NHS
Haringey
Clinical Commissioning Group

Draft Minutes of the
Meeting of the Haringey Clinical Commissioning Group Governing Body
Thursday 24 March 2016 at 1.30pm
Cypriot Centre, Earlham Grove

Present:

Dr Sherry Tang	SP	Chair of Haringey CCG, Central GP Member
Dr Muhammad Akunjee	MA	GP Governing Body Member, South East Lead
Dr Gino Amato	GA	GP Governing Body Member, North East
Dr Simon Caplan	SC	GP Governing Body Member, North East
Dr Peter Christian	PC	GP Governing Body Member, West Lead
Dr Jeanelle de Gruchy	JG	Director of Public Health, LB Haringey
Dr Dina Dhorajiwala	DD	GP Governing Body Member, West
Catherine Herman	CH	Lay Member and Vice Chair, Haringey CCG
David Maloney	DM	Chief Finance Officer, Haringey CCG
Dr David Masters	DMs	GP Governing Body Member, West
Dr Sheena Patel	SPa	GP Governing Body Member, Central Lead
Sharon Seber	SS	South East Primary Care Health Professional Member, Haringey CCG
Adam Sharples	AS	Lay Member, Haringey CCG
Sarah Timms	STi	Nurse Member, Haringey CCG
In attendance:		
Sharon Grant	SG	Chair, Heathwatch Haringey (Observer with speaking rights)
Sarah Hart	SH	Senior Public Health Commissioner, LB Haringey
Alice Hopkinson	AH	Manager, Carnall Farrar
Jill Shattock	JS	Director of Commissioning, Haringey CCG
Jennie Williams	JW	Executive Nurse and Director of Quality and Integrated Governance, Haringey CCG
Linda Roast	LR	Minutes

		Action
1.	**INTRODUCTION**	
1.1	**Apologies for Absence**	
1.1.1	Apologies were received from Sarah Price, Dr John Rohan and Dr Dai Tan.	
1.2	**Declarations of Interest**	
1.2.1	There were no additional declarations of interest.	
1.3	**Chair's Introduction and Opening Remarks**	
1.3.1	The Chair welcomed all present to the meeting.	
1.4	**Minutes of the Previous Meeting**	
1.4.1	The Governing Body **APPROVED** the minutes of the meeting held on 4 February 2016 as an accurate record.	
1.5	**Matters Arising**	

1.5.1	Action 04/02/16 – 02 It was noted that the year-end report from Brent CCG related to LAS and would be circulated.	
1.6	**Questions from the Public**	
1.6.1	Questions relating to items on the agenda had been submitted by members of the public in advance of the meeting.	
1.6.2	Verbal responses were provided to these questions and written details included as an appendix to the minutes of this meeting.	
2.	**OVERVIEW REPORTS**	
2.1	**Chief Officer's Report**	
2.1.1	In the absence of Sarah Price, David Maloney presented a report to update the Governing Body on developments in the local NHS and wider policy issues. Key issues were highlighted.	
2.1.2	David Maloney explained that Dr Sherry Tang had resigned as Chair of the CCG and today's meeting would be her last as Governing Body Chair. Dr Peter Christian had agreed to stand and it was hoped to confirm his appointment as the new Chair of the CCG within the next two weeks.	
2.1.3	The report provided summary details of the contracting round negotiations for 2016/2017 which were progressing well to date. Dr Simon Caplan queried clinical input into contracting discussions, particularly in relation to issues such as the agreement of KPIs. David Maloney advised that the CCG's Finance and Performance Committee provided oversight and received regular reports. The Committee included GP members. Jennie Williams added that most KPIs would be continued from last year and also four CQUINS schemes agreed at NCL level. Clinicians had been involved in the agreement of an additional CQUIN related to obesity.	
2.1.4	David Maloney advised that CCGs were required to submit their audited Annual Accounts and Annual Report for 2015/2016 by 27 May 2016. A meeting of the CCG's Audit Committee had been arranged for 19 May and the Governing Body was asked to delegate approval of the Annual Accounts and Annual Report to the Audit Committee.	
2.1.5	The Governing Body **AGREED** to delegate approval of the Annual Accounts and Annual Report for 2015/2016 to the Audit Committee.	
2.1.6	David Maloney reported that the CCG's Investment Committee had met on 22 March 2016 and a number of investment proposals had been agreed. These investments had mainly related to mental health and prescribing services. The Investment Committee had delegated authority for approval of investments to a maximum of £150,000. Any investments exceeding this threshold required Governing Body approval. As the Governing Body would not meet again until 26 May, delegation of approval via Chair's Action was requested for such recommendations made by the Investment Committee.	

