WEST MERCIA CLUSTER BOARD

Dear Colleague,

You are invited to attend a meeting of the Board of the West Mercia Cluster of Primary Care Trusts at **10.00 am, on Tuesday 29 May 2012, in the VIP Suite, The Council Offices, Coach Central, Telford**.

Yours sincerely

Joanna Newton
Chair

A G E N D A

		Pages
1.	**THE PATIENT STORY**	
2.	**APOLOGIES FOR ABSENCE**	
3.	**QUESTIONS FROM MEMBERS OF THE PUBLIC** *To receive questions from members of the public. Questions may be tabled in advance. Questions will be dealt with under item 23.*	
4.	**DECLARATION OF INTERESTS** *To declare formally any interests in relation to the agenda*	
5.	**CHAIR AND CHIEF EXECUTIVE ANNOUNCEMENTS**	
6.	**MINUTES OF THE PREVIOUS MEETINGS** *To approve the minutes of the Cluster Board meetings held on 27 March 2012 and 24 April 2012*	1 - 20
7.	**MATTERS ARISING AND THE SCHEDULE OF ACTIONS** *To review the schedule of actions and discuss matters arising not already on the agenda*	21 - 22
QUALITY		
8.	**QUALITY, PERFORMANCE & RESOURCES COMMITTEE** *Quality Performance & Resources Committee Report* *Quality and Performance Report* *To receive and note*	*To follow*
DELIVERING FOR TODAY		
9.	**FINANCE REPORT** *2011-12 Financial Outturn* *To receive and note*	23 - 26
10.	**STAFF SURVEY 2011 - REPORT** *To receive and note actions*	27 - 32

BUILDING FOR TOMORROW		
11.	**TRANSITION PLANNING**	33 - 68
11.1	*Transition Report*	*To follow*
11.2	*Supporting Staff Update*	*Verbal*
11.3	*Update on West Mercia Commissioning Support*	*Verbal*
11.4	*Mapping of Statutory Functions to Receiving Organisations: Delegations and Assurance*	*33-68*
	To receive and note	
12.	**TRANSFORMATION FUNDING UPDATE REPORT**	69 - 80
	To receive and approve	
13.	**CORPORATE OBJECTIVES DURING TRANSITION**	81 - 86
	To receive and approve	
14.	**HEALTH & WELLBEING BOARDS - UPDATE**	*To follow*
	To receive and note	
15.	**FUTURE OF ACUTE STROKE SERVICES IN WORCESTERSHIRE**	87 - 114
	To receive and approve	
BUSINESS AND GOVERNANCE		
16.	**CLINICAL COMMISSIONING GROUPS**	115 - 230
	Minutes of the West Mercia Cluster CCG Boards	
16.1	*Herefordshire CCG*	
16.2	*Redditch & Bromsgrove CCG*	
16.3	*Shropshire County CCG*	
16.4	*South Worcestershire CCG*	
16.5	*Telford & Wrekin CCG*	
16.6	*Wyre Forest CCG*	
	To receive and note	
17.	**AUDIT COMMITTEE REPORT**	231 - 254
	To receive and note	
18.	**NATIONAL COMMISSIONING COMMITTEE REPORT**	255 - 260
	To receive and note	
19.	**MIDLANDS & EAST SPECIALISED COMMISSIONING GROUP REPORT**	*To follow*
	To receive and note	
20.	**REGISTER OF INTERESTS 2011-12**	261 - 266
	To receive and note	
21.	**REGISTER OF SEALING**	267 - 270
	To receive and note	
22.	**CHILDREN'S CONGENITAL HEART SERVICES REVIEW - EQUALITY IMPACT ASSESSMENT**	*To follow*
	To receive and note	

23. QUESTIONS FROM MEMBERS OF THE PUBLIC

24. ANY OTHER BUSINESS

25. DATE OF NEXT MEETING

24 July 2012, The Council Chamber, Hereford, 10.00 a.m.

26. EXCLUSION OF THE PRESS AND OTHER MEMBERS OF THE PUBLIC

To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

Minutes of the Meeting of the West Mercia Cluster Board

27 March 2012, in the Council Chamber, Hereford, at 9.30a.m.

Present
Joanna Newton (Chair)
Eamonn Kelly (Chief Executive)
Dr Helen Herritty (Non Executive Director)
Andrew Mason (Vice Chair)
Susan Mead (Non Executive Director)
Dr Bryan Smith (Non Executive Director)
William Hutton (Non Executive Director)
Rob Parker (Non Executive Director)
Sue Doheny (Director of Nursing)
Brian Hanford (Director of Finance)
Dr Sarah Aitken (Director of Public Health, NHS Herefordshire)
Prof Rod Thomson (Director of Public Health, Shropshire County PCT)
Dr Mike Innes (Chair, Telford & Wrekin PEC & Telford & Wrekin CCG)
Dr Ian Tait (Chair, Herefordshire CRG)
Dr Bill Gowans (Chair, Shropshire Clinical Advisory Panel)

In attendance
Leigh Griffin (Deputy Chief Executive)
Paul Maubach (Director of Commissioning Development)
Chris Bull (Chief Executive, Herefordshire Public Services)
Simon Trickett (Chief Operating Officer, South Worcestershire CCG) *(for Dr Carl Ellson)*
Paul Taylor (Social Care Specialist, Telford & Wrekin Council) *(for Paul Clifford)*
Lin Jonsberg (Board Secretary)
Mr Nick Sherwood *(for 038/12 only)*
Mark O'Donnell *(PALS Officer, for 038/12 only)*
Nick Boffin (PA to Chair) (Minutes)

038/12 **Patient Story**

The Chair welcomed Mr Nick Sherwood, carer for his 23 year old son who had Laurence-Moon-Bardet-Biedl Syndrome (LMBB), a rare condition which provided many challenges. His son was registered blind and had obesity and renal issues. Mr Sherwood described his son's transition from child into young adult and the impact of his condition on his son's development. He believed that continuity of care was paramount. His son had renal impairment and other complications since birth, but had progressed through mainstream primary and secondary education. He had made regular visits to Great Ormond Street hospital and throughout the process had been supported with a very good local GP: continuity with the GP was very important. His son had transferred to Royal National College for the Blind, and at this point negative issues arose with the educational medical authorities around information sharing, with his son becoming independent at 18. There were further issues noted whilst he was at university in London around a lack of technology training considering his needs, which issue the university accepted, and his son was in consequence offered a fresh retake. In 2010 his son went on to a personal budget. Mr Sherwood undertook a valuable one-off course on personal budgets but observed that substantial savings could have been made with targeted, continuing support being in place; and a stable triangle of care (professional, service user, carer) was very important. The Director of Nursing acknowledged that further work on the young people's triangle of care

should be undertaken, and suggested Mr Sherwood could assist the PCT in this respect. Mr Sherwood felt that a confidentiality workshop would be a valuable starting point. Dr Tait also acknowledged the issue of confidentiality and from his own experience stressed the importance and value of mentoring. The Chair thanked Mr Sherwood for sharing with the Board his and his son's experiences. Mr Sherwood left the meeting at this point.

Dr Bryan Smith commented that previously a GP would have taken ownership of the problems raised by Mr Sherwood. Dr Ian Tait observed that there were variations in primary care particularly with GPS at universities. Dr Bill Gowans noted that the system required major effort to navigate which resulted in management difficulties.

Dr Mike Innes arrived at this point and declared an interest in the case of Mr Sherwood's son. The Chief Executive agreed that the system was complex but added that nurse carers were in place to navigate through the systems; and added that expectations were too high that general practice could resolve all these issues, whilst acknowledging the challenge in relation to carers.

039/12 **Apologies for Absence**

Apologies were received from: Dr Kiran Patel, Medical Director; Louise Lomax, Non Executive Director; Dr Anthony Kelly, Chair, Worcestershire Clinical Senate; Dr Richard Harling, Director of Public Health, Worcestershire; Dr Catherine Woodward, Director of Public Health, Telford & Wrekin; Dr Carl Ellson, Chair, S Worcestershire CCG; Cllr Marcus Hart, Worcestershire Council; Dr Simon Gates, Chair, Wyre Forest CCG; Paul Clifford, Corporate Director, Telford & Wrekin Council; Valerie Beint, Shropshire Council; Simon Hairsnape, COO for Wyre Forest & Redditch & Bromsgrove CCGs; Dr Andy Watts, Chair, HHHCC; and Suzanne Penny, Interim Director of HR.

040/12 **Questions Received from Members of the Public**

There were no questions received from members of the public.

041/12 **Declaration of Interests**

There were no interests declared with respect to the agenda.

042/12 **Chair and Chief Executive Announcements**

The Chair reported that the Health and Social Care Bill had moved through parliament and would shortly receive Royal Assent. The cluster board was therefore sitting as the board of the four PCTs concurrently. The Chair stated the objectives of the board: delivering today's services, and building for tomorrow, and stressed the key issue of managing and looking after staff in the transition to the new arrangements.

The Chief Executive reiterated the importance of supporting staff in a period of change, which was now gaining momentum following the passage of the Bill. David Evans had been appointed Chief Operating Officer for Telford & Wrekin CCG and would start on 1 May 2012.

043/12 **Minutes of the Previous PCT Board**

The minutes of the cluster board meeting held on 28th February 2012 were **approved**.

044/12 **Matters Arising from the Minutes and the Schedule of Actions**

From actions sheet:

026/12 supporting staff: it was confirmed that guidance was expected in April/May 2012,

and was not yet received.

030/12 Specialised Commissioning Board. The Deputy Chief Executive confirmed that the request to make the amendment to the establishment agreement had been made to the Midlands & East specialist commissioning group.

032/12: Governance and corporate objectives. The Director of Commissioning Developments reported that executive team had met on Friday 23rd March and outcomes were being completed. Immediate priorities had been identified.

045/12 **West Mercia Quality and Performance Report.**

The Director of Nursing gave an overview of the quality and performance dashboard. The Board's attention was drawn to the detail on red rated issues shown on p21. In summary, there was movement in some areas in terms of performance, but areas of concern remained, particularly for Worcestershire Acute A&E performance where financial penalties were being applied. Improvements were noted during March at Wye Valley NHS Trust (WVT) and Shrewsbury & Telford Hospital (SaTH). Never Events had been discussed in great detail at the Quality, Performance & Resources Committee, with further discussion to take place as part of the following agenda item. Andrew Mason referred to the indicator for pressure ulcers: given that their elimination was an SHA ambition, there was a concern that there was no reference as to how this would be achieved. In addition, the board required more clarity on the ratings dashboard for non acute performance issues, for example breastfeeding. The Director of Nursing agreed that avoidable pressure ulcers should be eliminated and reported that a programme had commenced with district nursing caseloads. The cluster aimed to the first to eliminate pressure ulcers within the region. Regarding non acute performance, the Director of Nursing noted that there were status reports in the current red issues section of the performance and quality report (pps 22-23).

Dr Bryan Smith required clarity around the summary hospital-level mortality indicator (SHMI): on p22 the commentary noted Worcestershire Acute Hospitals Trust (WAHT) was showing a high rate, however on p39 WAHT was shown as the lowest of 3 acute trusts and red rated but Wye Valley was higher and green rated within control limit. The Director of Nursing acknowledged that the data was complex and retrospective, and reported that Dr Kiran Patel was working within the region to get consistency. It was agreed that a report should be brought back to board via the QPR committee to provide assurance on SHMI.

Sue Mead noted that through timing issues the information in the current quality & performance report had not been available at the previous QPR committee meeting, and also highlighted the issue noted on p 21 with the information on emergency readmissions, which was a critical indicator. The Director of Nursing noted that there was a reliance on providers to supply data, but provider data supplied direct to the SHA was being accessed to facilitate reporting. Regarding readmission rates, this year charges were being incurred therefore a lot of data checking was being undertaken, which could cause reporting delays. However it was agreed that this was a critical issue and would be taken forward as a priority through the QPR committee.

Rob Parker noted that there appeared to be no significant improvement on the important TIA performance indicator, particularly with respect to the data for SaTH. The Director of Nursing confirmed that TIA was a priority through the work of the CCGs, and added that the TIA numbers were often low. Reviewing the dashboard, SaTH had 9 out of 16 indicators rated red, and WAH had 7 rated red: and Rob Parker observed that as an important part of the handover legacy going forward, the board should be concerned about the RAG ratings on the dashboard over the next 3 months: the current colour mix was unacceptable. The Chief Executive acknowledged that there were still issues with the presentation of the report. SHMI was a primary indicator so clarity of reporting was essential: it was confirmed that the WAHT score was now well below 100, and the Chief Executive expected the SHMI for all 3 acute trusts to start to show a green rating. Mortality

data was being examined on a weekly basis. Regarding TIAs, the Chief Executive noted that there was improvement in the Worcester position, but this clearly needed to be sustainable. Discussing the potential position over the next three months, the Chief Executive expected the MRSA figure to improve and move from amber to green. There were improvements in *C.difficile* but in the community further improvement was needed. There was a significant number of Never Events but the high profile they carried could ensure green rating. VTE and SHMI were both improving. CQC alerts were held at the same level. On 18 weeks the Chief Executive expected SaTH to be green rated but noted that Robert Jones & Agnes Hunt NHS FT (RJAH) might become amber given current profile, although this should be resolved by Quarter 2. Current improvements underway in A&E should take SaTH and WVT to green; at WAHT intensive support would be required probably until the end of Q1. An action plan was in place at SaTh for delayed transfers. The TIA indicator was improving in all 3 acute trusts. Re: midwife-birth ratio: there was a commitment to have full ratio complete by the end of the year, and actions to achieve the ratio are in place. It was noted that the figure for mixed sex wards had been affected by the knock-on impact from A&E. Rob Parker felt that it would be helpful to receive a dashboard based on expectations. There was a gap in the SaTH data for TIA: Dr Mike Innes confirmed that 24/7 cover was in place and the gap was surprising: to be taken forward.

Resolved that

The Board **noted** the report and the actions undertaken.

Actions:

- SHMI and Readmission Rates report to be taken to QPR Committee (Director of Nursing)
- Gap on TIA 24/7 cover in SaTH data: to be taken forward.

046/12 **Quality, Performance & Resources Committee**

The Chair of the committee summarised key points from the March meeting, which did not have the benefit of the recent performance report discussed above. Future meetings would have the current quality and performance reports, and she reiterated that the committee would expect to see and monitor actions that were in place. Information from local PCT quality forums would be incorporated into the committee forward plan; the content was agreed but some structural changes needed to made to progress the plan. The committee discussed how information would be made available to the CCGs and CCG capacity.

The committee had a valuable discussion on the forward financial plan, to gain an understanding of the significant challenges and risks. Examination of particular quality issues had started with Never Events: a detailed report had been received, highlighting preventative and investigative mechanisms and the committee had received assurance in this respect. The Director of Nursing added that since the report there had been a further Never Event in ophthalmology at SaTH: a full investigation was being undertaken. The Director of Nursing felt that mature governance was in place around never events. SaTH had invited all parties, including patients and the CQC to be present at the root cause analysis (RCA) meeting, which was to be commended. Helen Herritty asked for further clarity around the sequence of never events in ophthalmology. The Director of Nursing responded that the never events had occurred retrospectively prior to the actions being put in place, and confirmed that alternative services had been provided for patients following a suspension of the service.

Resolved that

The Board **noted** the report and the chair stressed the importance of maintaining quality in transition.

046/12 **Financial Reporting**

The financial report covered the period to February 2012 (month 11) for all four statutory bodies. The Board's attention was drawn to the item of substance is on p.87 around monies for sustaining improvements around A&E and waiting times, and the Director of Finance highlighted the implied threat that resources would be withdrawn if the improvements were not delivered. Discussions were still ongoing with the SHA. The Director of Finance expected that following discussions some levies could possibly be made but did not believe there would be a breach of statutory duties. The question remained as to whether any fines would be passed on to those providers who had breached. Issues of concern: A&E has been disappointing, and the RJAH waiting times might also be an issue.

There was one item of process for Board approval. Each Board would need a resolution to delegate to the audit committee to sign off individual PCT final accounts. As the cluster board was sitting as the four boards simultaneously:

Resolved that

The Board **delegated** signing off the annual accounts to the audit committee.

Dr Bryan Smith required clarification under paragraph 3.3 on which financial penalties could be imposed on acute trusts on failure of targets. The Director of Finance confirmed that national contracts did allow for trusts to be penalised, which could be escalated to withholding of resources and eventually to the removal of funds from the trusts, which procedure had been followed in Worcestershire. A sensible approach had been taken regarding the effect of penalties on providers: assistance had been provided in other ways to help performance. Separate to this, additional funds had been received to sustain and improve targets, although with conditions. The Director of Finance added that the SHA threat was around these extra monies.

Rob Parker queried two items: firstly the £8m SaTH overspend to contract; and secondly noting that the Worcestershire Acute spend was being managed, but out of county contracts were showing an overspend. The Director of Finance reported that in Shropshire County and Telford & Wrekin there was an unprecedented requirement to improve waiting times therefore given the number of patients to be treated there was significant over-performance to resolve. A key feature for next year would be to understand sustainable activity levels. Other issues for SaTH included the Trust's improving ability to cost and code activity, which had fed into the contract. At present the contract volumes set for next year addressed the recurrent nature of performance: the contracts made assumptions about the ability CCGs to achieve QIPP targets to reduce additional referrals for non-elective admissions, which would require monitoring. Regarding the out of county issues in Worcestershire, this was being monitored. CCG budgets in the new year had allowance for future growth but is was acknowledged to be a particular issue for Worcestershire. RP enquired whether there was a choice element in going out of county. Dr Bryan Smith added that the joint services review was addressing this issue. It was agreed that a report to look at the detail on this issue should be taken to the QPR committee. The chair commended the work of the PCTs' finance team in achieving the statutory targets.

Resolved that

The board **noted** the report.

Action
Report on out of county spend in Worcestershire to be taken to QPR committee (Director of Finance).

047/12 **Transition Planning**

The board received the position paper giving an overview of the progress on transferring PCT responsibilities to successor bodies. For the CCGs and the Commissioning Support Organisation (CSO) the staff consultation document (Appendix 1) showed top level structures. The consultation would run to 8 April and would be supported by workshops across the cluster. The report briefly summarized the CCG authorisation process as currently understood, and included further information on the accountable officer assessment process. Regarding the CSO, the business case would shortly be assessed initially via the SHA and then the Department of Health, on a West Mercia footprint.

The paper identified those responsibilities expected to transfer to the National Commissioning Board (NCB) and Public Health England (PHE). Health & Well-being Board (HWBB) update: to note on p 98 4.3 "*April 2013*" should read "*April 2012*". Effective engagement at a local level was noted and a progress overview on HWBB would be brought back to the next board: each individual HWBB was picking up the pace with good CCG involvement and input noted.

With respect to the NHS Commissioning Board, it was clear that there was a drive nationally for a much tighter consistency in commissioning and to achieve convergence. Across the Midlands and East SHA collaborative arrangements were being shaped to enable convergence of local commissioning and make best use of resources in effective commissioning of specialized services, including military and prison health. It was noted that primary care commissioning functions were not yet clear nor was there an indication of what flexibility there might be in developing local variance. The Chair reminded the board that the PCT cluster was a sending organisation and that there were between 15-18 receiving organisations, which clearly demonstrated the complexity of the transition.

The Director of Commissioning Development noted the complex issue of CCGs being authorised at different stages and how statutory responsibilities would therefore be dealt with in the varying stages of devolvement to the CCGs. It was recommended that an assessment and plan should be produced indicating where these responsibilities lay which would prevent duplication of work and identifying any gaps. It was agreed that the Director of Commissioning Development produce the matrix. The Chair asked for clarification around CCG authorisation, particularly around authorisation with conditions: the Director of Commissioning Development confirmed that that there were three authorisation outcomes: the first without conditions, secondly, with conditions which would be largely around development issues to be addressed, and the third option, not authorised. The process would take place in four phases, starting in July with the last phase concluding at the end of January 13. The route for the individual CCGs would probably be known by the end of April following SHA consultation. Dr Helen Herritty referred to paragraph 2.1.4 regarding the timetabled plan and whether there was sufficient capacity and pace to enable the decision to be made, particularly for CCGs in the first wave. The Director of Commissioning Development acknowledged that the first wave would start in July so clarity on responsibilities was essential before then, although, for example, CCGs already had delegated budgets. The Chief Executive made the distinction between the requirement of CCGs to demonstrate a track record as opposed to receiving formal delegation of all PCT functions, and acknowledged the need for clarity on which functions would be delegated to CCGs and which functions would remain residual to the PCT until April 2013. There was a corporate governance issue about tracking what was and was not delegated, i.e. for the QPR committee. The journey to full delegation needed to be mapped out. Simon Trickett confirmed that the authorisation process was essentially around the CCG track record and there should be no obstacle to establishment: in terms of timescale, in practice, for wave one July is misleading, given that the respective paperwork would have to be ready by 1 June 12, and a stakeholder survey and engagement process would need to be undertaken prior to this in May.

Referring to the CSO, Dr Bryan Smith complimented the work undertaken but raised a strong concern that it appeared, according to figure 1 on p121, that the CSO would have a performance and provider contract management role: this should unequivocally be the responsibility of the CCGs as contract owners. The Director of Finance confirmed that the CCGs would be constrained by the £25 cost per head of population, and would be performance managed by the system, and would be supported by CSO, but the CCGs would carry the statutory burden and be the responsible bodies. Chris Bull felt this was a very helpful report but observed there was no mention of any arrangements that CCGs might make with local authorities with respect to commissioning support. There was a need to resolve the extent to which CCGs would consistently buy the same services from the CSO or differ in their choice, for example on a place-based basis. The Chief Executive referred to the section on p.118 "our ambition": a business case was required against a nationally led process template describing a commercially-based organisation not aligned to its key customers, and which did not draw out local commissioning arrangements. The Chief Executive reiterated the commitment to joint commissioning and a place-based model. The shaping of CSOs had been undertaken with the CCGs, but there was a major risk around lack of delivery of the West Mercia-based CSO because of the desire to see a smaller number of large CSOs nationally; this should not, however, undermine local commissioning agreements. It was agreed that this should be made more visible in the documentation, and assurance was given that the cluster was sighted on joint commissioning. Chris Bull added that this was not just a West Mercia cluster debate. There was a broader debate about the extent to which the creation of CSOs, and the way in which they were being created, mitigated against CCGs entering local arrangements. The Director of Commissioning Development noted that all of the CCGs in the cluster, as part of development of structures, were building in plans for joint commissioning arrangements with local authorities.

Dr Sarah Aitken commented that it would be helpful to make the mandated public health core offer by local authorities to CCG groups more visible in the future iteration of documents. There was guidance on what would be covered under these offers. Dr Ian Tait noted that the key challenge demonstrated by the patient story earlier in the meeting was that arrangements made had to deliver systems for patients. Dr Mike Innes added that the demonstration of joint commissioning was evident in CCG structures rather than in that of the CSO. There was a challenge that authorization of commissioning support would be very robust and equally robustly tested. Dr Bill Gowans noted that in terms of service redesign work, processes should be looked at first, but there was no clarity as yet on how the processes work and their relationships between disparate CCGs and a potentially distant CSO; when driving through a major level of change ideally the processes should be identified first with the structures following. It would be essential to understand how the business supported better relationships for patients. Simon Trickett echoed this and understood there was still lot of work still to do to plot the practicalities around structures. The authorization process could not be entered without a signed SLA with a CSO provider. From the CCG point of view Simon Trickett believed the CSO proposal as presented was workable and firmly supported it. There were however concerns should the proposal not proceed and the CSO be implemented on a bigger footprint. The Deputy Chief Executive noted that certain direct commissioning functions may be provided to the NCB.

The Chair suggested that a CSO task and finish group of the cluster board should be set up to provide oversight and assurance around governance in transition, with the Vice-Chair as lead: the Board agreed.

Transfer of Public Health responsibilities: Professor Thomson commented on the allocation for Shropshire. The four Directors of Public Health had worked closely with the Director of Finance to ensure then when reporting financial expenditure for 2010-11 that the reporting was consistent. It highlighted a flaw where the Department of Health was looking at expenditure which excluded a range of items, including for example the public health expenditure on sexual assault referral centres. Nor was it taking into account where PCTs had significant financial pressures and funding was being used from public health

expenditure to support the broader aspects of healthcare of the population, which was not included in the returns that the Department of Health wished to have filled in - this particularly affected Shropshire. Therefore even though more was being spent on health in Shropshire, it was not being viewed as public health expenditure, consequently a combination of factors were affecting Shropshire - as a rural economy there was a tradition of underfunding. Vacancies were being used to support the financial pressures on the system reflecting in a lower perceived spend on public health, therefore the figure was significantly lower than national or regional average. The net effect is there would be a £5m worth of public health investment in Shropshire if it was getting the national average.

The national funding formula being developed for public health for the future will be announced in the next few months. It was recognised that there were some flaws in the formula. It would be important to ensure a fair investment for the population of Shropshire, and lobbying for fair investment to be able to invest upstream for a range of conditions. It had an implication for the clinical commissioning groups, in terms of the core offer of support from the public health department; depending on future resourcing there could be a significant challenge. The Deputy Chief Executive reassured members that these points had been taken up with the department of health, and although they may not affect the allocations for 2013-14, the key issue is the extent to which it may influence future allocations. The variation is 8-10-fold across the country in public health spend per head of population.

Chris Bull noted that this was a live debate regarding the extent to which local government would want to see allocations based on a needs-based formula rather than historical spend; and given the commitment the Department of Health had made for the allocations in 2013-14 would not be less than the spend in the base year, a move to a needs based formula would happen over a number of years; and it was accepted that the historical allocations had no logic other than the idiosyncratic behaviour of particular organisations.

Dr Sarah Aitken commented that the new NHS constitutional right to the offer of a 5-yr health check for people aged 40-74 was not in effect for 2010-11, therefore most of the population of West Mercia was not covered by a programme at that point, and it would require a significant financial programme to provide the check. There was an ethical point to note around following this up - in that other services could be cut back to offer the health check and therefore not be able to offer the services which could bring about behavioural change and effect the transformation.

