NHS
Eastern Cheshire
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY held in public

Wednesday 30 March 2016 – 9 am

Council Chamber, Macclesfield Town Hall

MINUTES

VOTING MEMBERS OF THE GOVERNING BODY

Dr Paul Bowen	Executive Chair, GP McIlvride Medical Centre, Poynton	PRESENT	
Gill Boston	Lay Member, Patient and Public Involvement	PRESENT	
Dr Mike Clark	General Practice Representative – Macclesfield	PRESENT	
Gerry Gray	Lay member, Governance	PRESENT	
Jerry Hawker	Chief Officer	PRESENT	
Dr Jennifer Lawn	General Practice Representative – Knutsford	PRESENT	
Duncan Matheson	Secondary Care Doctor Member		APOLOGIES
Joanne Morton	General Practice Representative – Alderley Edge, Chelford, Handforth, Wilmslow		APOLOGIES
Alex Mitchell	Chief Finance Officer	PRESENT	
Sally Rogers	Registered Nurse Member		APOLOGIES
Julie Sercombe	General Practice Representative – Congleton and Holmes Chapel	PRESENT	
Dr Julie Sin	Senior Public Health Representative, Associate Director of Public Health, Public Health department, Cheshire East Council	PRESENT	
Bill Swann	Lay Member, Patient and Public Involvement	PRESENT	
Warren Tuite	General Practice Representative – Bollington, Disley, Poynton	PRESENT	

IN ATTENDANCE

Fleur Blakeman	Director of Strategy & Transformation	Whole meeting
Hazel Burgess	Note taker	Whole meeting
Matthew Cunningham	Corporate Services Manager	Whole meeting
Neil Evans	Commissioning Director	Whole meeting
Elizabeth Insley	Finance Manager	Part meeting
	Members of the CCG management support team	
five	Members of the public	Whole & part meeting

1.	PRELIMINARY BUSINESS
1.1	**Welcome and apologies for absence** Dr Bowen opened the meeting. Apologies for absence had been received from Joanne Morton, Sally Rogers and Duncan Matheson. Dr Bowen put on record thanks to Joanne Morton who has stepped down as Peer Group Lead for Alderley Edge, Chelford, Handforth & Wilmslow and expressed thanks to Handforth Health Centre for lending her time to the CCG as a Governing Body member. Next month Dr Alex Garvey from Alderley Edge will take up the role.
1.2	**Declaration of any new interests** No new interests were declared.
1.3	**Notes from previous meeting held in public – Wednesday 24 February 2016** Bill Swann asked for an addition at item 4.1.6, the penultimate paragraph on page 21, third line down, "….He agreed the actions in the action plan address **some of** the issues" He raised a further point that he felt the wording of the decision (**The Governing Body endorsed the strategy document: "Caring for Carers: A Joint Strategy for Carers of All Ages in Cheshire East 2016-2018**" was ambiguous and could be interpreted as unanimous. Given his positon as Lay Member for Patient and Public Involvement he felt it important that the pubic and carers know his position on the carer strategy and at the time the Chair had asked if he wishes his objection recorded and he had said yes. There followed a discussion about the wording and recording of decisions made by the Governing Body as a body. Highlighting that that Bill Swann's views had been included in the paragraph above the decision, Dr Paul Bowen said that ultimately the Governing Body as a group had endorsed the strategy on a majority decision. Gerry Gray, who had chaired the meeting agreed that he had asked if Bill Swann wanted his objection minuted. Noting that Billl Swann's feeling on the point was quite strong, the general consensus had been that there was nonetheless a need to move the item along and endorsement was given. It was raised that the precedent of recording an objection within the decision had already been set at a previous meeting (October 2015, held in public) on Gerry Gray's objection to agreement for the CCG to proceed to apply for delegated commissioning of primary care services. Bill Swann asked that it be recorded he did not agree that inclusion of objections in the paragraph above the decision was sufficient, and he maintained that without inclusion of his objection within the wording of the

	decision, he is put in a difficult positon opposite carers and the public, who might assume he had endorsed the Carer Strategy. There was a discussion about how individuals on the Governing Body may have individual positions on items, which could be noted in the paragraph immediately above the decision, although as a body a collective decision must be reached and clearly recorded as such. Dr Paul Bowen reaffirmed that decisions of the Governing Body should be recorded in a way which demonstrates to external parties that the Governing Body acknowledges its duty to act as one. Further assurance was given by the Chair that this discussion would be recorded in the minutes of the March meeting as further transparent recording of Bill Swann's strength of opinion on the Carer Strategy and his individual positon. With the inclusion of additional wording noted as above, and at the conclusion of the discussion, the notes of the meeting held in public on 24th February were accepted as an accurate record. *[Note: to provide clarity and for avoidance of doubt, the minutes of the meeting held in public on 24th February 2016 have been amended to include the following wording above the decision at item 4.1 : Caring For Carers: A Joint Strategy for Carers of All Ages in Cheshire East 2016-2018 : "Whilst the Governing Body agreed to endorse the Carer Strategy, Bill Swann asked for his objection to the strategy to be recorded. Bill Swann stated that he accepted and will abide by the decision of the Governing Body."]*
1.3.1	**Matters arising from the Minutes** None on this occasion other than the matter raised as noted above.
1.4	**Public Speaking Time** No requests to speak had been received in advance of the meeting.
1.5	**Chief Officer Report** **electronic link to paper here** The Chief Officer Report covered a broad range of items including the various transformation programmes the CCG is involved with and also an update on general practice peer group appointments. Jerry Hawker highlighted that this month the report showed the challenges CCG faces in scale and breadth of work the CCG is involved with from Caring Together programme, involvement healthier together and Pioneer Programme and the Sustainability and Transformation Plans.
1.5.1	He clarified that Eastern Cheshire CCG is an associate to the Healthier Together South East Sector work, referred to in item 2 of his report. The CCG is working with Stockport NHS Foundation Trust and Tameside Hospital NHS Foundation Trust, recognising the challenge to develop and improve high standards in the provision of acute general surgery to the same standard 24 hours 7 days per week, which will require hospitals to work more closely together.

