NHS
Eastern Cheshire
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY held in public

Wednesday 22 February 2017 at 12.30

Assembly Room, Macclesfield Town Hall

MINUTES

VOTING MEMBERS OF THE GOVERNING BODY

CCG Chair GP McIlvride Medical Centre, Poynton	Dr Paul Bowen	PB	PRESENT	
Chief Officer	Jerry Hawker	JH	PRESENT	
Chief Finance Officer	Alex Mitchell	AMi	PRESENT	
General Practice Representative – Bollington, Disley, Poynton	Laura Beresford	LB		APOLOGIES
Deputy General Practice Representative – Bollington, Disley, Poynton	Dr Andrew Maurice	AMa	PRESENT	
General Practice Representative – Chelford, Handforth, Alderley Edge, Wilmslow	Dr Alex Garvey	AG	PRESENT	
General Practice Representative – Congleton and Holmes Chapel	Dr Rob Thorburn	RT		APOLOGIES
Deputy General Practice Representative – Congleton and Holmes Chapel	Dr Stuart Thomas	ST	PRESENT	
General Practice Representative – Knutsford	Dr Jennifer Lawn	JL		APOLOGIES
General Practice Representative – Macclesfield	Dr Mike Clark	MC	PRESENT	
Lay member, Governance	Gerry Gray	GG	PRESENT	
Lay Member, Patient and Public Involvement	Gill Boston	GB	PRESENT	
Lay Member, Patient and Public Involvement	Jane Stephens	JSt	PRESENT	
Public Health Representative, Associate Director of Public Health, Public Health Department, Cheshire East Council	Dr Julie Sin	JSi	PRESENT	
Secondary Care Doctor Member	Duncan Matheson	DM	PRESENT	
Registered Nurse Member, Interim Executive Nurse and Director of Quality	Sally Rogers	SR	PRESENT	

NON-VOTING MEMBERS

Fleur Blakeman	Director of Strategy & Transformation	FB	PRESENT	
Neil Evans	Commissioning Director	NE	PRESENT	

IN ATTENDANCE

Hazel Burgess	Note taker, PA to Chief Officer	Whole meeting
Matthew Cunningham	Head of Corporate Services	Whole meeting
Julia Curtis	Head of Quality	For item 2.1
1	Other Members of the CCG management support team	Whole and part meeting

3	Members of the public	Whole and part meeting

1.	PRELIMINARY BUSINESS
1.1	**Welcome and apologies for absence** Dr Bowen opened the meeting. Apologies for absence had been received from Laura Beresford, Dr Jenny Lawn and Dr Rob Thorburn. He thanked those deputising today: Dr Andrew Maurice Deputy GP Peer Group Representative for Bollington, Disley & Poynton Dr Stuart Thomas Deputy GP Peer Group Lead for Congleton and Holmes Chapel.
1.2	**Declaration of any new interests** Drs Maurice and Thomas are both partners in member GP Practices and the practices are members of Vernova Healthcare CiC. Dr Maurice is also a director of Middlewood. No other interests were declared. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests. The Register is available either via the secretary to the governing body or the CCG website https://www.easterncheshireccg.nhs.uk/
1.3	**Notes from previous meeting held in public – 25 January 2017** With the following amendment at item 2.3.3 " communication channels between health visitors and General Practice have deteriorated since the new arrangements and this may pose a risk to sharing information about child protection issues", the notes of the previous meeting were accepted as an accurate record
1.3.1	**Matters arising from the Minutes** None
1.4	**Public Speaking Time** No requests to speak had been received.
1.5	**Chief Officer Report** electronic link to paper here
1.5	**National Continuing Healthcare Review** - Jerry Hawker (JH) reported on an additional item. Cheshire and Wirral is one of nine areas taking part in a review of the Continuing Healthcare process being conducted at a national level. The Cheshire & Wirral CCGs have the opportunity to showcase the work done locally to develop a single team operating across several CCGs. The review will commence in March and reports will be brought back periodically. In answer to a query, JH explained the review has been initiated by NHS England, recognising the ageing population and seeking to better understand the challenges around the country regarding how the national policy is being applied, and different cost pressures

