NHS
Vale of York
Clinical Commissioning Group

Item 3.2

Minutes of the Extraordinary Governing Body Meeting held on 6 October 2016 at West Offices, Station Rise, York YO1 6GA

Present

Mr Keith Ramsay (KR)	Chairman
Dr Louise Barker (LB)	GP Member
Mr David Booker (DB)	Lay Member
Dr Emma Broughton (EB)	GP Member
Mrs Michelle Carrington (MC)	Chief Nurse
Dr Paula Evans (PE)	GP, Council of Representatives Member
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Tim Maycock (TM)	GP Member
Mr Phil Mettam (PM)	Accountable Officer
Dr Shaun O'Connell (SOC)	GP Member
Dr Andrew Phillips (AP)	GP Member, Interim Deputy Chief Clinical Officer
Mrs Rachel Potts (RP)	Chief Operating Officer
Mrs Tracey Preece (TP)	Chief Finance Officer

In Attendance – Non Voting

Miss Siân Balsom (SB)	Manager, HealthWatch York
Dr John Lethem (JL)	GP, Local Medical Committee Liaison Officer, Selby and York
Ms Michèle Saidman (MS)	Executive Assistant

In Attendance for item 5

Mr Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Mrs Fiona Bell (FB)	Deputy Chief Operating Officer/Innovation Lead
Mr Christopher Bound (CB)	Health Navigator
Ms Karin Hogsander (KH)	Health Navigator
Mr Patrik Sjöbom (PS)	Health Navigator

Apologies

Dr Stuart Calder (SC)	GP, Council of Representatives Member
Mrs Louise Johnston (LS)	Practice Manager Representative
Mrs Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

1. Apologies

As noted above.

2. Declaration of Members' Interests in Relation to the Business of the Meeting

All declarations were as per the Register of Interests with the exception of SB declaring a potential interest in item 5 due to York Council for Voluntary Service providing social prescribing and access to voluntary support.

3. Emergency Preparedness, Resilience and Response Assurance 2016/17

RP referred to the report that comprised the CCG's Emergency Preparedness, Resilience and Response (EPRR) Self Assessment against core standards, Statement of Compliance, Improvement Plan, draft Escalation Plan 2016/17 (subject to approval by the A and E Delivery Board), EPRR Policy and On-Call Policy. RP noted that the CCG had assessed itself as "Substantial" overall in relation to compliance with the NHS Core Standards for EPRR, part of the annual EPRR assurance process for 2016/17, and that the self assessment return required submission to NHS England by 18 October.

Members noted that the improvements required to achieve compliance related to increasing the number of on-call Directors on the rota, aligning the Escalation Plan with NHS England guidance from six to four levels, and inclusion in business continuity plans of Critical Functions and Tolerable Periods. RP also noted that the on-call contact was now through a Flextel number.

In response to TP noting that learning from the Christmas 2015 floods had been incorporated in the CCG's policy, discussion took place regarding levels of assurance of partner organisations, opportunities for working together across the CCG footprint in regard to EPRR and potential for identifying emerging issues. SS proposed that the protocols of the respective organisations be considered outside the Governing Body meeting to identify any areas not currently incorporated through such forums as the Local Resilience Groups, Unplanned Care Working Group and A and E Delivery Board.

RP agreed to circulate the on-call contact details to the CCG Chair and Lay Members.

The Governing Body:

1. Approved the Emergency Preparedness, Resilience and Response arrangements for 2016/17.
2. Noted that RP and SS would arrange for protocols to be shared in order to identify any EPRR areas not currently incorporated in other forums.
3. Requested that RP circulate the on-call contact details to the CCG Chair and Lay Members.

4. Month Five

4.1 Financial Performance Report

In presenting the month 5 Financial Performance Report TP advised that the position was £6.5m behind plan. She noted that, following discussion with NHS England, the impact of the £4m difference between the CCG's financial plan and York Teaching Hospital NHS Foundation Trust contracted values was included in the forecast outturn for the first time. As a result of this and a review of risks and mitigation the level of unmitigated risk had reduced from £8.6m in month 4 to £4.16m. TP emphasised that access to the non recurrent 1% would be dependent on achieving as close as possible to the £4m and subject to HM Treasury approval.

TP reported that the previous slight improvement in the position with York Teaching Hospital NHS Foundation Trust had deteriorated again in month 6. Elective activity in August had been over plan and had for the first time in three years been maintained during that month.

TP referred to the forecast risks and mitigations and explained the risk adjusted forecast outturn assumptions. She reported that information received following issue of the report indicated that the mitigation relating to prescribing savings should be reduced from £1.5m to between £600k and £700k and that the CCG had reached a risk share agreement with City of York Council for the Better Care Fund of £1.2m at 50:50 for each of the two organisations. The latter would be established as a pooled budget through a Section 75 agreement.

