EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

Minutes of the Governing Body Meeting held on Tuesday 14 August 2018 at 9.30am In the Council Chambers, County Hall, Leicester LE3 8TB

Present:

Dr Richard Palin	Chairman
Mr Clive Wood	Deputy Chair / Independent Lay Member
Mrs Karen English	Managing Director
Dr Andy Ker	Clinical Vice Chair
Mr Tim Sacks	Chief Operating Officer
Ms Donna Enoux	Chief Finance Officer
Mr Alan Smith	Independent Lay Member
Dr Nick Glover	GP Locality Lead, Blaby and Lutterworth
Dr Anuj Chahal	GP Locality Lead, Melton, Rutland and Harborough
Dr Girish Purohit	GP Locality Lead, Melton, Rutland and Harborough
Mr Warwick Kendrick	Independent Lay Member
Mr Simon Pizzey	Head of Planning and Strategic Commissioning (on behalf of Mr Paul Gibara)
Mrs Amanda Bland	Acting Deputy Chief Nurse (on behalf of Mrs Tracy Burton)
Dr Tim Daniel	Public Health Consultant

In Attendance:

Mrs Daljit K. Bains	Head of Corporate Governance and Legal Affairs
Mrs Emma Casteleijn	Head of Communications
Dr Hilary Fox	Senior Clinical Lead for Planned Care
Dr Janet Underwood	Healthwatch Rutland
Mrs Sarah Warmington	Associate Director of Commissioning
Mrs Cheryl Davenport	Director of Health and Care Integration (Item B/14/141 only)
Mrs Claire Middlebrook	Corporate Affairs Support Officer (minutes)

Members of the public: 5 members of the public seated in the public gallery

ITEM	DISCUSSION	LEAD RESPONSIBLE
B/18/132	**Welcome and Introductions** Dr Richard Palin welcomed members of the Governing Body and members of the public to the August 2018 meeting of the East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) Governing Body, specifically welcoming Mrs Amanda Bland and Mrs Sarah Warmington.	
B/18/133	**Apologies for Absence:** Apologies for absence were received from: • Dr Vivek Varakantam, GP Locality Lead, Oadby and Wigston • Mrs Tracy Burton, Interim Chief Nurse and Quality Officer • Dr Graham Johnson, GP Locality Lead, Blaby and Lutterworth • Dr Tabitha Randell, Secondary Care Clinician • Mr Paul Gibara, Chief Commissioning and Performance Officer	

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B/18/134	**Notification of Any Other Business** The Chairman informed that he had received no items of additional business.	
B/18/135	**Declarations of Interest on Agenda Topics** All GP members declared an interest in items relating to primary care where a potential conflict may arise and also where there are any items concerning the Leicester, Leicestershire and Rutland Provider Arm where GP members' are minor shareholders. It was noted that no further action was required at this stage and that the Register of Interests is published on the CCG website. Dr Palin noted that all members of the Executive Management Team (EMT) are conflicted with Paper M, Next steps towards greater collaboration between LLR CCGs. Members of EMT will remain in the room for the discussion; however, will not be voting for this item although will remain in the meeting room. Mrs Daljit Bains informed that all GPs, with the exception of Dr Richard Palin and Dr Andy Ker, were conflicted in relation to Paper K, Review of clinical roles and responsibilities on the Governing Body, and therefore will be excluded when voting on this paper, however will remain in the meeting room. It was **RESOLVED** to: • **RECEIVE** and **NOTE** the declarations made and the actions agreed.	
B/18/136	**Minutes of the Meeting Held on Tuesday 10 July 2018 (Paper A)** The following amendments were noted for the minutes of the Governing Body meeting held on 10 July 2018: Dr Palin apologised to Dr Underwood, for the incorrect salutation being used on the previous set on minutes and noted that Dr Underwood has sent some clarifications on the minutes to Mrs Daljit Bains, which will be included in the final, approved version. This included the following: • **Page 3, item B/18/121** Full Business Case for the Relocation of Level 3 ICU and associated service off the LGH site – bullet point three should state, "urology" not "neurology". In addition, Dr Underwood advised that within this discussion she had cited the NHS England (2018) *Planning, assuring and delivering service change for patients* in particular that where a proposal for	