	across England.
1.5.2	**Future of the healthcare system** – Following the last meeting, as agreed JH and Dr Paul Bowen (PB) had written to partner organisations setting out how the CCG thinks finances and leadership in the care system could be managed in a partnership approach. Positive responses have been received from Cheshire East Council, Cheshire & Wirral Partnership NHS Foundation Trust, and the Lead of the Cheshire & Merseyside STP. Responses from the remaining partners are awaited and this will be discussed at the next Caring Together Programme Board.
1.5.3	From 1 April 2017, **responsibility for Commissioning of obesity surgery** will transfer to CCGs. The two existing providers locally have withdrawn from providing obesity surgery and two alternative options were identified through work with NHS England. Outpatient care will be provided on a local basis. Travel distance to both prospective providers is similar, but University Hospital North Midlands would provide surgery under the national tariff whereas Salford Royal would require a 30% premium. The financial challenges facing the CCG must be taken into account. The preferred option is to use University Hospital North Midlands as the preferred provider.
1.5.4	**Joint Cheshire Health and Wellbeing Board meeting** – a first meeting of the three boards took place on 21st February. JH stated this had been a valuable opportunity to get the Local Authorities and NHS together to talk about how the care system needs to develop across Cheshire in the future. There was agreement that Health and Wellbeing Boards have an opportunity to help support collaborative work and integration ambitions.
1.5.5	Reporting the **outcome of the Cheshire & Wirral consultation on review of the policy for procedures of lower clinical priority** has been delayed pending further discussions to achieve a consistent Cheshire-wide approach. Wirral CCG has already taken to their Governing Body a policy adapted to their local population It was raised that this had formerly been a policy across Cheshire and Merseyside. Neil Evans (NE) explained that the policy was due for review at the end of 3 years and Cheshire was ready to go out to consultation. The materials from the review will be shared with Northwest CCGs, who have expressed keenness to align. Both Merseyside and Greater Manchester CCGs are also keen to receive the outcome of the work done on the health optimisation paper.
1.5.4	JH invited Dr Mike Clark (MCl) to share the main points of the recent agreement on the General Medical Services contract. MCl reported that some work which GPs already do as a “Direct Enhanced Service” is now included in the new main contract for general medical services, with the expectation that it will be standard work for primary care. There is a new Direct Enhanced Service to identify frail elderly patients. Additional funding to offset the costs of indemnity insurance for GPs, which have risen by 30% in the last year, has also been included. GPs must have indemnity insurance and the majority will cover practice managers

	and nurses.
	The Governing Body • **Noted the contents of the Chief Officer Report**
2.	**STANDING ITEMS**
2.1	**Quality and Performance Progress Update** electronic link to paper here electronic link to appendix here *[Note: this item was taken out of sequence, after item 2.2 but is reported here for consistency and ease of reference]* Julia Curtis (JC), Head of Quality, attended the meeting to present the new quarterly report providing assurance that the CCG is delivering its statutory duties under the NHS Constitution in assuring the quality and safety of services for its local population. She highlighted that the CCG is performing well on quality standards in Learning Disabilities, Cancer and Mental Health services. The challenged areas are the 4-hour A&E target, and 18 weeks referral to treatment target. There were appreciative comments from Governing Body members on the usefulness of the new report, including comparison of the CCG's performance with peers.
2.1.1	In answer to a question, JC explained that "52 week breaches" refers to where people have been waiting longer than 52 weeks for treatment; the pathway is treatment within 18 weeks = six months. The number of patients waiting longer than 52 weeks has reduced.
2.1.2	Commenting that to meet the required standards, the CCG is reliant on providers playing their part, it was queried what contracting levers can be applied. JH responded that although NHS England continue to hold their CCGs to account for meeting targets set out in the NHS Constitution, trusts are now no longer obliged to meet all the national targets, having agreed local targets with NHS Improvement, and therefore contract levers can no longer be used the same way. He cited the example of ambulance services. NWAS delivers ambulance services across the North West of England and is held to account on that wider geographical basis only, with no requirement to meet targets at the local Eastern Cheshire level. The lack of requirement to deliver performance at a local level has been raised nationally. Neil Evans (NE) commented that there is a move, through the STF (Sustainable Transformation Fund) work, to incentivise trusts by rewarding them for reaching a trajectory, rather than penalising them for failing to achieve a target.
2.1.3	PB invited GP Representatives to comment on whether the performance report bore out their experience in general practice. It was commented that GPs are recognising that ambulance response times are worsening, and they understand this is a reflection of the strain on the system as a whole, as vehicles having to wait outside some