Dr Bill Gowans noted that there was uncertainty around the extent of influence on local variations in primary care services and their delivery, from the perspective of service redesign, primary care delivers 95% of urgent care and the imposition of a national solution would have a major impact on service redesign and integration. The Deputy Chief Executive reported that the indications were that there would be a significant degree of flexibility locally, but a question remained about its actual extent, some clear arrangements were anticipated with local outposts of the NCB managing primary care commissioning, but these were delayed. The Chief Executive confirmed that the delegation of functions would fully involve the CCGs. In terms of primary care governance, Dr Tait added that further understanding of positioning, with performers list for example, was essential; as running nationally could be a problem for organisations given the requirement to provide information on local arrangements, and required clarity on the arrangements for joining up all the contractor professions. The Chair felt this could be picked up under the national commissioning sub-committee discussion below. The point was echoed by Rob Parker with respect to the national commissioning board being established as a remote body, and with the driver being cost reduction, rather than being close enough to manage local contract/performance relationships.

Supporting Staff

The Chief Executive gave a general update on the current position. It was clear that the cluster was responsible for delivery and also that it had a critically important role in shaping the new organization, albeit without the final say. An example was in relation to senior appointments in the system: as part of the process CCGs have been asked directly to nominate chairs and accountable officers; the processes reflected the changes being undertaken in the system. In addition the DoH was attempting to align the appointments to the local office director roles in the NCB with appointments to the CSO. This was expected to take place in May/June; an external consultancy would be involved in working with the Commissioning Board and DoH in this process, although final written confirmation of these processes has not yet been received. It was recommended that a workforce task & finish group be appointed to work through issues in further detail, to include in particular work on staff surveys, reporting through to the Board. The Director of HR was working with staff side representatives both regionally and locally to ensure confidence in the arrangements in place.

Andrew Mason noted that given the CSO structure out for consultation may not be the final version and that CSO may not be on the West Mercia footprint, would this affect the consultation process, and what assurance could be given around keeping staff updated? The Director of Finance reported that the consultation documentation went out with some options for staff comment, and confirmed staff would be kept informed of developments; the Chief Executive added that there was a change management policy in each of the employing organisations and the expectation was that there would be reflection on the need to consult again, and advice would be sought from the Director of HR in this respect. Dr Mike Innes recognised the importance of the consultations but reinforced the importance of the visibility of board directors which should not be sidelined in the consultation process. The Chief Executive gave further information on the appointments process underway: the Managing Director roles would cease from 1 April. The Deputy Chief Executive would take the lead with the National Commissioning Board, and Dr Jonathan Leach would co-ordinate primary care.

Resolved that

The Board **noted** the report and **supported** the identified actions.
The Board **agreed** the establishment of the CSO Task & Finish Group
The Board **agreed** the establishment of the Workforce Task & Finish Group

Actions:

- Matrix and report on mapping of statutory functions to receiving organisations to be produced and reported to April board (Director of Commissioning Development)
- CSO Task & Finish Group to be established
- Workforce Task & Finish Group to be established**.**

048/12 **PCT Budgets 2012-13**

The Board received the PCT budgets for the four statutory bodies for 2012-3. The Director of Finance summarised the main issues. The Board should be conscious of the risks going into the new financial year. Budget divisions were based on existing management arrangements and span of control, but regarding the public health move, shadow allocations needed to be taken forward. Otherwise the budget structure was similar to that of last year. A key aspect was the organisation of specialised services for the next financial year to more closely reflect local arrangements: there has therefore been a transfer between CCG and NCB budgets. The report indicated the current position with each PCT and highlighted the QIPP challenge ahead and identified the relative levels of risk. On p6 of the report a comparatively higher risk was identified for Herefordshire; influenced by financial challenges in the health economy particularly around WVT, and also the level of the QIPP challenge

going forward. To meet reserve targets, each of the CCGs would have an assurance risk reserve which sat outside the budget; the resource for this has been identified. Also within the CCG budgets a risk reserve had been allocated. Shropshire County PCT was identified as a lower risk; however the Shropshire County CCG outturn would still need to be monitored for this year. On p 150, a particular issue was noted for Worcestershire regarding the presence of more than one CCG which added an extra level of complexity. For the current year Worcestershire had moved to a fair share budget under the national form which had been brought forward for 12-13. A risk had been identified around the potential move to historical funding, unless local agreement, there was a risk of planning blight which might limit recurrent investment. The Director of Finance suggested the board might facilitate this agreement with non-executive director involvement.

The operating framework requirement identified that each PCT identified 2% of resources non-recurrent should be set aside for transformation. The planning requirements had been met in the budget and the implementation would require board oversight. Plans needed to be submitted to the SHA for the use of the resource. The SHA had signalled that one third of the resource would be committed to priority areas such as Rapid Assessment Interface and Discharge (RAID) and dementia. Before the allocation of resources and support to providers, discussions with key providers around contractual agreements and recompense for levels of activity under national funding arrangements were in an advanced stage but were yet to be finalised. Board to board meetings would be arranged with the acute providers before submission of the bids for the reserve to the SHA.

Simon Trickett welcomed the proposed approach of the cluster board assistance to broker the agreement between the Worcestershire CCGs around funding formulae, and also welcomed the information provided on the 2% transformational reserve. From the Worcestershire CCG perspective assurance was sought as a guiding principle that the QPR committee would seek to limit the availability of the 2% funding to the originating health economy that it originated from, especially regarding the transformation investment that would be needed in Worcestershire around the joint service review (JSR). It was important for the CCGs to retain access to the funding, and board support for this was sought as a principle. The Chair added that a non-executive director had been identified to lead on the fair share in Worcestershire and this would be taken forward outside the meeting.

Dr Bryan Smith as a member of two CCGs in Worcestershire, one of which could be viewed as a winner and the other a loser under the formulae, felt that irrational national blanket guidance imposed without consultation should be challenged. Dr Smith also reiterated support for the first call on the Worcestershire 2% transformational funding being retained in the Worcestershire health economy, given the major issues with the acute trust. Dr Smith added fundamentally that as a non-executive director he did not believe in supporting and approving without a full understanding of the issues involved, in this instance regarding budgets other than that of Worcestershire, and therefore wished to register that he would not be prepared to approve the budgets for Herefordshire, Shropshire or Telford & Wrekin and would therefore abstain. He registered his support for the budget for Worcestershire.

Dr Ian Tait commented on the 2% risk reserve and welcomed the commitment to RAID and the improvement in dementia care; having due regard to the Herefordshire financial risks, could the board consider commitments which would allow the continuation of the maximum level of integration and shared achievement of targets; there was a danger of aligning resources with organisations rather than with care pathways; organisational targeting of funds might not facilitate the collaboration which would allow the delivery of better care.

Rob Parker reiterated the need to resolve the Worcestershire issue speedily, and raised two further points; firstly around mechanisms to ensure the CCGs up to speed on financial ownership, including the ownership and understanding of financial risks and production of action plans. Secondly, re transformational money and indication of what the benefits are against the £37m - it would help the board to have an indication of ongoing benefits to allow a framework to judge how appropriate the allocation is.

The Director of Commissioning Development observed that there was one significant difference between the PCTs' allocations which represented an additional challenge: Herefordshire has a significant QIPP challenge alongside the corporate budget which would represent a significant operational challenge alongside the transformational change.

The Director of Finance responded to the above points. Regarding the fundamental issue of signing off budgets as sustainable and deliverable: in his view these budgets could be signed off and it was important to do so whilst being mindful of the level of risks identified, which would be added to the risk registers. It was fundamental for CCGs to understand their budgets and QIPP targets. As soon as practicable there would be financial staff dedicated to supporting CCGs. Regarding collaboration and the transformational resource, the Director of Finance confirmed that bids were being looked at and recommended across the health economy, for example RAID, and were not targeted to one organisation.

The Chief Executive reminded the board that it held the statutory responsibility to ensure each PCT worked within the resources allocated to it, and acknowledged the significant challenges to delivery in Herefordshire and Shropshire. There were many good initiatives in place across the cluster but these were not sufficiently scaled up to deliver the financial savings: discussions with the CCGs should take place to progress the initiatives, particularly around unplanned admissions. The Chief Executive referred to the table on p152 which showed how the resources would be used across the cluster according to the system plan. There was a significant financial challenge sitting with providers, noting that they had 73% of the QIPP challenge. Providers were looking for £25m support from the £37m to balance budgets; of the £25m, £10m in Herefordshire, £5m from Shropshire/Telford and £10m from Worcestershire; and therefore with respect to the issue raised about systems living within the resource limit contribution, in principle this would be expected but no guarantee could be given that the 2% would be delivered to the CCGs.

Board to board meetings will need to take place to understand the required the level of support, and to make clear the PCTs' expectations to commit the support: there needed to be buy in to system wide transformation and delivery of cost improvement programmes or improvement initiatives. It was acknowledged that an increased level of organisational co-operation was necessary to ensure delivery. The Chief Executive emphasised that the cluster would have firm expectations about delivery and behavioural change: previous performance had not been good enough. The arrangement of the board to board meetings was a priority to clarify required resources to ensure the viability of providers to protect the interests of patients. In relation to RAID, which was underpinned by a strong cost-base assessment, the Chief Executive hoped that a decision could be made as rapidly as possible.

Dr Bill Gowans identified the risk that, by looking first at viability of organisations and allocating resources accordingly to retain viability, there would be a failure to integrate and transform in order to remain viable. Within Shropshire it was argued strongly that the ability to engage in integration should be looked at before the viability from a stand-alone point of view. Secondly, there was a long standing legacy in providers of an extreme disconnect between management and finance, and workforce and in terms of delivering change the workforce should be engaged first. Sue Mead agreed that care should be taken that funding was not used to support existing unsustainable organisational models, and also an understanding of the quality impact of taking substantial monies out of system was required. There was a difficulty in considering budgets in isolation of the wider strategy: an alignment was necessary to service and organisational redesign and any additional monies should have conditions to meet not only national performance targets but also local strategic objectives.

The Chief Executive noted that West Mercia Clinical Leaders Concordat addressed the points made above and noted that the challenges would only be resolved by changes in provider behaviour. Regarding the quality impact the Chief Executive confirmed that all

support would be signed off at board and any transitional support would need to be aligned to a clear strategic change programme.

Resolved that

1: The board **approved** the 2012-13 budgets for the respective PCTs. An abstention was recorded from Dr Bryan Smith.
2: The board **noted** the level of resources to be delegated
3: The board **noted** the commissioner challenge and risks under QIPP
4: The board **noted** the current status of the recurrent transformation fund.
5: The board **agreed** that board to board meetings be implemented as soon as possible. The Chief Executive confirmed that board to boards with the three acute trusts would be prioritised.
6. The board **agreed** that the transformational risks be added to the risk registers. The Chief Executive added that detailed risk assessments were in place.

Actions:
- Board to Board meetings be arranged as a priority initially with the three acute providers.
- Transformational risks to be added to risk registers.

049/12 **Legacy Documentation - Refresh**

The board received the update on legacy documentation. There were no issues for clarification.

Resolved that

The board **noted** the report.

050/12 **Clinical Commissioning Group Reports**

The Chair highlighted the importance of receiving the minutes of the CCG boards, as sub-committees of the board with a significant amount of resources delegated to them. The Chair thanked the groups who submitted their minutes and exception reports.

- Herefordshire CCG: Dr Ian Tait highlighted that a quality format in their approach.
- Redditch & Bromsgrove CCG: because of deadlines, no approved minutes presented to this Board, to be carried forward.
- Shropshire County CCG: no further issues to highlighted.
- South Worcestershire CCG: additional risks noted in Worcestershire around staff transition from one PCT to two CCG management teams, with considerable debate on staff structures and the operating model moving forward.
- Telford & Wrekin CCG: Dr Mike Innes highlighted the risks identified around QIPP and on p231 the CCG's work on referral tracking;
- Wyre Forest CCG: no issues to report, but Dr Bryan Smith reported that the CCG was being formally launched this evening.

The Chair suggested that CCG reporting should be a topic included on the agenda for the April board development meeting.

Actions:
- Redditch & Bromsgrove CCG minutes to be submitted to the Board upon approval
- CCG reporting to be taken forward at the April board development session.

051/12 **Audit Committee Report and Terms of Reference**

The Chair of Audit Committee summarised the report. A key topic for the committee was CCG support with respect to governance procedures. The committee agreed that the Audit Commission would re-contact all CCGs about their workshop, which had only taken up by Wyre Forest CCG to date; the feedback from the workshop was that conflict of interests was a key issue. A second piece of work was around the provision of a common sense framework for CCGs to set governance procedures and establish audit committees. The committee received details of an internal audit report on safeguarding adults. This report was for Telford & Wrekin and only gave moderate assurance; a number of immediate key recommendations were made: it was agreed that the Director of Finance should take this forward with the Director of Nursing to investigate the report and the wider potential issues across the cluster. The next audit committee meeting would revisit both the safeguarding report and the audit plans for the new year. In terms of the board assurance framework, following review and discussion it was agreed that the Director of Finance and the Board Secretary would summarise the issues that were still relevant to then be taken forward to either the cluster board agenda or to locality meetings. The BAF format would be agreed and would be sent out after the next meeting. Draft corporate objectives for 12-13 were expected at the next meeting and would be input to the BAF. Finally the chair of audit reminded subcommittee chairs to fill in the assurance pro forma agreed at the last board. This would be a key part of assurance framework going forward.

The Director of Nursing confirmed that she had been made of aware of the adult safeguarding issues and a piece of work across the cluster would be undertaken and reported back.

Resolved that

The revised Audit Committee Terms of Reference were **approved** and the report was **noted**.

Actions:

- The Board Secretary to work with the Audit Commission to re-contact CCGs for board development
- The Board Secretary to follow up receipt of assurance pro-formas to sub-committee chairs.
- The Director of Nursing to report back to board following cluster-wide work on adult safeguarding issues.

052/12 **National Commissioning Committee Report**

Dr Helen Herritty reported that the first meeting had only recently taken place and provided a report to board as the approved minutes were not yet available. Minor amendments to the Terms of Reference had been made following comments from February's cluster board, and the Terms of Reference were now resubmitted for board approval. The meeting focused on primary care but future meetings would look at position statements on military and prison health, public health and emergency resilience. The committee supported a proposal for a cluster wide primary care operational team made of heads of primary care across the cluster PCTs. A number of workstreams were agreed, looking at for example pharmacy, dentistry, and ophthalmology, which would examine current performance and respond to the requirements of the national commissioning board, and would also look at what could be released following alignments across PCTs. Dr Jonathan Leach had raised the issue of the cluster primary care teams having the capacity to deliver and asked whether the committee could consider whether some of the 2% transformational fund could be used to provide extra flexibility and support in this respect.

The Deputy Chief Executive reported that the first meeting of the primary care operational executive group was yesterday 26th March; leads for workstreams had been appointed and

work was progressing. Regarding the 2% fund, in the budgets paper there was a sum set aside against primary care transformation as one of the "big bets", and also for SHA ambitions to develop consistent metrics across primary care.

The committee chair raised a further point regarding clarity of reporting of key issues, for example contracting and quality issues and risks, to the cluster board. The Chair suggested exception reporting to public board with some items being taken to confidential board as appropriate.

Rob Parker asked for clarity where the local responsibility would lie for service issues, for example dentistry, and the appropriate role of the Health & Wellbeing Boards (HWBB). The Deputy Chief Executive noted that the role of the local office of National Commissioning Board would be critical and the point had been made that primary care commissioning work would require local input to work effectively; Paul Taylor added that at the previous Telford & Wrekin HWBB a range of areas for consideration had been flagged, and dentistry was included. The Chief Executive expected that representatives from the NCB would attend HWBB meetings and would expect the HWBB, taking the example of dentistry, to be looking at access to NHS services as well as oral health prevention. It was also expected that the transition to direct contracting of services taking place with a local footprint within the NCB would be West Mercia based. It was not yet known what the single operating model would be for the whole country and it was possible that the location of certain functions would be changed. The Chief Executive endorsed the view of the Deputy Chief Executive and added that given the number of contractors involved retaining a local footprint would be essential, and that is what would be initially implemented for the transition.

Dr Ian Tait reiterated the concern of clinicians with governance and policing of contractors being carried out at national level rather than at a local level, because local intelligence often provided the lead on dealing with performance issues.

Dr Bill Gowans gave the example of access as a workstream requiring primary care to be looked at at a local level. It was clear that unless access was looked at across the whole economy it could not be addressed: it was essential that A&E, MIU, Ambulance and Walk-In Centres were linked and this could only be joined up at a local level. The Chief Executive noted that this theme had been picked up and recognised in an NHS Confederation statement yesterday, 26th March, on the next eight issues necessary to move forward. Dr Helen Herritty confirmed that access had been picked up as one of the workstreams to be taken forward through the NCC.

Resolved that

The board **approved** the terms of reference and **noted** the report.

053/12 **Midlands and East Specialised Commissioning Group Update**

The Deputy Chief Executive reported that no meeting had been held since the February 27 Board, and there were no further issues to report.

054/12 **Questions from Members of the Public**

There were no questions from members of the public.

055/12 **Any Other Business**

There were no items under any other business**.**

056/12 **Date of Next Meeting**

Tuesday, 29th May 2012, Telford, 10.00

057/12 **Exclusion of the Press and Other Members of the Public**

Resolved that:
Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960)

Signed: …….. (Chair)

Dated: ……

Minutes of the Extraordinary Meeting of the West Mercia Cluster Board

24 April 2012, in East Box Room 8, Worcester Warriors Rugby Club, Worcester, at 10.00a.m.

Present
Joanna Newton (Chair)
Eamonn Kelly (Chief Executive)
Dr Helen Herritty (Non Executive Director)
Andrew Mason (Vice Chair)
Louise Lomax (Non Executive Director)
Susan Mead (Non Executive Director)
Dr Bryan Smith (Non Executive Director)
William Hutton (Non Executive Director)
Rob Parker (Non Executive Director)
Sue Doheny (Director of Nursing)
Dr Sarah Aitken (Director of Public Health, NHS Herefordshire)
Prof Rod Thomson (Director of Public Health, Shropshire County PCT)
Dr Mike Innes (Chair, Telford & Wrekin PEC & Telford & Wrekin CCG)

In attendance
Leigh Griffin (Deputy Chief Executive)
Paul Maubach (Director of Commissioning Development)
Paul Clifford (Corporate Director, Telford & Wrekin Council)
Dr Caron Morton (Chair, Shropshire County CCG)
Dr Andy Watts (Chair, Herefordshire CCG)
Chris Bull (Chief Executive, Herefordshire Public Services)
Cllr Marcus Hart (Worcestershire County Council)
Adam Cairns (Chief Executive, Shrewsbury & Telford Hospital NHS Trust)
Kate Shaw (FCHS Programme Manager, Shrewsbury & Telford Hospital NHS Trust)
Chris Benham (Assistant Director, Financial Accounting, Shrewsbury & Telford NHS Trust)
Chris Hudson (Communications Officer, Shrewsbury & Telford NHS Trust).
Lucy Noon (Head of Corporate Development, West Mercia Cluster)
Jenny Fullard (Communications Officer, NHS Telford & Wrekin)
Lin Jonsberg (Board Secretary)
Nick Boffin (PA to Chair) (Minutes)

058/12 **Apologies for Absence**

Apologies were received from: Brian Hanford, Director of Finance; Dr Kiran Patel, Medical Director; Dr Anthony Kelly, Chair, Worcestershire Clinical Senate; Dr Ian Tait, Chair, Herefordshire CRG (PEC); Dr Bill Gowans, Chair, Worcestershire CAP; Dr Richard Harling, Director of Public Health, Worcestershire; Dr Catherine Woodward, Director of Public Health, Telford & Wrekin; Dr Sarah Aitken, Director of Public Health, Herefordshire; Dr Carl Ellson, Chair, S Worcestershire CCG; Dr Simon Gates, Chair, Wyre Forest CCG; Simon Hairsnape, COO, Wyre Forest & Redditch & Bromsgrove CCGs; and Simon Trickett, COO, S Worcs CCG.

059/12 **Declarations of Interest**

There were no declarations of interest with regard to the agenda.

060/12 **Business Case – Shrewsbury and Telford Hospital NHS Trust**

The Chair reminded the board that the West Mercia Cluster comprised 4 PCTs meeting concurrently but for purpose of the meeting today the board was operating as Shropshire County PCT and Telford & Wrekin PCT.

The Board received the overview paper and summary full business case for the future configuration of hospital services for the Shrewsbury and Telford Hospital NHS Trust (SaTH). The Deputy Chief Executive introduced the paper and noted the continuing public and patient engagement with regard to the future configuration of hospital services between Shrewsbury and Telford and the board was being requested formally to approve the full business case (FBC) for future configuration.

The following key aspects of the business case were identified in the paper:

- The development of the full business case
- The continued public, staff and stakeholder engagement
- The recent and ongoing assurance element of the programme including quality and financial sustainability
- The support and approval process.

A preferred capital option had been identified for both the Princess Royal Hospital (PRH) in Telford and the Royal Shrewsbury Hospital (RSH) requiring £34.8m capital investment through public dividend capital funding. The revenue consequences were neutral. The full business case included a management of change process for the Trust's workforce. A programme of full public, staff and stakeholder engagement had been undertaken, including production of bulletins, visits to established groups and networks, patient and public focus groups, briefings and meetings with councils, journalists and MPs. The majority of MPs approached were broadly supportive A major concern was identified from patient groups affected by travel issues. The mitigation of the impact of travel was a key action going forward. The FBC had been presented to the Telford & Wrekin CCG board, which was supportive. Shropshire CCG would review the full business case at its next meeting on 2 May.

The Chief Executive of the Shrewsbury and Telford Hospital NHS Trust presented the FBC. Since the outline business case there was more detail provided in particular on care pathway work and estates and facilities. The provision of an Integrated Assessment Zone alongside A&E had been reconsidered. In terms of options, it was noted that the "do nothing" option would be more expensive overall: therefore there was a clear case for change. A further key issue was around the provision of paediatric services. At the PRH new accommodation would be provided for paediatric outpatients, cancer and haematology with a refurbishment of the existing children's ward. At RSH a relocation and improvement of paediatric outpatients with a PAU adjacent to A&E was planned. There were currently concerns on the provision of paediatric services in a small, restricted area which could lead to issues around safety of care. The re-provision of a new Women and Children's unit at the PRH was also a response to the demographic of the population served by the trust, although the transportation issues for some patients were acknowledged through the move to Telford.

The RSH had been designated as a trauma unit and a centre for AAA screening, which was enabled by the plans to consolidate surgery on one site. The concerns around patient transport had been addressed by the implementation of a shuttle system between the two sites. The finance was viewed as affordable at £34.8m. Capital costs were £28m across the PRH, and £34.8m including RSH site. Regarding running costs, a surplus of £200k was forecast for 2012-13 although the significant CIPs were noted over the next 5 years. The draft FBC would be submitted to the SHA Board on 24th May, and the public and patient engagement process would continue. The planned start of work on the PRH site was August 2012 with a completion date of 2014.

Sue Mead highlighted the current quality challenges for SaTH and noted the possible impact and distraction of the significant planned changes: in particular with respect to assurance around children's safeguarding. The SaTH Chief Executive acknowledged the serious issues over the past two years and was grateful for the support over this period to improve the position. The SaTH board was clear that quality and safety issues were there to be managed and affirmed that the board was focused on maximising quality. The current concerns in ophthalmology were noted. With respect to safeguarding the trust would be taking great pains to ensure robust systems and processes were in place.

William Hutton identified the risk of staff leaving the organisation during the period of change. The SaTH Chief Executive reported that staff had been aware for some time of the reconfiguration and extensive consultations had been carried out. Practical solutions were being looked at – for example the shuttle bus service between sites. Dr Mike Innes confirmed that Telford & Wrekin CCG supported the business case and did not see any substantial changes in the FBC which increased risk, and in fact felt that the FBC gave more assurance and would deliver a balanced solution for SaTH. For Shropshire CCG Dr Caron Morton noted that sustainability of services was the most important factor, and the CCG had facilitated the implementation of work streams which had already started, and which overall would keep services in the county. Andrew Mason echoed this and noted felt that this was an excellent solution which could bring benefits around the repatriation of services and even extend local ones provided the correct governance was in place.

Dr Bryan Smith felt that the report made a compelling case but felt that the financial case was not powerful and questioned whether other capital options had been identified. The concern around transport was also reiterated. Louise Lomax noted that plans for the reconfiguration of the two sites had been ongoing for 20 years and was satisfied that for the first time there could be confidence around sustainability. Rob Parker added that a key point was the ability of senior staff to implement the programme given its scale. There could be an issue around the capability of senior staff: were there sufficient skills in clinical and non-clinical staff to achieve the programme? Secondly the FBC identified financial benefits before the opening date of 2014.

The SaTH Chief Executive noted that capital options had been covered in the outline business case and added that regarding transport, part of the approach was to increase the parking capacity by 100 spaces. With respect to staff capacity and capability, a director of transformation had been appointed and a programme management board was in place. There would also be a recruitment programme for paediatric nurses

The Cluster Chief Executive noted that the SHA would subject the FBC to a robust assurance process.

Resolved that

The Board **noted** the engagement programme and the continued assurance activities
The Board **approved** the full business case for the future configuration of hospital services. An abstention was recorded for Dr Bryan Smith.

061/12 **AOB**

There was no other business.