2.1.7	Dr Gino Amato noted that, due to considerations regarding potential conflicts of interest, only one Haringey GP was included as a member of the Investment Committee. He asked how Governing Body members would receive details of the investments proposed. David Maloney advised that a summary report would usually be prepared for submission at the next meeting of the Governing Body. However, in this instance there had been insufficient time, given the fact that there had been only a two day gap between the meetings and the next meeting of the Governing Body was not until the end of May. There had been only two recommendations made for investment in excess £150,000. The Committee had not felt either of these proposals to be contentious and agreement to delegate approval via Chair's Action was in order to avoid delay. Dr Simon Caplan noted that having clarified the position this was an acceptable way forward but he emphasised that this should not set a precedent. David Maloney agreed that this was by exception and confirmed that he would circulate a summary of these investment decisions to Governing Body members.	
2.1.8	**ACTION 24/3/16 – 1** To circulate to Governing Body members a summary of Investment Committee recommendations for investment in excess of £150,000 as agreed by Chair's Action.	**DM**
2.1.9	The Governing Body **AGREED** to delegate approval via Chair's Action where required for recommendations made at the Investment Committee on 22 March 2016.	
2.1.10	David Maloney reported that a Risk Summit had been convened by NHSE on 8 February 2016 as a result of concerns associated with the Emergency Department (ED) at NMUH. The key actions agreed were summarised in the accompanying report and Jennie Williams provided regular progress reports to the CCG's Senior Management Team, the CCG's Quality Committee and the London Quality and Surveillance Group (QSAG). A Quality Oversight Group had been established to monitor delivery of the key actions agreed, which met on a monthly basis and included the Trust CEO, the CCG Chief Officer and the TDA portfolio director.	
2.1.11	Dr Gino Amato confirmed that the updates by Jennie Williams provided assurance of the close monitoring and scrutiny applied to ensure improvement. Dr Sherry Tang advised that she had met the newly appointed Medical Director for NMUH and felt similarly reassured of a clear focus on the issues involved.	
2.1.12	The report included details of the procurement process undertaken to select a provider for the new combined NHS111 and GP Out of Hours Services. A final recommendation to award the contract had been approved by all five NCL CCG Governing Bodies this month. In Haringey this recommendation had been approved at a Part II meeting of the Governing Body convened on 3 March due to the timing and reasons of commercial sensitivity. Bidders had now been informed and a required standstill period was in place until 5 April. The next steps were set out in the accompanying report and the new service would commence in October 2016.	
2.1.13	The report highlighted on-going partnership work across Haringey and Islington. A Vanguard proposal to explore opportunities for transforming health and social care services involved the two councils, both CCGs and Whittington Health working jointly. The support of the Health and Wellbeing Board as sponsor of the programme was being sought. Work was underway to establish a project management team, a strategic proposal, committed resource plus leadership and delivery milestones by the end of March 2016.	

2.1.14	Adam Sharples queried overlap between the Haringey and Islington partnership work and other NCL-wide initiatives. David Maloney noted that the Haringey and Islington work complemented the NCL work and there were some aspects where Haringey and Islington working together was a more relevant approach.	
2.1.15	Sharon Grant asked if there had been a Joint Strategic Needs Assessment (JSNA) for partnership work. Dr Jeanelle de Gruchy advised that she worked very closely with the Directors of Public Health for Camden and Islington. Directors of Public Health in NCL were all working together to support the case for change and how needs across London should inform transformation. Dr Sherry Tang added that although there had not been a new JSNA, existing individual JSNAs would be referenced.	
2.1.16	Sharon Grant suggested that Haringey and Islington could have different priorities for this joint work and queried how decisions would then be agreed. Catherine Herman acknowledged that there would be some areas where joint work was not applicable. However, there would also be many areas of similarity and where there were advantages to joint working this was an opportunity to do so. Dr Sherry Tang agreed that commonality could offer significant benefits.	
2.1.17	Sharon Grant asked how outcomes would be evaluated against Haringey priorities. Jill Shattock explained that schemes of work would be evaluated. Indicators were included as part of the Better Care Fund (BCF) and would enable monitoring. Sharon Grant suggested this was insufficiently defined. Catherine Herman emphasised that this was not the case as each specific programme of work would have agreed outcomes and associated indicators by which to measure performance. Both Catherine Herman and Dr Sherry Tang agreed that assurance to this effect and oversight would be provided by the Health and Wellbeing and HASCI Boards.	
2.1.18	Sharon Grant noted the report referred to discussion of social prescribing at the Health and Wellbeing Board's meeting in February and asked how this would be progressed locally. She suggested a Task and Finish Group could be established. She emphasised the significant potential of social prescribing which the CCG as well as the Local Authority could potentially commission. Dr Sherry Tang advised that this would be part of the joint BCF work by the Local Authority and CCG. Catherine Herman noted that when established the CCG would be involved and the outcome of pilot initiatives would inform future commissioning.	
2.1.19	The Governing Body **NOTED** the Chief Officer's report.	
3.	**DISCUSSION**	
3.1	**Alcohol and the Impact on NHS Services**	