	hospitals are not available to pick up new patients. The view was expressed that as organisations change the way they work, the way metrics are collected needs to change. MCl said that the 18 week referral to treatment target performance was one of the reasons for reviewing the musculoskeletal service (item 3.2 on the agenda).
2.1.4	JC offered assurance that plans are in place to address areas of low performance, and progress is being monitored, although realisation of the plans is reliant on the providers.
2.1.5	Dr Bowen thanked the Quality Team for the report, and asked that any comments or suggestions for the next iteration be sent to Julia Curtis and Sally Rogers.
	The Governing Body • **Noted the report on current performance against NHS Constitutional quality targets for the population of Eastern Cheshire CCG, and actions being taken by the CCG to review, monitor and improve the areas of challenge**
2.2	**Financial Performance Report** **Month 10, as at 31 January 2017** electronic link to paper here Alex Mitchell (AMi) assured the Governing Body that the forecast outturn deficit of £15.2 million is accurate and unlikely to change. Approximately half of the deficit is due to unanticipated additional costs which the CCG was required to accept. In line with accounting requirements from NHS England, 1% non-recurrent headroom will be returned to the CCG at the end of the year, which will reduce the figure to a deficit of £12.4 million. The QIPP schemes will deliver around £6.2 million for the year. The target was £9.6 million, always with the proviso that this would not all be achieved in-year. The Better Payment Practice Code performance is back on target for the year end and Cash balance is in order. Questions were taken on the contents of the report.
2.2.1	AMi will check and respond later with an explanation on the £ 250K overspend on a block Mental Health contract. It was clarified that the figure for intermediate care in table Six-B is the budget, not the spend, and that those schemes colour coded blue are completed.
2.2.2	In answer to a queries regarding the QIPP total, AM responded • The QIPP plan is 2.5% of the CCG's turnover. • NHS England has stated that QIPP of 2-3% is reasonable, regardless of geographic location • £9.6 million is very ambitious to aspire to achieve within year.

2.2.3	NHS England has asked the CCG to confirm its year end position and communicate what more it can do to reduce the deficit between now and the year end. JH recommended a response that the CCG will continue to explore every opportunity, but in the time available (5 weeks) it is unlikely any new additional scheme could be implemented and have a material impact on the financial position. There was a discussion about what more can be done and whether there are other areas where costs can be reduced. AMi reported there are daily reconciliations to monitor the financial position, and there is close communication with East Cheshire NHS Trust, the largest provider, ensuring alignment of positions. It was agreed that it is in the patients' interests to continue to strive to meet access to treatment targets set out in the NHS constitution. NE commented that NHS England's support for this is illustrated by how locally planned hospital activity which cannot be accommodated in NHS hospitals locally is being carried out in the private sector, with such a degree of success that NHS England is asking the CCG to broker arrangements for patients from outside the area. It was noted and appreciated that toward the end of the year the CCG had not asked GPs to defer referring patients for reasons of financial expediency. It was suggested that fundamentally changing the payment model for care, removing duplication and waste and giving equity to social and physical health care is the only way forward. JH stated that it is not acceptable for the CCG to operate outside its available resources and the responsibility lies with the CCG and the Governing Body to address. The CCG is under close scrutiny from NHS England, although the CCG has not yet been placed formally "in Directions", although this remains likely if the deficit is not improved.
	The Governing Body • **Noted the update on the Better Care Fund** • **Noted the forecast outturn for 2016/17, including all risks, remains a revised forecast deficit of £15.2million, which will be £12.44 million once 1% non-recurrent headroom is returned to the CCG at the end of the year.** • **Agreed that Jerry Hawker should respond to NHS England re the CCG's year end position and that there is nothing further that can be done in year to materially impact the financial deficit**
2.3	**Governing Body Assurance Framework –February 2017** electronic link to paper here AM invited any questions.
2.3.1	Regarding Ambulance Performance, there was a query about assurance on "See and Treat" being implemented locally. JH reported that data for the last two years shows a growth in activity for "See and Treat", where patients are treated in the community, rather than taken to hospital.