062/12 **Date of Next Meeting**

Tuesday, 29th May 2012, Telford, 10.00

063/12 **Exclusion of the Press and Other Members of the Public**

Resolved that:

Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960)

Signed: …….. (Chair)

Dated: ……

ACTIONS ARISING FROM THE WEST MERCIA CLUSTER BOARD MEETING HELD ON TUESDAY 27 MARCH 2012

Agenda Item	Detail	Responsible Executive/Manager	Date due	Update/Status
044/12 Matters Arising	Supporting Staff through transition: further detail and report on national framework for HR during the transition to be provided when available	Director of HR	Expected April/May 12	Update included in Transition Reporting
045/12 Quality & Performance Report	• SHMI and Readmission Rates report to be taken to QPR Committee • Gap on TIA 24/7 cover in SaTH data: to be taken forward.	Director of Nursing	May 12	
046/12 Financial Reporting	Report on out of county spend in Worcestershire to be taken to QPR committee	Director of Finance	May 12	
047/12 Transition Planning	• Matrix and report on mapping of statutory functions to receiving organisations to be produced and reported to April board • CSO Task & Finish Group to be established • Workforce Task & Finish Group to be established.	Director of Commissioning Development Director of Finance Director of HR	April 12 April/May 12 April/May 12	On agenda for May Board
048/12 Budgets	• Board to Board meetings be arranged as a priority initially with the three acute providers. • Transformational risks to be added to risk registers.	Board Secretary Board Secretary	April 12 April 12	Implemented
050/12 CCG Reporting	• Redditch & Bromsgrove CCG minutes to be submitted to the Board upon approval • CCG reporting to be taken forward at the April board development session.	Board Secretary	May 12 April 12	On agenda, implemented Implemented

051/12 Audit Committee Report	• The Board Secretary to work with the Audit Commission to re-contact CCGs for board development • The Board Secretary to follow up receipt of assurance pro-formas to sub-committee chairs. • The Director of Nursing to report back to board following cluster-wide work on adult safeguarding issues.	Board Secretary Board Secretary Director of Nursing	May 12 April 12 Ongoing	 Implemented

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	**FINANCE REPORT 2011/12 OUTTURN**
REPORT AUTHOR :	**BRIAN HANFORD**
PRESENTED BY:	**BRIAN HANFORD**
PURPOSE OF REPORT:	**To advise Cluster Board members on the 2011/12 Outturn (subject to audit).**
KEY POINTS:	**The West Mercia Cluster Board notes that the four statutory bodies are on track to deliver against the financial duty to break-even and hit the control total surplus agreed with the Strategic Health Authority (SHA).** **The West Mercia Cluster Board notes that the four statutory bodies are on track to deliver against the Capital Resource Limit statutory duty.** **The West Mercia Cluster Board notes the year end performance against each PCT Cash Limit.** **The West Mercia Cluster Board is asked to note that as previously approved by the Board the Audit Committee will formally sign off the Final Accounts on behalf of the Board.**
RECOMMENDATION TO THE BOARD:	The Board is asked to note the report

CONTEXT & IMPLICATIONS	
Strategic Objectives	PCT delivers 2011/12 Outturn.
Financial	See report.
Legal	Each PCT is required to deliver all Statutory Financial Duties.
Risk & Assurance	All PCTs delivered all Statutory Financial Duties in 2011/12.
HR, Equality & Diversity	N/A
National Policy	2011/12 NHS Operating Framework required all PCTs to deliver an operating surplus.
Carbon/Sustainability	N/A
Partnership	N/A

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Quality, Performance & Resources Committee on 18th April 2012.

West Mercia Cluster Board
29 May 2012

Item		FINANCE REPORT 2011/12 OUTTURN (Subject to Audit) Brian Hanford Director of Finance, West Mercia Cluster
1. Recommendations	**1.1**	**The West Mercia Cluster Board notes that the four statutory bodies are on track to deliver against the financial duty to break-even and hit the control total surplus agreed with the Strategic Health Authority (SHA).**
	1.2	**The West Mercia Cluster Board notes that the four statutory bodies are on track to deliver against the Capital Resource Limit statutory duty.**
	1.3	**The West Mercia Cluster Board notes the year end performance against each PCT Cash Limit.**
	1.4	**The West Mercia Cluster Board is asked to note that as previously approved by the Board the Audit Committee will formally sign off the Final Accounts on behalf of the Board.**
2. 2011/12 Outturn Position		Each PCT is currently undergoing the External Audit of their draft Final Accounts for 2011/12 submitted to the Department of Health by the deadline on the 23rd April 2012.
Operating Surplus	**2.1**	As Board members will be aware each PCT has the statutory duty to contain its revenue expenditure within its Revenue Resource Limit and is additionally performance managed against a requirement to hit a control target surplus agreed at the start of the financial year with the Strategic Health Authority (SHA).

2.1.1 Subject to audit by the External Auditors detailed below is the draft position for each PCT within the West Mercia Cluster.

NHS Herefordshire - £291,000 (target £250,000).
Shropshire County - £1,295,000 (target £1m).
NHS Telford & Wrekin - £1,098,000 (target £1m).
NHS Worcestershire - £3,044,000 (target £3m).

2.2 Each PCT is required to contain its capital expenditure within its notified Capital Resource Limit net of any income from asset sales. Members are asked to note that for 2011/12 the PCTs continue to account for capital expenditure on assets yet to transfer under Transforming Community Services.

2.2.1 Subject to audit by the External Auditors detailed below is the draft position for each PCT within the West Mercia Cluster.

NHS Herefordshire - £1,000 under.
Shropshire County - £577,000 under.
NHS Telford & Wrekin - £2,000 under.
NHS Worcestershire - £9,000 under.

2.3 Each PCT has the facility to drawn down cash against a notified Cash Limit and should not be overdrawn as at the 31st March 2012.

2.3.1 Subject to audit by the External Auditors detailed below is the draft cash position for each PCT within the West Mercia Cluster as at 31st March 2012.

NHS Herefordshire - £3,000 balance.
Shropshire County PCT – £243,000 balance.
NHS Telford & Wrekin – less than £1,000.
NHS Worcestershire – less than £1,000.

Note all PCTs drew down the entire notified Cash Limit except Shropshire County PCT which drew down £1m less.

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	2011 NHS Staff Survey Results
REPORT AUTHOR :	Suzanne Penny, Interim Director of HR
PRESENTED BY:	Suzanne Penny, Interim Director of HR
PURPOSE OF REPORT:	To inform the Board of the Staff Survey Results and seek agreement to the actions suggested
KEY POINTS:	Overall disappointing results with some small improvements
RECOMMENDATION TO THE BOARD:	The Board is asked to note the report and agree the action plan.

CONTEXT & IMPLICATIONS	
Strategic Objectives	Effective Leadership and Support to Staff
Financial	Health & Wellbeing resources.
Legal	N/A
Risk & Assurance	As per report
HR, Equality & Diversity	As per report
National Policy	Requirement under National HR Framework
Carbon/Sustainability	N/A
Partnership	N/A
GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	N/A

West Mercia NHS Cluster

2011 National NGHS Staff Survey Results

Introduction

This paper gives the key messages from the 2011 staff survey and the key actions that are being taken by cluster managers. The overall results do not show positive engagement from staff and demonstrate that the protracted period of organisational change does not impact well upon most staff.

PCTs have been in a period of organisational change for some considerable time. Prior to the NHS Health and Social Care Bill now being implemented, community services moved from PCTs to other providers. Staff are unsure of their own career and work prospects and the staff survey results reflect this.

However, it is concerning that when looked at in comparison with the other 79 non-commissioning PCTs, staff in Herefordshire in particular do not report positively, and when compared with results from last year's surveys, in each of the 4 PCTs there is little improvement in the 38 key findings.

Background and key results

The staff survey was undertaken in late 2011 across the 4 PCTs as part of the national programme. Responses were anonymous and each PCT has been provided with a detailed report and a brief summary of the results. These are available on-line from the DoH website, which also gives detailed comparisons with other Provider-only PCTs and all other NHS organisations.

Results for West Mercia PCTs

1 Response rates % of staff who responded

All NHS orgs	All similar PCTs	Telford	Shropshire	Worcester	Hereford
54	62	68	52	52	62

The response rate varied across the cluster PCTs but all responses were at least 52% of the staff so can be considered representative.

1

2 For each PCT, there is an overall indicator of staff engagement compared with the average of Trusts of a similar type, on a scale of 1 (poorly engaged) to 5 (highly engaged). This overall indicator of staff engagement is calculated from 3 of the key findings covering:

- perceived ability to contribute to improvements at work
- willingness to recommend the trust as a place to work or receive treatment
- extent to which staff feel motivated and engaged with their work

Telford	Shropshire	Worcester	Hereford
3.55 (average)	3.48 (worse than)	3.58 (average)	3.41 (lowest [worse])

3 For a broader perspective, it is useful to look at the results above as part of the 38 key findings and compare with the results for the 2010 survey. These additional key findings include

- staff feeling valued by their work colleagues
- staff feeling satisfied with the quality of work and patient care they are able to deliver
- work pressures felt by staff
- staff reporting good communication between senior management and staff

Using this information, it is pleasing to note some improvements, for example:

- Telford fewer staff working extra hours
- Shropshire fewer staff suffering work-related stress in the last 12 months
- Herefordshire more staff report receiving appraisals in the last 12 months
- Worcestershire more staff believing the trust provides equal opportunities for
- for career progression or promotion

4 Actions

Objective

1 Improve communications and support from managers	Appraisal rates to be improved, with target rate of 95%.
2 Increase staff receiving development and training	Support training already in place; mini-staff survey being

2

	undertaken to identify further development and support needs
3 Improve % of staff recommending trust as place to work	Ensure staff are made aware of the improvements in services and how important is their contribution; staff meetings held regularly at each location by executive team, focussing on positive results
4 Improve staff communications	Board members, Executives and managers to be visible and ensure that staff feel able to give comments, raise issues etc. Staff newsletters already in place for some of the CCGs; all to be in place by end June 2012. Website covering FAQs, DoH, NCB,etc already set up – staff to be reminded about it
5 Staff Partnership Board	The Staff Partnership Board meets every two months. Full-time officers to be asked to meet PCT staff members. Minutes of the SPB are on the website.

Conclusions

During the next 10 months or so, the rate of organisational change will be increased as the new organisations are set up. The cluster aim is to move as quickly as possible to the new organisational architecture so that uncertainty is removed for as many staff as possible. It is essential that staff are supported through this process and the Board is asked to endorse the actions above and to ask for regular progress reports.

Suzanne Penny

Interim Director of HR

May 2012

3

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Review of Cluster Delegations to Sub-Committees and Mapping of Statutory Functions (PCT)
REPORT AUTHOR :	Lin Jonsberg, Board Secretary and Alison Smith, Head of Governance, Shropshire County and Telford & Wrekin PCTs
PRESENTED BY:	Paul Maubach, Director of Commissioning Development
PURPOSE OF REPORT:	To highlight to the Board those duties and functions that are currently expected to be discharged by CCG's, National Commissioning Committee and QPR under delegated authority during the transition period, to ensure business continuity.
KEY POINTS:	• The Health and Social Care Act 2012 sets out broad statutory duties and functions that CCGs, the National Commissioning Board and local authorities will discharge. However, further legislation is expected that will provide more detailed information about the extent of these duties and functions. Consequently, we are not able at this time to provide a definitive list based upon the new Act of all statutory and non-statutory duties and functions of PCTs that maps the successor organisations of each duty and function. • Work is being undertaken at both CCG and Cluster level to manage transitional arrangements. The National Commissioning Board Special Authority has published a model constitution for CCGs to use as their key governance document which will help them to describe their authority and duties. Public Health functions for each PCT have produced their respective transition plans which set out the process of transfer of functions and duties to local authorities. The cluster's National Commissioning Committee currently has the function of overseeing the transition of primary care functions to the NCB. • PCTs are statutory bodies with a range of functions, powers and duties which are set out in legislation. These statutory duties must be carried out by law and range from adhering to anti-discrimination law to publishing an annual document

setting out information in relation to the quality of services they commission (or provide), following EU procurement law and co-operating with local authorities to improve the well-being of children. PCTs also have statutory powers which enable them to undertake particular courses of action. These include powers to delegate functions to other PCTs and to give grants to voluntary organisations for example. The report reflects our current understanding of the existing Schedule of PCT Statutory functions and considers where they may be allocated amongst the emerging organisations; which executive function currently holds responsibility; and how this may change during and post transition. The Schedule is attached as Appendix 1

- In addition to statutory roles and functions PCTs are tasked with delivering a range of non-statutory functions which are extremely diverse and span demand modelling, forecasting and capacity planning, responding to emergencies e.g pandemic flu, internal and external financial audit and undertaking serious case reviews. Whilst not set in statute, PCTs are nevertheless required to deliver them as part of fulfilling their role as local commissioners of the NHS.

- While the Cluster Implementation Guidance is clear about where leadership and accountability should rest it is not prescriptive about how this is carried out locally. The NHS Act 2006 allows for the functions of PCTs to be carried out by third parties.

- Functions that cannot be delegated by PCTs are:
- Responsibility for statutory accounts
- Employment of staff
- Responsibility for PCT owned estate

- The Scheme of Delegation approved and adopted by all PCT Boards at the inaugural meeting of the West Mercia Cluster of PCTs on 17 January 2012 delegated some commissioning functions and budgets to the Clinical Commissioning Groups. At that time it was anticipated that the Board would, in the future, approve full delegation of budgets subject to CCG development to enable CCG shadow operation through 2012/13. Current Delegations to CCGs are attached as Appendix 2

- By March 2012 all Terms of Reference for the committees had been approved and delegations clarified. CCG Authorisation: Draft Applicants' Guide was presented to the NHSCBA at its meeting on 13 April 2012 and a model constitution Framework – guidance for clinical commission groups was published in March 2012.

- To date, the Audit Committee, National Commissioning Committee and Quality, Performance and Resources Committee have yet to receive assurance on CCG development. The terms of Reference for each committee are attached as Appendices 3, 4 and 5. This report recommends the establishment of a process to enable

	detailed scrutiny of CCG readiness to assume additional responsibilities and proposes further delegations as appropriate (see Appendix 2). • Using the Schedule (Appendix 1) and comparing with the Scheme of Delegation and Reservation for CCGs and the terms of reference for the 3 sub-committees referred to above an initial attempt has been made to draw conclusions as to the current delegation to CCGs, Audit Committee, Quality, Performance and Resources Committee and the National Commissioning Committee as they relate to PCT duties and functions. In Appendix 1 those duties and functions the PCTs would expect these bodies to be currently undertaking are listed for consideration by the Board. • The areas highlighted can be broadly described as follows: 1. Section 1 – generic duties that will remain with the cluster Board with the exception of: CCGs (and the NCC for relevant services) should take responsibility for 18 week RTT waiting times as these are commissioned from their delegated budgets 2. Section 2 – CCGs planning production of commissioning plans 3. Section 3 – CCGs having joint plans with their local authorities and providing support to patients and carers 4. Section 4 - primary care duties that the NCB will inherit and which the NCC is currently overseeing 5. Section 5 – CCG contracting of services and performance management by QPR 6. Section 6 – generic duties that will remain with the cluster Board 7. Section 7 – workforce functions that will remain with Cluster Board 8. Section 8 – estates and IT that will remain with Cluster Board - but these require an executive director to oversee the legacy and transition to the successor organisations 9. Section 9 – specific duties with regard to service provision and split between the CCGs and NCC with the exception of safeguarding which need to be retained by the Cluster Board • Currently there are a number of performance monitoring functions carried out by QPR on behalf of the Board. It is suggested that QPR takes a view on the maturity of the CCGs across the Cluster and relinquishes performance monitoring of their respective areas as and when it is felt that the CCGs have sufficient capacity/skills and structures in place to provide adequate assurance to the Board.

RECOMMENDATION TO THE BOARD:	The Board is asked to: • Note the approach to business continuity currently being

	undertaken • Consider and agree the list of statutory duties and functions listed in Appendix 1 • Appoint an executive director to oversee the transition of estate and IT issues to successor organisations • Task QPR to agree transfer of performance monitoring to CCGs as and when they are mature enough to undertake this function on behalf of the Cluster Board. • Task Audit Committee to review the development of the CCGs and the work of the NCC with a view to facilitating further delegations.

CONTEXT & IMPLICATIONS	
Strategic Objectives	Will support the future commissioning of high quality care for the residents of Herefordshire, Shropshire, Telford and Wrekin and Worcestershire during a period of transition and facilitate robust handover arrangements and will highlight known risks associated with the changes
Financial	None identified
Legal	Complies with relevant primary and secondary legislation.
Risk & Assurance	Assurance via Audit Committee, National Commissioning Committee and Quality, Performance and Resources Committee to the Board.
HR, Equality & Diversity	None identified
National Policy	Health and Social Care Act and supporting policy and guidance
Carbon/Sustainability	None identified
Partnership	None identified

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	None

Review of Cluster Delegations to Sub-Committees and Mapping of Statutory Functions (PCT)

INTRODUCTION

It is important to note that currently no final national, definitive guidance has been produced to describe how and where the PCT statutory and non-statutory functions will be delegated except in some cases including Primary Care which will be overseen by the NHSNCB and commissioning functions to CCGs. Furthermore, there has been no legal analysis which has reviewed each and every clause of the Heath and Social Care Act correlating the Statutory Functions described in Appendix 2. This report has been brought to the Board for the purpose of tracking and managing business continuity during this transition period. Updates will be provided both: as and when national guidance is produced regarding these matters; and as the CCGs assume greater responsibility and demonstrate a track record in undertaking these function, duties and powers. However, it is also necessary to maintain oversight on the migration of Public Health functions to local authorities and the NHSNCB, and the emerging responsibilities of the Health and Wellbeing Boards.

This paper represents a first attempt to map out the future destination of many of the existing PCT functions as currently understood to CCGs, NHSNCB, Local Authorities and other successor organisations including the creation of the NHS Property Services Limited. It describes where responsibility lies currently and how this may change. Risks associated with further delegation of commissioning functions and budgets will be captured in relevant risk registers and where necessary escalated to the BAF and the Board will receive assurance via the Committee structure..

KEY PRINCIPLES

1. Functions should be delegated to the relevant Sub-Committee unless they must be retained by the PCTs.
2. CCGs are not yet statutory bodies and so the Chief Executive of the Cluster will remain the Accountable Officer
3. The delegation should take account of the future destination of function (with the caveat that this may change over time)
4. Delivery of work does not always have to follow location of accountability. For example, the Cluster will be accountable for QIPP delivery but this will be carried out by the CCGs and locally based PCT/Cluster staff
5. The Schedule attached as Appendix 1 has been completed to indicate which duties/powers should be retained and attempts to set out the future destination of each function but is subject to national guidance and development work with emerging CCGs etc.
6. The Board to receive appropriate assurance that the work carried out on behalf of the Cluster of PCTs by CCGs;
    - is undertaken appropriately and within agreed limits;
    - is supportive of the Cluster Board's strategic direction and QIPP delivery;
    - services commissioned are of appropriate quality and also allow the NHS to meet any locally or nationally agreed performance targets;
    - there is a strategic approach to commissioning which engages with key partners and stakeholders.

CONCLUSION

It is important that the committees referred to above will carry out the necessary oversight to assure the Board that work carried out on behalf of the West Mercia cluster of PCTs by the CCGs under delegated authority with the purpose of ensuring an appropriately phased transfer of functions and duties to full delegation to CCGs subject to readiness. It is anticipated that within an agreed timeframe with each CCG the CCG committees themselves will provide assurance to the Board across all delegated functions. CCGs will be subject to a model constitution framework which will include standing orders, prime financial policies and scheme of delegation. The draft model can be accessed here:

http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-6-Guidance-Towards-establishment-Final.pdf

Risks associated with further delegation of commissioning functions and budgets are to be mitigated by the development of an appropriate governance model which will provide assurance on delegation and risk management. Risks will continue to be captured in the Board Assurance Framework or relevant risk register as appropriate and the Audit committee will receive reports from the Board Secretary on completion of Assurance pro-forma.

Appendix 1
PCT Functions and Duties – Managing the Transition – Delegation to Board Sub-Committees
Key:- CCG – Clinical Commissioning Group (Board Sub-Committee); NCC – National Commissioning Committee (functions eventually to be delegated to NCB); LA – Local Authority (Health and Wellbeing Boards); X – likely destination

Description of Statutory Duty or Power	CCG	NBC	LA	Other	Comment
1. Overall duties					General Duties across all NHS organisations and relevant Public Authorities
Statutory duties of PCTs:					
Duty to have regard to the NHS Constitution section 2(1) of the Health Act 2009.	X	X			
It is in the exercise of these functions that PCTs are responsible for the provision of hospital, community health and certain public health services to their local population and the basis for their commissioning role. The functions under sections 2 to 4 and Schedule 1 to the NHS Act 2006 ("the Act") are stated as duties or powers to provide; but the duties is to provide services "to such extent as [the PCT] considers necessary to meet all reasonable requirements".	X	x			NCB role limited to specialised services and direct commissioning role.
Waiting Times - There are duties imposed on PCTs under the Primary Care Trusts and Strategic Health Authorities (Waiting Times) Directions 2010 to make arrangements to meet 18 week operational standards and subject to exceptions, where that target will not be met to offer an alternative provider.	X	x			CCG (and cluster NCC for relevant services) responsibility as part of budgetary responsibility (previously delegated function - see Scheme of Delegation) but Board to retain oversight*
Duty to act compatibly with the rights under the European Convention on Human Rights (section 6 of the Human Rights Act 1998).	X	X	X		Duty imposed on all Public Authorities
Duties not to discriminate in the provision of services or otherwise in the exercise of the PCT's functions : Now Equality Act 2010	X	X	x		Duties imposed on all Public Authorities
sections 19B and 20 of the Race Relations Act 1976 (race)	X	X	x		Duty imposed on all Public Authorities

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- sections 46 and 52 of the Equality Act 2006 (religion)	X	X	x		Duty imposed on all Public Authorities
- sections 21A and 29 of the Sex Discrimination Act 1975 (sex)	X	X	x		Duty imposed on all Public Authorities
Statutory powers of PCTs:					
· In addition, the Secretary of State has delegated to PCTs his power under section 12 of the Act to arrange for other persons or bodies to provide services. This enables PCTs to enter commissioning arrangements for secondary care and community services with NHS trusts, FTs and independent providers.	X	x			NCB role limited to specialised services and direct commissioning role. CCG responsibility as part of its delegated power/function to plan and commission services within their areas (See Scheme of Delegation)*
sections 19 and 21B of the Disability Discrimination Act 1995 (disability)	X	X	x		Generic
- regulations 4 and 8 of the Equality Act (Sexual Orientation) Regulations 2007 (sexual orientation).	X	X	x		Generic
· Duties to have due regard to the need to eliminate unlawful discrimination and promote equality of opportunity:	X	X	x		Generic
- race (section 71 of the Race Relations Act 1976)	X	X	x		Generic
- sex (section 76A of the Sex Discrimination Act 1975)	X	X	x		Generic
- disability (section 49A of the Disability Discrimination Act 1995).	X	X	x		Generic
· Duties to publish race, sex and disability equality schemes (Race Relations Act (Statutory Duties) Order 2001, Sex Discrimination Act 1975 (Public Authorities) (Statutory Duties) Order 2006 and Disability Discrimination Public Authorities) (Statutory Duties) Regulations 2005).	X	X	x		Retained by PCTs
3. Strategic Leadership and Duties					
Key role description: Responsibility for ensuring that services for their population are commissioned in a	X	X	x		QIPP – delegated to CCGs under budgetary responsibilities)(see

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way which delivers improved health, better clinical outcomes, excellent patient experience and productivity, and reduces health inequalities.					Scheme of Delegation* and Board retains oversight
Statutory duties of PCTs:					
· PCTs must determine local health needs and determine what services are to be provided to meet those, having regard to the resources available to them.	X	x	x		CCGs and H&WBB*
· Quality and Standards - Duty to make arrangements to secure continuous improvement in the quality of care by or for the PCT, having regard to standards published by the Secretary of State ("the duty of quality") section 23 of the Act. QPR should take a view of the extent to which CCGs take over this assurance role to Board during transition	X	X	x		QPR Committee retains overview but expected to take a view on when CCGS are able to assume responsibility.
· Duty to make arrangements with a view to securing that it receives appropriate advice from persons with professional expertise relating to health (section 23 of the NHS Act 2006)	X	X	x		CCGs and H&WBB*
· Duty to prepare health improvement plans (section 24 of the 2006 Act)	x		x		CCGs and H&WBB*
Statutory powers of PCTs:					
· [none]					
Functions:					
· Locally leading the NHS – setting priorities, system management, managing and being accountable for the reputation of the NHS locally.	X	X	x		Board to retain in the interim
· Develop Strategic commissioning plans which should reflect individual strategies and NSFs including for Carers, Dementia,	X				CCGs as part of budgetary responsibilities previously delegated*

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Cancer services, CHD, Mental Health, Diabetes, Renal Services, Long Term conditions, Young People, Maternity Services, and the National Cancer Plan, and Valuing People. The commissioning plan should also describe how the PCT will meet operating framework targets such as eliminating mixed sex wards.					
· Ensure strong commissioning through Practice Based Commissioning.	x				CCGs*
· Develop QIPP plans with detailed milestones demonstrating the PCT will meet SHA requirements of quality improvement, and productivity.	X				CCGs (previously delegated)*
· Undertake strategic planning and service redesign at a health economy level to include undertaking demand modelling, forecasting and capacity planning.	X	x			Statutory organisations and CCGs
· Develop disinvestment as well as investment plans based on agreed criteria including quality, local needs, cost evidence of effectiveness.	X	x			CCGS (previously delegated)*
· Facilitate links with clinicians (acute, primary care and mental health) to redesign services across whole patient pathways, including specialised services.	x				CCGs* (as part of responsibilities associated with previously delegated functions)
· Work in partnership with Local Authorities (LAs) to undertake regular needs assessments. Using the identified current health needs, and identifying future trends, ensure that all commissioned services meet the needs of the population, especially those whose needs are the greatest.	X	X	X		CCGs (Scheme of Delegation)*