3.1.1	Sarah Hart explained that excess alcohol had been identified as one of the top five risk factors for long term conditions, poor health and early death in Haringey. Two methods of measuring alcohol-related admissions and mortality included alcohol-specific conditions where alcohol was implicated and alcohol-related conditions. Alcohol mortality data demonstrated decreases in Haringey which were now below national but above London rates. However, alcohol-related hospital admissions had increased by 29% from 2009 to 2014 and local rates were higher than for neighbouring areas and England (sixth highest in London). Alcohol-specific admissions had plateaued in Haringey but remained high (fourth highest in London). Harmful alcohol use was estimated to cost the NHS £3.5bn per year with impact for both primary and secondary care. It was estimated that 35% of A&E attendances could be alcohol-related, rising to 70% at peak times, and 22%-35% of GP visits were estimated to be related to alcohol. Sarah Hart presented profiles of drinking consumption with increases for men. The 2015 Public Health Report for Haringey had focussed on the issues of male life expectancy.	
3.1.2	Sarah Hart reported different levels of intervention. This included population-based measures in relation to the pricing and marketing of alcohol and also tiers of intervention at community and service level, providing a wide range of opportunities for screening and advice. The presentation today was particularly based on hospital services. Initiatives at NMUH included an A&E CQUIN linked to evidence that early intervention in patients at low risk supported changed behaviour. The alcohol liaison service supported interventions on medical wards and through to the community. Detoxification services had recently been developed in the community. A pilot link worker post had been targeted to working with patients who had repeat hospital attendance/admission and the case load demonstrated associated factors of housing issues (75%) and mental health issues (65%). The Governing Body was asked to consider the contributing factor of alcohol to many medical conditions and to support initiatives to identify and tackle alcohol use at an early stage. The Governing Body was also asked to support the whole system approach to reducing alcohol-related harm to health at population, community and service level. Questions and comments were invited.	
3.1.3	Dr Simon Caplan noted that the high percentages quoted for primary care visits did not seem to relate to his experience and he queried further detail. Dr Gino Amato suggested that this was for potentially related issues, rather than those specifically related to alcohol.	
3.1.4	Dr Simon Caplan noted that the relationship to domestic violence had not been included. He also noted that alcohol problems could be more prevalent in certain communities and whether there were specific initiatives in this respect. Sarah Hart advised that the domestic violence factor was certainly recognised and there was a funded post for a worker in this area linked to a wider programme of work. Work with the perpetrators of domestic violence was also being reviewed. Dr Jeanelle de Gruchy emphasised that whilst today's presentation had been focussed on clinical services, there were many other aspects and associated non-clinical services. Sarah Hart also confirmed that there were programmes of work underway in relation to the cultural context.	

3.1.5	Catherine Herman asked if there were parts of the system that required service improvement and, if so, whether action was needed from commissioners. Sarah Hart asked for continued support for the two posts at NMUH and she acknowledged that there generally needed to be greater ownership in secondary care. Dr Sheena Patel suggested involving GPs regarding repeat attenders. She also noted that it could be difficult to identify tier three services. Sarah Hart noted that the link worker referred to had proved very effective. The post holder was not a nurse but a community engagement expert and worked as outreach in the community. Services based in the four hubs also provided a good contact point for GPs and referrals to these services were increasing. Catherine Herman suggested ensuring details of services available and how they could be accessed, were included on the primary care intranet for GPs to reference.	
3.1.6	Jennie Williams reported that there were a number of performance issues in ED at NMUH but the CQUIN in A&E was now being achieved, which was very positive and this would now be rolled over for a third year. Dr Gino Amato noted that if supported by Public Health this did not necessarily represent Trust ownership. Jennie Williams emphasised that the CQUIN involved the whole team and Sarah Hart agreed that this should be encouraged and enhanced. Dr Jeanelle de Gruchy emphasised the need to sustain delivery and Jennie Williams agreed this could be made a focus for the CQRG over the next year.	
3.1.7	Dr Sherry Tang concluded that the issues raised were recognised and the Governing Body supported the whole system approach to reducing alcohol-related harm	
4.	**STRATEGY AND DEVELOPMENT**	
4.1	**Sustainability and Transformation Plan Update**	
4.1.2	Dr Sherry Tang explained that the NCL Strategic Planning Group (SPG) was required to submit a sustainability and transformation plan (STP) to close gaps in three key areas defined as health and wellbeing; care and quality; and finance and efficiency. The STP was intended to reflect the ambitions of the DoH *Five Year Forward View* for the NHS with submissions from SPGs representing geographical divisions across the country. An initial submission was to be made on 15 April and there had already been a great deal of collaborative work locally with support from the independent healthcare management consultancy Carnall Farrar. Dr Sherry Tang introduced Alice Hopkinson of Carnall Farrar to present a progress update on the STP. The five key deliverables to form the core content for the initial submission were noted as the clinical case for change; the financial base case; the programme plan; the STP governance framework; and proposed programme resourcing.	