	Eastern Cheshire is one of the best performing areas in the Northwest.
2.3.1	The changes to the narrative on the risk on Community Services were queried. AMi and JC replied that originally it had been written focusing on the financial impact of a change to how the service was structured; this was mitigated by a funding decision made by the CCG. The risk has now been reframed to reflect quality and sustainability risks. The Clinical Quality and Performance Committee will review the risk and bring back a recommendation on a reduced risk rating. It was requested the wording of the risk be strengthened to pick up on the residual impact of the change to the staffing structure of community services. It was suggested the Committee may wish to consider describing separate risks for the clinical and financial sustainability of community services.
2.3.2	**Assurance Framework Deep Dive :** GBAF242 – East Cheshire NHS Trust Underlying Financial Position electronic link to presentation here AMi explained the conditions during which the risk was written and accepted onto the Assurance Framework. He described the contract arrangements for acute hospital activity and how some services were not financially sustainable for ECT due to the level of activity and funding not matching their costs. This had led to ECT serving notice on some of those services. This reduced their financial deficit positon, but required the CCG to find alternative providers, and in the case of stroke services, at a rate well over standard tariff. Current assessment : The overall financial position for ECT has improved and contracts have been signed for 2017/18. No further changes are anticipated, most acute services are funded on a Payment by Results basis and no requests for top ups are anticipated. ECT's deficit has been contained, but the CCG's financial position for 2017/18 has deteriorated. For the future a system-wide approach to QIPP is needed, through the Caring Together Programme Board. ECT's financial position has stabilised so it is recommended the risk be reduced down to likelihood: 4, impact: 4 = 16.
2.3.1.1	There was a lengthy discussion seeking to clarify and quantify the interrelationship between the clinical and financial risks posed by the financial deficit of ECT, and whether although the deficit figure had reduced, there was sufficient evidence that the overall risk to the CCG had reduced. Discussion included whether signed contracts for 2017/18 were adequate evidence to give confidence there would be stability in delivery and quality of services provided by ECT. AMi gave assurance that the CCG is writing to ECT asking what the focus of their QIPP plans is for next year, particularly around community services and block contracts. He acknowledged that District General Hospitals have a challenge in

	financially sustaining activity-led services, which are often operating at a loss and he agreed the risk exists of application for increased tariffs for services. It is understood this is being looked at nationally. There was a discussion about whether there is sufficient evidence to reduce the level of the current risk- either the likelihood score or the impact score - and whether instead it should be retained at 25, given that ECT is still in financial deficit and there is a potential for impact on the CCG of any actions ECT may take to improve its financial position. JH commented that there is a need to be clear about what is within the CCG's ability to mitigate or influence. Caring Together may be the only way to mitigate the impact of ECT's financial position on the potential risk to the CCG delivering its statutory duties. The Governing Body concluded that although ECT's financial position has improved, the CCG's had worsened, and therefore the risk had not decreased. It was agreed that the risk score would remain at 25, pending closure and replacement describing the potential financial risks to the CCG. Consideration will also be given to either writing a separate risk on quality aspects of ECT's services, or including this within the scope of Risk 249: Sustainability of Clinical Services.
	The Governing Body • **Following the Deep Dive presentation, decided that the score for GBAF242 – East Cheshire NHS Trust Underlying Financial Position should remain at 25 pending a reframed risk being brought to the next meeting for consideration.** • **Noted that updates have been made to the narrative of GBAF245 – Non-Delivery of the NHS Constitutional Standard for A&E Waiting Times and for GBAF249 – Sustainability of Community Services** • **Approved the list of Strategic Risks**
2.4	**Sub Committee Minutes and Reports**
2.4.1	**Governance and Audit Committee** electronic link to paper here Gerry Gray highlighted the discussion about conflicts of interest around holding "Board to Board" meetings with other providers. It was commented that new Conflicts of Interests guidelines have recently been issued, with a focus on CCGs and General Practice, but so far there has been little interest in conflict of interests issues related to providers.
	The Governing Body • **Note the report and minutes from the January 2017 Governance and Audit Committee**
2.4.2	**Remuneration Committee** No report on this occasion
2.4.3	**Clinical Quality and Performance Committee**