1.5.2	With reference to a lead for the **Sustainable Transformation Plan (STP**) for Cheshire and Merseyside, he announced that Louise Shepherd, Chief Executive of Alder Hey Children's Hospital, has been asked by NHS England to be the Accountable Leader. Nationally, leaders appointed to STPs are a mixture of CCG Accountable Officers, Trust Chief Executives and Local Authority Chief Executives.
1.5.3	**Cheshire Pioneer Programme** (item 4 in the report) – The Cheshire Shared Care Record goes live on 1st April 2016 and Jerry Hawker put on record his thanks to all the practices who have been very proative in supporting the programme. The roll out is expected to be completed by the end of June 2016. Work is being done with the Academic Science Network and Health Education England to begin to get Cheshire colleges involved in developing the workforce for Cheshire's future, looking how to link to key worker homes and supported accommodation for healthcare workers.
1.5.4	Referring to a paper on updates to the CCG's Constitution later on the agenda, including amendments made to support succession planning, Jerry Hawker drew attention to item 8 in the paper setting out the names of the Locality Peer Group representatives on the Governing Body and their newly appointed deputies.
1.5.5	Regarding the Sustainable Transformation Plan (STP) Working Group, Dr Julie Sin noted and queried that this only has only one public health representative from the CHAMPS Public Health Collaborative, although the challenges at the Merseyside level may vary from those in Cheshire, and two Public Health representatives might be preferable. Jerry Hawker clarified that the STP is an umbrella for five local delivery plans (e.g Caring Together in Eastern Cheshire), each of which have strong Public Health Involvement. He stressed that the five plans are being developed locally and the role of the STP Working Group is to coordinate the five plans. It was queried whether if the Cheshire & Merseyside STP is to be led by a Merseyside-based Chief Executive from a Trust, was there confidence that Cheshire, and CCGs, would have good representation in the work. Jerry Hawker said that identification of a Leader role for the STP is for national visibility of the STP rather than for driving work in the STP area. The Working Group includes four CCG Chief Officers (including himself) who are writing the Governance arrangements and it is the STP Working Group which is intended to provide the engine for what is affecting front-line clinicians and the public. Decisions will continue to be made at a local level, but there will be coordination where it can be demonstrated that work at a regional level would be of greatest value. He reflected that the work continues to be an evolving picture, concerns and comments raised were well made, and he will continue to seek assurances.
	The discussion on the purpose and work of STPs continued with a comment that the name "Sustainable Transformation Plan" is not accurate, and that STPs are now footprints and a new governance and decision-making structure is being built over a wider area. The product will be a

	plan but with recruitment of individuals and appointment of leads it is becoming an infrastructure. Jerry Hawker explained that NHS England has set out transformation plans to bring the NHS back into a sustainable position. Substantial funds from 2017/18 onwards will be given to STP groups, and they make decisions on its expenditure, a process which will require a governance structure, with parallels to the Greater Manchester devolution work on which STPs are being modelled. With the inclusion of providers in the STPs, which will be operating like large scale commissioning bodies, it was commented that there will be significant conflict of interests considerations to be taken account of. Jerry Hawker stated that it has not been made clear at this stage whether the STPs will be commissioning structures, but it is a case of individual statutory bodies (NHS trusts, CCGs, Local Authorities) being brought together, and the decision making currently lies with the individual organisations. He said that to address the scale of the NHS deficit will require substantial transformation of acute care trusts, particularly hospitals, to work collectively together in networks and linked arrangements. He commented that the difference between the commissioning and provision approach is being diluted in these developments. It was queried whether a Cheshire Health and Care economy was being formed. Jerry Hawker said that the STP is not an organisation run by the NHS, it has been instigated by the NHS and is being set up by CCGs, Local Authorities and Trusts. The scale of the challenge in the NHS can be looked at on a local level, but the scale of challenge in hospitals needs to be done on a larger geographic footprint, to enable hospitals to work differently to be able to provide sustainable services 24 hours a day, 7 days a week, sharing staff and sharing the scale of the deficit. Dr Paul Bowen said that an eye needs to be kept on governance of conflicts of interest and that it was his view that moving forward patients, carers and e.g. community pharmacies would need to be represented. Jerry Hawker said that it is a challenge for NHS England that on the STP CCGs are seen to be representing both the member practices as commissioners and as providers, which he did not feel was a comfortable position.
1.5.6	Concern was expressed that there may be a capacity issue for the Chief Officer in the need to attend more meetings outside the CCG and it was asked whether he required any support from the Governing Body. Jerry Hawker said that the Executive Team does a fantastic job supporting him and keeping him on track. The paper on the CCG Cheshire Warrington and Wirral Alliance later on the agenda mentions the appointment of a Head of Collaborative Commissioning which he stated had been a crucial appointment for all Cheshire Chief Officers. He himself intended to step down from a number of regional roles, conscious that there is a need to find a balance between supporting regional work, the STP work and carrying out duties within the CCG.

1.5.7	There was a request for information in point 4 on the paper, on the appointment of a Benefits Manager. Fleur Blakeman explained that the post was funded with part of a bid made for Tech2 fund monies towards implementing the Cheshire Shared Care Record in recognition of the importance of demonstrating the return on the investment in the Shared Care Record, which will work across the health economy of Cheshire. The post is specific to determining the benefits from the Cheshire Shared Care Record.
	The Governing Body • **Noted the contents of the Chief Officer Report**
2.	**STANDING ITEMS**
2.1	**Finance & Performance Report** **Month 11, as at 29 February 2016** electronic link to paper here Alex Mitchell highlighted the main points of the paper, close to the end of the financial year. The year to date surplus of £1.4 million is in line with the forecast position. Additional financial allocations received this year have not all been expended. Some of this funding has been used to achieve the end of year forecast position, but will be spent in the coming year 2016/17. There has been a delay in implementing some of the Better Care Fund schemes, predominantly those run by Cheshire East Council, and these are consequently underspent. Following the transfer of funding for neurology from specialised services, there has been a robust assessment of the CCG's annual expenditure on neurology and this allocation has been adjusted, resulting in removal of £35,000, leaving £502,000 which there is confidence is enough to cover expenditure on neurology. Better Payment Practice Code – an improvement in performance in this measure has been maintained. The cash balance of £23,000 is on target. Regarding the Productivity Schemes, these are on target to deliver £2.4 million by the year end and help deliver the year end forecast figure. It is recognised that there is overdependence on non-recurrent schemes which have helped significantly to reduce costs. Later on the agenda there is a paper on how the CCG will approach more permanent and recurrent cost improvement savings.
2.1.1	In response to a comment that Table Two-B was difficult for clinicians to interpret and draw conclusions and comparisons from, Alex Mitchell agreed and stated that the reporting would be refined going forward. Until now date has had to be gathered manually from systems but a new business support tool, "Aristotle", provided by the new Commissioning Support Unit which will make it much easier to obtain information and benchmark data on activity and cost with other CCGs in the Midlands and Lancashire.

	In answer to a suggestion that it would be useful to use programme budgeting data to see at a system level what the CCG and other commissioners are purchasing, Neil Evans confirmed that Aristotle will hold sets of data for both the CCG and the wider system but he cautioned that information from programme budgeting has strengths and weaknesses, and he indicated that there is a lot that can be done with the NHS Right Care approach, which looks at system spend. Alex Mitchell confirmed that for the financial year 2016/17 a variety of interpretation of finances will be made available to the Governing Body.
	The Governing Body noted • **The year to date surplus of £1,298,000 as at 29 February 2016.** • **The forecast year end surplus of £1.4 million** • **That productivity efficiencies are forecast to deliver £2.4 million in savings.** • **Performance on the Better Payments Practice Code (BPPC) and Cash Management remain on target**
2.2	**Governing Body Assurance Framework – March 2016** electronic link to paper here Alex Mitchell presented the Assurance Framework for approval. Risks have been updated, there are no proposed deductions or significant changes to the existing risks. He highlighted that although there was no "Deep dive" into a specific risk on the agenda this month, a new risk was being proposed for inclusion, and the papers later on the agenda on the draft 2016/17 Financial Plan (item 3.5) and draft Financial Recovery Plan (item 3.6) would provide in depth detail on the risk. The new risk proposed is GBAF22: ECCCG's 2016/17 Planned Deficit. The CCG has a statutory duty to remain in financial balance therefore this is a significant risk and has been allocated an initial score of 25 = 5 for likelihood and 5 for impact. There was a suggestion that the description of the risk could be narrowed and include acknowledgement that figures may change. Alex Mitchell accepted the suggestion, explaining that the risk as presented had been written based on the draft submission of the financial plan, and that it would be changed when the revised plan is submitted on 11 April 2016. Jerry Hawker observed that the essential risk is that the CCG would not meet its statutory duties.
	It was observed that the new risk GBAF22 would replace GBAF9 – "CCG Financial Challenge in 2015/16" and Alex Mitchell confirmed that until the work on the end of year accounts was complete, GBAF9 should remain on the framework and at the current level of 16
	GBAF5 – Caring Together Delivery. In answer to a query whether timescales or other indicators could be added to the risk to show more clearly the progress being made, Fleur Blakeman acknowledged that the wording of the risk and the way it was set out on the framework had been