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	substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider and that both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. It was noted that Dr Underwood was unconvinced that public consultation has been adequate. • **Page 7 and 8, Finance Report –** Ms Donna Enoux raised some corrections to item **B/18/122**: o Page 7, Second paragraph, second sentence to read: "*At month two there is £10.4m of QIPP risk plus £0.8m of co-commissioning cost pressure; £0.6m of running cost expenditure control; £3m of potential pressures from 2017/18 and the EMAS contractual pressure* …." o Page 7, Third paragraph to be amended to read: "*ELR CCG has an activity reserve of £4.8m with a £2m contingency; adding up all the reserves equates to £7m, against a risk of £15m and therefore we are reliant on existing QIPP schemes delivering or new schemes being developed*." o Page 8, first paragraph, first couple of sentences to read: "*Ms Enoux confirmed that the net budget for CHC has been reduced from 2017/18 to 2018/19 and has been set using a forecast as a starting point. The budget has been uplifted by 9% in line with historic growth spends and then reduced down based on QIPP schemes. ELR CCG was an outlier in the CHC spend, however, ….only appropriate packages were being put in place, in …."* It was **RESOLVED** to: • **APPROVE** the minutes of the meeting held on Tuesday 10 July 2018 **SUBJECT** to the amendments made.	
B/18/137	**Matters Arising: Update on Actions from the Meeting held on Tuesday 10 July 2018 (Paper B)** The following action was noted as complete: • B/18/18/109 Summary report from the Primary Care Commissioning Committee – this item will be covered by the Paper O on the agenda. It was **RESOLVED** to:	

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	• **RECEIVE** and **NOTE** the update on the actions.	
B/18/138	**To Receive Questions from the Public in relation to items on the agenda** Dr Palin welcomed the members of the public and invited questions from the members of public relating to items on the agenda. There were no questions raised on the agenda items. It was **RESOLVED** to: • **NOTE** that no questions were raised on agenda items from the public.	
B/18/139	**Chairman's Report (Paper C)** Dr Palin presented the report, which provided an overview and update on some of the key constitutional and strategic areas that affect the Governing Body, including meetings attend by Dr Palin since his last report in July 2018. The report was noted. It was **RESOLVED** to: • **RECEIVE** the Chairman's Report	
B/18/140	**Accountable Officer's Corporate Report (Paper D)** Mrs English drew attention to the following key items from the report: • **Integration Executive and Integration and Finance Performance Group (IFPG) -** a proposal to change the remit of these meetings has been discussed with the Local Authority and it is therefore proposed to change these meetings to bi-monthly. The Integration Executive will concentrate on the Better Care Fund agenda, such as Delayed Transfer of Care (DTOCs). The Terms of Reference have been revised to take into account the proposed changes and have since been approved by Leicester City (LC) and West Leicestershire (WL) CCGs and the Local Authority. The Integration Executive will remain as a sub-group of the Health and Wellbeing Board and will be chaired by a CCG; currently East Leicestershire and Rutland (ELR); however, this will shortly change to WL CCG. The aim is to make it easier to have strategic discussions regarding Finance and Performance. The revised Terms or Reference are attached as appendices. • **Emergency Preparedness, Resilience and Response (EPRR)** –	

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	The annual return on EPRR is due to be submitted to NHS England; Mr Tim Sacks is ELRs EPRR lead and Mr Clive Wood has agreed to become the LLR Lay Member responsible for this area of work. Ms Enoux asked that the membership list be changed to read 'Chief Finance Officer' rather than 'the finance director' and also that the role of Chief Strategy and Planning director be corrected to read 'Chief Performance and Commissioning Director'. Ms Enoux further noted that the fifth paragraph on Page 6, is hard to understand and asked that this is re-worded. It was **RESOLVED** to: • **RECEIVE** the Accountable Officer's Corporate Report. • **APPROVE** the revised terms of reference and extended remit for the Integration Finance and Performance Group (Appendix 1); and **APPROVE** the minor amendments to the terms of reference for the Integration Executive (Appendix 2) subject to the amendments raised.	
B/18/142	**Summary Report from the Financial Turnaround Committee (26 July 2018) (paper F)** Mr Smith took the paper as read and no questions or queries were raised. It was **RESOLVED** to: • **RECEIVE** the Summary Report from the Financial Turnaround Committee (26 July 2018)	
B/18/143	**Finance Report: Month 3 update (Paper G)** Ms Donna Enoux took the detailed paper as read and highlighted the following items from the summary report: The summary report shows the month three total, which is reported as break-even; there is still £8m of QIPP risk, when looking at red and amber rated schemes. This is based on the assumption that red rated schemes will deliver only 10%; and amber 40% of their totals. Ms Enoux confirmed that this is still a massive risk to the CCG and the current list of risks is shown in the table on page two. The main risks to highlight are: acute, CHC, prescribing, running costs, 2017/18 accruals and EMAS but there is an unreleased contingency reserve of £2m and national growth reserve of £4.8m to aid mitigation.	