TP reported that a number of formal query notices were being issued to York Teaching Hospital NHS Foundation Trust due to concerns about activity levels which may relate to coding or counting issues. Additionally, the CCG was writing to them giving formal notice of intent to review clinical and payment models. The latter included notice with effect from 30 September in respect of the Ambulatory Care Unit in its current model as this was not sustainable for the system. TP advised that the Governing Body would receive regular reports on the challenges noting the importance of accurate information for 2017/18 contract planning. She also clarified an issue relating to double counting of rehabilitation and excess bed days and explained that discussions had taken place about the need to review these commissioning arrangements.

In respect of support from GP Practices JL highlighted the need for data to enable variation to be addressed and for progress with development of community care to avoid hospital attendances.

TP reported on Tees, Esk and Wear Valleys NHS Foundation Trust's action plan which aimed to reduce mental health out of contract costs and explained with regard to funded nursing care that £200k had been included in the budget but that the CCG's proportion of a national multi million pound pressure, which CCGs were expected to absorb, had added a further c£1m.

In respect of the closure of Bootham Park Hospital TP reported that the contract with Tees, Esk and Wear Valleys NHS Foundation Trust included a non recurrent proportional payment. No extra cost would be incurred now that Peppermill Court had opened and currently no risk of void costs for Bootham Park Hospital had been reported as the empty spaces could not be utilised for clinical services.

MC reported on work relating to continuing healthcare noting that c£5m savings over three years had been achieved across the Partnership Commissioning Unit footprint and noted that a number of QIPP schemes had been proposed. The North Yorkshire Chief Nurses had also been discussing potential improvements relating to continuing healthcare and a workshop was taking place to agree QIPP savings, including controls to drive efficiencies. An Implementation Plan with timescales had been requested by 13 October. MC also reported that a workshop was taking place on 17 October with colleagues from City of York Council to consider ways of reducing costs through joint working. She added that there was the potential for

contractual processes to lead to savings citing as an example that anyone on Section 117 should not receive continuing healthcare funding.

PM emphasised the need for urgent action including working with Practices to enhance their understanding of the effect of their decision making on levels of activity, progressing the contract challenges described, and at the same time considering action required to address the worsening financial position. Addressing the “gap” was the responsibility of the Governing Body as a whole.

With regard to working with GPs, AP and TM noted that Practice visits should be used as an opportunity for provision and discussion of data as well as considering the GP Five Year Forward View; this approach would be progressed via the Clinical Executive. PE additionally proposed a Council of Representatives workshop session focusing on availability and flow of data to enhance GPs’ understanding.

In response to TP reporting that work was currently taking place on the month 6 position, KR requested that the Governing Body be informed when this was finalised and noted the expectation of a number of interventions being implemented prior to the next meeting on 3 November. KR also referred to discussion at the Governing Body Part II meeting earlier in the day regarding the Improvement Plan 2016/17 when members had agreed a number of priorities, including discussing affordability of the York Teaching Hospital NHS Foundation Trust contract, with a move to non payment by results from 1 April 2017 in discussion with the STP footprint.

PM left the meeting

4.2 QIPP Update

RP referred to the report which described the 2016/17 QIPP programme as at month 5 with associated risks and mitigations, QIPP for 2017/18 and beyond, and ongoing enhancement and development of QIPP management and reporting. The report would continue to evolve to ensure appropriate reporting at the various meetings in line with the current review of the CCG’s governance arrangements. The Governing Body would receive highlights and reporting of any schemes that were not performing as expected with associated mitigating actions.

KR highlighted the identified risk to delivery of £8.1m of the planned savings, emphasised the need for progress with the Financial Recovery Plan, and reiterated the earlier concerns discussed relating to the York Teaching Hospital NHS Foundation Trust contract. The context of the historic financial system issues and the overall need for transformation were recognised.

SB left the meeting

Discussion ensued on the 2017/18 financial plan in terms of “one team” and collective responsibility but with recognition of the need for clearly identified accountability for delivery. Members required assurance and the ability to scrutinise progress. RP noted that the focus of the report was risk and mitigation and assessment as to whether the risk was being addressed to an acceptable level.

Detailed discussion of schemes would take place at the new Finance and Performance Committee.

The Governing Body:

1. Noted with concern the deteriorating financial position and emphasised the expectation that a number of interventions would be implemented prior to the Governing Body meeting to address this.
2. Noted the continuing development of the QIPP report requesting clarity of responsibility for delivery of schemes.

MA-M, FB, CB, KH and PS joined the meeting

5. Proactive Health Coaching

AP reported that the Clinical Executive had considered and approved for recommendation to the Governing Body the business case to extend the current Proactive Health Coaching pilot scheme to include up to 400 concurrent patients in the CCG area; an average of 283 per month during the current financial year.