	electronic link to paper here electronic link to appendix here In Dr Jenny Lawn's absence Sally Rogers (SR) talked about discussions at the meeting held in December, including how the contribution of Duncan Matheson, as a secondary care doctor, has been much valued at Serious Untoward Incident meetings, and how it is hoped clinical input will continue after his term of office ends in a few months' time. There followed a discussion about the membership of the A&E Delivery Board, with opinions expressed that it should include clinicians. It was explained that the A&E Delivery Board, which is run by ECT as per national guidelines, is the senior level executive board to resolve issues raised by the A&E Operational Board, which includes clinicians. The Director of Nursing for ECT is on the A&E Delivery Board and can progress issues with the A&E Department. In response to a previous request, Laura Beresford has attend to give a general view from primary care. Nonetheless views were still being expressed that clinicians also ought to be involved in the A&E Delivery Board. JH agreed to raise the matter with the Chair of the A&E Delivery Board to indicate the concerns and requests raised by the Clinical Quality and Performance Committee, and the views of some Governing Body members.
	The Governing Body • **Noted the summary and notes of the Clinical Quality and Performance meeting held in December 2016**
2.4.4	**Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee** There has been no meeting to report on this month.
2.5	**Advisory Committees – summary reports**
2.5.1	**Locality Management Meeting** There has been no meeting to report on this month
2.5.2	**Eastern Cheshire Community HealthVoice** electronic link to paper here electronic link to minutes here Jane Stephens summarised the topics discussed at the meeting. At the next meeting there will be discussions about the future of HealthVoice.
	The Governing Body • **Noted the minutes of the HealthVoice meeting held on 27 January 2017**
3.	**ITEMS FOR DISCUSSION**
3.1	**Financial Plan 2017/18 and 2018/19** electronic link to paper here Alex Mitchell commented that, as a result of on-going conversations with NHS England, earlier versions of the plan had to be altered between their issue and the date of the Governing Body meetings. He expressed

	confidence that the plan presented for approval is now the final version. The CCG's 2017/18 financial plan has always forecast a likely outturn deficit of £20.4 million. Guidance from NHS England is that QIPP plans must not result in passing debt from one organisation to another, and that a QIPP total of 2-3% of total income is reasonable, with anything higher likely to be high risk. During discussions with NHS England North Cheshire & Merseyside in early February 2017, two options for setting a plan were discussed, one including and one excluding unidentified QIPP. There was acknowledgment that additional, currently unidentified, QIPP savings were unlikely to be found and agreement from NHS England that the CCG should report its expected outturn position from April 2017 as a deficit of £20,436 million. This plan - referred to as Option 2 in the report - with a challenging QIPP Plan of £10.8 million, has been submitted to NHS England Cheshire & Merseyside for comment ahead of formal submission to NHS England nationally on 23 February. No response has yet been received. Given the extent of the forecast deficit, the scale of the stretching QIPP Plan, aiming for 3.9% of the CCG's turnover, is more ambitious than the 2-3% efficiency savings suggested by NHS England as realistic. There are risks of £5million on the plan overall related to: • the possibility of increased charges as a result of coding changes • the requirement to provide additional investment in mental health for the delivery of the Five Year Forward View for Mental Health • Growth in Continuing Health Care costs plus increased costs charged by care homes. QIPP Schemes listed in Table Two-B have been colour coded to reflect the risk of achievement. Cheshire & Merseyside has been allocated a combined deficit control total of c£22million. This is across all CCGs within the wider area. AMi highlighted that Eastern Cheshire CCG's forecast deficit is £20 million.
3.1.1	Regarding Table One-C There was a query about spend with other contractors in the private sector. NE and AMi responded that there is a requirement to offer choice to patients, and assurance was given that any activity paid for is at the same rate as paid to NHS organisations.
3.1.2	The Governing Body sought reassurance that the proposed target for identified QIPP would be realistically achievable. The Executives stated that due to the size of the potential financial deficit, it is necessary for the CCG to set a very stretching target, and also to demonstrate there is a long-term plan. The CCG is committed to exploring every opportunity to mitigate the financial deficit whilst maintaining sustainable services for the local population. The Executives expressed confidence that all QIPP schemes will deliver, including those recommended under the national RightCare programme, although the anticipated dates of full financial benefit may extend into the