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Develop collaborative commissioning arrangements through Specialised Commissioning Groups, (SCGs), with other PCTs, and other commissioners such as prison services, schools etc.	X	X	x		NCB (NCC)*
· Ensure an "appropriate" degree of stability across the LHE.	X	x			Board (PCTs)
· Horizon scanning – in relation to policy development across all sectors	x				CCG* (see delegated functions)
· Local delivery of national public health policies	x	X	X		CCGs*
· Deliver on 2010 Carbon Reduction Strategy.	X	X	X		CCGs*
· Local implementation of national operating framework/vital signs	x				CCGs *
· Joint strategic needs assessment	X		x		CCGs/HWBBs/
3. Partnership, engagement & advocacy					
Key role description: Ensuring continuous and meaningful engagement with the public and patients to shape services and improve health. Work collaboratively with a range of partners to commission services which will improve health, and reduce health inequalities.	X	X	x		CCGs/H&WBBs in involving and engaging where appropriate with carers and patient groups
Statutory duties of PCTs:					
· Duty to co-operate with other NHS bodies (section 72 of the 2006 Act)	X	X	x		As above
· Duty to co-operate with local authorities (section 82 of the 2006 Act)	X	X	x		As above
· SofS may issue guidance to NHS bodies and LAs in respect of prescribed arrangements; and has powers to direct LAs and NHS bodies (not FTs) to enter	X	X	x		As above

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partnership arrangements where a body is failing to exercise its functions adequately (section 78)					
· Duties under the Local Government and Public Involvement in Health Act 2007 (local area agreements and joint strategic needs assessments)–	X	X	x		As above
- duty to co-operate with local authority in determining local improvement targets, additional targets, or changes to or removal of existing targets, in local area agreements (sections 106(3) and 111(5));	X		x		As above
- duty to have regard to local improvement targets in their local area agreement (section 108); and	X		x		As above
- duty to prepare joint strategic needs assessments for health & social care, with local authorities and other PCTs (section 116).	X		x		As above
· Duty to consider requests from local authorities for assistance in the planning of services for carers etc (section 3 of the Carers (Equal Opportunities) Act 2004).	x				CCGs (as per delegated functions)
· Various Secretary of State functions relating to local authorities are delegated to PCTs by direction.	X	X?	X?		To be clarified
· Duty to make arrangements with a view to securing that health service users are involved in the planning of the provision of services for which the PCT is responsible, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services (section 242 of the 2006 Act).	X	x			Cluster (PCT Boards)

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· Duty to consult local authority overview and scrutiny committee(s) on proposals for substantial developments or variations in the local health service (regulations made under section 244 of the 2006 Act[1]).	X	x			Cluster f(PCT Boards)
· Child Poverty Act 2010 - s20 (PCT partnership duty in respect of child poverty).	X	x	x		Across LHA
· Duty to act under guidance issued by the Secretary of State pursuant to section 2 of the Autism Act 2009, under section 3 of that Act (applies to a local authority or an NHS body).	x				CCGs* (Scheme of Delegation)
· NHS Act 2006 Section 24A (inserted under section 234 (2) of the Local Government and Public Involvement in Health Act 2007 c.27); PCT must prepare and publish a report on consultations carried out before making commissioning decisions and on the influence that the results of the consultation have on its commissioning decisions.	X	x			Board overview
· Civil Contingencies Act 2004 – duty to assess, plan and advise in relation to emergencies and the risk of emergencies.		X			NCB*
Statutory powers of PCTs:					
· Power to enter partnership arrangements (pooled budgets etc) with local authorities (regulations under section 75).	x				CCGS (current delegations)*
· Power to delegate functions to another PCT (by agreement) and to exercise functions jointly with other PCTs, SHAs, SpHAs and NHS trusts bodies (regulations under section 19 of the Act[2])	x				Cluster (PCT Boards)
· Director of Public Health local authority proper officers (National			x		

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Assistance Act 1947)					
Functions:					
· Undertake formal consultation before making significant commissioning decisions	X	x	x		Cluster (PCT Boards)
· Consult formally and informally with Overview and Scrutiny Committees (OSCs) on proposals for service development or variation.	X	X	x		Cluster (PCT Boards)
· Working with a range of partners, e.g. social care, education and the voluntary sector, develop and deliver the Local Area Agreement.	X		x		CCGs/HWBBs
· Actively participate in the Local Strategic Partnership, working with a range of partners, (education, commerce, LAs , police etc) to consider the wider determinants of health and the inpact the PCT can make in improving health ad reducing health inequalities.	X		x		CCGs/H&WBBs
· Ensure there are effective systems in place for effective adult protection – including policies, procedures and relationships with key partners. This has particular relevance to e.g victims of domestic violence, users of mental health services, and clients with a Learning Disability.	X	x	X		Cluster (PCT Boards)
· Working with LAs, jointly commission (plan, agree, monitor and evaluate) services e.g. through joint commissioning arrangements, section 75 agreements and shared posts.	x				CCGs (Scheme of Delegation)*
· Ensure effective winter planning.	X	X	x		Across LHE
Undertake emergency planning duties including assessment, planning and advising in relation to emergencies or risks of emergencies.	X	X	x		Across LHE

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· Respond to emergencies – e.g. swine flu – procuring equipment, changing working arrangements, communications	X	X	x		Cluster (PCT Boards)
· Effectively participate in local resilience forums.	X	X	X		Cluster (PCT Boards)
· Working with partners to develop and implement strategies to reduce crime and disorder, and reduce misuse of drugs, alcohol and other substances.	X	X	x		Across LHE
· Participate in Children's Trusts to ensure the health and wellbeing of children including undertaking responsibilities for Safeguarding (membership of the Local Safeguarding Board, ensuring roles of Designated Dr and Nurse are fulfilled)	X	X	x		CCGs reporting to HWBBs*
· Provide effective support for carers.	X	X	x		CCGs
· Effectively involve patients, the public, their carers, and other stakeholders in the planning and delivery of services.	X	x	x		CCGs*
· Undertake Equality impact assessments.	X	X	x		CCGs/NCC
· Engage with Local Involvement Networks (LINks) (Healthwatch)	X	x			CCGs
· Respond effectively to patients through the PCT patient advisory and liaison service (PALS)	X	x	x		CCGs
Act as a natural point of contact for local MPs and other community leaders – dealing with all written correspondence and ensuring regular and effective relationship management.	X	X	x		Cluster (PCT Boards)
· Protect the reputation of the NHS	X	X	x		Cluster/CCGs/HWBBs
Manage internal and external communication strategies – including effective media handling.	X	X	x		CCGs

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· Proactively influence the behaviours of patients and the public eg using social marketing to support stop smoking campaigns.	X	X	x		CCGs/HWBBs
4. Providing or securing services					
Key role description: Ensure there is a full range of providers which provide choice, and which secure the desired outcomes, quality and value for money	X	X	x		CCGs
Statutory duties of PCTs:					
· Duty to provide or secure the provision of primary medical services in its area (section 83 of the Act); the duty is to provide or secure.		X			NCC*
· Duty to provide or secure the provision of primary dental services in its area (section 99 of the Act).		X			As above
· Duty to provide or secure the provision of certain ophthalmic services, including sight-testing, in its area (section 115 of the Act).		X			As above
· Duty to make arrangements for the provision of pharmaceutical services in their area – i.e. the provision of drugs, medicines and certain appliances prescribed by GPs or dentists, and such additional pharmaceutical services as directed by Secretary of State (sections 126 and 127 and 129 of the Act).		x			As above
· Duty to administer the arrangements for primary care services (i.e. the services referred to above), and perform such other management and other functions as may be prescribed (section 22 of the Act).		X			As above
· PCT duty under Directions to make arrangements to ensure vaccination is offered in accordance with JCVI recommendations.		X			NCC*

Appendix 1
PCT Functions and Duties – Managing the Transition – Delegation to Board Sub-Committees
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· Affects who has to decide if it is safe to discharge patient and notify LA of likely need for community care services. If health service hospital, done by the hospital. If independent, done by the contracting NHS body. (Community Care (Delayed Discharges etc.) Act 2003 (c.5))	x				CCGs
· Duty to follow EU procurement law	X	X	x		Generic
Statutory powers of PCTs:					
· Power to make pilot schemes for the provision of local pharmaceutical services (section 134 of the Act).		x			NCC
· PCTs have a power to provide services under primary medical services & primary dental services agreements (section 21(1) of the 2006 Act).		x			NCC
· Power to make payments to local authorities and voluntary organisations towards expenditure on community services (sections 256 and 257.	X				CCGs
· Power to give grants to voluntary organisations (section 64 of the Health Services and Public Health Act 1968 – Secretary of State functions delegated to PCTs by direction – see Annex A).	x				CCGs
Functions:					
· PCTs currently contract Home Oxygen services. Current contracts expiring around 2012/13 but Capital & Revenues Investment branch are in the process of procuring 5-year contracts starting in 2011 with lead PCT as a party. This function requires significant contract management capability and need to recover costs from other commissioners.	?	?			NCC/CRGs

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· Negotiate contracts with full range of providers (acute, primary, community, mental health, third sector independent sector etc) to include:	x	x	x		As above
- Financial envelope	X	X	x		
- Capacity plans	X	x	x		
- Incentives e.g. CQIN	X	X	x		
- Clinical and quality outcomes	X	X	x		
(N.B. Contracts with foundation trusts are legally binding)					
· Ensure application of mandatory NICE guidance across providers.	X	X	x		
· Determination for treatment abroad.	X	x			CCGs
· Develop "section 75 "arrangements to manage jointly commissioned services – most commonly in mental health, learning disability and children's services. Such arrangements have clear governance and specific accountability arrangements for LAs and NHS organisations.	x				CCGs
· Ensure pathway coordination across commissioners and providers for "high end" secondary care services. This is usually managed through the networks for stroke, CHD, cancer etc.	x				CCGs
· Develop a procurement strategy and ensure compliance with PRCC. This includes development of service specifications, tendering, Board sign off of award of contract, and managing the transition between providers.	X	X	x		Delegate to CSO
· Manage the local provider market to ensure there is an appropriate range and choice of providers.	X	X	x		CCGs

Appendix 1
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· Manage vaccination and screening programmes (implemented through primary care providers) – notifying call and recall to practices, maintaining databases for breast and cervical screening – see appendix 1 for more detail.		x			NCC
· Managing individual funding requests – e.g. to meet complex health care needs, working with education, social services, prison services etc when appropriate.	x				CCGS*
· Assessing/appraising evidence to underpin commissioning	X	X	x		CCGs (under Scheme of Delegation)
· Issuing commissioning intentions	X	X	x		CCGs (Scheme of Delegation)
5. Monitoring and Evaluating.					
Key role description: Ensure contract compliance and continuous improvement in quality, health outcomes, and value for money.	X	X	x		CCGs*
Statutory duties of PCTs:					
· Duty to maintain and publish Performers Lists (NHS Act 2006 and subsequent regulations):		X			NCC
- S91 Primary Medical services		X			As above
- S106 Primary Dental services		X			As above
- S123 Primary Optical services		X			As above
- S129 Pharmaceutical services (inc. appliance contractor)		X			As above
· Duty to make payments to suspended performers (SofS Determination 2004), aligns with Performers list above)		X			As above
Statutory powers of PCTs:					
· [none]					
Functions:					
· Continuously monitor performance of contracts (and grants) with all providers (NHS, L A, independent or third sector. Specifically, regularly review:	X	X	X		QPR (keep CCGs development in this area under review and delegate where appropriate)

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- Financial performance	X	X	x		As above
- Activity levels	X	X	x		As above
- Quality standards and outcomes including patient experience	X	X	x		As above
- Clinical standards.	X	X	x		As above
· Provide pre intervention support to providers where there is a concern over performance.	X	X			As above
· Put in place:					As above
- Contract variations if required	X	X	x		As above
- Exception reports	X	x	x		As above
- Actions to address under performance including agreement and implementation and of recovery plans.	X	X	x		As above
· *"Relationship management"*with range of providers (informal and formal).	X	X	x		As above
· Comment on and agree quality accounts	x				As above
· Undertake surveys, analyse and use the data to improve services e.g patient choice surveys.	X	X	x		As above
· Working with clinicians, patients and others, continually review effectiveness and improve pathways.	X	X	x		As above
· Continually review PCTs performance and outcomes against similar populations.	X	X	x		As above
· Measure and understand the efficiency and effectiveness of PCT spend in all commissioned services, benchmarking against identified best practice.	X	X	x		As above
· Undertake payment and invoice reconciliation.	X	X	x		As above
· Financial audit (internal and external)	X	X	x		As above
6. Accountability and Assurance					
Key role description: Accountable for ensuring and demonstrating high quality services, and ensuring the	X	X	x		CCGs scheme of Delegation)

Appendix 1
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most effective and efficient use of resources.					
Statutory duties of PCTs:					
· Duty to publish an annual document setting out information in relation to the quality of the services they provide or commission (other than in relation to primary care services and community health services) section 8 of the Health Act 2009.	X	x			Cluster f(PCTs)
· A PCT has various financial duties under the NHS Act 2006 including:	X	x			As above
- to secure that its expenditure in any financial year does not exceed its allotment from Secretary of State for that year (section 229)	X	x			As above
- to secure that its use of resources in any financial year do not exceed the amount specified by the Secretary of State (section 230)	X	x			As above
- to keep proper accounts and related records (Schedule 15, paragraph 2)	X	x			As above
- to prepare annual accounts and send copy of accounts to SHA and Secretary of State (Schedule 15, paragraphs 3 and 4).	X	x			As above
· Duties to prepare an annual report, send it to SHA & Secretary of State and to publicise the report and annual accounts (NHS Act 2006, Schedule 3, paragraphs 20 and 21).	X	x			As above
· Power to provide hospital services for private patients or provide other services, or carry out other activities, for the purpose of making additional income available ("income generation") (section 21(5)).	?	?			Not applicable
· Power to raise money (by appeals, competitions etc) (section 222 of the 2006 Act).	x				CCGs

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· Data Protection Act 1998 –					All
-duty to process personal data in accordance with the Act	X	X	x		All
-duty to grant individuals access to personal data relating to them (sections 7 to 15 of the Act)	X	X	x		All
-duties to register with Information Commissioner (sections 17 to 21).	X	X	x		All
· Freedom of Information Act 2000 –					All
- duty to comply with requests for information in accordance with the Act (sections 1 to 16);	X	X	x		All
- duty adopt and maintain a publication scheme and publish information in accordance with that scheme (section 19).	X	X	x		Cluster (PCTs)
· Duties in relation to the supervision and management of controlled drugs (regulations under sections 17 and 18).	X	X	x		Cluster (PCTs)
· Duty to provide periodical reports on matters relating to HIV and AIDS (section 1 of the Aids (Control) Act 1987.			x		Cluster (PCTs)
· PCTs currently hold some contracts for Wave 1, Phase 2 ISTCs and now successors to Wave 1 contracts.	?	?			CCGs (delegated functions)
· For some contracts for Wave 1, Phase 2 ISTCs, PCTs have provided indemnities to the ISTC contractor to cover their clinical negligence. Effectively, if a claim is made, the indemnity means it is made against the PCT rather than the ISTC and the PCT is covered through the clinical negligence scheme for trusts (CNST).	?	?			CCGs (delegated functions)
· Mental Capacity Act 2005; A PCT has a duty to act as a Supervisory Body in relation to Deprivation of Liberty Safeguards.			x		Cluster (PCTs)
· Duty to appoint Responsible Officer (RO Regulations 2010 under		x			NCC

Appendix 1
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Health and Social Care Act 2008) – duties of responsible officers in PCTs relate to all doctors on Performers List and some locum doctors.					
· Duty to make a pharmaceutical needs assessments for its area (section 128A of the Act)		x			NCC
FT Board membership – NHS Act 2006, Schedule 7, Para 9(3); "at least one member of the board must be appointed by a Primary Care Trust for which the corporation provides goods and services"	x				
· Apply Equality Act 2010 (from 1 October 2010)	X	X	X		All
Statutory powers of PCTs:					
· Power to enter agreements for the provision of overseas development	?	?			Not applicable
· Education and Skills Act 2008 - s16 (PCT power to supply information to local education authorities)	X	X			CCGs/NCC
Functions:					
· Function/role of Local Security Management Specialists working in PCTs	X	X			As above
· Publish an annual public health report.			X		HWBB
· Management of communicable diseases – including providing reports matters relating to HIV and AIDs.			X		As above
· Manage decision-making process for use of high cost drugs and new interventions	X	X			CCGs/NCC
· Medicines management – provision of prescribing advice to all primary care contractors, supervising and managing controlled drugs.	X				CCGs
- Communicating and managing drugs and medical devices alerts.	X				As above
- Provide prescribing advice to	X				As above

Appendix 1
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care homes.					
- Manage prescribing incentive schemes for practices.	X				As above
- Accountable officer across the system (including independent sector)	X				As above
- Maintaining drugs – eg. cold chain vaccines	X?				Provider responsibility
· Manage all elements of Data Protection.	X	X	X		all
· Assurance and risk management – review all risks and issues eg internal risks, SUIs, provider risks, risks associated with partners such as Safeguarding Boards.	X	X	x		QPR*
· Ensure effective information governance.	X	X	x		Cluster (PCTs)
· Comply with all requests under FOI –and publish information in accordance with the publication scheme.	X	X	x		As above
· Manage requests for access to medical records.	X	x			As above
· Manage all complaints (including complaints made directly to PCT).	X	X	x		Scrutinised by QPR but remains responsibility of Accountable Officer (Scheme of Delegations and Complaints regulations)
· Respond appropriately to all SUIs , independent enquiries and incidents, child death reviews.	X	X	x		As above
· Undertake serious case reviews.	X	X			As above
· Prepare and publish annual report and annual accounts.	X	X	X		Cluster (PCTs)
· Manage litigation issues and Clinical Negligence Scheme for Trusts (CNST).	X	X	x		CCGs
· Manage charitable funds.	x				Not applicable
· Ensure links with CQC and meet requirements and requests.	x	x			CCGs/NCC
· Provide management account	x				CCGs

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support to commissioners, PBC clusters etc.					
· Ensure effective financial governance including adhering to Standing Orders, Standing Financial Instructions etc.	X	X	x		Audit Committee/CCGs/NCC
· Financial services – cash management.	X	X	x		Across system
· Meet Infection control responsibilities.(inc. Auditing and monitoring implementation of recovery plans)	?	?			QPR – anticipated delegation hen appropriate
· NHS Library services.	?	?			To be clarified
· Ensure effective business continuity planning and testing.	X	X	x		Whole system
· Clinical governance responsibilities	X	X	x		QPR with anticipated future delegation to CCGs
· Communications planning/local voice of NHS	X	X	x		Cluster (PCTs)
· Research governance	x				CCGs/NCC
7. Workforce					
Key role description: Ensuring the organisation develops the capacity and capability to commission outcomes that deliver high quality care and give value for money.	X	X	x		Whole system f=but PCTs retain responsibility for employees until CCGs established
Statutory duties of PCTs:					
· Duty not to discriminate in relation to staff and recruitment:	X	X	X		All
- section 4 of the Race Relations Act 1976 (race)	X	X	X		All
- section 6 of the Sex Discrimination Act 1975 (sex)	X	X	x		All
- section 4 of the Disability Discrimination Act 1995 (disability)	X	X	x		All
- regulation 6 of the Equality Act (Sexual Orientation) Regulations 2003 (sexual orientation)	X	X	x		All
- regulation 7 of the Employment Equality (Age) Regulations 2006 (age)	X	X	x		All
· Health & safety					
- duty to ensure, so far as	X	X	X		Assurance to and from Audit Committee*

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reasonable practicable, the health, safety and welfare of employees at work (section 2 of the Health and Safety at Work etc Act 1974)					
- duty to ensure, so far as reasonable practicable, that persons who may be affected by the PCT's undertaking are not exposed to risks to their health and safety (section 3 of the 1974 Act)	X	X	x		As above
- duty to ensure that PCT premises are safe for visitors etc (section 4 of the 1974 Act)	X	X	x		As above
- function of making arrangements for a medical practitioner to provide medical records of persons under 18 to employment medical advisers (section 60 of the 1974 Act)		x			NCC
· Health Act 2006 –					
- duties to prevent smoking and to display no-smoking signs in PCT premises (sections 6 and 8)	X	X	X		All
Statutory powers of PCTs:					
· Schedule 3 to the NHS Act 2006 confers various miscellaneous powers including–					
- employ staff (paragraph 7);	X	X	X		
- pay remuneration and allowances to chairman and other board members of the PCT (paragraph 11);	X	X	X		Retained by Cluster PCTs, delegation to CCGs as appropriate post establishment
- do anything which appears to the PCT to be necessary or expedient for the purposes of or in connection with its functions, including acquiring and disposing of property, entering contracts and accepting gifts of property (paragraph 15);	X	X	x		Subject to NHS Property Services Limited currently with PCTs
- enter externally financed development agreements (PFI etc) (paragraph 17);	?	?			Further clarification required
- conduct, commission or assist	x				CCGs

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the conduct of research (paragraph 18);					
- make staff available for training purposes (paragraph 19);	X	X	X		All but currently NHS staff retained by PCTs
- to purchase land compulsorily where approved by Secretary of State (paragraph 22).	?	?			Further clarification required but possibly NHS Property Services Limited
Functions:					
· Commissioning of education programmes – clinical and non clinical.	X	X			Local authorities if Section 75 Agreements in place as part of contractual agreement
· Providing training and development opportunities for all staff.	X	X	x		All
· Ensuring effective clinical leadership .	x				CCGs (delegated currently)
· Ensure organisational development which in turn ensures development of people, capacity and capability of the organisation to meet the QIPP challenges.	X	X	X		CCG lead responsibility for delivery of QIPP
· Development of Board and PEC.	X				CCG to develop Board and associated committees and Assurance Frameworks*
· Workforce planning	X	X	x		But delegate to CSO for CCG staff
· payroll	X	X	x		As above
· Develop recruitment and retention strategies for staff	X	X	x		As above
Ensure workforce policies are developed to demonstrate the PCT is a good employer, and reflects best practice in relation to equality and diversity (including occupational health, personal development, protecting and improving staff wellbeing).	X	X	x		As above
· Undertake formal trade union processes in relation to recognition and consultation.	X	X	x		As above
· Undertake annual staff surveys	X	X	x		As above
· Meet all statutory health and	X	X	x		As above

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safety duties					
· Develop and implement a single diversity scheme.	X	X	x		As above
· Undertake CRB checks	X	X	x		As above
8. Estates and IT					
Key role description: Ensure the PCTs estate & I.T are effective and enable the delivery of high quality and cost effective care.	X			X Prop Com	CCG/NHS Property Services Limited currently retained by PCTs
Statutory duties of PCTs:					
· Duties in relation to Estates:					
- Reimbursing GPs for the costs of operating their premises (unless, of course, major changes are made to the arrangements for funding primary care);		x			NCC
- Planning and funding of NHS-owned primary and community facilities;				X Prop Com	
- Contracting through frameworks, in particular LIFT and Procure 21 for the delivery of facilities.		X			Requires further clarification
Statutory powers of PCTs:					
· Power to provide premises for the use of persons providing primary care services (section 21(3) of the Act).		x			NCC
· Power to form, or participate in the formation of, companies for the purposes of improving primary care facilities or services (in LIFT areas) (section 223 of the 2006 Act – Secretary of State power delegated to PCTs by directions – see Annex A)		X			NCC but further clarification required
· Licensing Act 2003 - s16 (PCT power to apply for premises license).				X Prop Com	Director of Finance
Functions:					
· Ownership and maintenance of PCT asset.				X Prop Com	
· Support local implementation of national transformational projects such as Connecting for	x				CCGs

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Health ensuring that there is an integrated approach to service development and informatics planning.					
· Ensure primary care premises are developed and maintained in such a way as to support provision of high quality primary care.		x		NHS Property Services Limited	
· Assure quality of premises, issuing improvement notices or closure orders where problems are identified		x			NCC
· Strategic planning of wider estates policy		X		X Prop Com	
· Enter into externally financed development agreements such as PFI and LIFT.		x			Also NHS Prop Ltd
· Holding contracts with LIFT/PFI and paying rent		x			As above
· Management of all IT .	X				As above
· Providing IT support to GPs and other primary care contractors.	?	?			As above
· Ownership of IT equipment in practices.					To be clarified
· Knowledge management including data systems					To be clarified
9. Service specific responsibilities					
Most PCT functions apply to all services, services settings and care groups. There are some specific services issues and duties listed below.					
Mental Health					
Statutory duties of PCTs:					
· *After-care services for mental health patients* - Duty on PCTs and local authorities to provide after-care services for patients after detention under the Mental Health Act (section 117 of the Mental Health Act 1983).	x				CCGs (Scheme of Delegation)*

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· *Direct Payments* - There is provision in sections 12A to 13 of the 2006 Act for the Secretary of State to make direct payments to patients in lieu of providing healthcare. Section 12A(4) provides for PCTs to make direct payments to secure after-care services under section 117 of the Mental Health Act 1983, if regulations so provide	x				As above
· Mental Health Act 1983, s23/s24 – power to discharge NHS patients from detention (etc) in independent hospitals. Associated power to authorise certain persons to visit and interview such patients.	x				As above
· Mental Health Act 1983, s39 – duty to provide court on request with information about availability etc of hospital places	x				As above
· Mental Health Act 1983, s130A – duty to make arrangements for independent mental health advocates (IMHAs) to be available to qualifying patients. (Power conferred on SofS, but is delegated to PCTs via the Functions Regulations).	X				As above
· Mental Health Act 1983, s140 – duty to notify local social services authorities of availability of suitable hospital places for emergency admissions and for under 18s.	x				As above
· NHS Act 2006, s236. Duty to make payments to doctors for medical examinations in connection with Part 2 of the Mental Health Act.	x				As above
· Mental Capacity Act 2005; A PCT has a duty (by virtue of regulations) under ss 37 & 38 MCA to consult an IMCA	x				As above
· Coroners and Justice Act 2009 - ss19 & 20 (PCT duty to appoint	x				As above