	queried at the last meeting in light of the actions listed and she agreed to reframe it ahead of next meeting. She agreed that as previously raised, the actions listed do not necessarily tie back to the description of the risk or the titles and it is a challenge to effectively present a picture of progress achieved in such a large scale delivery plan. She stated that progress is being made, and pieces of work are on track, which should reduce the risk score, but it is still rated as high because the bigger pieces of work (particularly those requiring additional significant investment) which are required in order to deliver the vision and values of the programme as a whole have not yet been completed.
	The Governing Body • **Approved the addition of a new risk to the Assurance Framework: GBAF 22 ECCCG's Planned Deficit** • **Noted and approve the list of Strategic Risks for ECCCG.**
2.3	**Sub Committee Minutes and Reports**
2.3.1	**Governance and Audit Committee** The notes of the meeting held on 27th January 2016 had been circulated with the agenda. electronic link to paper here electronic link to paper here Gerry Gray reported that as part of its internal procedures, the Committee had conducted an in-depth self-assessment of its performance over the last 18 months.
	The Governing Body • **noted the summary and the unconfirmed notes of the meeting held on 27 January 2016**
2.3.2	**Remuneration Committee** Gerry Gray gave a verbal update on the meeting which took place on 24th February 2016. Following the last Governing Body meeting there was a discussion on succession planning and the changes to the Constitution which are being proposed later in today's meeting. There was also a discussion about the benchmarking exercise which is been undertaken on comparison of time commitments and remuneration for Governing Body members across neighbouring CCGs.
2.3.3	**Clinical Quality and Performance Committee** A summary, and the notes of the meetings held in February and March 2016 had been circulated with the agenda. electronic link to paper here link to appendix A - Quality and Performance Report March 2016 link to minutes of March 2016 meeting link to minutes of February 2016 meeting
2.3.3.1	There was a query whether the failure to meet performance targets of 99% of patients waiting for 6 weeks or less from referral for diagnostic tests at providers other than East Cheshire NHS Trust and whether was an issue for just Eastern Cheshire CCG patients.

	Neil Evans gave assurance that there is good performance on diagnostic waits for people on the cancer pathway. The CCG is escalating the waits for other diagnostic tests, primarily for gastroenterology or general surgery, at University Hospital South Manchester, but a small buyer of care the CCG's influence is limited. The number of patients affected is small. It was commented that it would be useful for GPs to know where there are issues in order to refer patients elsewhere if necessary and Neil Evans reported that access to a new tool called Aristotle provided by the new Commissioning Support Unit which provides useful and helpful data and information will be made available to GPs. Regarding cancer diagnosis and outcomes, it was observed that the report provided at Appendix B shows that the CCG's performance is very good compared to peers, and that this is an indication of the system working well as a whole.
2.3.3.2	Picking up on the figures of Delayed Transfers of Care (DTOC) when people are medically fit for discharge from hospital but are awaiting social care support or places in care homes, Jerry Hawker commented that there remains a challenging situation at Macclesfield Hospital. It is not good for people, particularly frail people, to spend longer in a hospital than they need to, and the delays are also having an impact on performance on wait times in Accident and Emergency at the hospital. There is an issue with availability of social care assessments and social care-funded capacity in care homes. Recognising that this is a challenge for the whole health economy, there have been discussions with Cheshire East Council at a senior level, from whom more support is required. The Local Authority recognises the priority to increase the availability of social care beds and social care support and states it is trying to stimulate the market, but positive results are not yet being seen. Dr Paul Bowen commented he had discussed with the Medical Director of ECT the risks for medically optimised patients having to stay in hospital longer than necessary and was pleased to hear that the discussions with the Council include a recognition of the medical and health costs of delayed transfer of care, as well as the financial cost.
	The Governing Body • **noted the summary of the Clinical Quality and Performance Committee meetings held in February and March 2016**
2.3.4	**Eastern Cheshire Primary (General Medical) Care Joint Commissioning Committee** **electronic link to cover paper here** **electronic link to minutes here** Gill Boston reported that, at the second and final meeting of this committee on 25 February 2016, the principal item for discussion was the terms of reference for the new Primary Care Commissioning Committee as the CCG undertakes fully delegated commissioning responsibility from 1 April 2016. The first meeting of the Primary Care Commissioning Committee will take place in May.

	The Governing Body • **Noted the summary and the notes of the Eastern Cheshire Primary (General Medical) Care Joint Commissioning Committee meeting held on 25 February 2016**
2.4	**Advisory Committees – summary reports**
2.4.1	**Locality Management Meeting** There was no meeting of this group in March 2016. Dr Paul Bowen stated that from April there will be monthly meetings with the member practices. There will be two formats of meetings • the traditional format of an opportunity for the CCG management team and practices to meet as commissioners • a new format of meeting with the opportunity to work with and the practices on the implementation of the new Caring Together primary care contract and hold them to account for delivery of improvements in quality It was commented that, as a membership organisation, the CCG member practices will be holding themselves and each other to account.
2.4.2	**Eastern Cheshire Community HealthVoice** Bill Swann gave a verbal update on the meeting which took place on 17 March 2016 at Marthall, attended by approximately 16 members of the public. The minutes will be available at the next Governing Body meeting. Presentations and updates were provided in the meeting by North West Ambulance Service, HealthVoice representatives on various CCG groups, and an update from Rosie Kendrew on the CCG's complaints team. The next meeting will be held on 10th May. Bill Swann said that people appreciate being kept up to date on work in progress. In answer to a question, he stated he believed more could always be done but he has the impression that HealthVoice does have general appreciation that they have had the opportunity to input to the commissioning intentions for 2016/17 for the CCG and that the group does feel that the CCG genuinely makes the effort to seek their input. Regarding the idea of theming meetings, Dr Paul Bowen suggested that not just the commissioners but the providers of the services be invited along to the meeting to hear the experiences of users of the services and be held accountable to them. Bill Swann felt this might be attractive to HealthVoice members and increase attendance at the meetings: at the moment there is an opportunity to comment on future plans but people are sometimes more engaged if they have a problem with a current service. Bill Swann suggested that if issues are brought up at HealthVoice they could then be brought along and aligned with Governing Body meetings. Dr Bowen offered to make contact with Trevor Lerman, Chair of HealthVoice, regarding inviting providers of services to future HealthVoice