	next year; the risk levels of each scheme have been assessed and rated accordingly. Some of the QIPP schemes assessed as high risk are anticipated to be achievable only under the Caring Together Programme, which is seen as the key to improving finance across the whole system. It was noted that some high risk schemes are dependent on outside factors (e.g. CHC review) but the plan is annotated with clear and realistic risk levels accordingly. Risk levels may well change as the year progresses and factors outside the CCG's control are concluded. NHS England has offered CCGs additional support to review and refine QIPP opportunities.
3.1.3	There was general agreement that the option of including additional unidentified and unlikely to be achieved QIPP savings in the plan would be contrary to the CCG's value of transparency.
	Acknowledging the forecast deficit position and the QIPP schemes identified and risk assessed as set out in the paper, by consensus The Governing Body • **Approved submission to NHS England of the 2017/18 & 2018/19 Financial Plans with a planned deficit of £20.436 million and £20.342 million respectively, as detailed within the report** • **Noted the level of perceived risk with the delivery of the planned deficits of £3.8milliion for 2017/19 and £4.1 million in 2018/19** • **Noted the range and value of the QIPP schemes totalling £10.8 million and delegated the implementation of the schemes to the Executives**
3.2	**Securing Improved Musculoskeletal and Outpatient Physiotherapy Services for Eastern Cheshire** electronic link to paper here Dr Paul Bowen commented that business cases brought to the Governing Body have already been endorsed by committees following engagement and consultation. Dr Mike Clark (MCl) introduced the proposal, which aims to provide equitable access to a musculoskeletal and outpatient physiotherapy service to all residents of Eastern Cheshire. The focus is on improved access, quality of service, and value for money. The service specification is aimed at ensuring patients see the right clinician the first time. Stakeholders (including existing providers and patients) and potential new providers were engaged through a range of events with the and a Task and Finish group kept stakeholders involved as the specification was developed. The specification is based on strong evidence from other areas already operating a similar service. In developing the business case, a wide range of options for the service was considered: The recommendation of the Executive Committee is to proceed on a "bundle" basis : procurement of a single triage service, and procurement of providers of outpatient physiotherapy on an Any Qualified Provider basis. Notice would be served on the current contracts with providers, all of whom can apply as Any Qualified Providers in addition to

	any new providers.
3.2.1	There was a lengthy discussion about the proposals, MCl and Fleur Blakeman (FB) responded to questions and comments.
3.2.1.1	There were questions about how the new service will look different to patients who already self-refer for physiotherapy, and how they would access the new service. Not all Eastern Cheshire general practices currently offer self-referral to physiotherapy (except for private treatment). The aspiration is for all residents to enjoy the same level of access at each practice. Patients within all peer groups will have the option of self referring for assessment through the new single triage service. Patients would access the triage service in one of the following four ways • self refer • via practice receptionist – be given a contact number to access the triage and assessment service. • after seeing a GP • after seeing a secondary care consultant They would then have the choice of treatment with any of the potential providers
3.2.1.2	It was raised that there was potential for a conflict of interest should the appointed provider of the triage service also be a provider of the physiotherapy service, e.g. with the possibility of patients being referred for unnecessary treatments. Modelling has shown any potential conflict of interest should be addressed through meeting of the outcomes of the specification. An anticipated percentage of telephone advice alone, and progression to treatment, has been modelled through. The triage service will be required to evidence that patients referred for treatment have been offered a choice of providers. The risk will be reduced through contract monitoring of performance indicators. It was confirmed that the triage service will be tailored to individual need: applications from the empowered individual self-referring for advice as well as less experienced clinicians seeking advice, and experienced clinicians confident in their assessment of the patient's needs.
3.2.1.3	There were queries about the impact on the current main provider of services, East Cheshire NHS Trust (ECT), It was emphasised that notice on the current provision will be served on all providers, not just ECT, and that all have the opportunity to bid for an Any Qualified Provider contract. The specification is specifically for outpatient community physiotherapy: it does not affect inpatient physiotherapy provision. Concern for potential negative impact on the stability of ECT's inpatient physiotherapy service was raised. It was acknowledged that inpatient-outpatient services may have interdependencies as regards staffing. It was reiterated that the Any Qualified Provider contracting mechanism