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	Dr Nick Glover noted paragraph eight, on page five and queried the figure for University Hospitals of Leicester NHS Trust (UHL) over-performance of £1.883m, and its relationship to the Independent Sector, which is showing an underspend. Dr Glover asked if the Independent Sector continues to under-perform; if the £1.833m will also reduce. Ms Enoux stated that this could potentially happen; the contract team are currently focussing on the relationship between activity at UHL, independent sector and out of county. Dr Glover noted that historically Referral to Treatment (RTT) performance has been modest and resulted in unmet needs and additional activity in the system. Following a recent presentation from Mr Simon Pizzey, the team are aiming to direct patients to more appropriate clinics / health care settings, in an effort to reduce costs in this area. **Dr Glover asked if patients sitting on the RTT waiting list could be looked at to see if they could be re-directed to an alternative place for treatment; this would also be of a benefit for patients.** Mr Pizzey concurred that this was a good idea and noted that if UHL have patients on a 20 week waiting list this could be a good opportunity to look at reducing the lists. Mr Pizzey will take this suggestion forward. Dr Hilary Fox asked for some more information on CHC. Ms Enoux confirmed that the CHC QIPP is on track to deliver. Mr Alan Smith reported that the Financial Turnaround Committee noted their concern with the current financial situation; ELR has been looking for QIPP for the past two years and therefore savings are getting harder to find each year. The list of risks, noted, this early in the year is worrying. It was **RESOLVED** to**:** • **RECEIVE** the finance report, month 3 update	**Simon Pizzey**
B/18/144	**Corporate Performance Assurance Report (Paper H)** Mr Pizzey took the paper as read and highlighted the following items from the report: The annual performance assessment result from NHS England, noted that ELR 'requires improvement', this was mainly due to the CCGs finances and some elements of performance that require improvement. All 31 day cancer waits were achieved in May 2018.	

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	Improving Access to Psychological Therapy (IAPT) performance remains a challenge and a contract notification has been given to the providers. Referral to Treatment (RTT) is not achieving targets; in May it reached 86.94% against a target of 92%. Mrs Bland noted the reduction in 12 hour trolley waits, on page six of the report and reported that this was good news for patients and due to UHLs hard work. Dr Glover expressed concern over the IAPT performance, as NHS England have focussed on this at previous checkpoint meetings; the recovering rate of 64% is acceptable, however, waiting times continue to be a problem. Mrs Karen English confirmed that contract notices have been issued to providers and waiting time initiatives have been put in place; there have been improvements in the past few months. The waiting list is reducing and an action plan is in place to make further improvements. The regional 'intensive support team' have been working with the CCGs to help; including trying to change attitudes. Staff are now ensuring that cases are referred upwards, when appropriate and real time data is now available. The team are also looking into what the situation feels like for practices. The main problem with the service; is the number of therapists available. Dr Glover asked how slots are filled by practices, as he noted this as a problem and GPs do not have any control over this area. Mrs English confirmed that the team are looking at the performance of therapists; however, this information will not be shared or discussed outside of the team. Dr Palin noted that Dr Graham Johnson has previously provided information about slot issues. Dr Ker reported that the number of sessions for patients is being cut and although this will help reduce the waiting times the impact on patients will be significant. Dr Ker does not know why the changes have been put in place. Mrs English expects that waiting lists will reduce, in line with less sessions being offered; however, how this will affect the recovery rates of patients remains to be seen. Mr Warwick Kendrick queried the a LLR cancer wait figures for 62 day waits and asked for clarity on the performance levels. Mr Pizzey was unsure and confirmed he would seek clarity from Dr Vivek Varakantam outside of the meeting; however, thought the performance would not be improving. *Mr Sacks left the meeting; Mrs Cheryl Davenport joined the meeting.*	