	meetings on themes.
2.4.3	**ACTION Contact Trevor Lerman, Chair of HealthVoice, re inviting providers of services to future HealthVoice meetings on themes – Paul Bowen**
	The Governing Body • **Noted the update on the HealthVoice meeting which took place on 17th March 2016**
3.	**ITEMS FOR DISCUSSION**
3.1	**Update to the CCG Constitution** electronic link to paper here Matthew Cunningham presented a summary of revisions to the CCG's Constitution. These include re-wording and amendment of typographical and grammatical errors, as well as the inclusion of arrangements made for business continuity in the short term; succession planning for key posts within the CCG and on the Governing Body; and the strengthening of clinical leadership and engagement in the CCG.. The appendix lists the amendments made after conversations held at Governing Body and Remuneration Committee meetings, and following engagement with the member practices. electronic link to summary of amendments The principal changes are • **Title of the Executive Chair amended to "CCG Clinical Chair"** • **Appointment of an Assistant Clinical Chair of the CCG** • **Appointment to the new role of Medical Director** • **A new role of Chief Nurse and Director of Quality (incorporating the role of registered nurse on the Governing Body)** • **Appointment of deputies for the Peer Group Leads** The proposals were checked with NHS England's Constitution Team to ensure that they were in line with guidance in the Health and Social Care Act and guidance on Conflicts of Interest. Subject to any further amendments, following endorsement by the Governing Body, version 1.5 of the Constitution will be submitted to NHS England for final approval and then published on the CCG's website.
3.1.1	As Chair of the Governance and Audit, and Remuneration Committees, Gerry Gray gave his support in general for the amendments regarding succession planning, which he commented had come out of a review requested by the Remuneration Committee. However he wished to put on record his opposition to the need for having both a Deputy Chair and an Assistant Clinical Chair with responsibilities for chairing Governing Body meetings, which he believes is a counter intuitive move, and he requested clarification on the rationale for the proposal as set out in the draft amendment to the constitution.

3.1.2	There followed an in-depth discussion of the scope of the proposed new role of Assistant Clinical Chair, with particular focus on the chairing of Governing Body meetings. All present were in agreement that there should be a Clinical Deputy (the proposed Assistant Clinical Chair) to cover as Chair of the CCG, a clinically-led organisation, for short periods of absence of the Clinical Chair of the CCG, and that there are aspects of the CCG Chair role which would be more appropriately covered by a clinician than a Lay Member. The point of contention was whether the new Assistant Clinical Chair should, as proposed, in the absence of the Clinical Chair, take on routinely chairing the Governing Body meetings in preference to the current Lay Deputy Chair, except on occasions where there may be a potential conflict of interest in an item on the agenda. It was suggested by some members that this is not necessary and there is already a Lay Deputy Chair who should continue to stand in as Chair of the Governing Body as is currently the case, although there was full support that the Assistant Clinical Chair would be a fitting deputy for the Clinical Chair of the CCG in every other aspect of the role. Points made in favour of the Assistant Clinical Chair taking on the role of chairing Governing Body meetings in the absence of the Clinical Chair were • GPs working in the CCG 1-2 days per week have not only clinical experience to bring to discussions, but also operational insight into the CCG. • no other GP in the CCG currently has experience of chairing a public meeting; this would be remedied by the Assistant Clinical Chair building up experience by deputising in short periods of absence of the Clinical Chair. • Always having a clinician chairing Governing Body meetings would reinforce to the general public that the CCG is a clinically led organisation Points made against the Assistant Chair routinely taking on the role of chairing Governing Body meetings in the absence of the Clinical Chair were: • the perception that the role of the Lay Deputy Chair is being superseded is at odds with the spirit in which the Governing Body arrangements were set up, in that the original intention had been that there would be a non-clinical person in a senior supporting role to the CCG and it was suggested that there is no need for an additional Chair role. • The only role of the Lay Deputy Chair is to chair Governing Body meetings in the absence of the Clinical Chair or for agenda items where the Clinical Chair may have a conflict of interest. It would seem good governance to continue with this. If this is not required, any Lay Member could chair an item where a conflict of interest may arise for clinicians and there would be no need for the role of Lay Deputy Chair.

	• The Assistant Clinical Chair will not have been appointed by the member practices but will have a casting vote on decisions if / when required. On this point Matthew Cunningham confirmed that the membership had approved the proposals and Dr Paul Bowen indicated that approval of the member practices for the post holder would be sought
3.1.3	As regards consistency with guidance on the role of Chair of the CCG from NHS England, Matthew Cunningham confirmed that the stipulation is that in the case of any conflict of interest during a discussion at a Governing Body meeting, a Lay Governing Body member will chair the item. The only other stipulation about the role of the Chair of the CCG is that it cannot be held by the Chair of the Governance and Audit Committee. When the CCG was formed the member practices decided the Chair of the CCG should be a GP. There is no other guidance from NHS England. It is within the CCG's gift to make decisions about any deputy role. The proposals in version 1.5 of the Constitution state that if the Assistant Clinical Chair is also a serving GP Locality Lead, they could not continue also serve in that capacity whilst deputising for the Clinical Chair, and in that instance, their deputy would step up and fulfil the role of Lead for their Peer Group.
3.1.4	The discussion resulted in complete agreement that: • There be a clinical deputy for the Clinical Chair of the CCG • That items in Governing Body meetings where a conflict of interest may arise for GPs be chaired by the Lay Deputy Chair
3.1.5	Some members remained concerned, and not supportive of the proposal that effectively the Lay Deputy Chair be replaced as default deputy Chair of the Governing Body meetings except in cases where conflicts of interest might occur.
3.1.6	Dr Paul Bowen referred to his absence from the CCG for two months at the end of 2015 and his wish for a confirmed process to cover any absence in future by appointing a Clinical Assistant Chair. He gave assurance that he would work with the appointed post holder to prepare them for the demands of the role.
3.1.7	There were requests for clarification about why the Assistant Clinical Chair would need to be a GP, whereas Locality Peer Group Leads can be any employee of a practice. Jerry Hawker said that Peer Group Leads have a different role and responsibility to that of the Chair. The practices had agreed that any employee of the practices could be eligible to take on the responsibilities of a Peer Group Lead. The practices had also decided, and it was written into the CCG's constitution, that the Chair of the CCG must be a GP. National legislation does not place any requirement for there to be a Lay Deputy Chair other than where there is a potential conflict of interest for a Clinical Chair during a discussion at a Governing Body meeting. The Constitution could be changed to not have a Deputy Chair. Returning to the new role of Assistant Clinical Chair, there was a request