	means that any provider who can meet the criteria can provide services, including ECT. It is expected that inpatient physiotherapy will continue to be provided by ECT within the tariff price. The difference between services provided on a "block" and a "bundle" contract was explained to the Governing Body.
3.2.1.4	A question was raised as to whether there will be a reduction in hospital attendances; overall the same amount of physiotherapy is expected to continue, although there should be better outcomes for patients as they see the most appropriate clinician first time. Modelling has been done of both the private and the NHS market to determine the expected number of first and follow up appointments. Each provider would have to evidence they are achieving the specification.
3.2.1.5	Clarification was requested on provision of post-operative rehabilitation. The cost of physiotherapy following surgery is already on Payment by Results basis, it is not included within the cost of the procedure. The acute hospital trust which has carried out the operation will generally refer people to their own physiotherapy service but in line with the new specification, patients would have the option of going to another provider. It was agreed that there can currently be an interruption in care e.g. after orthopaedic procedures and it is to be hoped that the new service will mean an improvement by offering patients quicker access to physiotherapy, which will aid their recovery.
3.2.1.7	Regarding potential variations in clinical need for physiotherapy across the area, it was queried how the proposals fit with the "primary care home" and "hub and spoke" models described within Caring Together. It was explained that this service specification is a step towards establishing community teams in each of the five peer group areas. The business case was focused on a solution based around the five peer groups in Eastern Cheshire, with the specification setting quality standards and offering providers flexibility to provide the service that is right in each area.
3.2.1.8	Regarding the possibility of home assessments for people in care homes, this has been raised with potential providers and has received a positive response;
3.2.1.9	It was queried whether demand was expected to increase as a result of the new service. Evidence shows that self-referral by patients is cost effective in the long run. National data from areas where a similar service has been implemented shows a slight increase in activity initially, levelling off quickly once the service is established. Face-to-face appointments for triage are not always necessary; telephone appointments are sometimes sufficient.
3.2.2	In recapping the aims of the proposal, FB and MCl stated that the model for the musculoskeletal outpatient physiotherapy service has been developed as part of Caring Together and it is intended that the approach will be extended to the commissioning of other services. The service specification reflects the aim of empowering individuals to self-manage their care and have more control. Dr Bowen commented that it should be

	recognised it is a needs-based, not demand-based service. MCl gave assurance that all the questions raised, including a request for a flow diagram, are answered within the business case, which was approved by the Finance Committee and is available on request. The Executives undertook to review the business case for assurance that all has been covered.
	The Governing Body • **Approved the Executive Committee's recommendation to adopt Option Three for the c£1.6 million procurement of musculoskeletal and outpatient physiotherapy services for Eastern Cheshire CCG: This would include two lots: a triage service and Any Qualified Provider procurement of musculoskeletal physiotherapy outpatient/community services, the tariff would be built on a bundled activity basis.**
	Dr Mike Clark undertook to bring a report on new the service to the Governing Body six months after implementation of the service.
3.3	**Preoperative Optimisation of a person's health prior to non-urgent surgery** electronic link to paper here Neil Evans (NE) reminded the Governing Body that an initial paper based on work being done in Harrogate had been brought for consideration in October 2016 and that further work had been undertaken as directed. He outlined the intention of the approach to establishing guidelines to be used as a system-wide approach on advising patients on optimisation of their health prior to surgery to enhance or improve the anticipated benefits. The proposal has been discussed by CCGs across the Northwest with a view to adopting a similar approach. Locally there have been discussions with secondary care doctors, GPs, HealthVoice and the Clinical Leadership Team to agree a position. As reported in the paper, a review has been completed to identify and map the number of patients who would derive benefit in terms of reduced wound infections, reduced readmission, and a reduction in the need for follow-on interventions. MCl clarified that pre-optimisation for health would not be required for patients requiring urgent surgery and would not be a condition for receiving surgery. It was suggested, and agreed, that the proposal be renamed "preoperative optimisation of a person's health prior to non-urgent surgery". It was specified that this would not be used to deny access to surgery, it is about educating patients and supporting optimisation of their health. Discussions are taking place nationally, the Royal College of Surgeons in Edinburgh is working towards imposing a smoking ban on patients before surgery.