4.1.3	Alice Hopkinson referred to page 7 of the update which set out a number of objectives for the NCL STP. The five year plan was a basis for ensuring clinical and financial sustainability across the five boroughs. NHSE had emphasised the importance of a longer term approach and the involvement of providers, CCGs, local authorities plus public engagement. NHSE had also been clear that robust STPs were essential in order to access investment. The update presented had been shared with the Transformation Board yesterday. The key goals were sustainability; improving the quality and equality of care; moving towards place-based commissioning; access to national transformation funding to ensure viability for secondary care providers; support to delivery of the Five Year Forward View; and for new investment in priorities such as primary care, mental health and cancer services. The collaborative process applied had been essential to ensuring wide ownership. The five key deliverables within the STP were as previously described and the development, sign off and review process for each was set out on pages 5 and 6 of the update. Further input was required and key milestones were noted in the report. Deadlines were tight and guidance on requirements from NHSE had been received quite late. The initial April submission was to demonstrate that work was on track in order for Governing Bodies to approve a final submission on 30 June.	
4.1.4	Alice Hopkinson emphasised that the clinical base case and supporting financial base case were the key areas of focus. A high level summary of the messages for the clinical case for change were included and would be expanded with more supporting analysis in the main document. The population of NCL was living longer but in poor health and there were high rates of mental illness and differing levels of health and social care need. Deprivation was widespread. Primary care provision was challenged in some areas and there was a lack of integrated care and support for people with long term conditions. There were too many people unnecessarily in hospital beds, challenges in specialist care and also mental health provision. This was combined with workforce challenges and estates that were not fit for purpose. Questions and comments were invited.	
4.1.5	Dr Sherry Tang noted that she had attended the Transformation Board meeting and there had been widespread concern regarding workforce challenges. It had been agreed that this needed to be more strongly reflected in the next version of the STP. Alice Hopkinson reported that a Workforce Advisory Group was to be established as part of the governance framework to support this requirement.	
4.1.6	Sharon Grant noted patient and public engagement was acknowledged and would be resourced but she cautioned that this would be a significant task for existing agencies. Alice Hopkinson advised that patient and public involvement was a recognised priority but work was still at an early stage. A Communication and Engagement lead with appropriate expertise would be recruited to work on the STP with existing agencies and resource requirements would be identified. Sharon Grant noted concern if this was limited to a lead individual and wished to highlight that the HealthWatch resource was small. Dr Sherry Tang acknowledged these concerns. The Transformation Board had also raised communication as a priority and that this was not yet fully reflected in the draft version of the STP.	

4.1.7	Adam Sharples noted that the financial difficulties of the NHS were increasing. Locally there was a significant financial gap and, given that no additional income was anticipated, the gap could presumably only be addressed by reduced costs. He asked about work to jointly identify costs and recognition of difficult decisions such as service closures. He did not feel that the STP process provided an answer, particularly as formal decision-making authority was unclear. Dr Simon Caplan agreed that he felt similarly unconvinced that it was possible to address the scale of deficit involved by the measures discussed. Dr David Masters emphasised that workforce challenges and low morale were complicating factors. David Maloney advised that access to any additional funding was dependent on the STP. Catherine Herman emphasised that collaborative working and having all agencies represented and "at the table" was the best way to avoid dispute. She acknowledged that the process appeared bureaucratic but the report provided was of high quality. CCGs might be reluctant to delegate decisions but would have to do so and there would need to be compromise to achieve the outcomes required.	
4.1.8	Dr Gino Amato felt that whilst there was a current opportunity for change this was not evident in the document as presented. In his view investment in primary care was a top priority in order to shift activity from more expensive secondary care settings but conversely the document referred to additional hospital beds. Alice Hopkinson stressed that the STP proposals would be focussed on radical change but this was a starting point and decisions had not yet been made. The document did not propose additional beds but made the point that without change demand would just increase. She recognised the frustration felt but this was a real opportunity to drive change.	
4.1.9	David Maloney reported that NCL Chief Finance Officers had been working on the financial base case since June 2015. It was evident that to close the financial gap collective action needed to begin quickly. The clinical case for change in particular needed further development and he queried the workplan between now and June. Alice Hopkinson advised that priorities had been identified and there had been work to scope the detailed plans required in moving forward. However, high level analysis demonstrated that this would not be enough and input on further opportunity areas was being collated. An initial "long list" of additional priorities was included in the report and had been shared with the Transformation Board the previous day. Work on further evaluation to produce a "short list" for inclusion in the initial submission was underway. These would then be formalised as programmes of work for the June submission, together with detail of dependencies. It was acknowledged that mobilisation would need to be from early July.	
4.1.10	Sarah Timms commended the document. She emphasised that engagement and involvement of clinicians would be essential in order to change care pathways. She cited the success of how stroke and cardiac care had been transformed but noted that past experience demonstrated how difficult could be to change the sites of service delivery. Alice Hopkinson acknowledged the need for political support and Sarah Timms agreed that this needed to be on both a local and national basis. She also noted that radical change required transformation of the workforce and for services to be delivered outside of traditional settings.	