	for clarification on who would be appropriately qualified and eligible to take on the role and how it would be preferable / necessary to appoint somebody who was already a member of the Governing Body or a Sub-Committee. The amendment to the Constitution has kept options open on this point such that it need only be a GP from one of the practices, which means it could be one of the Clinical Leads working in the CCG who are not currently a sitting member of the Governing Body.
3.1.8	Dr Paul Bowen summarised the point that as Chair of the CCG, he will identify in advance an individual who is able and willing to lead the CCG externally and internally including chairing the Governing Body, except where there is a potential conflict of interest, in the event of his absence for a period of up to three months. Acknowledging that no other GP in the CCG has had any experience of chairing a public Governing Body meeting, he indicated that it would be sensible if the Assistant Clinical Chair had experience at Governing Body level. He emphasised that the appointment will have to be approved by the member practices. He recognised the concerns raised about the Lay Deputy Chair role being enacted only on occasions where there are potential conflicts of interest. He concluded with the assurance that should it be necessary for cover for the role of Chair of the CCG for more than three months, elections would be held.
3.1.9	The proposal that version 1.5 of the Constitution be endorsed was put to the Governing Body, with a vote taken on the proposal to appoint an Assistant Clinical Chair who would, as detailed in the appendix, chair the Governing Body meetings in the absence of the Clinical Chair, except where there is a potential conflict of interest. **The Governing Body** • **endorsed Version 1.5 of the Constitution, with a majority of 7 votes for, and 4 against (Dr Julie Sin and all three of the Lay Governing Body members: Gill Boston, Gerry Gray and Bill Swann) and no abstentions.**
	Dr Paul Bowen commented that the concerns raised today were noticed and he gave a commitment that any further changes to the Constitution would be communicated well in advance with a view to gaining more consensus on a future occasion.
3.2	**Cheshire Warrington and Wirral CCG Alliance** electronic link to paper here Jerry Hawker referred to the Chief Officer report which included indications of the scale and diversity of programmes, projects and transformation work in which Eastern Cheshire CCG is involved. This is a context recognise and shared by the other CCGs and organisations across Cheshire Warrington and Wirral. Recognising capacity challenges within the CCGs, the Chief Officers have agreed the value of a Cheshire Warrington and Wirral (CWW) CCG alliance to formalise and build on a number of existing collaborative arrangements (e.g. commissioning of services over across the North West, Continuing Healthcare Services across Cheshire Warrington and Wirral). The alliance will not be a decision-making body, each CCG will retain its individual

	decision-making authority. The Memorandum of Understanding electronic link to paper here and Terms of Reference electronic link to document here are presented to the Governing Body to seek support for Eastern Cheshire CCG to enter into the alliance.
3.2.1	In response to a query about the description of the alliance as a non-decision-making body, there was a query about references to "decisions by consensus" and "quorum" mentioned in the Terms of Reference, Jerry Hawker acknowledged the ambiguity of the terminology and clarified that CCGs would operate under their existing Schemes of Delegation, with the Chief Officer and Chief Finance Officer of each organisation making decisions on how the CCG manages its own resources.
3.2.2	There was a question about the implications of the Alliance for the Pioneer programme, which includes Cheshire CCGs but not Warrington and Wirral CCGs. Jerry Hawker said the alliance would give an opportunity to align programmes of work across the region and there may be opportunities to pick up on pieces of work going on which conflict, rather than complement. In response to a question about the link between the Alliance and the Health and Wellbeing Board, he said that part of the early work of the alliance will be to look at the governance arrangements and working relationships of all cross-organisational groups and committees across the area (e.g. including the Sub Regional Management and Leadership Group, organised by the Local Authorities) recognising that there may be duplication of work
3.2.3	With reference to the emerging STP arrangements across the Cheshire and Merseyside footprint, it was queried what added value the CWW CCG Alliance would provide. Jerry Hawker indicated the example that ambulance services and non-emergency patient transport services are commissioned at a Cheshire level, not an STP level. There is a need to continue to develop working arrangements as the NHS organisational structures continue to evolve. Cheshire as a rural region sits between large conurbations, a CCG alliance offers the opportunity to work together to have a stronger health voice for Cheshire residents. At the next meeting of the CWW CCG Alliance the Cheshire and Merseyside Public Health Collaborative (CHAMPS) will present on public health in Cheshire, where issues are different to those in Merseyside. It was commented that the CWW CCG Alliance offers reassurance about Cheshire's influence in the STP by building a stronger voice to defend the Pioneer programme and the position in Cheshire in conversation with Merseyside. It was queried where the CCG should concentrate its efforts – on working with Greater Manchester, with the CWW CCG Alliance, or with the STP work. Jerry Hawker responded that the CCG has to work as a clinically-led organisation with strong relationships with the GP practices in Eastern Cheshire. Its closest relationships are those working with local partners in Eastern Cheshire and the wider Cheshire footprint. On geographic

	considerations, from the point of view of hospital interventions for its residents, it needs to continue to strengthen relationships with Greater Manchester rather than across Cheshire. It needs to work for the benefit of its local population regardless of boundaries or footprints created artificially by external initiatives. Another point of view was expressed that the benefit of having the number of committees and groups which are in existence across the area is yet to be demonstrated. This new group will add further additional workload for the Chief Officer, with the knock-on implication for the Executive Committee. Particularly as it is a non-decision-making body, there was a request that a review evaluating the benefits of the group be brought back to the Governing Body in 6 or 12 months. Jerry Hawker offered to provide continuous feedback on the alliance monthly in the Chief Officer reports. He highlighted that workload is already spread across the CWW CCGs as the Chief Officers Cheshire take an agreed lead on behalf of the others on areas such as: ambulance services and the Cheshire Care Record (Jerry Hawker); transformation of learning disabilities services, and working with the Unions (Alison Lee, West Cheshire CCG); NHS England Education (Simon Whitehouse, South Cheshire & Vale Royal CCGs). Dr Paul Bowen agreed to the request that a formal "stand back" review of the added value of the CCG CWW Alliance be brought to the Governing Body.
3.2.4	**ACTION Have the Terms of Reference for the CWW CCG Alliance amended to clarify that as a group it does not have decision-making powers and that the member CCGs retain their individual decision making powers according to their organisation's Schemes of Reservation and Delegation**
3.2.5	**ACTION A "stand back" review of the benefits and achievements produced by the CWW CCG Alliance to be brought back to the Governing Body in 9 months' time November 2016 - Jerry Hawker**
	Noting that amendment will be made to the wording in the Terms of Reference on decision making to reflect that each CCG will operate under its own Scheme of Reservation and Delegation, **The Governing Body** • **Noted the content of the report and the establishment of the Cheshire Wirral & Warrington Alliance** • **Noted the proposed Memorandum of Understanding for the Cheshire, Wirral and Warrington CCGs Alliance** • **Noted the Terms of Reference will be amended to clarify that as a group it does not have decision-making powers and that the member CCGs retain their individual decision-making powers according to their organisation's Schemes of Reservation and Delegation** • **Supported the Chief Officer's recommendation that he sign the Memorandum of Understanding and agree the Terms of Reference on behalf of the CCG**