3.3.1	The principle of raising issues to patients requiring surgery was roundly welcomed by clinicians on the Governing Body. Issues identified by the GP would be shared in the referral letter and be helpful to inform both the surgeon and the anaesthetist. It was noted that people may choose not to engage, but they will have information to help them understand the risks they are accepting. It was reaffirmed that the approach would not preclude individuals from having a procedure.
3.3.2	It was clarified that option 2 in the paper applies the approach to GPs only, option 3, the recommended option, is to roll out a system-wide approach.
3.3.3	The point was made that poorer members of the community will be disproportionately affected in that they are more likely to have less healthy lifestyles and may not wish to reveal or discuss alcohol or smoking habits.
3.3.4	Acknowledging that it was a clinical proposal, NE commented that financial benefits existed across the system. MCl stated that there are likely to be longer term clinical and financial benefits, related to a reduction in patients suffering strokes and heart attacks.
3.3.5	The point was made that it would be sensible for the proposal to make use of the existing links with the local health and wellbeing services ('One You Cheshire East') and this should continue to be explored. The point was also made that as part of the planning for this proposal, it should be acknowledged that should the existing capacity for the local health and wellbeing service 'One You' become full, the CCG and Local Authority would need to consider funding the extra activity arising from the pre-operative pathway. This should be factored in as part of the proposal's planning.
3.3.6	It was acknowledged that there should be ongoing evaluation of the effectiveness of the proposal on health outcomes with regard to the smoking cessation, alcohol and weight recommendations that are used.
3.3.7	It was agreed that it will be important to get the communications right; this will be about a whole system approach to collaborate around care ("every contact counts").
3.3.8	PB acknowledged that the Governing Body had thoroughly supported the proposed approach. JH offered to write to partner and provider organisations seeking their support for the programme of work. NE reported that an outline of the intention to initiate the approach had been included in all the 2017/18 contracts, which have been agree with all providers and stated that it will be necessary to embed the process within the working practice of clinicians.
	The Governing Body • **Noted the support from the Clinical and Executive Teams for developing and implementing a Preoperative Optimisation Policy** • **Approved the development and implementation of a structured policy for preoperative optimisation of health prior to non-urgent surgery with the final policy to be approved by the CCG**

	Executive Team.
3.4	**Redesign of services for Frail Older People in Eastern Cheshire** electronic link to paper here electronic link to appendix here NE introduced the paper and reminded the Governing Body of approval in November 2016 of short term contracts for 12 additional intermediate care beds until the end of March 2017. It is proposed the contracts are not renewed due to operational issues including relatively low occupancy levels - 79%, saving £564,000 next year. It is proposed that six intermediate care beds are now funded as part of the frailty investment. NE explained that beds designated for intermediate care are generally only being used as "step down" facilities for patients leaving hospital. Work is being done to develop the scope of the frailty service, looking at the possibility of people going to intermediate care beds without having first to go to hospital. People using the intermediate beds currently often need only residential home beds, not nursing home beds and it is felt there are better outcomes for patients cared for in less dependent settings. The plans being worked also include "discharge to assess" beds for people being considered for continuing healthcare. This proposal is part of a wider Caring Together reablement programme which will take 20 weeks to complete. There were comments and questions on the proposal.
3.4.1	In answer to the difference between beds in the community and beds in an in-patient unit, NE explained that more beds in the community means the opportunity for people to be cared for closer to their own home, with their own GP looking after them.
3.4.2	There was a question about the value for money of the CCG's £1 million investment in East Cheshire Trust's Frailty service, and whether the service was sustainable. NE and FB gave assurance that the service is evolving and that development continues across the CCG team, ECT clinicians and Cheshire East Council. It is anticipated that a new long term care model will reduce costs and eliminate duplication.
3.4.4	It was queried whether there will be genuine savings if the intention is to recommission 11 beds in a different way. NE confirmed that £564,000 will disappear from the budget as from 1st April 2017.
	The Governing Body • **Approved the recommendation of the Executive Committee not to extend fixed term contracts for 12 intermediate care beds, with a further six to now be funded within the frailty pathway investment** • **Approved as part of the CCG's Financial Plan the continued investment of £1.02 million in frail care, noting that this funding beyond Quarter 1 (2017/18) is conditional on an agreed system**

	approach to financial recovery • **Noted that work is under way to develop a new model of delivery for a Frailty Service through an integrated partnership**
3.5	**2016/17 CCG Operational Plan – Implementation Update** electronic link to paper here The report had been provided for information and no questions raised.
	The Governing Body • **noted the report on progress in delivering the CCG's Operational Plan for 2016/17**
4.	**ANY OTHER BUSINESS**
	Dr Paul Bowen closed the meeting commenting that a lot of interest has been raised in our new primary mental health service – the CCG been approached to present to the Department of Health.
5.	**DATE AND TIME OF NEXT MEETING**
	Wednesday 29 March 2017, 12.30-16.30 Congleton Town Hall. **Informal Q&A 16.30-17.00**