4.1.11	Jennie Williams observed that there were currently wide variations of quality and the STP needed to articulate how to close this gap and deliver consistent quality of services. Alice Hopkinson confirmed that this detail would be included in the next version of the plan and all service proposals. It was discussed that, as small organisations, the capacity of CCGs for this work could be very stretched. Jennie Williams noted the work by the Healthy London Partnership in respect to workforce and Alice Hopkinson confirmed that this work would be linked to the STP workstreams.	
4.1.12	Alice Hopkinson encouraged members to attend a workshop session on the clinical case for change to be held on the evening of 20 April. She agreed to circulate invites and supporting documentation. A further update would be presented at the Governing Body's next meeting.	
4.1.13	**ACTION 24/3/16 – 2** To provide Governing Body members with details of a workshop session on the STP clinical case for change to be held on 20 April.	**AH**
4.1.14	The Governing Body **NOTED** the progress update on the STP.	
4.2	**Organisation Development (OD) End of Year Progress Report 2015/2016**	
4.2.1	Jennie William explained that the CCG's original three year OD plan had included a range of initiatives to establish and develop the newly-formed CCG and to deliver its vision for the health of Haringey's communities. The focus agreed for 2015/2016 had been on ensuring the continued development of staff and Governing Body members. The report described progress and a great deal had been achieved in the absence of any designated resource for this work. A new staff appraisal framework had been developed, with associated training and robust links to staff development. For 2016/2017 there would be continued efforts in many of the same priority areas. This would include staff appraisal and support for the health and wellbeing of staff. There would also be work to further embed the appraisal process for Governing Body members and to support their development needs. OD priorities would be discussed with the new CCG Chair. Questions and comments were invited.	
4.2.2	Dr Simon Caplan queried quality assurance for the staff appraisal process and whether this was subject to any independent scrutiny, including that of individual appraisals. Jennie Williams explained that this was not a registration or validation/revalidation process. In developing the appraisal framework examples elsewhere had been reviewed. There had been a pilot and changes made to reflect feedback. The setting of individual objectives was linked to CCG objectives and subject to both formal discussion and regular routine review in one-to-one meetings with managers. The continuing development plans of all staff had been reviewed to inform training. Reference had also been made to the results of the staff survey to further inform development. Full details of the process and associated documentation were included on the CCG's intranet site. It was also planned to ensure the use of exit questionnaires to gather views on the experience of staff working for the CCG.	
4.2.3	The Governing Body **NOTED** the Organisation Development progress report for 2015/2016.	
4.3	**Healthy London Partnership update**	