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	Dr Purohit noted the good news around dementia diagnosis rates; of 67% for June and 67.7% for July. Currently 3125 patients' over 65 years of age have been diagnosed with dementia; the challenge is the attrition rate and the fact that the population is getting older. The fact that the GP Cost Improvement Programme (CIP) has been fundamental in focussing on Primary Care has enabled the diagnosis rates to continue to improve. It was **RESOLVED** to: • **RECEIVE** the Corporate Performance Assurance Report	
B/18/141	**Better Care Fund 2018/19 Plan update (Paper E)** Mrs Davenport reported that the national Better Care Fund (BCF) guidance for 2018/19 was published on 18 July 2018, which meant that possible changes were needed to the expenditure plan; although once checked no changes were required. The contingency and risk pool amounts are shown in paragraph nine. The cost improvement plan has also not changed. The BCF plan was assessed against the national outcome metrics and a paper presented to the Integration Executive. The DTOC target of 7.88 days, per 100,000 population was not met in May or June, however, did improve from 4.72 to 5.51; the situation is being carefully monitored. *Mr Sacks re-joined the meeting.* The baseline for non-elective admissions has been aligned to the CCG Operational Plan for 2017-19. The BCF guidance states that the local areas can submit revisions to the planned residential admissions metric, if they wish too; and therefore some slight adjustments have been made; these have been agreed with adult social care and the Integration Executive. The new guidance includes a new section on long term stays, of 21 days or more and therefore this area is being focussed on and discharge plans are being put in place to take the account of this cohort of patients; adult social care are looking into this further with the discharge group. Due to pre-work taking place, before the guidance was issued, the team did not have a lot of additional work to carry out and confirmation of the changes made will be sent to NHS England by 24 August 2018. Planning for 2018/19 has commenced, with a session arranged for 24 September with all partners, to look at community services and new	

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	models of care etc. Mr Pizzey noted the non-elective target has not been met and the NHS England guidance splits this area into two sections. Providers are being pushed to look at short-term admissions, such as one day admissions and this should be reflected in the paper. Dr Purohit spoke about paragraph 43 in the paper, noting the 16 interventions developed by the LLR Frailty Working Group. Whilst the group understands the pressure on primary care, the needs of the patient have to be taken into account when looking at resources available. Mrs Davenport reported that as part of the frailty interventions all areas of care, including community, hospital and primary care will be discussed in detail by the multi-agency group. The wider integrated local team will then carry out testing of the model of care and share learning from the testing. It is hoped to use existing resources, as some interventions should be happening already; however, a query has been raised over if they are being consistently applied. Mr Sacks confirmed that the primary care team are also looking at frailty in GP practices and are cross-checking the key interventions of the frailty group against the core contract and GP CIP. The vast majority of the interventions are already managed, through care planning. The number of Summary Care Records is high and therefore coding levels appear to be lower than they should be. Dr Purohit noted that whilst the CCG commissions services for the frail elderly, in practice, communities are not accessing the services available and identifying these patients is important to reduce the pressure on the service. It was **RESOLVED** to: • **NOTE** the revisions to the BCF plan for 2018/19 following the publication of the operating guidance, per the target for each BCF metric as set out in paragraphs 14 to 33. • **NOTE** that the Integration Executive approved the revised metrics at its meeting on 7 August and that the BCF Plan will be submitted to NHS England, in line with the national timetable, by 24 August. • **NOTE** the new NHS England / Improvement requirements for long stay patients and the outputs of the LLR frailty work. *Mrs Davenport left the meeting.*	