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medical examiners)					
Statutory powers of PCTs:					
· Mental Health Act 1983, s122 – power to make pocket money patients to certain psychiatric in-patients. (Power conferred on SofS, but is delegated – by implication – via the Functions Regulations).	x	X			Joint commissioning responsibility MH Sp Services
Functions:					
· provide courts with information about availability of hospital places.	x				Joint commissioning responsibility
· Ensure independent mental health advocates are available to patients where appropriate.	x				Joint commissioning responsibility
· Working with Local Authorities, provide aftercare for patients who have been detained under the mental health act.	x				Joint commissioning responsibility
Children & Young People					
Statutory duties of PCTs:					
· Duty to co-operate with local authorities and other to improve well-being of children (section 10 of the Children Act 2004);	x	x			Joint commissioning responsibility
· Duty to make arrangements to ensure that PCT functions are discharged having regard to the need to safeguard and promote the welfare of children (section 11 of the Children Act 2004);	x	x			Joint commissioning responsibility but overall responsibility retained by cluster (PCTs) apart from Safeguarding which remains the responsibility of QPR*
· Duty to work with local authority in connection with the authority's arrangements for improving well-being etc of young children (section 4 of the Childcare Act 2006).	x	x			Joint commissioning responsibility
Statutory powers of PCTs:					
· Learning and Skills Act 2000 - s120 (PCT power to supply information about young people to SofS etc)	x	x			CCGs/NCC
Functions:					

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· Commissioning services for looked after children.	x	x	x		Joint commissioning responsibility
· *Managing transition* :between adult and older peoples services, and between children's and adult services. Specifically patients and users face issues in transition in Mental health, learning disability and services provided for children with complex health care needs.	X		X		Joint commissioning responsibility CCGs and LA
· *Commissioning for vulnerable groups*: ensure services are commissioned specifically, for seldom heard and vulnerable groups such as travellers, asylum seekers.	X	X	O		CCGs under current delegations and NCB from primary care and sp services perspective
Offender Health					
Statutory duties of PCTs:					
· Duty to co-operate with the prison service with a view to improving the way in which functions are exercised in relation to the health of prisoners (section 249 of the NHS Act 2006)		X			NCC
· Duty to formulate and implement, with local authorities etc, strategies for the reduction of crime and disorder, and for combatting the misuse of drugs, alcohol and other substances (section 6 of the Crime and Disorder Act 1998);	x	X			CCG and NCC but Substance misuse and sexual offending to Local Authorities
· Duty to co-operate with local authorities in relation to youth justice services, youth offending teams etc (sections 38 and 39 of the Crime and Disorder Act 1998);	X	x			CCG/NCC
· Duty to co-operate with police, probation and prison services in relation to arrangements for assessing risks of violent or sexual offenders (section 325 of the Criminal Justice Act 2003).	x	x			CCG/NCC
Statutory powers of PCTs:					
· [none]					

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Functions:					
· work with prison services to improve the health of prisoners.		x			NCC
· working with police, probation and prison services to asses risks of violent or sexual offenders.	x	x			CCG/NCC under current delegations
· Cooperate with youth justice services and youth offending teams to ensure effective health care services are available.		x			NCC (current delegations)
· Appoint medical examiners.	X	X			Requires further clarification
Continuing Health Care					
Statutory duties of PCTs:					
· There is a single set of eligibility criteria for NHS CHC used across England. The criteria are set out in Directions and are supported by guidance in the revised National Framework for NHS Continuing Healthcare introduced in 2007 and revised in 2009.	x				CCGs as per budgetary responsibilities under Scheme of Delegation
Functions:					
· Undertake assessment processes and review panels jointly with Local Authorities using the nationally agreed criteria.	x				Delegated currently under budgetary responsibilities
Maternity					
Statutory duties of PCTs:					
· Duty to establish Maternity Services Liaison Committees (MSLCs) comprising both users and providers of maternity services	x				As above
Functions:					
· Establishment of maternity services liaison committees	x				As above
Primary Care					
A dedicated list of commissioning functions relating to primary care can be found in appendix 1. This is currently being reviewed and will be updated shortly.					
Patient registration		X			Terms of Reference and Scheme of Delegation

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					NCC*
· Screening (Cervical and Breast and pilot chlamydia)		X			As above
· FHS Finance		X			As above
· Provision of financial information		X			As above
· Pay contractor		X			As above
· Ophthalmic care contracts		X			As above
· Pharmaceutical contracts		X			As above
· Contract management for all primary care contracts		X			As above
· Support to primary care providers		X			As above
· Regulatory Support		X			As above
· Information services and systems notification of births, vaccination and immunisation activities)		X			As above
· Performance & Contracting (FHSA)		X			As above
· Budget management		X			As above
· Procurement		X			As above
· Contract negotiation		x			As above

- *** = Areas where assurance to the Board via regular reporting is required**

APPENDIX 2

INTRODUCTION

Information and guidance with respect to the emerging successor organisations and their respective duties has revealed that the situation remains fluid and initial decisions on composition, numbers and functions have been subject to various revisions since the publication of the Health and Social Care Bill. CCGs in West Mercia are at different stages in their development and support is being provide by the governance leads in the cluster PCTS to assist in the authorisation process and work is currently in hand in an effort to map out the PCT functions to the likely receiving organisations and a report will be submitted to the Board at its meeting in May for consideration and approval. However, we will need to remain flexible and responsive as further guidance and policies emerge.

CURRENT DELEGATIONS TO CCGs

1. **Strategy, Plans and Budget –**
    - Preparation of operational and financial plans within budgets for approval by Board
    - Provision of advice to the Board on the strategic aims and objectives of the PCTs/cluster
    - Preparation and review on an annual basis of draft plans in respect of the application of available financial resources to deliver the agreed system plans for approval by the Board
    - Preparation and review on an annual basis a draft PCT/cluster annual commissioning strategy or plan for their delegated area of approval by the Board
    - Preparation of proposals for PCT/cluster or Practice incentive schemes and to monitor and review such schemes.

2. **As Committees of the Board**
    - Plan and commission services within their areas
    - Initiate service reviews and implement service changes within delegated limits
    - Advise the Board on service changes outised delegated limits
    - Agree local QIPP plans and ensure achievement of these
    - Ensure GP practices support the achievement of local plans, implementation of PCT strategies and national targets
    - Manage relationships with GPs and performance manage GP practice input into commissioning
    - Mange relationships with their respective local authorities through participation in the H&WBB
    - Engage patients and the public in its commission activity
    - Develop a constitution which outlines the responsibilities of individual practices and the accountability to the PCTs, government and local population

3. **NHS commissioned Part B clinical services**
    - Ratify annual SLAs and contracts
    - Approve business cases, issue tenders, seek any willing providers and present budget to PCT executive director for signature.
    - All expenditure must be in line with the PCT system plan
    - Submission to QPR for approval all business cases above 0.1% where they are not part of approved business plan
    - Set GP prescribing budgets

4. **For Part A non-clinical services**
    - Submit to the Remuneration Committee plans to spend the approved running costs allowance
    - To commit resources at delegated limits set for individual directors (250,000) where expenditure is part of an agreed business plan
    - To commit resources up to £10,000 where expenditure is funded from in year flexibilities
    - SFIs on approving contractors will apply

AUDIT AND ASSURANCE REQUIREMENTS

The CCGs are required to appoint governance leads to ensure that legal and governance requirements are satisfied in relation to their responsibilities and accountability. The following statutory requirements are likely to be necessary although external auditors have confirmed recently that the position remains somewhat unclear and will need to be kept under review as the Cluster CCGs move to authorisation.

- Formation of an Audit Committee and development of terms of reference
- Appointment of External and Internal Auditors
- Final Accounts process
- Provision for Counter Fraud role
- Maintain a register of interests and a register of gifts and hospitality
- Ensure that conflicts of interest are recorded and appropriate action taken
- Establish a Remuneration Committee (significant difficulties identified) and terms of reference
- Ensure appropriate Health and Safety arrangements are in place with proper person appointed.
- It is also necessary for the CCGs to develop robust risk management processes and develop a Board Assurance Framework

5. **CONCLUSION**

Work is ongoing with respect to the mapping out of statutory functions to all known receiving organisations including CCGs, National Commissioning Board and Local Authorities.

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	**TRANSFORMATION FUND 2012/13**
REPORT AUTHOR :	**BRIAN HANFORD, DIRECTOR OF FINANCE**
PRESENTED BY:	**BRIAN HANFORD, DIRECTOR OF FINANCE**
PURPOSE OF REPORT:	The purpose of this report is to update the Cluster Board on progress to submit to the Strategic Health Authority bids for accessing the 2% Transformation Fund and to seek approval for the next steps.
KEY POINTS:	The West Mercia Cluster has available £37m of resource to fund non-recurrent Transformational Change as required under the 2012/13 Operating Framework. This report updates the West Mercia Cluster Board and seeks approval for next steps.
RECOMMENDATION TO THE BOARD:	The Cluster Board notes the update contained within this report on the process to utilise the Transformation Fund budgeted for as required under the 2012/13 NHS Operating Framework. The Cluster Board notes outcome of the recent Board-to-Board sessions and the ongoing dialogue with the Strategic Health Authority over the financial challenge faced by the Herefordshire health economy, most notably the Wye Valley Trust. The Cluster Board endorses the design principles identified in section three and the delegation of authority to progress the utilisation of the Transformation Fund as proposed.

CONTEXT & IMPLICATIONS	
Strategic Objectives	Transformation Fund use in 2012/13 is a key enabler within the West Mercia Cluster Integrated System Plan.
Financial	Transformation Fund is set under the NHS Operating Framework within West Mercia at £37m.
Legal	PCT powers to utilise this resource are as per all other PCT expenditure.
Risk & Assurance	Oversight of the process to be undertaken by the Cluster Board with specified duties delegated to PCT Committees.
HR, Equality & Diversity	N/A
National Policy	Fund required under the 2012/13 NHS Operating Framework.
Carbon/Sustainability	N/A
Partnership	Process requires partnership agreement across the health economy.

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Future application of the fund will be governed by the Quality, Performance & Resources Committee. This report also proposes delegation of certain powers to the CCG Boards. The West Mercia Cluster under the NHS Operating Framework is required to gain Strategic Health Authority approval before proceeding.

West Mercia Cluster Board
29 May 2012

Item		TRANSFORMATION FUND 2012/13 Brian Hanford Director of Finance, West Mercia Cluster
1. Recommendations	**1.1**	**The Cluster Board notes the update contained within this report on the process to utilise the Transformation Fund budgeted for as required under the 2012/13 NHS Operating Framework.**
	1.2	**The Cluster Board notes outcome of the recent Board-to-Board sessions and the on going dialogue with the Strategic Health Authority over the financial challenge faced by the Herefordshire health economy, most notably the Wye Valley Trust.**
	1.3	**The Cluster Board endorses the design principles identified in section three and the delegation of authority to progress the utilisation of the Transformation Fund as proposed.**
2. Introduction		The purpose of this report is to update the Cluster Board on progress to submit to the Strategic Health Authority bids for accessing the 2% Transformation Fund and to seek approval for the next steps.
Operating Framework 2012/13	**2.1**	Members will recall that the March 2012 Board approved the set-aside of £37m across the four PCTs for Transformational Change non-recurrent expenditure as required under the NHS Operating Framework for 2012/13.

2.1.1 The Transformational Fund is created through a top slice of each PCTs Revenue Resource Limit and the table below identifies how this falls across the four PCTs within the Cluster. It is currently assumed the same process will apply as in 2011/12 where the Strategic Health Authority (SHA) will top slice each PCT and place the holding account within the NHS Worcestershire Revenue Resource Limit pending release.

PCT	Requirement (£000s)
NHS Herefordshire	5,653
Shropshire County PCT	9,102
NHS Telford & Wrekin	5,161
NHS Worcestershire	16,969
Cluster Total	**36,885**

The Integrated System Plan stated, and the March Board agreed, that whilst the SHA has signalled that in governance terms the resource is to be administered at a Cluster level, best endeavours should be made to ensure that each health economy is restricted to accessing only the fund up to its original contribution.

Integrated System Plan 2012/13

2.2 Members will recall that the Integrated System Plan for 2012/13 notionally laid out an outline of how at a Cluster level this resource should be utilised. The table below summarises this position.

Category	Receiving Area	£ 000s
Health Economy Transformation Projects	Herefordshire (WV)	500
	Worcestershire (WAHT)	1,000
	Shropshire/T&W (SaTH)	500
Cluster Big Bets	Doing the ordinary extraordinary well	5,000
	Urgent Care inc. RAID	7,500
	Planned Care	5,000
	Primary Care	500
SHA Ambitions	Pressure Ulcers, Every patient Counts and Patient Revolution	2,750
Other	Structural Change	12,635
	Primary Care Premises	500
	Total	**36,885**

The Integrated System Plan also clarified the pre-requisites that any applications to access the transformational resource must follow to be successful.

1. 2012/13 contracts must be signed.
2. Expenditure must be non-recurrent.
3. Applications needed to be demonstrably health economy wide transformational programmes.
4. Organisations in receipt of transformational funds must commit to deliver the strategic intent of the Integrated System Plan.
5. Organisations in receipt of transformational funds commit to deliver all performance and quality targets laid down in the 2012/13 Operating Framework and national contract.

Process to date **2.3** In February 2012, the Cluster Executive wrote to all CCGs and Chief Executives of NHS Trusts laying out the process and including the SHA pro-forma for submission.

	2.3.1	In March 2012, the Quality Performance & Resources Committee received an update on the bids received at that point. At the Cluster Board on 27th March 2012 the Board agreed that given the extent to which the Acute providers within the West Mercia Cluster were signalling a material reliance on the Transformational Fund, Board-to-Board meetings would be held with each of them prior to any submission being made to the SHA for release of the Fund. These Board-to-Board meetings were held as follows: - Wye Valley – 19th April 2012. Worcestershire Acute – 26th April 2012. Shrewsbury and Telford Hospitals – 9th May 2012.
Board-to-Board Conclusions	**2.4**	Each of the Board-to-Board sessions were able to note that 2012/13 contracts had been signed and therefore given that contracts included the impact of the Commissioner QIPP plans, it was possible to ascertain where risk sat in each of the health economies.
	2.4.1	Of most significance was the outcome of the Board-to-Board discussion with the Wye Valley Trust. The Trust is signalling that over and above any access to Transformational Funds it is currently identifying a £9.5m short fall between its projected income and likely expenditure.
	2.4.2	Whilst this position has a potential impact on the organisation itself e.g. suspension of its path to Foundation Trust status, it does raise a governance issue for the Cluster Board. The issue for consideration by the Cluster Board is should it be influenced in its administration of the Transformational Fund by the statutory duty of its providers to achieve financial balance. This issue will be discussed further with SHA colleagues at the PCT Cluster Annual Accountability Review on the 26th May 2012.
	2.4.3	In addition, as is discussed later in this report the Herefordshire contribution to the Transformational Fund is only £5.7m and there already exists a material over subscription.

2.4.4 Feedback from the Annual Accountability Review will be made verbally at the Cluster Board but for the purposes of this report it is assumed that the PCT Cluster will draw up plans that focus on Transformational Change and maintain the discipline that each health economy (PCT) is mandated to develop plans to utilise the full extent of their contribution to the fund if they so require it.

2.4.5 Whilst there were a number of outputs from the sessions, most pertinent to this paper is that Shrewsbury & Telford Hospitals Trust (SaTH) identified a requirement to access £4.9m of Transformational Funding (subject to clarification on any redundancy impact of its QIPP plans) and Worcestershire Acute Hospitals identified a potential requirement of £10m (later reduced to £9.5m).

PCT Positions and way forward

3.1 Cluster Board approval is sought for the following design principles in assessing the relative PCT positions and more importantly as a foundation to setting the way forward.

3.1.1 Transformational Fund way forward design principles proposed are;

1. Each health economy is given the opportunity to present plans for approval up to its original contribution.

2. The original Integrated System Plan contributions to delivery of the SHA Ambitions Around Pressure Ulcers, Every Patient Counts and the Patient Revolution will be seen as a first call and the plans will be signed off at Cluster level by the previously identified Cluster Director.

3. The Cluster Executive agrees with CCG colleagues the appropriate level of access to the fund by West Mercia providers. This will draw on the Integrated System Plan prerequisites.

4. The Cluster Executive sets aside sufficient resources within each health economy for structural change required within the contribution of that health economy.

5. The Integrated System Plan priority to progress the dementia strategy investment referred to as RAID be maintained and CCG Boards be delegated the authority to sign off the various Business Cases within the sums identified within the appendices attached.

6. CCG Boards be delegated the authority to draw up final plans to present for the approval to the Quality Performance & Resources Committee (QPR) utilisation of all other schemes up to the values identified in the attached appendices. In nearly all cases this work is at an advanced stage of preparation and once QPR approval is received bids will be submitted to the SHA accordingly.

3.2.2 Based on the above design principles and given the previous assumptions made, the individual PCT positions would be as presented in Appendices 1 to 4.

APPENDIX 1

Transformation Fund 2012/13 NHS Herefordshire

Category	Integrated System Plan	Receiving Area	Original Bid £ 000s	Allowable Fund £ 000s	Delegated Body £ 000s
RAID (Dementia Care)	Urgent Care	2gether Foundation Trust	750	650	Herefordshire CCG
Pressure Ulcers - SHA Ambition	Doing ordinary extraordinary well	Various	77	77	Cluster Nurse Director
Every Patient Counts - SHA Ambition	Doing ordinary extraordinary well	Various	77	77	Cluster Deputy Chief Executive
Patient Revolution - SHA Ambition	Doing ordinary extraordinary well	Various	77	77	Cluster Deputy Chief Executive
Wye Valley Project Management Office	Other	Wye Valley Trust	500	230	Cluster Chief Executive
Wye Valley PwC Support	Other	Wye Valley Trust	500	80	Cluster Chief Executive
Wye Valley Redundancy Reserve	Other	Wye Valley Trust	500	0	N/A
Wye Valley Price Support	Other	Wye Valley Trust	9,500	0	N/A
Non Recurrent Waiting List Cohort (WV)	Planned Care	Wye Valley Trust	1,000	1,000	Herefordshire CCG
Reserve for NHSH Redundancy costs	Other	NHS Herefordshire	3,000	3,000	Cluster Director of Finance
Herefordshire CCG QIPP schemes	Planned Care / Urgent Care	Herefordshire CCG	2,300	462	Herefordshire CCG
Total			**18,281**	**5,653**	

APPENDIX 2

Transformation Fund 2012/13 NHS Telford & Wrekin

Category	Integrated System Plan	Receiving Area	Original Bid £ 000s	Allowable Fund £ 000s	Delegated Body £ 000s
RAID (Dementia Care)	Urgent Care	SSMHFT	400	400	Telford & Wrekin CCG
Pressure Ulcers - SHA Ambition	Doing ordinary extraordinary well	Various	70	70	Cluster Nurse Director
Every Patient Counts - SHA Ambition	Doing ordinary extraordinary well	Various	70	70	Cluster Deputy Chief Executive
Patient Revolution - SHA Ambition	Doing ordinary extraordinary well	Various	70	70	Cluster Deputy Chief Executive
SATH QIPP support	Other	SaTH	1,900	1,900	Telford & Wrekin CCG
Non Recurrent Waiting List Cohort	Planned Care	RJAH	400	400	Telford & Wrekin CCG
NHS T&W Transitional Costs	Other	NHS Telford & Wrekin	1,721	750	Cluster Director of Finance
Telford & Wrekin CCG	Planned Care	Telford & Wrekin CCG	440	440	Telford & Wrekin CCG
Telford & Wrekin CCG	Urgent Care	Telford & Wrekin CCG	540	540	Telford & Wrekin CCG
Telford & Wrekin CCG	QIPP Other	Telford & Wrekin CCG	2,153	521	Telford & Wrekin CCG
Total			**7,764**	**5,161**	

APPENDIX 3

Transformation Fund 2012/13 Shropshire County PCT

Category	Integrated System Plan	Receiving Area	Original Bid £ 000s	Allowable Fund £ 000s	Delegated Body £ 000s
RAID (Dementia Care)	Urgent Care	SSMHFT	600	600	Shropshire County CCG
Pressure Ulcers - SHA Ambition	Doing ordinary extraordinary well	Various	123	123	Cluster Nurse Director
Every Patient Counts - SHA Ambition	Doing ordinary extraordinary well	Various	123	123	Cluster Deputy Chief Executive
Patient Revolution - SHA Ambition	Doing ordinary extraordinary well	Various	123	123	Cluster Deputy Chief Executive
SATH QIPP support	Other	SaTH	3,060	3,060	Shropshire County CCG
Non Recurrent Waiting List Cohort	Planned Care	RJAH	2,000	2,000	Shropshire County CCG
SCPCT Transitional Costs	Other	Shropshire County CCG	500	500	Cluster Director of Finance
Shropshire County CCG	Planned Care	Shropshire County CCG	878	878	Shropshire County CCG
Shropshire County CCG	Urgent Care	Shropshire County CCG	1,221	1,221	Shropshire County CCG
Shropshire County CCG	QIPP Other	Various	843	474	Shropshire County CCG
Total			**9,471**	**9,102**	

APPENDIX 4

Transformation Fund 2012/13 NHS Worcestershire

Category	Integrated System Plan	Receiving Area	Original Bid £ 000s	Allowable Fund £ 000s	Delegated Body £ 000s
RAID (Dementia Care)	Urgent Care	Worcestershire H&CT	1,500	1,500	R&B CCG / WF CCG / SW CCG
Pressure Ulcers - SHA Ambition	Doing ordinary extraordinary well	Various	230	230	Cluster Nurse Director
Every Patient Counts - SHA Ambition	Doing ordinary extraordinary well	Various	230	230	Cluster Deputy Chief Executive
Patient Revolution - SHA Ambition	Doing ordinary extraordinary well	Various	230	230	Cluster Deputy Chief Executive
WAHT QIPP support	Other	Worcestershire Acute	10,000	9,500	R&B CCG / WF CCG / SW CCG
R&B CCG / WF CCG / SW CCG	JSR / Out of Hospital Care	R&B CCG / WF CCG / SW CCG	0	3,855	R&B CCG / WF CCG / SW CCG
R&B CCG / WF CCG / SW CCG	QIPP Other	Various	1,424	1,424	R&B CCG / WF CCG / SW CCG
Total			**13,614**	**16,969**	

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Draft West Mercia Cluster of PCTs Corporate Objectives
REPORT AUTHOR :	Brian Hanford, Director of Finance
PRESENTED BY:	Brian Hanford, Director of Finance
PURPOSE OF REPORT:	To secure Board agreement to and endorsement of the corporate objectives attached as Annex 1, and to note the proposal to develop a Corporate Risk Register/Board Assurance Framework
KEY POINTS:	The paper proposes a draft set of corporate objectives for the West Mercia Cluster which would be applicable for the remainder of the 2012/13 financial year. In addition the development of the corporate objectives for the cluster will facilitate the creation of a Corporate Risk Register/Board Assurance Framework which is an essential element for ensuring a sound and effective system of internal control and providing assurance to the Board around risk management arrangements. As part of the Governance Framework the Board will need to accept and endorse the corporate objectives.
RECOMMENDATION TO THE BOARD:	The Board is asked to discuss and comment on the corporate objectives and subject to any such comments approve and endorse them. The Board is also asked to note and endorse the proposal to develop a Corporate Risk Register/Board Assurance Framework.

CONTEXT & IMPLICATIONS	
Strategic Objectives	The creation of the West Mercia Cluster of PCTs is characterised by its clear commitment to the following key areas which also link in to the ambitions articulated by the Midlands and East Strategic Health Authority: • Delivering for today • Building for the future • Supporting staff The development of cluster wide corporate objectives will help to ensure that there is a clear connection between the purpose of the cluster during the transition and its focus over the coming year.
Financial	None identified as work currently undertaken within existing resources.
Legal	Will ensure the Cluster PCTs will fulfil their statutory obligations and contribute to the implementation of the Health and Social Care Act. The report supports the NHS Constitution with specific reference to accountability and good governance and is underpinned by appropriate legal and regulatory processes.
Risk & Assurance	Once the corporate objectives have been agreed by the Board a Board Assurance Framework will be developed which will identify critical risks and key controls and assurances.
HR, Equality & Diversity	No specific issues in relation to Equality and Diversity arise from this report although the importance of effective Equality and Diversity processes in relation to strong governance are well recognised.
National Policy	Compliant
Carbon/Sustainability	N/A
Partnership	Supports partnership arrangements.

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Reviewed and discussed at Audit Committee on 2 May 2012 when it was agreed that proposals would be brought to the Board for discussion

INTRODUCTION

The purpose of this report is to propose a draft set of corporate objectives for the West Mercia Cluster of PCTs which would be applicable for the remainder of the 2012/13 financial year.

In addition, the development of the corporate objectives for the Cluster will enable the creation of a Corporate Risk Register/Board Assurance Framework which will include a column linking the BAF to the Cluster's key objectives.

KEY POINTS

It is important that the Cluster's key objectives are clearly understood and accepted throughout the PCT organisations and by our Partners. As the Cluster continues to delegate more and more duties and responsibilities to its sub-committees in preparation for the development of their emerging successors the Board needs to be very clear about its own role during this process and to identify its corporate aims and priorities over this critical year.

The Board is very much aware of and committed to the need to significantly improve quality and safety in services and supporting the patient revolution. Equally, it wishes to ensure the continuing delivery and future capacity/capability to meet the QIPP challenges across West Mercia and maintaining performance during transition.

The draft corporate objectives at Annex 1 bring these highly important strands together. They demonstrate the connection between the purposes of the Cluster, the Cluster ambitions and the draft corporate objectives.

Once the corporate objectives have been agreed a Corporate Risk Register/ Board assurance Framework will be developed and brought to the Board meeting in July 2012. This will address high level and strategic risks. Operational risks, including risks associated with individual PCTs will be included within Directorate Risk Registers that will be monitored and reviewed on a regular basis.