4.3.1	David Maloney explained that the Healthy London Partnership (HLP) comprised thirteen transformation programmes and had been established in response to the Five Year Forward View, the Better Health for London report and the capital's health and healthcare challenges. The paper from the London Transformation Group was being presented to all London CCGs. It highlighted the continued progress of programme delivery, planning for 2016/2017 plus steps to secure commitment and funding for 2016/2017. A breakdown of allocations by CCG and NHSE (London) was included and totalled £18.5m. Detail of allocation across programmes and central functions was also provided. Questions and comments were invited.	
4.3.2	In response to Dr Simon Caplan, David Maloney confirmed that future reports on achievement would be provided by the teams leading the HLP programmes. Catherine Herman noted that she found it difficult to understand the specific focus of the project for children and young people.	
4.3.3	The Governing Body **APPROVED** proceeding with the proposed plans for 2016/2017 that had been developed during the planning process, on the basis of a 0.5% contribution per CCG according to 2016/2017 allocations, a contribution of £1.47m from NHSE (London) and a small level of associated risk to be managed in year.	
5.	**BUSINESS, QUALITY AND INTEGRATED PERFORMANCE**	
5.1	**Finance Report as at 29 February 2016 (Month 11)**	
5.1.1	David Maloney presented a report on the CCG financial position as at the end of February 2016 (month 11). An appendix to the report set out the financial position for each main budget line. The financial position for month 11 had been subject to detailed discussion at the Finance and Performance Committee meeting earlier this week. David Maloney advised that the CCG was reporting a breakeven position against its budget for the year end to date.	
	David Maloney reported that the run rate had increased marginally in month 11 to £17.5m and mainly reflected an increase of £0.4m at NMUH. The net acute overspend reported at month 11 was £2.1m and this was partly offset by the application of recurrent and non-recurrent mitigations. Non-acute budgets were overspending by £1.3m at month 11 and this was mainly due to significant financial pressures relating to Continuing Healthcare. Running cost budgets were performing to plan. Negotiations with major acute providers to close down year-end positions were continuing. A break-even position was being forecast for the CCG at the financial year-end. Questions and comments were invited.	
5.1.2	In response to Dr David Masters, David Maloney advised that information in relation to referrals was included in the Primary Care dashboard reports. Some members reported not having received these reports on a regular basis recently and Dr Dina Dhorajiwala agreed to raise this with the Primary Care Team.	
5.1.3	**ACTION 24/3/16 – 3** To raise with the Primary Care Team that all Practices should receive the Primary Care dashboard reports on a regular basis.	**DD**

5.1.4	Dr Muhammad Akunjee noted that mitigations had enabled balance this year but he queried the position for next year. David Maloney acknowledged that the financial position of the CCG going into 2016/17 was challenging and this was articulated in the accompanying paper regarding the 2016/17 financial plan.	
5.1.5	The Governing Body **NOTED** the financial position as at month 11.	
5.2	**Financial Plan 2016/2017**	
5.2.1	David Maloney presented a report outlining progress in setting the CCG's 2016/2017 Financial Plan. This built on the previous report regarding financial allocations presented to the Governing Body in February and also reflected points raised in discussion by the Finance and Performance Committee earlier this week. The total allocation for 2016/2017 was £350.4m and included a running cost allocation of £6.3m. The financial position was challenging, in common with that of most CCGs.	
5.2.2	The impact of the 2016/2017 tariff would increase CCG expenditure by approximately 2% and this would represent half of the increase to the CCG allocation. Additionally, provision had been made for both demographic and non-demographic growth; an estimate for inflation not covered by the tariff; contingency at 0.5% of budget; and budgetary provision for services identified as national financial priorities (GP IT, CAMHS and BCF). David Maloney highlighted that national guidance was for CCGs to leave 1% of overall budget as 'uncommitted'. In the most recent Operating Plan submission the CCG had indicated that it was able to set aside 1% but this was committed to cover contribution to the Healthy London Partnership, funding for NCL transformation, CHC retrospective claims and contribution of costs in respect to the RFL acquisition of Barnet and Chase Farm Hospital. This represented a total sum of £3.4m and there would be further discussion with NHSE regarding the CCG's position in this respect.	
5.2.3	David Maloney explained that the intention was to set a breakeven financial plan for 2016/2017 but the savings target, at approximately 3% of budget, would be challenging. Key financial risks to delivery of the 2016/2017 Financial Plan were explained in the report. These included any deterioration in the underlying position at year end 2015/2016; the negotiation of contracts with providers to be in line with CCG affordability envelopes; management of activity within contracted levels; delivery of a significant QIPP Plan; and the issue of 1% uncommitted reserve as previously noted. The next steps in the timetable for the 2016/2017 planning round were detailed in the report and the deadline for final submission of the Operating Plan was 11 April 2016. It was understood that if contracts with providers were not agreed by 25 April negotiations would automatically proceed to arbitration. Questions and comments were invited.	
5.2.4	Sarah Timms queried the uncommitted 1% and whether this was in addition to the CCG's contingency. David Maloney explained that this was an NHSE requirement of all CCGs and represented a reserve against in-year financial pressures. This reserve could be managed at an SPG, rather than CCG, level.	
5.2.5	In response to Dr Gino Amato, David Maloney advised that an aim of the work on devolution of estates across NCL was to ensure all capital receipts were retained within NCL for re-investment in local services.	