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	The meeting was paused at this time for a short break.	
B/18/145	**Summary report from the Integrated Governance Committee meeting in August 2018 (Paper I)** Mr Kendrick took the paper as read and highlighted the following two items: • **Finance Update** - The committee will now receive a regular finance update each month; this is to ensure that the committee has an overview of the financial position, prior to committing any expenditure. • **Redirection of Adults form the Emergency Department** - The committee agreed this procedure in principle, however, asked for some changes to terminology and queried the tariff. It was **RESOLVED** to: • **RECEIVE** the Summary report from the Integrated Governance Committee meeting in August 2018	
B/18/146	**Summary Report form the Audit Committee (1 August 2018) and Annual Report from the Audit Committee Chair (Paper J)** Mr Kendrick noted that the Annual Report from the Audit Committee Chair is attached as an appendix; this has been drafted in line with the *Audit Committee Handbook*, to show that the Audit Committee has discharged its responsibilities and met its Terms of Reference. The report also confirms that the Committee has the right systems in place to identify risks and review the Board Assurance Framework to ensure that it is fit for purpose. The report further confirms that the Committee has checked that the organisation has no outstanding areas of significant duplication in the system of governance. The Audit Committee has been proactive in supporting the Executive Management Team in identifying risk and the independence of the external auditors has been confirmed. Dr Palin formally thanked the Audit Committee for their work over the past 12 months. It was **RESOLVED** to: • **RECEIVE** the Summary Report form the Audit Committee (1 August 2018) and Annual Report from the Audit Committee Chair	

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B/18/147	**Review of clinical roles and responsibilities on the Governing Body (Paper K)** Dr Ker noted that the report was a follow up from a previous report to the Governing Body and includes results following consultation with the CCG Member Practices. It was noted that the majority of the CCG Member Practices approved the move to six localities which essentially means splitting Blaby and Lutterworth Locality into two localities: North Blaby, and South Blaby & Lutterworth. The outcome of the consultation with the Membership also highlighted support for Option 3 as described in the report which related to the focus of the GP Locality Lead role, which was positive as this would include a session dedicated to developing the locality. It was noted that the membership did not support the move to change the term of office for GPs and therefore the tenure remains as three years, following which the CCG will seek expressions of interest as it does at present. The proposed next steps were detailed on page 12 of the report, along with the recommendations. Governing Body members who were not conflicted with this item were in agreement and approved the recommendations. It was **RESOLVED** to: • **RECEIVE** the results of the consultation process with Member Practices; • **APPROVE** the next steps as outlined in paragraph 26 of the report, and to **APPROVE** the amendments to the CCG Constitution to reflect the agreement from the member practices.	
B/18/148	**Locality Chairs' Report: (Paper I)** **Melton, Rutland and Harborough** Dr Purohit noted the following items from the report: • **Acute Visiting Service** – a presentation was well received from Mr Rob Haines, the main item highlighted by the members was the number of rejected referrals. Care homes can no longer directly refer into the service; this was due to be a temporary arrangement, however, has not been reverted back. This means that the service is not responsive for housebound patients. The comments will be fed back to WL CCG as the contract lead. • **Primary Care** – a presentation was received and covered acute access, extended primary care and the QIPP / CIP funding options for 2018/19. Members felt that the 4%	

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	reduction was not clearly communicated. Practices are looking to work at scale by changing structures etc and felt that **having a clear picture of the potential funding available was important; alongside how much is recurrent or time limited.** • **Alzheimer's Society presentation** – the presentation was well received by the members and the service was noted as excellent, however, underutilised. The main reasons for this were noted to be the PRISM form being onerous to complete and the SPA telephone service not being easy to use. **North Blaby** Dr Glover noted the following items from the report / locality: • **House bound INR patients** – work is ongoing with community nurses, to look at blood tests for this cohort of patients. • **Governing Body Report** - whilst members agreed in principle with the reduction of 4%; however, asked for more clarity around the funding streams and how these are represented in planning. • **The MH practitioner post** - this post has now been filled and patients are being seen. • **MSK** – this service (at The Limes and Glenfield Surgery) is working successfully. All referrals have been accepted and funding is being sought to fund additional Physiotherapists. **South Blaby and Lutterworth** Dr Glover noted the following items from the report: • **Locality Integrated Leadership Team** – it was noted that patients discharged from hospital with self-injecting drugs, such as Heparin, cannot have the Community Nurses to carry out this work, as a 12 hour gap is required and this is outside the time that the nurses work and therefore the integrated care system (ICS) is being used, which is not a cost effective use of time. • **4% funding gap** – this was discussed and the locality would welcome some clarity on what this means for them. It as • **Patient Safety -** two patient safety issues were raised in relation to rejected letters; however, no easy solution to resolve the situation was suggested. **Oadby and Wigston** In the absence of Dr Varakantam, the report was taken as read. **I**t was **RESOLVED** to: • **RECEIVE** the Locality Chairs' Report.	**Tim Sacks**