RECOMMENDATIONS

Members of the Board are invited to agree and endorse the corporate objectives as set out in Annex1 and note the proposed development of a Corporate Risk register/ Board Assurance Framework

ANNEX 1

WEST MERCIA – CORPORATE OBJECTIVES		
OBJECTIVE	**KEY RESULT AREAS/PERFORMANCE MEASURE**	**MILESTONES**
1. **To ensure the improvement in the quality and safety of services and patient experience during 2012/13**		
1.1 Key service improvement areas are: • Dementia and care of older people • Support to carers • Military and Veteran's health • Health Visitors and Family Nurse Partnerships	Set out in NHS Operating Framework 2012/13	March 2013
1.2 Delivery against the key National Performance measures across the Cluster within the 5 key domains: • Preventing people from dying prematurely • Enhancing quality of life for people with long term condition • Helping people to recover from episodes of ill health or injury • Ensuring that people have a positive experience of care • Treating and caring for people in a safe environment and protecting them from avoidable harm.	Improved delivery against National Performance measures, especially A&E, RTT and C Difficile Successful implementation of SHA ambitions relating to avoidable pressure ulcers, MECC, improving the quality of primary care and patient revolution (specific performance measures are being set out for each ambition)	Monthly/Year End Monthly/Year End
2. **To ensure the continuing delivery and future capacity/capability to meet the QIPP Challenge across West Mercia and maintaining performance during transition**	Agreement of Integrated System Plan by key stakeholders Evidence of increasing system wide ownership of the QIPP Challenge through participation on QIPP Boards Delivery of QIPP financial targets Successful completion of Worcestershire JSR – enabling consultation and production of an implementation plan Progression of Shropshire reconfiguration Development of the integrated system in Herefordshire Successful handover to CCG's, NCB and local H&WBs of the Integrated System plan through: • SHA/NCB sign-off of the system plan (and therefore the 2013/14 and longer-term milestones) • Cluster support to CCG, NCB and H&WB development of 2013/14 plans	April 2012 On-going Monthly December 2013 Ongoing Ongoing June 2012 March 2013
3. **To ensure the effective transition across West Mercia to the new Commissioning System**	Establishment of Commissioning Support Services Authorisation of Clinical Commissioning Groups Development of NCB operating model (as guided by the NCB) to enable smooth handover of functions Effective NHS input to Health and Well Being Boards (measure Cluster attendance) Effective transfer of Public Health function to Local Authorities (measure agreement of staff transfer and financial baselines) Providing an effective legacy handover and business continuity to the receiving organisations	April through to October 2012 July 2012 through to October 2012 March 2013 On-going March 2013 March 2013

ANNEX 1

4.	**To provide effective leadership and support to staff**	On-going staff survey feedback NHS Staff Survey Establishing new commissioning arrangements in shadow form (subject to receiving organisation requirements) Managing the transition into the new receiving organisations	Bi-monthly Annually October 2013 March 2013
5.	**To ensure that each of the 4 PCTs meets its statutory financial duties and control targets**	Financial Outturn Delivery of running cost targets	March 2013
6.	**To deliver effective Cluster and System wide Leadership**	Board Assessment Stakeholder organisation feedback including, through SHA ambitions, to radically strengthen partnerships with LAs System wide performance and QIPP delivery	On-going/annual appraisal On-going Monthly/Year End Outturn

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Acute Stroke Services for Worcestershire.
REPORT AUTHOR :	Simon Hairsnape, Chief Operating Officer, Wyre Forest Clinical Commissioning Group and Redditch and Bromsgrove Clinical Commissioning Group.
PRESENTED BY:	Eamonn Kelly, Cluster Chief Executive.
PURPOSE OF REPORT:	To recommend commissioning led changes to the configuration of acute stroke services in Worcestershire.
KEY POINTS:	The attached report sets out the background to the recommendation that acute stroke services for Worcestershire should be centralised at Worcestershire Royal Hospital as soon as possible so that the service can achieve the infrastructure and processes recommended by the National Stroke Strategy and NICE guidance. This proposal will combine good access for the whole of Worcestershire with the benefits of centralisation of the service, including a larger critical mass of patients and staff. This change should lead to improvements in mortality, reductions in length of stay for people with stroke and reduced long-term disability. The Worcestershire Health Overview and Scrutiny Committee (HOSC) considered the proposal at its meeting of 22nd May and supported the recommendations.

RECOMMENDATION TO THE BOARD:	It is recommended that: a) Acute stroke services for Worcestershire should be centralised at Worcestershire Royal Hospital as soon as possible; b) A detailed plan for this change, including clear timescales for i) infrastructure changes, ii) achievement of expected performance targets and iii) any transitional arrangements required, should be developed by Worcestershire Acute Hospitals NHS Trust as soon as possible; c) Discussions should take place with the West Midlands Ambulance Service NHS Trust, University Hospitals Birmingham NHS Foundation Trust and Dudley Group NHS Foundation Trust about the implications of the proposed change for their services, and with NHS Warwickshire about implications for its population.

CONTEXT & IMPLICATIONS	
Strategic Objectives	The proposed changes will ensure that local acute services can achieve the standards of patient care recommended by the National Stroke Strategy and NICE guidance.
Financial	If the recommendations are approved Worcestershire Acute Hospital NHS Trust will put forward a detailed implementation plan designed to deliver the required changes as soon as possible. No specific financial implications are known but likely costs are expected to be accommodated within existing budgets.
Legal	The PCT believes that it has satisfied its responsibilities under Section 242 of the NHS Act 2006 i.e. the duty to involve.
Risk & Assurance	Both the PCT and Worcestershire Acute Hospitals NHS Trust believe that the recommended changes are required to deliver the expected standards of care for patients.

HR, Equality & Diversity	No specific implications known at this time.
National Policy	The recommendations support national policy e.g. the National Stroke Strategy and NICE guidance and are required to deliver national performance standards for stroke services.
Carbon/Sustainability	No specific implications known at this time however transport issues will need to be considered through the implementation plan.
Partnership	The recommendations are fully supported by Worcestershire Acute Hospitals NHS Trust.

NHS WORCESTERSHIRE

ACUTE STROKE SERVICES FOR WORCESTERSHIRE – 2012 OPTION APPRAISAL

BACKGROUND

1 Stroke is a significant cause of death and long-term disability. Implementing the improvements to stroke services described in the National Stroke Strategy and NICE guidance within Worcestershire should save 58 emergency admissions. If this reduction carries through to a similar reduction in deaths, then 44 deaths from stroke would be saved along with significantly reduced long-term disability.

2 Stroke services for Worcestershire were the subject of an option appraisal in June 2011[1]. The conclusion reached at that time was that centralisation of acute stroke services at Worcestershire Royal Hospital had the potential to give the highest quality of acute stroke care for Worcestershire. Delivery of this option was considered to be very difficult to achieve and may require identifying another service which could move off the Worcestershire Royal Hospital site. Actively working to improve services at both Worcestershire Royal Hospital and the Alexandra Hospital was therefore recommended.

3 The 2011 option appraisal also recommended that measures of the expected improvement by March 2012 should be agreed with Worcestershire Acute Hospitals NHS Trust and that the option appraisal should be repeated by the summer of 2012 at the latest. A further recommendation was that "If services of appropriate quality are not achieved on both sites then option B (acute stroke services at Worcestershire Royal Hospital) should be seriously considered and more detailed work undertaken regarding its feasibility".

4 Since June 2011 improvements to stroke care for Worcestershire residents have been achieved. The proportion of eligible patients receiving thrombolysis within 60 minutes of arrival has increased from 50% (Q1[2]) to 67% (Q3) and the proportion of patients admitted directly to a stroke unit has increased from 50% (2010/11 Q4) to 70% (2011/12 Q3). Despite these improvements, Worcestershire is still not achieving key performance standards for the quality of care of people with stroke (Appendix 1). Areas such as London which have put in place the infrastructure and processes recommended by the National Stroke Strategy and NICE are now exceeding most key performance targets and have seen significant reductions in post-stroke mortality and length of stay in hospital (Q3 SINAP data; NHS Midlands and East 2012[3])

5 Structural issues which have proved particularly difficult in Worcestershire are:

a. Capacity pressures on all beds, especially at Worcestershire Royal Hospital;

b. Appointment to a consultant stroke specialist post was not made and so the Trust continues to have only 1 wte consultants at Worcestershire Royal Hospital (WRH) and 0.8 wte general physician with an interest in stroke the Alexandra Hospital. To support these individuals, the Trust has secured 1 wte locum stroke consultant and 1 wte locum Specialist Registrar at WRH and 1 wte locum consultant at the Alexandra Hospital. It has not proved possible to establish county-wide ward rounds by a senior member of the stroke team at weekends although this is under development.

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[1] The full report of the 2011 Option Appraisal is available from Menna.Wyn-Wright@worcestershire.nhs.uk

[2] 'Q' = Quarter of 2011/12 unless otherwise stated.

[3] *'Proposal for a review of stroke services in the three SHA areas of NHS Midlands and East'.* R Harris, 26 January 2012

c. Therapy staff are not available at weekends to undertake rehabilitation assessments of stroke patients on either site.

6 Two other issues also prompted the review of the 2011 option appraisal. Firstly, results from the model adopted in Scarborough[4] caused some people to question the decision in June 2011 that "The option of thrombolysis being provided on two sites with acute stroke beds on one site only was not considered clinically viable and so was not evaluated" even though this model does not fit with the National Stroke Strategy and NICE recommendations.

7 Secondly, the reductions in length of stay on acute stroke units being achieved elsewhere in the country led to questions of whether the current capacity at Worcestershire Royal Hospital (the preferred option in June 2011) could be sufficient for Worcestershire. Average length of stay of patients discharged from Worcestershire Acute Hospitals NHS Trust between April 2011 and January 2012 with a diagnosis of ischaemic or haemorrhagic stroke were 15 and 13 days respectively. North Central London has reported a reduction in average length of stay from 15 to 11.5 days with approximately 40% patients being discharged directly to home from a hyper-acute stroke unit[5]. Similar reductions in length of stay at Stoke and Bournemouth were reported to the Evaluation Team. If acute stroke services for Worcestershire were located in Worcestershire Royal Hospital, the nearest hospital for an increased proportion of North Worcestershire and Wyre Forest residents would be either the Queen Elizabeth Hospital, Birmingham or Russells Hall Hospital, Dudley. (Some patients from these areas already go to these hospitals.) This would reduce the capacity required at Worcestershire Royal Hospital.[6]

8 The Evaluation Team was aware of the Joint Strategic Review taking place in Worcestershire. The Team was advised that the Joint Strategic Review was aware of, and would take account of, the outcome of the option appraisal for stroke services.

OPTION APPRAISAL

9 The 2012 option appraisal built on the work undertaken in 2011. An expanded Evaluation Team with representatives of patients, providers, commissioners and external clinical advisers (Appendix 2) met on 4th April 2012. Information additional to that considered by the 2011 option appraisal is listed in Appendix 3. The group used the same evaluation criteria (Appendix 4) which have also been used in other NHS Worcestershire option appraisals. The weightings developed in 2011 were reviewed.

10 The three options for the siting of Worcestershire's acute stroke services from 2011 were considered again:

A Worcestershire Royal Hospital (WRH) and Alexandra Hospital (AH);

B Worcestershire Royal Hospital;

C Alexandra Hospital.

11 An additional option was also considered:

D Thrombolysis at both WRH and AH but acute stroke unit on one site only.

On the other site post-thrombolysis patients would remain on the coronary care unit for approximately 24 hours until they were fit enough to transfer to the acute stroke unit.

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[4] Volans AP, European Medical Journal, 2011, 10.1136/emermed-2011-200223

[5] *'Proposal for a review of stroke services in the three SHA areas of NHS Midlands and East'.* R Harris, 26 January 2012

[6] Approximately 10% of Worcestershire residents currently travel out of county for acute services because of out of county hospitals are nearer. The maximum estimated flow of stroke patients out of county if acute stroke services were based in Worcester is 30%. In practice, the increased out of county flow is likely to be less than this as there is little difference in distance travelled for many of this 30%.

12 The extent to which each option met each evaluation criterion was scored between 0 and 10. Zero indicated that the criterion was not met at all and 10 that it was met to the fullest possible extent. The 2012 process reviewed the scores allocated to options A, B and C in 2011 and considered whether these should be changed in view of the information now available. Option D was scored for the first time. Participants discussed and agreed the scores for each option, initially in four groups and then as a single group. Weighted scores were then calculated.

EVALUATION

13 Table 1 gives the weights developed by the 2012 Team and the agreed scores for each option. Appendix 5 gives more detail of the issues considered in reaching each score and reasons for changes from the 2011 scoring. The evaluation showed that siting acute stroke services for Worcestershire at Worcestershire Royal Hospital was the preferred option. As in 2011, this option combined good access for the whole of Worcestershire (Appendix 6) with the benefits of centralisation of the service, including a larger critical mass of patients and staff. The scoring for 'ease of delivery' was higher than in 2011 though, because of the data now available on expected length of stay. When combined with the anticipated shift of a small proportion patients to out of county hospitals because of proximity to their home, this suggests that capacity at Worcestershire Royal Hospital acute stroke unit may be sufficient for Worcestershire patients with stroke **if** the service had the infrastructure and processes recommended by the National Stroke Strategy and NICE guidance. Achieving this change would be challenging and some transitional arrangements will be needed.

Table 1 Scoring of Options

	Criteria	Weight	Option A WRH & AH		Option B WRH only		Option C AH only		Option D	
			Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
1	Improved clinical quality of services in line with meeting national, regional and local policy imperatives	34	5	170	8	272	7.5	255	2	68
2	Better access to services	15	9	135	7	105	5	75	4.5	67.5
3	Development of existing services and/or provision of new services	12	5	60	8	96	8	96	4	48
4	Improved strategic fit of services	10	6	60	7	70	7	70	5	50
5	Meeting training, teaching and resource needs	9	3	27	8	72	7	63	4	36
6	Making more effective use of resource	12	3	36	8	96	8	96	3	36
7	Ease of delivery	8	5	40	6	48	3	24	3	24
Total		**100**		**528**		**759**		**679**		**329.5**

14 For some options it was difficult for the group to reach agreement on the scoring and Appendix 7 gives some sensitivity analysis for scores which were difficult to agree. Appendix 7 also includes an analysis of the 2012 scores with the 2011 weightings. Option B, centralisation of acute stroke services at Worcestershire Royal Hospital, remains the preferred option throughout these analyses.

RECOMMENDATIONS

15 The Evaluation Team therefore recommended that:

a. Acute stroke services for Worcestershire should be centralised at Worcestershire Royal Hospital as soon as possible so that the service can achieve the infrastructure and processes recommended by the National Stroke Strategy and NICE guidance. This option combines good access for the whole of Worcestershire with the benefits of centralisation of the service, including a larger critical mass of patients and staff. This change should lead to improvements in mortality, reductions in length of stay for people with stroke and reduced long-term disability. The Health Overview and Scrutiny Committee (HOSC) will be informed of the options considered, the appraisal process, details of those involved and the preferred service option. HOSC will be asked to consider whether the process undertaken has sufficiently met its duty to consult and engage public and patients on service options or whether public consultation is required;

b. A detailed plan for this change, including clear timescales for a) infrastructure changes, b) achievement of expected performance targets and c) any transitional arrangements required, should be developed by Worcestershire Acute Hospitals NHS Trust as soon as possible;

c. Discussions should take place with the West Midlands Ambulance Service NHS Trust, University Hospitals Birmingham NHS Foundation Trust and Dudley Group NHS Foundation Trust about the implications of the proposed change for their services, and with NHS Warwickshire about implications for its population.

APPENDIX 1 ACHIEVEMENT OF KEY PERFORMANCE TARGETS FOR STROKE SERVICES

Target:

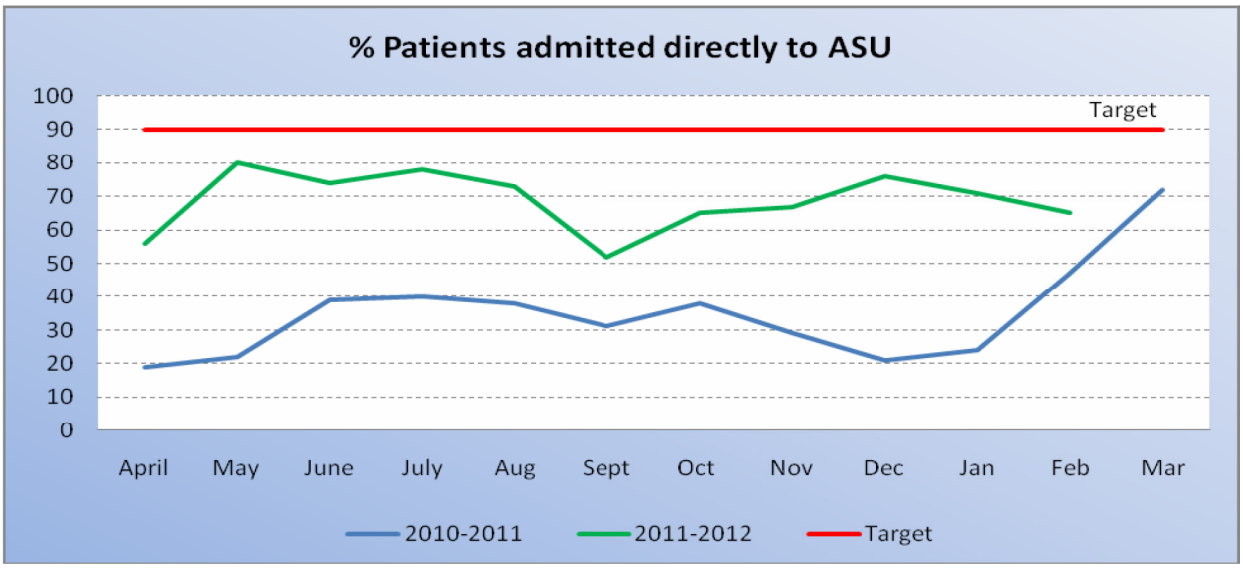
90% of patients with confirmed stroke will be admitted to a stroke unit within four hours of arrival at hospital.

See SINAP report for Q3 figures on the above measure.

Table below details direct admission only to an acute stroke unit.

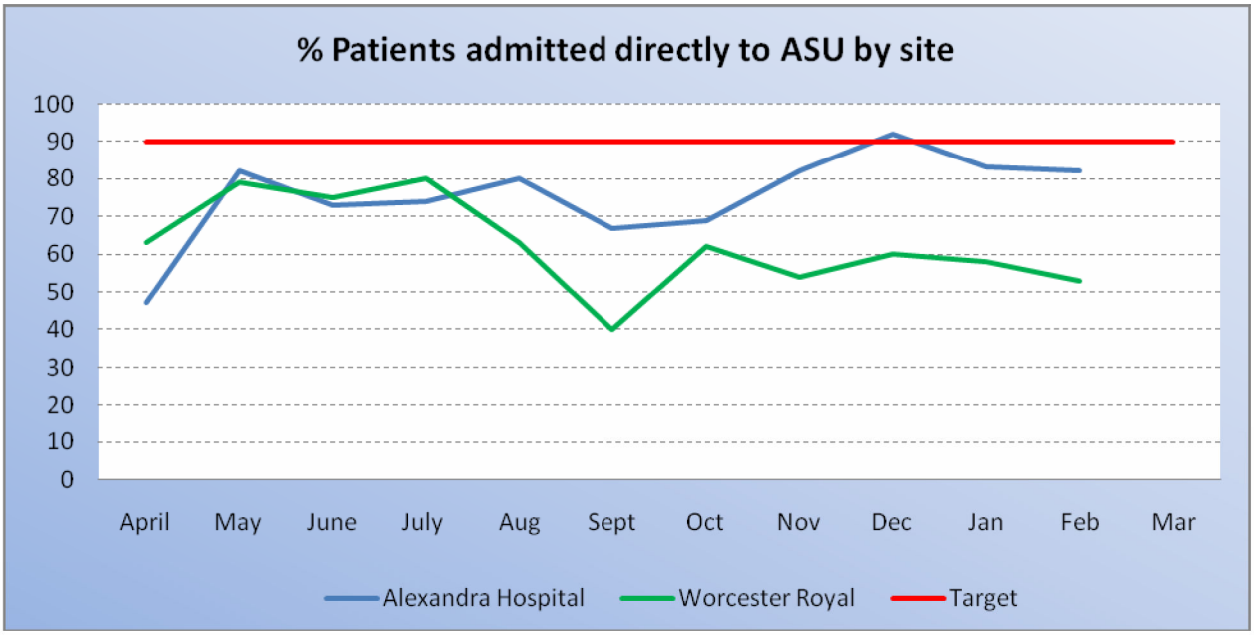
Trust wide figures:

2010	%	2011	%	2012	%
April	19	Jan	24	Jan	71
May	22	Feb	47	Feb	65
June	39	March	72		
July	40	April	56		
Aug	38	May	80		
Sept	31	June	74		
Oct	38	July	78		
Nov	29	Aug	73		
Dec	21	Sept	52		
		Oct	65		
		Nov	67		
		Dec	76		



Hospital Figures:

2011/12	Alex	Worcester
April	47	63
May	82	79
June	73	75
July	74	80
Aug	80	63
Sept	67	40
Oct	69	62
Nov	82	54
Dec	92	60
Jan	83	58
Feb	82	53

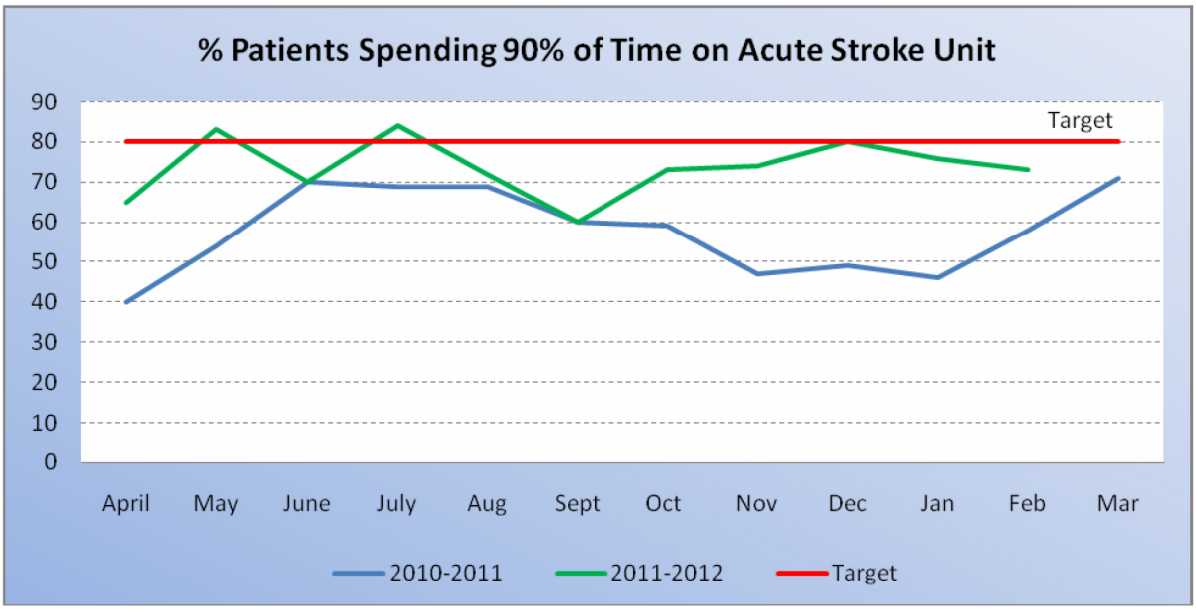


Target:

80% of stroke patients will spend 90% of their time on an acute stroke unit.