FB explained that NHS Vale of York CCG was currently the only site in the country where Proactive Health Coaching was being implemented, noting that it was a randomised control trial supported by the Nuffield Trust and York Teaching Hospital NHS Foundation Trust Research Department. The original funding had been agreed by Senior Management Team within its delegated limits; the pilot had subsequently been extended through national Pioneer funding. To date 367 patients had been included in the pilot and in light of the outcomes the request for extension was now presented. FB highlighted that the approach complemented the CCG's out of hospital strategy and integrated care pilots.

CB, KH and PS highlighted aspects of Proactive Health Coaching – a non-clinical telephone based patient coaching model for high need patients, typically patients with long term conditions – describing reduction in the need for emergency care, support expressed by patients and providers, positive results verifying potential benefits of continuation, and the strong fit with the CCG's out of hospital strategy. Members sought and received clarification on aspects of this approach.

Discussion included the fact that Proactive Health Coaching was complementary to the existing care received by patients, the care was provided by qualified nurses from a variety of backgrounds, and coaches would link with available services, including lifestyle services such as stop smoking and weight management, as appropriate. Coaches were not making clinical decisions but practised a holistic approach and would support patients in any health related concerns. A network of shadowing arrangements provided support to coaches; any concerns such as in respect of safeguarding would be escalated to the patient's GP. Patients were identified for inclusion in terms of potential benefit they would receive.

SS referred to investment in wellbeing services by City of York Council and North Yorkshire County Council noting they would be supportive of progressing the approach at scale.

MA-M explained that the financial model, which would be a QIPP supporting the out of hospital strategy, was premised on a risk / gain share arrangement for non elective costs. The average savings per patient would be split 50:50 between the CCG and Health Navigator. The risk / gain share saving per patient through the 12 month period of the pilot had been £920, with a total saving to the CCG per patient of £1,234 when factoring in Elective, Outpatient and A&E activity savings. Clinical evidence from Sweden indicated further savings in the second year, typically in the region of 50% of the first year values.

SOC highlighted that the Clinical Executive had identified further potential areas of savings, such as prescribing and GP consultations. Extending the coaching model, based on the pilot evidence and evidence from Sweden, would build on integrated working including with Local Authorities, and would be a step change towards transformation.

Members noted that Health Navigator was a private company with approximately 10 years experience in both urban and rural areas of Sweden. The service provided was dependent on the needs of the patient. On average a coach would have between 50 and 80 patients and would make an average of 40 calls per week. In terms of the CCG pilot an average of 80 patients per coach was anticipated and with regard to extending the randomised control trial model the maximum number of patients would be up to 1500 for the Vale of York population.

CB, KH and PS left the meeting

MA-M explained that the additional £480k commitment being requested to extend the pilot had been profiled over two years. He confirmed that the anticipated net savings were in the Financial Recovery Plan, but not the gross investment and saving

Members discussed further the coaching approach as part of system change noting the support of York Teaching Hospital NHS Foundation Trust Research Department and that the Nuffield Trust were producing an independent report on the national pilot. MA-M advised that capacity within the timescale of the pilot was becoming available with the current three health coaches. He proposed that, if the additional commitment was agreed for a further 12 months for 400 patients, a detailed review be required at the end of the next year. In respect of equity of access FB explained that patients were selected randomly across the CCG footprint based on current health behaviour using a complex algorithm but confirmed that a more targeted approach could be sought.

Whilst recognising that the CCG investment was proposed on the basis of benefit to the system, members noted the potential for discussion with the Local Authorities regarding investment. Additionally, when the accountable care system was established, this model would not be commissioned separately but would be part of outcomes based commissioning.

Following assurance from MA-M that Health Navigator would mobilise the extension quickly following the additional investment and that he and FB were currently leading this project from the CCG perspective, members unanimously supported the

expansion of Proactive Health Coaching, subject to review of procurement rules. Additionally, the Clinical Executive would review the evidence at the end of a year and a report would be provided for the Governing Body meeting in January 2017 regarding the number of patients recruited.

The Governing Body:

1. Unanimously approved an expansion of the current Proactive Health Coaching pilot scheme to include up to 400 concurrent patients in the Vale of York to the end of 2017/18, subject to confirmation that this did not breach procurement rules.
2. Noted that the Clinical Executive would review the pilot for the agreed end date.
3. Requested a report at the January 2017 Governing Body meeting on the number of patients recruited.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 27 SEPTEMBER 2016

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
27 September 2016	Emergency Preparedness, Resilience and Response Assurance 2016/17	• Protocols to be shared in order to identify any EPRR areas not currently incorporated in other forums. • On-call contact details to the CCG Chair and Lay Members.	RP/SS RP	Completed 24 October 2016 Completed 24 October 2016
27 September 2016	Proactive Health Coaching	• Report at the January 2017 Governing Body meeting on the number of patients recruited	AP	