3.3	**CCG Annual Plan 2016/17** electronic link to paper here Neil Evans presented the CCCG's annual plan for 2016/17, devised using national guidance issued by the Secretary of State and including nine national priorities alongside local priorities. An additional factor this year in setting plans is the local and national challenge around finance in the NHS. Accordingly the CCG is not in a position to invest in radical change where a quick return on investment could not be shown. He referred to Appendix A, the Plan on a Page, electronic link to paper here which provides a summary view of the priorities for the year. The plan takes account of the Joint Strategic Needs Assessment, work has been done with member practices and members of HealthVoice, with a Commissioning Intentions Group working through a priorities matrix .age. Further work is now being done to develop the work programmes in more detail. The detail of the QIPP schemes will follow later in the meeting at item 3.6 – Financial Recovery Plan. Neil Evans highlighted that there are two areas where the CCG will not be able to meet its statutory duties on delivering performance targets: the maximum four hour wait in Accident and Emergency target, and the two standards for access to psychological therapies (IAPT). A business case for IAPT will be brought to a future meeting. Submissions on progress have been made to NHS England since the beginning of February 2016, the final submission is due on 11th April 2016. Item 5.4, Table A shows the CCG's estimation of how hospital activity will change. Figures from the Caring Together primary care business case and the frailty service have been used to model the assumptions through. Our local assumption is lower than the national assumption, other than for cancer. The CCG is required to select three areas where it will improve efficiency and effectiveness through the NHS Right Care methodology. Item 6.2 lists Commissioning for quality schemes mandated under the NHS contract – negotiations are being finalised with providers on an additional range of local improvement schemes.
3.3.1	It was commented that it is pleasing to see service improvement. It was confirmed that important issues identified within Right Care will be covered under QIPP. Right Care is an NHS approach indicating areas of expenditure where it is believed there is more opportunity to influence change quickly. This can be applied directly to the local situation as regards IAPT (Improving Access to Psychological Therapies) and the approach will help ensure the service is being implemented effectively to maximise the benefits.
3.3.2	Alex Mitchell cautioned that the two standards on Accident and Emergency wait times and access to IAPT which the CCG is not going to meet this year may have a further impact on other standards which the CCG needs to aspire to meet.

3.3.3	Caution was advised that there is a risk of QIPP initiatives such as investment in general practice being counted twice in planning. Neil Evans indicated there are national formulas to be applied to planning which are not necessarily applicable to the local situation. He cited the national assumption for 2.1% growth in Accident and Emergency attendances; there was no increase in Eastern Cheshire in the last year so using that assumption would be a flawed approach.
	The Governing Body • **Approved the service developments and transformational change priorities identified in the draft Annual Plan** • **Approved the trajectories and growth assumptions used in the NHS England Operational Plan Template Submissions**
3.4	**Better Care Fund (BCF) 2016/17 Plan and Section 275 Agreement** Alex Mitchell asked to put on record his thanks to Jacki Wilkes, and to Caroline Baines of Cheshire East Council, for their work on the paper. electronic link to paper here The BCF was implemented in April 2015, with shared arrangements under a Section 75 contract between Cheshire East Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG. Alex Mitchell said it has progressed reasonably well, and the organisations are working more transparently together, with some schemes requiring the organisations to work together. A review is being conducted of the effectiveness of the schemes in the plan.
3.4.1	To draft the 2016/17 plan, NHS England has mandated the direction and the minimum financial contribution required from the CCG is £11.894 million. Work on refining the plan is continuing and the final submission of the plans for 2016/17 is due on 25th April 2016. The Joint Commissioning Leadership Team (JCLT) comprising senior commissioning managers, directors of partnership and finance officers from all partners looked at options for setting the plan as described in full in Table Two: • **maintain the same contributions as last year** • **increase contributions** • **increase contributions on a larger scale and bring further work into the scope of the BCF** The recommendation from the group was to increase contributions and include further areas in the BCF. Table 3 in the paper shows the breakdown of the draft plan. Note: the figure quoted within Table 3 outlining NHS Eastern Cheshire CCG investment in the Shared Care Record should state £250,000. It is proposed that the CCG contributes additional money from its budget

	into the pooled budget as contributions towards work on the Cheshire Care Record, the Community Equipment Scheme, Carers, Mental Health Reablement and Integrated Teams. It is proposed the Section 75 agreement be continued for another year, with an option to decide how to take it forward. It is a national recommendation that the agreements be for one-year periods. Work will continue on refining the list of schemes identified in the paper up to the deadline of 25th April 2016. Alex Mitchell asked for delegation to himself and Jacki Wilkes to finalise the plan.
3.4.2	It was observed that the proportion of funding contributed to the BCF by Council has always been lower than that contributed by the CCG, but as this is now increasing it gives reassurance against concerns that nationally health funding is being secured but diverted to social care.
3.4.3	Observing that generally people do not mind where money comes from as long as services work, it was queried whether the monitoring and evaluation of the effectiveness of the BCF schemes are just as robust as if the services were commissioned by the CCG. Alex Mitchell gave assurance that the BCF partners have commissioned an effectiveness review of the schemes already in place, and that this will be shared with the Governing Body. Through the Health and Wellbeing Board the CCGs are consistent in expressing concerns about evidence that the BCF is making a real difference to people's lives, their health outcomes and their experience of care and there is an expectation that the Health and Wellbeing Board will be looking to a wider review of the BCF in 2017/18 to demonstrate the benefits.
3.4.4	It was queried whether the Caring Together initiative Community Based Coordinated Care, which is being carried out by district nurses and social workers, would be commissioned via the BCF or by the CCG. Alex Mitchell referred to Table 3 and indicated that community based coordinated care is already going on via those element listed in the table using the £8,342 contributed to the BCF by the CCG. Longer term if it is working well and there is a move to joint procurement of social and health services a decision may be taken to commission it as a whole service.
3.4.5	Regarding whether all funds in the BCF have been spent, and if not which areas were underspent, Alex Mitchell responded that some work is still required on the final outturn against the plans and the Review mentioned earlier will provide analysis of spend. The majority of schemes in the 2016/17 plans are being rolled forward from the 2015/16 plan; some are still pilot schemes and will be evaluated. It is not clear whether any underspend on schemes will be returned to the CCG or left with the delivery partner (Cheshire East Council).
	The Governing Body approved • **ECCCG's continuation of the Better Care Fund arrangements in 2016/17 in line with the national guidance** • **The creation of Section 75 contractual agreements between**

	Cheshire East Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG • **The delegation of authority to the Chief Finance Officer and Associate Director of Commissioning to finalise the schemes funded by the Better Care Fund in line with the 25 April 2016 submission date** • **The proposal that ECCCG increases the Better Care Fund pool over and above the national minimum of £11.894 million by adding additional schemes to the value of £636,000**
3.5	**2016/17 Draft Financial Plan** electronic link to paper here Submission to NHS England of the CCG's final plans for 2016/17 is due on 11th April 2016. Alex Mitchell explained that the draft financial plan submitted to the meeting today had been prepared based on a draft submission made to NHS England on 2nd March 2016, and following discussions with NHS England in the intervening period, the situation has changed. He asked that the recommendations in the paper be disregarded and he would now put forward new options and make a new recommendation to the Governing Body.
3.5.1	He recapped the CCG's recent financial history: • for the financial year 2013/14 a balanced budget had been set, but the CCG delivered a surplus £204,000. • for 2014/15 an initial plan had forecast a £2 million deficit in progressing the transformation programme; the transformation programme did not quite deliver and the £2 million was retained, resulting in balanced position at the end of the year • For 2015/16 the CCG received a financial uplift which provided good gains and a balanced position and surplus will be achieved.
3.5.2	Alex Mitchell listed considerations used in drafting the plan for 2016/17, including local considerations and national updates. Appendix A indicates the financial allocation for 2016/17 from NHS England which includes a 3% uplift (Table 2a), and the breakdown of the uplift (Table 2b). 1.1% of the uplift (£ 2.9 million) is left to offset against local pressures. There are indicative robust allocations for next 2 years, and indicative allocations for years 3 and 5. Alex Mitchell talked about the CCG's "distance from aspirational target allocation" which is based on a revised national target. Table 2a indicates how the CCG is 3.4% below its ideal distance from target, equating to about £7.5 million. There was a pace of change to accelerate the uplift to CCGs who were further away from their aspirational target, but now that Eastern Cheshire CCG is under 5% away it is expected that the level of funding is likely to remain around 3% lower than target. Alex Mitchell talked through 4.2 in appendix A – the Financial Bridge, explaining how the initial draft plan showing a £8.9 million deficit was arrived at, (or £14.3 million if the Business Rules were adhered to).

