He drew the analogy with a football team noting a need for players to perform different functions and said the CCG should seek a balance of expertise.

Mr Harding said there were 14 clinicians on the Board and the question was should it be clinically led or locality led. The quorum could be changed to reduce the number of sessions used for the Board meetings.

Professor Lakhani asked whether it was possible to increase the number of options. He said he preferred Option 4 with the proviso that the roles were reviewed and that there was funding for essential extra services.

Mr Churton reflected on the views expressed noting that there was some support for Option 4 with a variation. There was a request for a bottom-up analysis of the clinical leadership required and an urgent need to bank savings. He thought Option 4 was supported as it could be achieved without changing the constitution and formal consultation with member practices. Mr Churton asked whether only option 4 should be presented to the member practices.

Mr Gay thought that if all the options were presented to the member practices there it would be difficult to arrive at a consensus and further delay would reduce the savings which could be achieved.

Dr Pulman said there was a need to revisit the STP approach to clinical support. He said there was the assumption that the clinicians would make themselves available but that had not been costed. The delivery of transformation needed to be costed across the patch. Mr Sanders noted there were additional monies for the vanguard work on urgent care but there was not a separate pot of money for the STP. He thought there was the demand to release Board GPs from work on governance. Mr Sanders said that with respect to the engagement with member practices there was a parallel to be drawn with the approach to a joint management team.

Professor Lakhani said it was important to engage with the membership and all the options should be presented with a recommendation for Option 4.

Mr Harding asked whether the Transforming Services Forum would be abolished with immediate effect. Mr Chudasama said he would be revising the terms of reference for the Board's committees to reduce the frequency of meetings. These would be presented to the Board at its next meeting.

Mr Chudasama asked whether Board was in a position to present Option 4 to the membership. It was thought that Option 4 was favoured but with a variance to review the roles.

Mr Sanders commented that when the term of office for the Board Members was extended for six months there was a process of engagement with the membership and following which the Board changed the proposal. He asked whether Board was able to agree on what to present to the membership to land the decision the following month.

It was agreed that the frequency of meetings should change.

Mr Churton said the intention was to take the decision the following month but it would be dependent on the views expressed by members. Professor Lakhani noted that the roles had been extended until the end of June 2018.

Mr Gay said there was need for the Board to adopt a preferred option in order to get clear feedback. Mr Churton asked each member for their preferred option and those canvassed expressed a preference for Option 4 with the exception of Dr Ogle who supported Option 3. Mr Sanders said his preference would be for Option 3 but he supported Option 4 as it was the most pragmatic option given that there were would be further change as a result of increased collaboration. Mr Gay had said he favoured either option 3 or 4.

Mr Churton concluded that the Board's preference was for option 4 with some further clarity regarding the respective roles. It was agreed not to present any other option to member practices.

Dr Sanganee reiterated the point about redesigning the GP role and acknowledging the disparity in workload with respect to the STP across the CCGs. Dr Shah said his support was conditional on GPs not required at every meeting and for time to be released. Dr Barlow commented that there disproportional reduction in the sessions between the Chair, Vice-chair and the locality leads.

It was noted that there was no representation from North Charnwood locality. It was thought Dr Hanlon would have expressed support for Option 4.

Mr Harding clarified that the changes meant there would be one board day per month and that meetings of the Board and TSF would alternate. Mr Chudasama said he would be bringing back a committee planner in May with the revised terms of reference.

Ms Adams asked whether there would be an impact on the timetable for elections. Mr Chudasama said that the timetable would be revised.

It was RESOLVED to:

- **SUPPORT** Option 4 as outlined in the report for further consideration and engagement.

Board Assurance Framework

WL/18/068

The paper was withdrawn. **KC**

WL/18/069 Report from PPAG

Mr Harding presented paper G, which summarised the issues considered by the Provider Performance Assurance Group in March 2018. He noted the following points:

- EMAS – there had been some improvements but the service was not meeting all the targets. There had been six serious incidents.
- TASL – the performance had improved. A new CEO and COO had been appointed.
- UHL Referral to Treatment – there was a risk the core standards would not be met as the elective pause had increased the backlog.

Dr Ogle asked whether there was an overlap in the functions of Quality and

Performance Committee and PPAG and thought that could be reviewed. Mr Gay commented that PPAG was a useful forum as it reviewed the performance of key contracts once on behalf of the three CCGs and held providers to account effectively. Mr Chudasama noted that 360 Assurance had reviewed the operation of PPAG and found it to be functioning well. Mr Sanders said that naturally PPAG reports focussed on performance issues and there were positive reports for other service areas.

Ms Hooton offered to bring a more detailed report on EMAS performance at a future meeting. She noted that Hardwick CCG, the lead commissioner, was seeking additional funding to invest in the Service.

It was RESOLVED to:

- **RECEIVE** the Quality Report.

WL/18/070 Performance Report

Mr Chudasama presented the Performance report, paper H.

Mr Chudasama referred to the performance on RTT noting that whilst the performance for the year to January was 91.2% against the national target of 92%, the performance in February had dipped to 88.5%. The waiting list had increased due to the elective pause and other pressures on the system. There were approximately 50% more patients on the waiting list than the same time last year and this reflected the national picture. Dr Pulman asked whether the performance of AQP and the Alliance was included in the figures. Mr Chudasama said that the Alliance was included but not AQP.

Mr Sanders said that in relation to the discussion earlier in the meeting and the need to communicate the CCG's financial position to stakeholders, the conversation should reflect the reality about performance and the increased waiting times.

Ms Hooton suggested that the consequences of the elective pause should be evaluated to see how the WLCCG's position compared nationally.

Dr Shah asked if anyone was looking at readmission rates and Mr Gay confirmed that they were reviewed by the Contract Team as WLCCG did not pay for 20% of readmissions. There was reference to readmission rates in the QIPP plan.

It was RESOLVED to

- **NOTE** the Performance Report.

WL/18/071 Finance Report

It was noted that all GPs had declared a conflict of interest. Members received for information; paper I, Finance Report.

WL/18/072 Minutes of the Collaborative Commissioning Board meeting held on 15 February 2018

Members received for information; paper J, minutes of the Collaborative Commissioning Board meeting on 15 February 2018.

WL/18/073 Minutes of the Audit Committee held on 23 January 2018

Members received for information; paper K, minutes of the Audit Committee on 23 January 2018.

WL/18/074 Any Other Business

There was no other business.

WL/18/075 Date of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group will be Held on Tuesday 8 May 2018 at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.