5.2.6	Sarah Timms noted her understanding that all retrospective continuing healthcare claims had been resolved. David Maloney confirmed that this was true in respect to Haringey but not so elsewhere and the contribution was a national requirement.	
5.2.7	David Maloney advised that, with more work still to be done, the Governing Body was asked to note progress made rather than to approve the Financial Plan for 2016/2017 at this stage. Updates would be provided to members of the Finance and Performance Committee.	
5.2.8	The Governing Body **NOTED** progress made to finalise the CCG's Financial Plan for 2016/2017.	
5.3	**Integrated Contract Monitoring Report**	
5.3.1	Jill Shattock reported that the Integrated Contract Monitoring Report provided an overview of the performance of the CCG and its main providers in relation to finance, performance and key quality indicators. In acknowledging current concerns a more in depth view of A&E at NMUH was included, alongside the usual summary of performance issues.	
5.3.2	The analysis of demand and patterns of attendance at NMUH A&E demonstrated that Haringey residents accounted for 40% of attendances. There had been no significant rise in overall demand, signifying that current problems related to the handling and throughput of presenting patients rather than numbers. For Haringey patients the busiest days of attendance were Tuesdays and Wednesdays. This differed from experience elsewhere, with Mondays usually having the highest attendance rates. Attendance for all age groups appeared to peak in late morning and reduce after 8.00pm, whereas previous figures had shown reduction after 5.00/6.00pm. Conversion rates demonstrated differences according to age group, with rises for paediatrics and adults over 85 years of age. There had been a significant rise in UCC attendances since the re-structuring of the care pathway. Jill Shattock advised that the next steps to improve performance were outlined in the report, including work by the North West Utilisation Management Unit currently on site. A Programme Director for emergency care had been appointed with four key workstreams focussed on management in A&E; assessment and short stay functions; work on wards/discharge planning; and "out of hospital" and health and social care aspects. The appointment of a substantive Clinical Director was underway and also efforts to increase the medical workforce. The GP See and Direct pilot was currently redirecting approximately 50 patients per day. It was acknowledged that recovery would take time but the aim was to see sustainable improvement by the end of quarter 4. It was noted that NMUH performance against standards for diagnostic and cancer waits had improved. Under-performance by LAS continued. Questions and comments were invited.	

5.3.3	Adam Sharples commented that the analysis regarding NMUH A&E was interesting and queried if any reasons for the mid-week peak had been identified. He also asked if there had been any increase in Enfield attendances. Jill Shattock confirmed that Enfield rates had similarly remained static and there seemed to be no apparent explanation for highest attendance on Tuesdays and Wednesdays. Dr Sheena Patel suggested there could be a link to the release of Practice appointments. She suggested analyses for Bounds Green and perhaps another Practice could be undertaken. Jennie Williams added that the patient survey associated to the See and Direct pilot could also provide information in this respect. Dr Gino Amato noted that attendances at A&E not having increased should be attributed to success in primary care and Jill Shattock agreed that various initiatives were beginning to have an effect. Dr Peter Christian noted the advantage of telephone access now widely available for GP advice, whereas A&E services required patients to attend. Jill Shattock agreed but noted that there were many factors for patients opting to attend A&E, such as knowledge of services, rapid access to diagnostics and obtaining a second opinion.	
5.3.4	Dr David Masters noted that the UCC was now performing well, particularly for paediatric attendances. He queried how paediatric attendances at A&E compared to other areas, given that local rates had previously been high against London averages. Dr Gino Amato added that paediatric attendances in primary care had greatly increased over the past years. In response to Sharon Seber, Jill Shattock advised that the split between east and west of the borough supported higher attendance figures for the east and this was the same for NMUH attendances. Work to compare to WH data was planned.	
5.3.5	Sharon Grant reported alarming accounts of patients fighting in the queues for blood testing services at NMUH. This appeared to stem from the use of separate queues for GP referrals and patients finding they had been waiting in the wrong place and being forced to queue again. Catherine Herman noted from personal experience that signage was unclear. Dr Sheena Patel reported that conversely she had heard positive feedback. Jennie Williams agreed to investigate, request FFT data and raise this at the next CQRG meeting.	
5.3.6	**ACTION 24/3/16 – 4** To investigate systems and signage for blood testing services at NMUH and associated feedback from patients.	**JW**
5.3.7	Catherine Herman noted that HealthWatch had previously highlighted issues with appointment systems at WH. There also appeared to be high numbers of appointments cancelled by the Trust and Jill Shattock agreed to provide a briefing.	
5.3.8	**ACTION 24/3/16 – 5** To provide a briefing on action taken in response to problems reported regarding patient appointment systems at WH.	**JS**
5.3.9	The Governing Body **NOTED** the Integrated Contract Monitoring Report.	
6.	**GOVERNANCE**	
6.1	**Strategic Risk Report**	