	Pressures come from the financial challenges faced by the main provider, East Cheshire NHS Trust, which has given notice on some services which it says payment did not cover costs of provision. From 1 September 2016 stroke services will be provided by Stockport FT, in the interim ECT say they cannot provide the service at a loss and additional costs will be incurred. Also included in the £8.8 million pressure are costs involved in the on-going work with Cheshire East Council on continuing healthcare costs. The initial plan set a QIPP target of 4.2%. The outcome was a planned deficit of £8.9 million at time the paper was written, or if business rules were followed, the deficit rose to £14.3million
3.5.3	In considering financial plans, NHS England aggregates the results across Cheshire and Merseyside, across the North of England, and finally across the whole of England. They have confirmed and stressed that CCGs must put 1% headroom into their plans. For Eastern Cheshire CCG this is another £2.7 million. This increases the £8.9 million deficit to a revised opening position of £13.1 million deficit, excluding delivering a surplus. NHS England is taking a more in-depth role in assessing any plans showing a deficit and has stated that the QIPP plan percentage of 2.4% was relatively low compared to other CCGs across the country and needs to be increased. There was a reminder that the CCG has no mandate to exceed its allocations and a directive was issued that the financial plans must get to as near a breakeven position as possible. It is therefore necessary to extend the work on QIPP to more wide-ranging in size. The upshot of all the recent discussions is that the size of the planned deficit is not acceptable to NHS England.
3.5.4	Alex Mitchell presented three options for the basis of a new financial plan, working from the start point of a £13 million deficit as outlined above : **Option1 – set the plan to achieve no deficit and no surplus at year end, with a QIPP plan of just short of £14 million.** He suggests this would be likely to be undeliverable, there would be a significant impact on access to services and it would not be possible to progress the transformation programme. **Option 2 : set the plan with a QIPP target of £9 million and forecasting a <u>recurrent</u> balanced position, but with <u>a deficit of £4.9 million in 2016/17</u> due to a number of non-recurrent pressures affecting the CCG in that year only.** Alex Mitchell emphasised that a QIPP target of £9 million will still have a hugely significant impact on local services, requiring revision or setting of access thresholds, redesigning or even withdrawing some. **Option 3 – continue with the plan as presented and the £13 million deficit, taking heed that the QIPP plan can be increased to take account of the 1% non-recurrent headroom, set the QIPP Target at delivery of £6 million and forecast a recurrent deficit of £4.1 million.** The result of this would be the ability to retain an element of the

	transformation programme and some stability of services but the size of the deficit would not be considered acceptable by NHS England and it is likely the CCG would be "put into special measures" meaning a Turnaround team would be brought in to impose a plan of efficiencies. Alex Mitchell's view for the record is that Option 3 is not challenging enough, Option 1 with a £14 million QIPP plan could not be delivered within a year, and Option 2 appears the most sensible course of action, recognising that nationally the performance of CCGs is measured in-year by how well they perform against their plan and if NHS England agrees the in-year deficit of £4.9 million its performance will be measured against that. He and Jerry Hawker will meet with NHS England tomorrow. Alex Mitchell confirmed that discussions with the NHS England Area Team have been taking place regularly, including the previous day, and there is strong pressure from them for the CCG to present a plan for a balanced financial position. Any flexibility NHS England has is based on looking at the position across Cheshire and Merseyside, and also the North as a whole, and there is a particular issue across Cheshire in that most CCGs are forecasting a deficit for next year.
3.5.5	There were queries about whether NHS England appreciates the local situation and understands the work that is being done, and whether there can be any surprise over the position of both the CCG and ECT, which was forecast by the work done by McKinsey & Co a few years ago. Alex Mitchell indicated that the level of financial challenge has escalated, making the extent of the economy's problem much greater than the McKinsey forecast. The CCG has an excellent relationship with the (local) NHS England Cheshire Warrington and Wirral (CWW) Area Team, who are represented on the Caring Together Programme Board and recognise the current challenges for the local economy. He explained that ultimately the challenge to getting recognition of local issues comes in the national NHS England management structure, which focuses on the here and now and the total NHS budget and does not appreciate individual challenges in local and longer term work. The NHS England CWW team has seen the detail behind the Financial Bridge (item 4.2 in the paper) but still maintain that the CCG must somehow balance the books. Jerry Hawker explained that the current situation is the outcome of the local CWW NHS England Team working being totally appraised of the local situation but being expected to carry out the direction coming from the central NHS England Team. On paper the CCG has had a £7.5 million uplift which creates surprise that there could be a deficit. NHS England needs to balance the books at a national level and the CCG will be expected to balance its books. The challenge from NHS England is that the CCG could see the situation ahead and was enough done / is enough being done to mitigate it. The numbers in the financial plan will be the demonstration of our commitment to address the deficit.
3.5.6	Jerry Hawker said that as the Accountable Officer he should only accept Option 1 – working to achieve a balanced position, but he believed that

	Option 2 – working towards a recurrently balanced position is a defensible and the appropriate strategy in light of exceptional non-recurrent costs which will be incurred in the year as part of the system rebalancing. Gerry Gray in his position as Lay Member for Governance and Chair of the Governance and Audit Committee stated that he was in a similar situation: whilst it should be necessary for him to recommend only working towards achieving a balanced income and expenditure, acknowledging the detrimental impact on services, he believed that looking at the situation from an accountancy point of view and appreciating that system transformation takes time, he was comfortable with Option 2 and that an appropriate course of action is to aim for a balanced income and expenditure position in 3 or 5 years' time. Gill Boston concurred. She expressed the belief that if Option 1 would be difficult to achieve and if it were followed, limiting options for transformation, the system would be put in a worse positon over the next 2-3 years and a longer term adverse knock-on effect would ensue. She held that achieving Option 2 was more realistic. Dr Mike Clark said he would support helping find an extra £5 million QIPP savings, recognising there will be a need to increase encouragement to clinicians to suggest change and acknowledging there will be a need to restrict access to some services, introduce prior approvals, and in some cases the option of services being decommissioned. Regarding the CCG's role in this, he suggested it would be helpful to provide clinicians with resources to have the conversations with their patients about changes to services, produce a list of services requiring prior approval, and deliver communication about the necessary changes to services. Gill Boson said it was essential that if changes are made to access to services, they are made in a fair and equitable way. She cautioned that the totality of the changes should not adversely disadvantage those who do not take care of their health and for whom outcomes are already poor.
3.5.7	Dr Jenny Lawn suggested that the QIPP plan cannot be delivered without the transformation programme, for which social care back up is also essential. Dr Paul Bowen cautioned that the Better Care Fund has been established recognising that there is a need to change the way people work. On the impact of quality and safety of any changes to services it was discussed that • The public will be engaged in decisions about the changes to services including assurances of quality • Acknowledging that quality as regards e.g. ease of access is sometimes compromised when changes are made, the CCG's ambition is for services which are as high quality as possible and although a "gold" standard service may not be provided, it should be at least "silver" • there will be no compromise on safety of services • any changes to services should be made in an equitable way