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B/18/149	**Next steps towards greater collaboration between the LLR CCGs (Paper M)** Dr Palin noted that this is a follow up paper, to the one brought to Governing Body two months ago and although it is being discussed in the public section of the meeting, all EMT members are conflicted and therefore will not participate in the vote. Dr Palin proposed that a vote is taken later this afternoon at approximately 3:00pm when the Governing Body will reconvene its meeting in public. Dr Palin advised that this will enable the non-conflicted Governing Body members to reflect on the report and vote on the proposals. Members of the public present in the public gallery were invited to join the Governing Body at 3;00pm should they wish to, alternatively if they could not attend and wished to know the outcome to provide Mrs Bains with their contact details and she would inform them of the outcome following the meeting. Dr Ker noted that the paper follows the CCG not approving the move to a single Accountable Officer in June 2018; the main reasons for this was that there was a lack of detail available on how the model would work; a lack of governance structure; and also a lack of detail about how the proposal would benefit patients. Although WL and LC CCGs did support the initial paper, it was noted that they still had some concerns. A joint informal meeting of the three LLR CCGs' Governing Bodies was held in July 2018 in order for all members to gain a better understanding of the position. Since then the Chairs of the three CCGs have met to discuss a move to more collaborative working and how to follow the national direction. The paper presented today is a result of all of these discussions. Dr Ker informed that the proposal is that a detailed piece of work is completed in the next 12 weeks to look at the benefits of appointing a single accountable officer and the governance arrangements. An external consultant will be appointed for a short period of time to complete this work and ensure that it is done independently. It is suggested that the proposal is re-submitted to the Governing Body for consideration in November, with further discussion expected in early 2019. This will also allow for further discussions on a possible legal merger of the organisations. Dr Palin reported his personal opinions which include further clarity around how the governance of having one Accountable Officer, Chief Nurse and Chief Finance Officer might work; alongside having three CCG Governing Bodies all needing to satisfy their legal requirements. The discussion on potential savings was welcomed and NHS England	

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	has been clear in directing the CCGs to work through the issues highlighted. Dr Palin is happy with the proposed suggestion for the next three months and is now supportive of the paper and would welcome a final decision being made in November. Mr Smith asked that clarity is given on how the Audit Committee would work in the future, as this is not clear in the proposals. Mr Smith also asked how the performance report will work; as the CCGs will remain as separate bodies, and therefore how would they can discharge their own responsibilities, with their own management teams and maintain three separate Governing Bodies. Mr Wood noted paragraph ten in the report, which recommends that an external resources is brought in and welcomed this suggestion, noting that the independent, impartial nature of this post is a positive step; alongside including Managing Directors' in the discussion to ensure that all local issues / concerns have been addressed. Whilst the idea of a merger needs further discussion, Mr Wood is keen to ensure that the CCG retains localism and does not lose its independence. Mr Kendrick concurred that the proposal is a logical way to review the benefits, identify risks to staff and patients, whilst ensuring that the best service is still delivered for our patients. Dr Glover commented that whilst he appreciated that this has been a difficult task and the CCG needs to find a constructive way forward; it is important that the local identity is not lost. The proposal does seem a more coherent way forward to explore what the structure may look like. Dr Ker thanked colleagues for their comments regarding the appointment of an external person to oversee the next piece of work and suggested that informal meetings will take place with potential appointees, prior to a final decision on the appointment being made. Mrs English concurred that this was a sensible suggestion to ensure that all members of the Governing Body were satisfied with the candidate and also were engaged in the review process. Dr Palin reminded members that a vote will be taken, by the non-conflicted members when the Governing Body re-convened at approximately 3.00pm. Dr Palin reminded members of the public were welcome to stay for the reconvened meeting, or, if they wished to be informed of the decision outside of the meeting, could provide their contact details to Mrs Bains. *Notes from the meeting re-convened at 3:00pm:* Dr Palin reconvened the meeting in public of the Governing Body to	