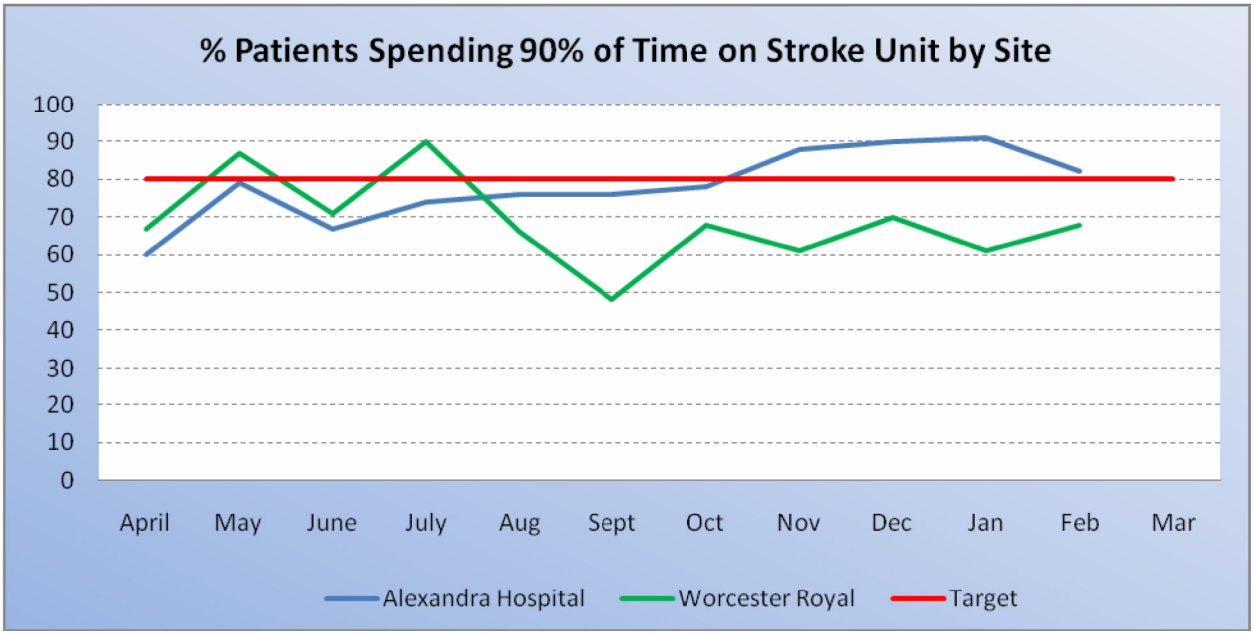
Trust-wide figures:

2010	%	2011	%	2012	%
April	40	Jan	46	Jan	75.7
May	54	Feb	58	Feb	73.2
June	70	March	71		
July	69	April	65		
Aug	69	May	83		
Sept	60	June	70		
Oct	59	July	84		
Nov	47	Aug	72		
Dec	49	Sept	60		
		Oct	73		
		Nov	74		
		Dec	80		



Hospital Figures:

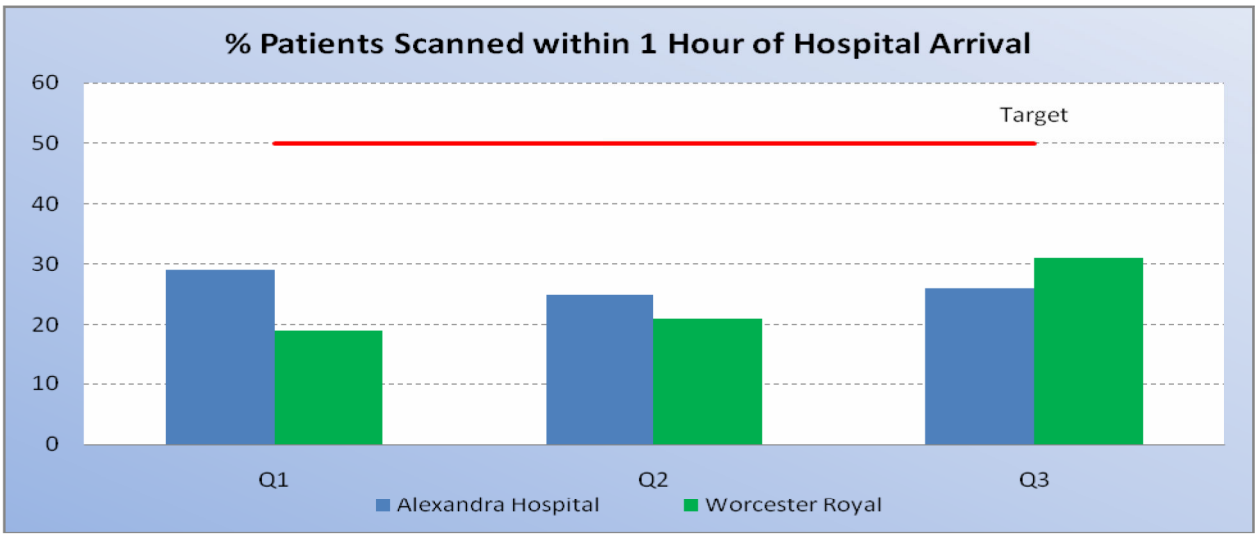
2011/12	Alex	Worcester
April	60	67
May	79	87
June	67	71
July	74	90
Aug	76	66
Sept	76	48
Oct	78	68
Nov	88	61
Dec	90	70
Jan	91	61
Feb	82	68



Target:

50% of all patients with a confirmed stroke will have a scan within one hour of arrival at hospital.

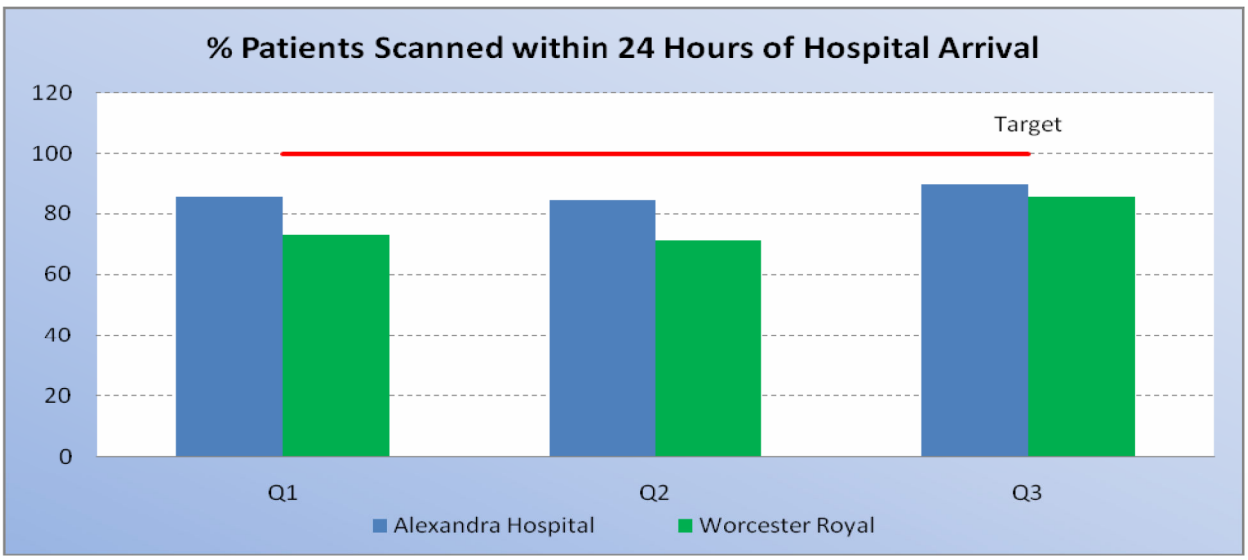
2011/12	Q1	Q2	Q3
Alex	29%	25%	26
WRH	19%	21%	31



Target:

100% of all patients with a confirmed stroke will have a scan within 24 hours of arrival at hospital.

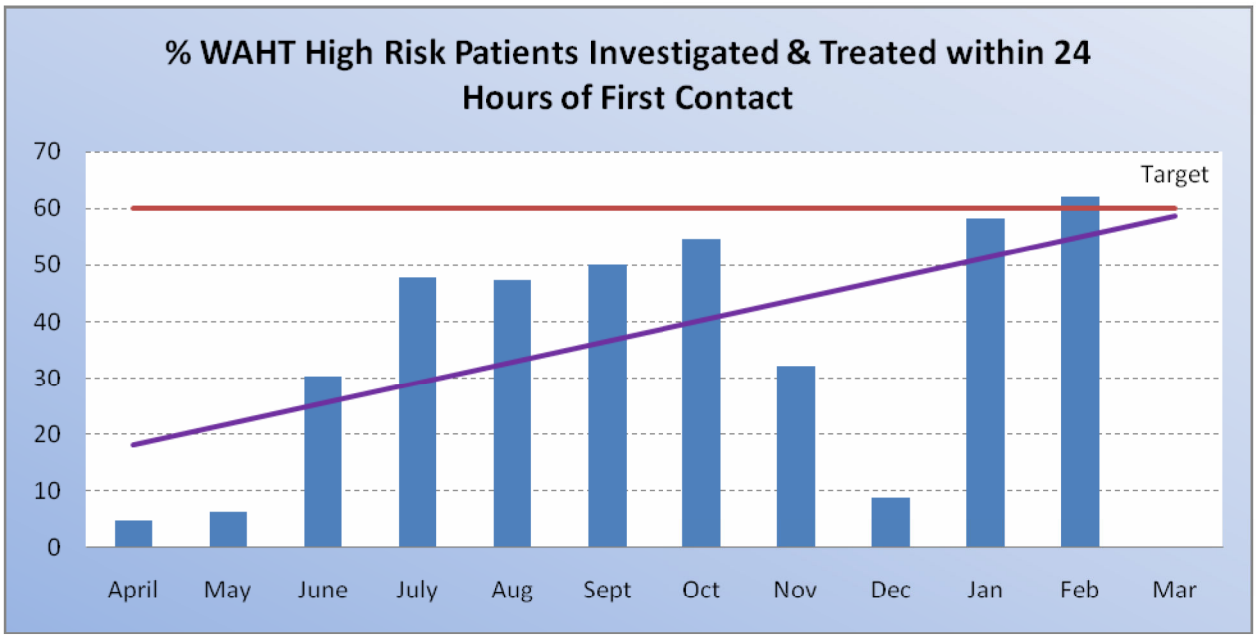
2011/12	Q1	Q2	Q3
Alex	86%	85%	90%
WRH	73%	71%	86%



Target:

60% of high risk TIA patients are investigated and treated with 24 hours of first contact with a health professional.

2011/12	WAHT
April	4.8
May	6.3
June	30.4
July	47.8
Aug	47.4
Sept	50
Oct	54.5
Nov	32.1
Dec	8.7
Jan	58.3
Feb	62



APPENDIX 2 EVALUATION TEAM

Attendees – Option Appraisal Workshop – 4th April 2012

NAME	TITLE	ORGANISATION
Dr Janette Adams	Patient Representative	Herefordshire & Worcestershire Cardiac and Stroke Board/LINK Member
Dr Ashok Asokan	Stroke Consultant	Worcestershire Acute Hospitals NHS Trust
Dr Stuart Bourne	Consultant in Public Health	NHS Worcestershire
Richard Brine	Patient Representative	Wyre Forest Resident
Paul Bytheway	General Manager, Medicine and Emergency Care	Worcestershire Acute Hospitals NHS Trust
Debbie Cannon	Stroke Specialist Nurse	Worcestershire Acute Hospitals NHS Trust
Zena Dalton	General Manager – Alexandra Hospital Site	Worcestershire Acute Hospitals Trust
Ruth Davoll	Programme Lead Clinical Development	NHS Worcestershire
Jane Eminson	Facilitator	
Helen Evers	Secretary to Programme Leads	NHS Worcestershire
Simon Hairsnape	Chief Operating Officer, Redditch and Bromsgrove Clinical Commissioning Group, Wyre Forest Clinical Commissioning Group	NHS Worcestershire
Emma Hall-Robinson	Clinical Lead, Neurology & Rehabilitation	Worcestershire Acute Hospitals NHS Trust
Fay Harrison	Programme Lead NHS Worcestershire /Service Improvement Manager Network	NHS Worcestershire
Nick Henry	General Manager, West Mercia	West Midlands Ambulance Service
Ann Hill & Keith Hill	Patient Representative	North Worcestershire Resident
Karen Hunter	Head of Quality and Patient Safety	NHS Worcestershire
Dr Damian Jenkinson	National Clinical Lead - Stroke	NHS Stroke Improvement
Dr Rose Johnson	Asst Medical Director	Worcestershire Acute Hospitals NHS Trust
Mary Jordan	Stroke Nurse Specialist	Worcestershire Acute Hospitals NHS Trust
Dr Anthony Kelly	GP representative	South Worcestershire
Jon Lofthouse	Director of Emergency Care	Worcestershire Acute Hospitals NHS Trust
Fiona Lunn	Nurse Consultant Stroke	University Hospital of North Staffordshire NHS Trust
Mr Richard Morrell	Emergency Department Consultant	Worcestershire Acute Hospitals NHS Trust
Dr Indira Natarajan	Stroke Consultant	University Hospital of North Staffordshire NHS Trust
Harrison Riley	Commissioning Manager	NHS Worcestershire

NAME	TITLE	ORGANISATION
Dr Phil Sanmugunathan	Stroke Consultant	Worcestershire Acute Hospitals NHS Trust
Dr Mark Talbot	GP representative	North Worcestershire
Menna Wyn-Wright	Programme Lead NHS Worcestershire/ Service Improvement Manager Network	NHS Worcestershire
Brendan Young	Patient Representative	Worcestershire Resident

APPENDIX 3 ADDITIONAL INFORMATION CONSIDERED

Listed below is the information considered for the 2012 option appraisal which was additional to that considered in 2011. Copies of these reports are available on request from Menna.Wyn-Wright@worcestershire.nhs.uk . A list of information considered in 2011 is given as Appendix 3 of the 2011 Option Appraisal report.

Worcs Stroke 2012 Background Report (pdf)

Annex 1 – Worc Acute Stroke Service – Option Appraisal 2011 Final Report (pdf)

Annex 2 - Thrombolysis Analysis (pdf)

Annex 3 - WAHT Briefing Summary on SINAP Q3 2011-12 (pdf)

Annex 4 – London Stroke Service (pdf)

Annex 5 – Scarborough Model (pdf)

Annex 6 - Travel Time Zones 30.03.2012 (Word)

Thrombolysis Time and Effect (Word)

Annex 2 - RWP – Worcestershire Acute Hospitals NHS Trust Stroke Activity 2011-2012 – Stroke Diagnosis Type by Site April- 11 – Jan-12 (Excel)

Annex 2 - RWP – Worcestershire Acute Hospitals NHS Trust Stroke Activity 2010-2011 – Stroke Diagnosis Type by Site April- 10 – May-11 (Excel)

APPENDIX 4 EVALUATION CRITERIA

Criteria
Improved clinical quality of services in line with meeting national, regional and local policy imperatives: a. Providing the best opportunity to enhance the quality of clinical services and teaching; b. Providing better health outcomes for patients; c. Facilitating modernisation, improvement and innovation in clinical practice and teaching; d. Enabling new methods of providing clinical care and undertaking teaching; e. Facilitating better configuration of services extending to the local health economy; f. Addressing existing clinical problems; g. Promoting new models for delivering services; h. Promoting other national teaching and health priorities; i. Flexibility to cope with future changes in service models / patterns; j. Enabling better integration of services including with social and voluntary care.
Better access to services: a. Increasing the provision of care close to people's homes; b. Travelling time by public and private transport for both patients and staff; c. Availability of car parking / accessibility of public transport; d. Equality of access (different catchments, ethnic and socioeconomic groups); e. Greater responsiveness and choice in the delivery of patients' health needs f. Minimising the environmental impact of the solution. g. Ensuring flexible working practices are implemented to enable better patient access, choice and convenience of service.
Development of existing services and/or provision of new services: a. Developing or providing services required by commissioners of clinical services; b. Contributing to an increase in the quantity of clinical services available; c. Ensuring the widest availability of services locally.
Improved strategic fit of services: a. Meeting strategic needs of the locality and region for clinical services; b. Contributing to the social and economic regeneration of the local area; c. Improving the quality of service relationships and departmental links; d. Realising benefits of inter-dependence with other services; e. Promoting opportunities for collaboration and the development of partnerships with other local facilities and businesses in the delivery of services; f. Providing flexibility to cope with changes in demand and changes in the delivery of services.
Meeting training, teaching and resource needs: a. Making it easier to recruit staff; b. Making it easier to retain staff; c. Enabling the development of a clear "skills escalator" to engage all staff; d. Meeting or protecting accreditation standards; e. Improving productivity; f. Providing social and cultural facilities and environments for staff.
Making more effective use of resource: a. Making better use of cash, human and estate resources; b. Meeting service needs within available resources; c. Providing opportunities for generating income, including from research funding and private practice; d. Encouraging the development of partnerships that facilitate the development of local businesses; e. Providing opportunities for transferring risk on a cost-effective basis; f. Providing better value for money overall for the public sector.

Ease of delivery:

a. Practicality of delivery of physical proposals;
b. Practicality of delivery of service proposals;
c. Timescale for implementation;
d. Impact on other local Projects;
e. Acceptability to staff;
f. Planning implications.

APPENDIX 5 ISSUES CONSIDERED IN DECIDING EACH SCORE

Criteria		Option A: WRH & AH		Option B: WRH only		Option C: AH only		Option D: Thrombolysis on both sites Acute stroke unit on one site	
		Score	Comment	Score	Comment	Score	Comment	Score	Comment
1	**Improved clinical quality of services in line with meeting national, regional and local policy imperatives**	5	2011 score was 6 with comment: *It should be possible to achieve the expected standards on both sites but this will be more difficult than if services were centralised. The number of admissions at the Alexandra Hospital is relatively small for an acute stroke service. This disadvantage could be offset by actively developing a county-wide stroke service, including staff rotation in order to ensure competences are maintained.* Score was reduced to 5 in 2012 because achieving expected standards on both sites has proved more difficult than expected.	8	A single stroke service for Worcestershire would enable the development of a team focused on the needs of patients with stroke. This should help to improve the quality of the service. The vascular service is on the WRH site and co-location should help collaboration between vascular and stroke services and associated patient pathways.	7.5	Score was 7 in 2011 with comment: *A single stroke service for Worcestershire would enable the development of a team focused on the needs of patients with stroke. This should help to improve the quality of the service.* This score was increased to 7.5 because a second CT scanner for AH has been ordered. This option did not score as highly as option B because links with vascular services would be more difficult.	2	This option does not comply with the recommendations of the National Stroke Strategy or NICE. Patients at the site without an acute stroke unit would receive thrombolysis quickly but would not be able to be admitted to an acute stroke unit - which has been shown to improve outcomes. During the initial, crucial stages patients would not be cared for by staff with specialist stroke skills. Organising rehabilitation assessments would be more difficult. Transfer to the acute stroke unit would bring associated risks.
2	**Better access to services**	9	This option gives the best access to acute stroke services for Worcestershire residents (Appendix 6).	7	This option gives an acceptable level of access to acute stroke services for Worcestershire residents (Appendix 6).	5	Access for some areas is poor and, as a result, some patients may miss the opportunity for thrombolysis (Appendix 6).	4.5	Access to thrombolysis is as good as option A but only up to 20% patients are eligible for thrombolysis. Although ambulance staff would triage as much as possible, some patients would initially be taken to the site without an acute stroke unit and then be unsuitable for thrombolysis. This option would delay access to an acute stroke unit for these patients as well as for thrombolysed patients.

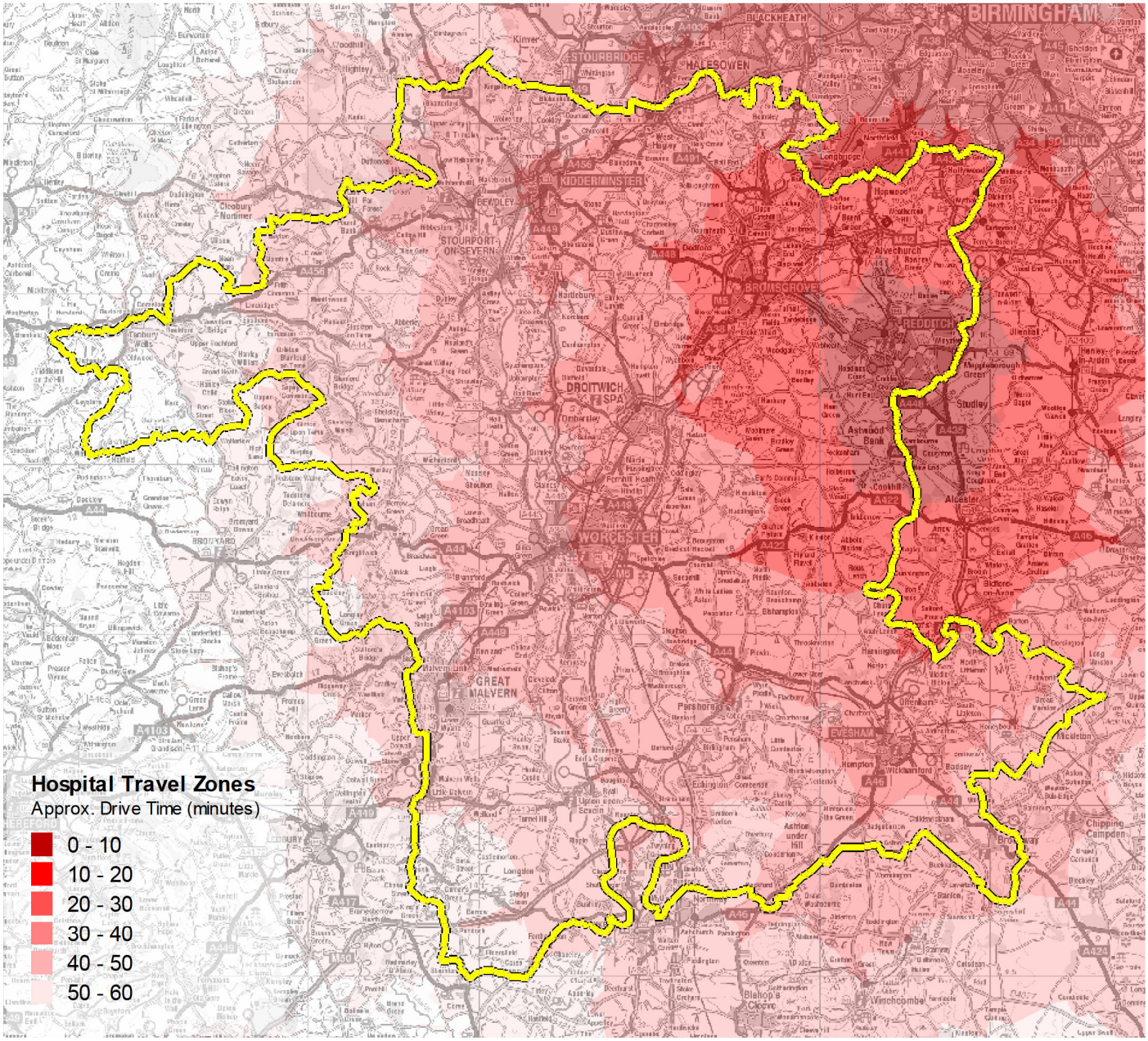
Criteria		Option A: WRH & AH		Option B: WRH only		Option C: AH only		Option D: Thrombolysis on both sites Acute stroke unit on one site	
3	**Development of existing services and/or provision of new services**	5	2011 score was 6 with comment: *This option has no impact on the development of existing services and / or new services.* Score was reduced to 5 in 2012 as improving existing services to a satisfactory level has proved so difficult which must impact on the Trust's ability to develop other new and existing services.	8	A single site stroke service would offer greater opportunity for the development of new services, especially relating to neurology and neuro-radiology.	8	A single site stroke service would offer greater opportunity for the development of new services, especially relating to neurology and neuro-radiology.	4	This option has neither the advantages to other services of an acute stroke unit on both sites (option A) nor the benefits of centralisation (options B and C)
4	**Improved strategic fit of services** **NB. The Evaluation Team noted that the outcome of the Joint Strategic Review**	6	2011 score was 7 with comment: *This option maintains the links between stroke services and A&E and acute medicine services on both sites. Patients with suspected stroke could be seen on both sites with no need for transfer.* Score was reduced to 6 in 2012 because improving services to a satisfactory level has provided difficult to achieve which reduces the benefits related to co-location with other services.	7	2011 score was 6 with comment: *A&E and acute medicine services at AH would not have access to an acute stroke service. Patients with suspected stroke who present to these services would need to transfer to WRH.* *This option would increase pressure on capacity at WRH which is already critically over-stretched.* *Links with vascular services would be easier – but these are most applicable to patients with TIA (rather than acute stroke).* Score was increased to 7 in 2012 because the predicted impact on capacity at WRH is smaller than was anticipated in 2011.	7	2011 score was 8 with comment: *A&E and acute medicine services at WRH would not have access to an acute stroke service. Patients with suspected stroke who present to these services would need to transfer to AH.* *This option would reduce bed pressure on the WRH which would be of benefit to other services for Worcestershire residents.* *The AH also offers much greater flexibility of beds and imaging capacity.* Score was reduced to 7 in 2012 because of the altered assumptions about impact on capacity at WRH.	5	This option has the benefit that A&E staff would maintain their skills and interest in care of patients with stroke on both sites. This benefit would be offset, however, by the difficulties of caring for post-thrombolysis patients outside of an acute stroke unit and the hazards and complexity of transferring post-thrombolysis patients.

Criteria		Option A: WRH & AH		Option B: WRH only		Option C: AH only		Option D: Thrombolysis on both sites Acute stroke unit on one site	
5	**Meeting training, teaching and resource needs**	3	2011 score was 4 with comment: *Recruitment of staff, especially medical staff, for the acute stroke service is difficult. (This is a common problem and not only applicable to Worcestershire.) Two, relatively small, services are likely to find recruitment and retention of staff more difficult than a centralised service.* Score was reduced to 3 in 2012 because improving stroke services on two sites has proved even more difficult than anticipated in 2011.	8	A centralised service should make recruitment and retention of staff easier. Worcestershire Acute Hospitals NHS Trust finds that, in general, recruitment to consultant posts at WRH is easier than to posts at AH.	7	A centralised service should make recruitment and retention of staff easier.	4	Recruitment, especially of stroke physicians, may be more difficult if Worcestershire operates a service model which is outside of the National Stroke Strategy and NICE guidance. Recruitment of other staff to the acute stroke unit would have the benefits of centralisation (options B and C).
6	**Making more effective use of resource**	3	2011 score was 4 with comment: *Running two separate services is a less efficient use of all resources.* Score was reduced to 3 in 2012 because of the impact of failure to achieve key performance targets on Trust income.	8	A centralised service would make better use of resources than a two site service. Many of the resources needed for the acute stroke service are already available at WRH. This advantage is offset by the limited space to expand the WRH service.	8	A centralised service would make better use of resources than a two site service. This option would make good use of available capacity at the AH site. This advantage is offset by a potential loss of income as patients from South Worcestershire may be closer to other hospitals providing acute stroke care and so may not access the service.	3	This option has similar disadvantages to option A. There would be benefits of centralisation of the acute stroke unit (as in options B and C). This benefit would be offset, however, by the difficulties of caring for post-thrombolysis patients outside of an acute stroke unit and the hazards and complexity of transferring post-thrombolysis patients.