3.5.8	Regarding consequences for providers of the CCG increasing the QIPP target to £9 million, it was noted that a reduction in use of services provided by the main provider, ECT will not also reduce their costs to run the services by a similar figure.
3.5.9	The discussion on the impact of the QIPP plan continued and points raised during the discussion were summarised: • There needs to be a way to balance the books but continue transformation; the Caring Together contract for general practice will help make it happen • The NHS has to manage within its resources, there is a finite amount of money available for services within Eastern Cheshire and if it is not sufficient to fund the services a more efficient way of providing the services needs to be found • Option 2 would mean the CCG meeting its statutory duties but looks more achievable than Options 1 or 3 • Reducing costs means activity levels will have to reduce: there will be an impact on providers • Decisions on QIPP schemes must follow the principle of maintaining quality and safety of services, and not disadvantaging the most vulnerable • There will be communication with the public about any reduction in service which requires consultation e.g. raising of thresholds for access and potentially decommissioning
3.5.10	Alex Mitchell and Jerry Hawker will provide feedback on the outcome of the discussions with NHS England taking place on 31st March and weekly updates will be provided to the Governing Body to keep them informed of progress. There was a discussion about the consequences of not achieving financial balance and the merits of choosing to follow Option 2 versus Option 3. It was agreed that Option 2 means the CCG retains control over how efficiencies will be made. Alex Mitchell emphasised that it is yet to be determined whether NHS England will agree the Option 2 plan with a deficit of £4.9 million.
	Acknowledging the significance of the QIPP challenge, **the Governing Body approved** • **The setting of a financial plan for 2016/17 with a QIPP target of £9 million and forecasting a recurrent balanced position, but with a deficit of £4.9 million in 2016/17 due to a number of non-recurrent pressures affecting the CCG in that year only.**
3.6	**Financial Recovery Plan 2016/17** electronic link to paper here Neil Evans summarised how the commissioning intentions working group, including CCG staff, members of Eastern Cheshire HealthVoice and other clinical members of the community, had identified and worked up Quality Innovation Improvement and Productivity (QIPP) schemes in the detail required to enable members

	of the public and clinicians to make decisions on prioritisation of CCG resources. The QIPP scheme suggestions were grouped under themes and a series half day workshops are under way to discuss the proposals and use the prioritisation matrix (electronic link to paper here) to assess and identify risks highlighted, then formulate more robust plans. A workshop on the Medicines Management schemes has already taken place, and Neil Evans observed that, given the discussions at today's meeting and the need to double the scale of the ambition, there will be a need to be twice as courageous at putting forward and working up ideas at the next workshop on the next theme on 20th April.
3.6.1	Table 1 in the paper shows the outcome of the recent workshop on Medicines Management QIPP schemes: Agreed: Drug switches which give savings - the practice of switching to generic brands of drugs; this is already being carried out. More fundamental and possibly requiring consultation with the public: ceasing some of the over-counter prescribing. Some CCGs have already done this, or are engaged in consultation, asking the public to help them make decisions on QIPP schemes, including include prescribing options. Neil Evans suggested that there is a need to begin the public discussion and initiate an on-going dialogue with the public over the next months as the schemes are refined in the workshops and made into proposals for consideration. Early public consideration and discussion will minimise delay to implementation and realisation of the benefits. It was agreed that consultation information will be prepared on the proposals re changes to access of readily available over-the-counter medication. It was suggested that the new Caring Together primary care contract will be a means of addressing and reducing wastage through over-ordering of medicines.
3.6.2	Regarding Elective Care (gastrointestinal; trauma and injuries; circulation; respiratory; neurological; musculoskeletal) QIPP - work will continue on this using the Right Care indicators, and work will also continue on the nine "National Must Do's" listed in Table Four.
3.6.3	Jerry Hawker said that the right balance must be struck between moving the QIPP programme along at pace, engaging with the public, and making sure the Governing Body is fully aware of the work and the progress. He asked if the Governing Body would be comfortable if the same approach for commissioning decisions were to be used for QIPP scheme decisions – i.e. rather than business cases for each being brought to the Governing Body, any decisions below £100,000 could be made by the Executive Committee, with anything above this figure going to the Governing Body for decision. Gerry Gray, as Chair of the Governance and Audit Committee, proposed that in the interests of enabling movement at pace the figure for delegated decision making by the Executive Committee be set at £250,000. Jerry Hawker gave assurance that a quality impact assessment and the

	same process and principles would be applied to decisions on smaller amounts of money which may have a bit impact on small numbers of patients. With a view to safeguarding the CCG's reputation, if it is deemed that a risk within a QIPP scheme might escalate, the proposal would be brought to the Governing Body.
3.6.3	It was suggested that different levels of engagement with the public – e.g. the CCG's website - could be used for different types of changes according to the potential impact. Jerry Hawker will provide Governing Body members with a standard A4 brief on the challenges the CCG faces, along with the CCG's answers to questions which they may be asked by members of the public. **<u>ACTION</u>: Ask the Communications Team to provide Governing Body members with a brief and Frequently Asked Questions about the QIPP Savings proposals – Jerry Hawker**
3.6.4	The discussions and the item were summarised: A paper will be brought to the meeting each month with an update on progress and Governing Body members will receive updates and information in between times as necessary. There will be a "deep dive" at next month's Governing Body meeting on the process including the governance process and a communications strategy. More information will be given to the Governing Body on the numbers behind two of the schemes in Table 2, (proposals to change policy on prescribing over the counter medicines; Reducing medicines waste); engagement with the public may also be required, and equality impact assessments will be carried out on all schemes proposed.
	The Governing Body approved implementation of the Medicines Management QIPP schemes with immediate effect: • **Drug switches which give savings** • **Savings on other prescribing budgets (acute high cost drugs etc.)** • **Review/re-procurement of Medicines Management Supporting IT systems**
4.	**ANY OTHER BUSINESS**
	None on this occasion.
	Dr Paul Bowen closed the meeting, commenting that important decisions had been made during the meeting. He stated that the CCG values the involvement and contribution the Governing Body members make to the running of the CCG. He expressed appreciation that members of the public had stayed for the length of the meeting.
5.	**DATE AND TIME OF NEXT MEETING**
	Wednesday 27th April 6pm at Congleton Town Hall