6.1.1	Jennie Williams presented an extract of the Risk Register, detailing high level strategic risks with a rating of 12 and above. She reported that all risks on the full Risk Register had been reviewed by individual risk owners, collectively by the CCG's Senior Management Team and by the Audit Committee. Risks were also reviewed on a regular basis by the respective sub-Committee of the Governing Body with lead responsibility of oversight. It was noted that in nearing year end the level of financial risk for 2015/2016 had reduced (Risk 30). It was recommended to close Risk 12 in that this was being appropriately managed as "business as usual". Jennie Williams provided assurance that, as previously discussed, the risk in relation to quality and performance at NMUH was subject to constant review. In discussion by the Audit Committee earlier this month it had been recommended to consider additional risks in relation to workforce capacity and delivery of the NCL Primary Care Strategy. These would be subject to discussion with the SMT for inclusion in the Risk Register. Comments and questions were invited.	
6.1.2	Dr Sherry Tang reported that it had been agreed at the recent meeting of London CCG Chairs, for the Chair to write to NHSE to formally raise the sustainability risk to Primary Care, STPs and all associated business programmes due to workforce recruitment and retention problems. NHSE had offered a meeting for further discussion. Jennie Williams advised that this had been discussed between NCL CCGs and was an emerging issue of risk.	
6.1.3	Formatting errors in the "heatmap" diagram were noted regarding Risks 32 and 33 and Jennie Williams agreed these would be corrected.	
6.1.4	The Governing Body **APPROVED** the Strategic Risk Report.	
6.2	**Quality Committee Terms of Reference**	
6.2.1	Jennie Williams explained that the Terms of Reference for the Quality Committee had been revised as part of an annual review. Changes reflected feedback from members of the Committee, operational changes and points of clarity. Sarah Timms, Chair of the Quality Committee confirmed that the Committee had agreed these revisions and the Terms of Reference were now presented to the Governing Body for approval. Questions and comments were invited.	
6.2.2	Dr Simon Caplan noted that membership should be amended as "one *elected* Governing Body clinician". In response to Dr Sheena Patel it was agreed that entry xxi of the Committee's remit and responsibilities stating "to identify and/or escalate any quality or safety-related issues …." should be made clearer as two separate points.	
6.2.3	The Governing Body **APPROVED** the revised Terms of Reference for the Quality Committee subject to the amendments agreed.	
6.3	**Investment Committee Terms of Reference**	

6.3.1	David Maloney explained that the Terms of Reference for the Investment Committee were presented following annual review. The Investment Committee had discussed the only key change proposed which was to reflect that the Primary Care (PC) Transformation Group would be accountable to the Investment Committee for issues relating to local investment. The Committee had agreed that currently it would not be appropriate to make this change. Questions and comments were invited.	
6.3.2	It was discussed that the PC Transformation Group had been established as part of the structure supporting the Co-Commissioning Committee and in order to manage conflict of interest considerations regarding GPs as primary care providers. Jennie Williams noted that clarity of appropriate governance was required in respect to decision-making and accountability and the Governing Body needed to confirm assurance in not making the change proposed.	
6.3.3	Catherine Herman reported the Investment Committee's discussion that introducing the Investment Committee into the chain of reporting, (ie the PC Steering Group reporting into the PC Transformation Group and then to the Co-Commissioning Committee), could introduce significant delays and complexity. In April there would be discussion of the wider issue of full delegation associated with co-commissioning. As part of the STP the Primary Care workstream would have its own governance structure. It had therefore been recommended that the existing reporting arrangements were adequate in the interim and should be reviewed in two or three months' time.	
6.3.4	Dr David Masters agreed that conflict of interests in decision-making was a challenging issue but this was a transitionary period and much would depend on the development of co-commissioning. Adam Sharples agreed that broader consideration was required and the Audit Committee was arranging a workshop session on integrated governance in order to review such issues.	
6.3.5	The Governing Body **AGREED** to continue with existing reporting arrangements pending future review and therefore the Terms of Reference for the Investment Committee would not be amended at this stage.	
7.	**FOR INFORMATION**	
7.1	**Governing Body Committee Minutes**	
7.1.1	The Governing Body **NOTED** the agreed minutes provided for the Audit Committee meeting held on 18 January 2016, the Clinical Cabinet meeting held on 7 January 2016, the Quality Committee meeting held on 9 December 2015 and the NCL Primary Care Joint Committee meeting held on 5 November 2015.	
8.	**ANY OTHER BUSINESS**	
8.1	On behalf of the Governing Body, Dr Simon Caplan expressed sincere thanks to Dr Sherry Tang for her leadership as Chair of the CCG. David Maloney also expressed the thanks of all at the CCG and his appreciation of Dr Sherry Tang's support personally. Dr Sherry Tang thanked the Governing Body members for their support and expressed her good wishes for the future to all members and staff of the CCG.	
8.2	There were no other items of business.	

9.	**DATE OF NEXT MEETING**		
9.1	Thursday 26 May 2016	12.30pm – 3.30pm	