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	consider this item. The Executive Management Team absented themselves from the discussion. Further to the earlier discussion, it was unanimously agreed to support a further detailed piece of work, in regards to options for future collaboration, to take place over the course of the next 12 weeks. The specific scope of this work includes: • Gathering information about the experience of other areas. This will include looking for the benefits, if available, of any new arrangement to the system, individual organisations and the patients they represent. • Further analysis of potential management arrangements and how a single accountable officer and management team could interact with, and fulfil their obligations to, individual statutory bodies. • Development of a firm proposal setting out how the governance arrangements of individual organisations and the wider system might evolve over time. This would include examination of existing organisational and collaborative arrangements, and consideration of any further opportunities (or otherwise) to streamline processes through the alignment of meetings and/or committees. • Examination of further opportunities to strengthen collaboration through consideration of the desirability and feasibility of moving towards sharing of some other key governing body posts. It is proposed that the findings of the above work would be presented back to governing bodies, along with final recommendations, for consideration in November 2018. It was **RESOLVED** to: • **APPROVE** the scope of the additional work set out in this paper, noting the expected timing of the outcome and recommendations coming back to boards in November 2018. • **APPROVE** the inclusion of current managing directors to the existing Joint Executive Steering Group to further strengthen input through their experience and expertise. • **SUPPORT** the proposal to bring in dedicated external management resource to provide additional capacity and independence. • **AGREE** that a review of long-term configuration options for the CCGs will take place in early 2019, concluding by mid-2019.	

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B/18/150	**Summary Report from the Commissioning Collaborative Board (July 2018) (Paper N)** Dr Palin took the report as read and no questions or queries were raised. It was **RESOLVED** to: • **RECEIVE** the Summary Report from the Commissioning Collaborative Board	
B/18/151	**Summary report from the Primary Care Commissioning Committee (August 2018) (Paper O)** Mr Wood took the paper as read and highlighted the following items from the report: • **Delegated Financial Authority** – a discussion took place on the proposals, which are shown in section 14 of the report. This is in line with the Terms of Reference of the Committee. • **Option on the future of Ketton Surgery** – the hard work of Mr Jamie Barrett and the Primary Care team on this piece of work was recognised and Mr Sacks was asked to ensure that this was fed back to his whole team. Mr Wood also asked that thanks be conveyed to Mrs Pragatic Baddhan, from the CCG's Communications team, for all her hard work on the consultation and presentation to the public. This was particularly noted as the representative from the Ketton Patient Participation Group left the meeting happy with the answers they had received. Dr Glover noted that the section 14.2, the budget being overspent, will always apply and even though GPs are excluded from voting at the PCCC meetings, due to being conflicted, the clinical voice is listened to. Difficult decisions have to be made and the Committee has the support of the GPs on the panel. Mr Wood thanked Dr Glover for his comments and noted that the clinical voice will always be heard at PCCC and the views of GPs sought and be taken into consideration. It was **RESOLVED** to: • **RECEIVE** the Summary report from the Primary Care Commissioning Committee.	
B/18/152	**Minutes from the System Leaders' Meeting (June 2018) (paper N)** Mrs English took the paper as read; and noted the following item from the report:	

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	The draft Business Intelligence strategy was presented and discussed; discussion focussed on the need for an IT system across the patch. Some additional LLR resource has been identified and may be used to invest money in UHL IT systems. It was **RESOLVED** to: • **RECEIVE** the minutes from the System Leaders' Meeting (June 2018).	
B/18/151	**Summary report from the Primary Care Commissioning Committee (August 2018)** *Mr Wood asked that an amendment be added to this section of the minutes.* Mr Wood noted that due to the Secondary Care Clinician being conflicted with the Committee, Dr Tabitha Randell had stood down from the PCCC. Mr Wood formally thanked Dr Randell for her contributions and noted that he is working with Mrs Bains to look for an alternative member to join the committee.	
B/18/153	**Date of next meeting** The next meeting of the Governing Body of the East Leicestershire and Rutland CCG Governing Body will be take place on **Tuesday 11 September 2018, in Stamford Court, Oadby, (venue to be confirmed)**	
	The meeting concluded at 11.05am	