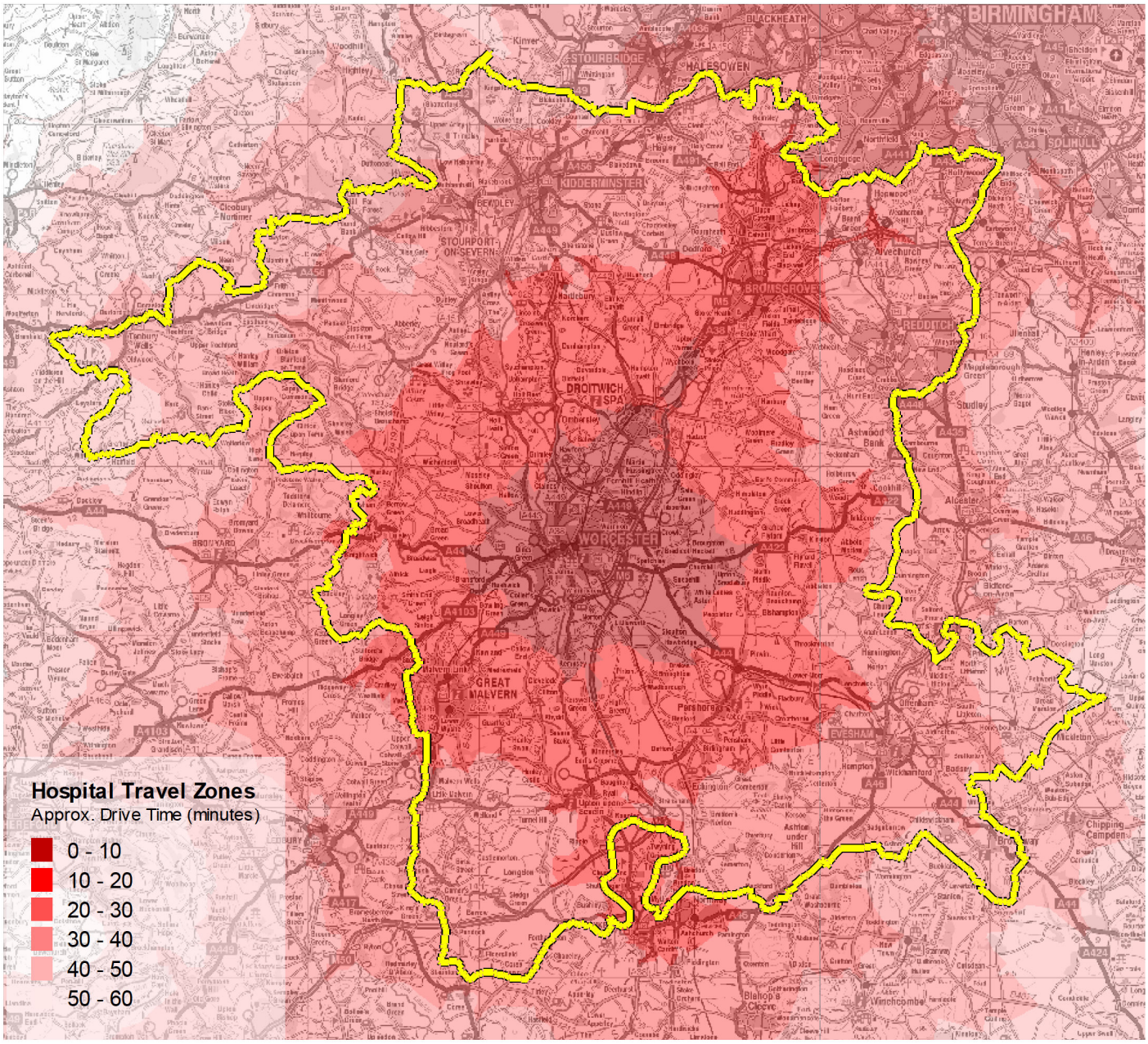
Criteria		Option A: WRH & AH		Option B: WRH only		Option C: AH only		Option D: Thrombolysis on both sites Acute stroke unit on one site	
7	**Ease of delivery**	5	2011 score was 9 with comment: *This option should be deliverable given significant commitment, energy and hard work.* *Recruitment of stroke consultants is likely still to be difficult.* Score was reduced to 5 in 2012 because this option has proved much harder than anticipated to implement.	6	2011 score was 1 with comment: *The A&E service at WRH would need to cope with the additional patients.* *Bed capacity for a Worcestershire stroke service is not at available at WRH. This option would require identifying another service which could be moved to the AH and public consultation on the move of this service.* Score was increased to 6 in 2012 on the expectation that capacity at WRH could be sufficient (given appropriate transitional arrangements).	3	2011 score was 1 with comment: *The A&E service at AH would need to cope with the additional patients.* *Public opposition to this option is already apparent. Given the poor access for people from parts of Worcestershire, this option would be difficult to justify during public consultation.* This score was increased to 3 in 2012. The group considered that the score in 2011 had been unreasonably harsh and that public opposition, although likely, could be overcome.	3	The likelihood of public opposition was considered to be similar to option C.

APPENDIX 6 TRAVEL TIMES

TRAVEL TIME ZONES TO THE ALEXANDRA HOSPITAL



TRAVEL TIME ZONES TO THE WORCESTERSHIRE ROYAL HOSPITAL



APPENDIX 7 SENSITIVITY ANALYSES

Scores for some options against some criteria proved difficult to agree. Where agreement was difficult, tables 2 and 3 show the lowest and highest scores respectively. Scores which are different from those in table 1 are shaded.

Table 2 Sensitivity Analysis – Lowest Scores

Criteria		Weight	Option A WRH & AH		Option B WRH only		Option C AH only		Option D	
			Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
1	Improved clinical quality of services in line with meeting national, regional and local policy imperatives	34	5	170	8	272	7	238	2	68
2	Better access to services	15	9	135	7	105	5	75	4	60
3	Development of existing services and/or provision of new services	12	5	60	8	96	8	96	4	48
4	Improved strategic fit of services	10	6	60	7	70	7	70	5	50
5	Meeting training, teaching and resource needs	9	3	27	8	72	7	63	4	36
6	Making more effective use of resource	12	3	36	8	96	7	84	3	36
7	Ease of delivery	8	5	40	3	24	3	24	3	24
Total		**100**		**528**		**735**		**650**		**322**

Table 3 Sensitivity Analysis – Highest Scores

Criteria		Weight	Option A WRH & AH		Option B WRH only		Option C AH only		Option D	
			Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
1	Improved clinical quality of services in line with meeting national, regional and local policy imperatives	34	5	170	8	272	8	272	2	68
2	Better access to services	15	9	135	7	105	5	75	5	75
3	Development of existing services and/or provision of new services	12	5	60	8	96	8	96	4	48
4	Improved strategic fit of services	10	6	60	7	70	7	70	5	50
5	Meeting training, teaching and resource needs	9	3	27	8	72	7	63	4	36
6	Making more effective use of resource	12	3	36	8	96	8	96	3	36
7	Ease of delivery	8	5	40	7	56	3	24	3	24
Total		**100**		**528**		**767**		**696**		**337**

Table 4 shows the impact of changing the criteria weightings. The 2012 scores are used with the 2011 weightings.

Table 4 2012 Scores with 2011 Weightings

Criteria		Weight	Option A WRH & AH		Option B WRH only		Option C AH only		Option D	
			Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
1	Improved clinical quality of services in line with meeting national, regional and local policy imperatives	31	5	155	8	248	7.5	232.5	2	62
2	Better access to services	20	9	180	7	140	5	100	4.5	90
3	Development of existing services and/or provision of new services	10	5	50	8	80	8	80	4	40
4	Improved strategic fit of services	12	6	72	7	84	7	84	5	60
5	Meeting training, teaching and resource needs	8	3	24	8	64	7	56	4	32
6	Making more effective use of resource	9	3	27	8	72	8	72	3	27
7	Ease of delivery	10	5	50	6	60	3	30	3	30
Total		**100**		**558**		**748**		**654.5**		**341**

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING
29 May 2012

TITLE OF REPORT:	Herefordshire Clinical Commissioning Group (HCCG)
REPORT AUTHOR :	Dr Andy Watts, HCCG Chair
PRESENTED BY:	Dr Andy Watts, HCCG Chair
PURPOSE OF REPORT:	To provide the Board with a report on the work of the Herefordshire Clinical Commissioning Group following recent meetings.
KEY POINTS:	In advance of the formal minutes being agreed a briefing of key items that were discussed at the formal meeting held on 1 May 2012 are identified at **Appendix 1** for Board members to review: Members are asked to note the ratified Minutes of the HHCC formal meeting held on 3 April 2012 in **Appendix 2.**
RECOMMENDATION TO THE BOARD:	The Board is asked to: • Note the ratified Minutes of the formal meeting held on 3 April 2012, and the key items discussed at the meeting held on 1 May 2012.
CONTEXT & IMPLICATIONS	

Strategic Objectives	Links in to Financial Strategy and delivery of QIPP National Agenda
Financial	£11m
Legal	DoH Legal Framework
Risk & Assurance	Amber
HR, Equality & Diversity	In line with national guidance
National Policy	Health and Social Care Bill Operating Framework 2012/13 Authorisation Toolkit
Carbon/Sustainability	n/a
Partnership	All PCT Directorates/Adult Social Care/ Wye Valley NHS Trust

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	West Mercia Cluster Board 28 February 2012

Appendix 1

Herefordshire Health Care Commissioning Consortium (HHCC)

Summary of the formal meeting held on 1 May 2012

The following is a summary of key points of meeting from 1 May 2012

New member appointment
The Committee welcomed Dr Richard Williams, who was recently appointed to the CCG as the Specialist Doctor for Secondary Care.

Performance and Quality
The Committee discussed the update on performance and quality issues in Herefordshire which detailed risks and areas where services are not optimum and the actions undertaken to improve quality, and mitigate those risks highlighted for particular attention:

- that Clostridium Difficile remains at the end of the year well over trajectory due to an outbreak earlier in the year;
- that there are still some issues around the Midwife to Birth ration;
- that there is still some extra work to be on breast feeding despite Herefordshire performing best in the region.

The Committee agreed to develop a cascade mechanism for infectious outbreaks in the health community.

Commissioning Update
The Committee received an update on the current issues within the NHS Commissioning arena and noted in particular progression on the NHS 111 implementation following a meeting on 20 April with the PCT and the West Midlands Project Manager.

The Committee agreed, after discussing the National Out of Hours benchmark publication and taking in to account the 111 update, that the HCCG Senior Management Team will lead on work to re-commission the walk-in centre.

The Committee also received the updated 2012 Low Priority Treatment Policy for approval agreeing to:

- the ongoing engagement with secondary care clinicians;
- a programme of engagement with primary care clinicians;
- a programme of audit and contractual implementation with providers.

Provider Landscape
The Committee received a draft business case/service development framework for use by providers proposing and the Committee agreed to the following recommendations:

- That use of the framework is a requirement for consideration of business cases/service developments
- That the completed framework's to be submitted to the CCG via the Service Improvement Group for initial consideration and scrutiny
- That a seminar is held with providers to raise profile and explain the detail

Transformation Bids
The Committee discussed the amended 2% non recurrent transformation bid. Members were not sufficiently reassured to support the bid and agreed to make recommendations around alternative investment schemes in a report to be presented to the next formal sitting of the Committee on 12 June 2012. In the meantime the members delegated authority to the COO and Chair to communicate its decision to Wye Valley NHS Trust.

Finance Updates
A summary of the revenue financial position for the devolved budgets for the period up to 31 March 2012 and an overview of the QIPP performance for 11/12 were received. The Committee noted the emerging 2012/13 risk and the next steps in accessing funding held by the Cluster and that 2012/13 budgets had been presented to the Cluster Board.

The Committee noted the update on the outturn on QIPP delivery for 11/12 and the QIPP delivery position as at month 12, the QIPP Plan delivery exception report for Commissioning noting in particular the key challenges and lessons learned in 2011/12. The Committee also received the 2012/13 QIPP update and the next steps to ensure successful implementation of the 2012/13 QIPP.

Organisational Development - Governance and Authorisation
The Committee received and noted an update of the work designed to develop a robust governance framework for the CCG, including its sub committees and agreed that the governance plan will be presented to the Committee for approval at its next formal sitting on 12 June 2012. The Committee also agreed that task and finish group would convene to develop terms of reference for sub committees for ratification on 12 June 2012.

The Committee received and noted an update of the work being undertaken by the CCG with regard to the NCB authorisation and assurance process providing detail on the evidence required and process that will be followed, as well as the potential risk areas for the CCG and timelines aimed to mitigate them.

The Committee also discussed the development of the CCG logo and brand and identified a preferred option, as well as an update on possible CCG accommodation. The Committee agreed in principle to the recommendation of Berrows Business Centre as first preference, based on initial evaluation and review of available premises, though recognised that further detailed options appraisal/business case needed to be completed and submitted to the SHA.

Appendix 2

HEREFORDSHIRE CLINICAL COMMISSIONING GROUP
FORMAL COMMITTEE MEETING

Tuesday 3 April 2012 in Room 22a, Brockington at 1.00pm.

RATIFIED M I N U T E S

Present:

Dr AW	Dr Andy Watts	GP, Chair
Dr AB	Dr Andy Black	GP, Finance and Contracting Lead
ATS	Dr Alison Talbot-Smith	Joint Clinical and Governance Lead
CG	Cathy Gritzner	Chief Operating Officer
NS	Nigel Sellar	Non Executive Director
SM	Susan Mead	Non Executive Director
In attendance (for all or part of the meeting):		
GW	Gail Williams	For the Minutes
JS	Jill Sinclair	Interim Finance Lead
AN	Andrew Nash	Programme Director of Finance
PE	Paul Edwards	Interim Contracts Lead
NW	Nicky Willett	Associate Director of Nursing, Quality and Clinical Leadership

01.04/12	**Apologies for Absence** Apologies for absence were received from: Mike Emery, Dr Ian Tait, Dr Sam Ghazawy, Chris Baird
02.04/12	**Declarations of Interest** Formal interests in relation to the Agenda were declared by: Andrew Nash in his interim role with commissioning support services for West Mercia Cluster; Cathy Gritzner was Any Qualified Provider lead for Wirrall PCT
03.04/12	**Minutes of Last Meeting** The minutes of the HHCC formal Board meeting held on Tuesday 6 March 2012 were agreed as accurate subject to the following: Under finance and activity AN asked for the following amendments: • That there are unknown risks around some volatile high volume activity; • That the statement 'NHS commissioning budget is overspent' should be replaced with 'CCG devolved budgets are overspent'; • That under QIPP (item 16) AN asked that his statement on the frail elderly should read - 'that work with substituted compensating QIPPs in relation to frail elderly'. • That the 'published guidelines on roles and responsibilities' for CCG

	Board members which SM agreed to send to Dr SG were should have read 'draft published guidelines'.
04.04/12.	**Matters Arising** The committee considered matters arising from the minutes, not otherwise included on the agenda: • Item 10 NHS 111 Service: NW stated that the minute should have read that she had raised concerns at regional level.. PE remarked that the West Mercia Cluster have formed a group overseeing the 111 implementation and he will represent Herefordshire in discussions. SM raised concerns over the timing of the implementation considering the current transformation. • Item 4. AW updated the committee on previous discussions around immunisation, explaining that a West Mercia wide approach is being proposed for next year's seasonal flu programme. An update will be provided by Dr Arif Mahmood as soon as a decision is made by the West Mercia DsPH meeting in April. With regards to Childhood Immunisation Dr Arif Mahmood will prepare a paper for a meeting in May requesting the committee to support a number of initiatives which are being developed to achieve high uptake.
	PATIENT QUALITY, SAFETY & EXPERIENCE
05.04/12	**Quality and Performance (including Safeguarding)** The Committee received an update of quality assurance activity that has been undertaken to provide assurance that NHS Herefordshire is commissioning high quality services including current performance (based on available information to date). The committee noted the following exceptions highlighted by NW: • That Clostridium difficile (WVT) is much improved as no cases reported during February in acute and the community however still an area of concern whilst remaining above the trajectory at the end of the year. • Midwife to Birth ratio (WVT) level of risk has been escalated and acknowledged as red on the WVNHST risk register. NW confirmed that a whole service is commissioned and the provider delivers to national guidelines. PE stated that a maternity care pathway has been agreed as part of the service development plan originated out of Women, Children's and Families work stream in line with the Royal College of Paediatrics recommendations. **Dr AW asked that outside of this meeting PE provide him with a formal brief on the objectives of the pathway.** • Breastfeeding ((initiation and prevalence) WVT). It was noted that breast feeding promotion is not achieving the desired target for new mothers initiating breast feeding. WVNHST are offering 1:1 support from community nursery nurses where anxiety over breast feeding has

	been identified. • A&E 4 hour waits. Despite weekly figures for March indicating that the end of year performance will be delivered above 95%. • Patient survey (WVT Acute). It was noted that provisional results indicate a lower score against previous years however this provisional score is not due to be confirmed until May 2012. • Delayed Transfers of Care (2gether). It was noted that relatively small numbers are involved. NW confirmed that delayed discharges are mainly patients on Cantilupe and waiting for specialist out of county placements. • Care Providers – Quality Concerns. It was noted that there are currently 6 providers subject to quality concerns processes. • **In response to the Chair's request that there is some assurance that action plans and target dates will be provided as part of the performance report NW also agreed to put some forensic narrative behind the figures for Cancer 62 day waits.**
	COMMISSIONING AGENDA
06.04/12	**Commissioning Update** The Committee noted a range of commissioning developments that are being addressed with respective providers in 2011/12 and the contractual position for both local Herefordshire Trust, regional and national services are completed. The report provided information on the West Midlands Trauma Care system, the 3 Counties and Arden Cancer Network, Satellite Radiotherapy, Any Qualified Provider, Stroke. The committee also noted the associated action plan for Winterbourne view (in relation to out of Area (Health funded) placements. PE discussed the review of Trauma centres across the West Midlands and that WVNHS have applied to become a Trauma unit. PE reported that the SHA have approved 'go live' status from 26 March and that WVNHST have been asked to develop a full action plan by July 2012. The Chair asked whether there would be any change to the service provided now and it was confirmed that the service may be slightly enhanced and formalised and PE confirmed that the SLA with the Ambulance Trust has to be uplifted as a result but business is expected to continue as usual. The committee noted the proposed merger of Cancer Networks across regional boundaries to ensure continuity and stability among teams during the transition phase. The committee discussed the merger of Arden and the 3CCN and the proposals outlined in detail in the report. The committee noted the update on the Satellite Radiotherapy unit

	acknowledging that the demolition of Dore Ward will commence on 2 April 2012, construction of unit to start on 21 May with an expectation that the LINEAC will start to treat patients in June 2013. The committee noted the next steps and timescale in the AQP process to secure additional providers of podiatry, adult hearing and MSK (low back and neck pain) services. The committee noted that the SHA have recently agreed to undertake a review of stroke services provided in the West Midlands with the aim of achieving more effective care pathway management. SM highlighted that in terms of seeking strategic provider partnerships as part of a review of stroke, or indeed other services, Gloucester, which is outside of SHA cluster boundaries, needed to be considered alongside within cluster options. PE confirmed that this issue will be emphasised. It was noted that members had received by email the latest version of the draft NHS Low Priority Treatment Policy v6 for advance perusal in preparation for discussion today. **It was agreed that CB should be asked as part of the consultation process to look at the policy from a social care perspective with all parties agreement it will be presented to the Committee for formal sign off at a formal meeting in May.**
07.04/12	**QIPP 11/12 & 12/13 update** The committee received tabled refreshed exception reports that were presented to the QIPP Delivery Board 11/12 on: 1. the overall progress against the 2011/12 QIPP targets (excluding social care) asking the committee to note progress at Month 11. Exception reporting was noted for the following areas: o MSK Care Pathway o Maternity Services o Frail Older People's Care Pathway o Reducing Out of County MH and LD Placements o Reduction in referrals It was noted that the key issues to resolve next reporting period are: o Further work on agreeing the specification of services in primary care for Frail Older People and the Locality Neighbourhood Teams based on the agreed new operational model. o Ensure that financial QIPP delivery fully achieves the 11/12 £10.8m target. o Continued Refinement and finalisation of agreement of QIPP Schemes for 2012/13. 2. the QIPP for 12/13 reflecting the latest QIPP which was updated for the West Mercia Integrated System Plan (March). It was noted that within the 2012/13 PCT QIPP challenge of £10m, £3.6m is attributable to Wye Valley Trust, £2.6m of this has been contracted for. A further £6.4m of QIPP is planned across the rest of the portfolio.

	The Chair, on behalf of the committee thanked all those involved for what looks like a promising 12/13 as we move in to the new financial year. **The Chair asked for clarity in future reports on what is the CCGs responsibility which JS agreed to action.** **The Committee noted the reports.**
	PROVIDER LANDSCAPE
08.04/12	**WVT Finance and Performance** Items 08 and 09 were taken together.
	PERFORMANCE AND FINANCE
09.04/12	**Finance and Activity** The committee received a tabled summary of the revenue financial position of the devolved budgets for the period up to the 29th February 2011, an overview of QIPP performance and a summary analysis of the drivers of secondary care activity including referral rates and waiting list movements. The key points of the report highlighted the non recurrent financial pressure resulting from the significant Wye Valley NHS Trust waiting list and sustained reduction in GP to Consultant referrals. The committee was asked to: • note the contents of this report which highlights the forecast deficit for the devolved budgets in 2011/12. • note the non recurrent nature of some the 2011/12 expenditure drivers including the significant Wye Valley NHS Trust waiting list reduction and the profile of the waiting list reduction. • note the work undertaken to date to understand and address the drivers of referral rate variability and the need to continue this work in 2012/13. • note the sustained reduction in GP to Consultant referrals in 2011/12. It was noted that future recurrent financial balance is dependant on the full delivery of the 2012/13 QIPP programme • note the drivers of emergency activity and the level of variability across practices. **The Chair asked that for future reports the Patient Treatment List is listed by speciality; an e-mail would be sent out to GPs to inform the CCG of inappropriate referrals.** It was noted that a WVNHST and Cluster Board to Board meeting is being held on 19 April to include CCG GPs. The Committee felt that it is critical that the clinical and organisational strategy is led by the CCG in order for a sustainable plan to emerge, and to ensure that outcomes are delivered for the people of

	Herefordshire. **The Committee noted the report.**
10.04/12	**Contract Update** The Committee received a tabled report on the latest contract portfolio for NHS Commissioning as at 30 March 2012 building upon the position reported to the Service Improvement Group on the 20th March 2012 including an updated portfolio (Appendix A) showing the offers that have now been agreed in principle for 12/13. **The Committee noted the report**
11.04/12	**2% Non Recurrent Transformation Bids** The Committee received for approval the outline business case (Transitional Support for Care Closer to Home) which formed WVNHST's bid to the Strategic Change Reserve for 2012/13. The business case stated that: • Although the bid is put forward by WVT it would rely on a collaboration between WVT and primary care (represented by the Taurus Group) and 2gether NHS Foundation Trust, West Midlands Ambulance Service and the third sector. • It would need to be considered alongside the Frail Older People LES (currently in draft) . However, although there is some overlap with elements of the LES this bid is not intended to directly fund the LES. • Version (6) of the bid had been re-written at the request of the commissioners in order to incorporate a joint approach with primary care. The bid was received by the Chair with an accompanying email from Paul Maubach confirming that the extended cluster executive had agreed two key actions on taking forward the use of the 2% : a) The bid featured as part of Board to Board discussions b) Secondly it was agreed that it is extremely important that the CCGs have ownership over the application of the 2% and determine the clinical vision and priorities for its use. " The Committee considered the revised plan at length making the following comments: • That the Committee supported the concept of neighbourhood team working. • That the Committee was not clear how the primary care element to the plan would contribute to the service model especially on whether they were advisory or assessing patients on a face to face basis. • That it would have been helpful to see primary care representatives as co-signatories of the business case or some supporting evidence to demonstrate their involvement and commitment to the model. • That the proposal represented a major investment in the community workforce but it would have been useful to see this represented alongside current numbers of staff so that the level of expansion was more transparent and it would be easier for the board to see progress

	in implementing this plan against the current baseline. • That there was a lack of clarity about how acute sector costs would be reduced as a result of this investment. • That it was recognised that the modelling was the basis of the KPMG work and it would be useful to see where WVNHST thinking has progressed since that time. • That in terms of measurable outcomes the Committee would like to see a demonstration of incremental change that will result in progression towards a sustainable model at year end. • That the proposal would have been stronger if it had emphasised a focus on improving staff morale and creating a culture of positive change • That the Committee would want to work closely with WVNHST on the plan to ensure that the proposal fits in with the larger strategy to resolve Herefordshire's financial difficulties • That the Committee is not opposed to an investment that results in double running of services for a short period of time to allow for development of the community teams, but would need assurance that that the end result will deliver a sustainable model. • That the next step involves more joint working and that financial modelling from respective teams runs alongside the clinical modelling to ensure the paper is not further delayed. **The Committee was unable to give its support to the proposal in its present form and agreed that the Chair would forward the comments made above to the WVNHST Executive and Programme Management team.**
	GOVERNANCE
12.04/12	**Reviewing Governance Structures including Programme Delivery Diagnostic** The Committee received an overview of the key governance challenges for the CCG, both to support the sustainability of the organisation, but also to support its authorisation application in 2012/13. To evaluate the current arrangements a programme Governance Review is being undertaken by Fiona Sanders of Thorley Torrance during April, to ensure present arrangements are fit for purpose as the CCG moves forward and the Committee received the Programme Delivery Diagnostic Proposal at Appendix 1. The Committee was asked to agree: • **That the proposed membership of the Task & Finish Governance working group established April/May comprises the COO, interim Business Manager, Chair of CCG and CCG Quality lead.** • **That the first Quality, Performance and Resources Committee, chaired by the CCG Chair, is to meet in shadow form in late April/May to agree terms of reference – membership to be**

	agreed at CCG board • **That the Quality Assurance Framework for CCG is developed and presented to HHCC board in June**. • **A review, assessment and evaluation around Herefordshire's 'do-share-buy' preferences for Commissioning services and organisational structure are developed.** The Committee received for consideration the West Mercia Commissioning Support Services Heads of Agreement setting out the Commissioning Support Services that will be provided. It was noted that it was not a contract or SLA but rather a formal memo of understanding between the clients and supplier. The Committee noted the high cost per head of population for Herefordshire compared to the other five CCGs was reasoned to be around the complexities of Herefordshire's integrated working. In relation to the need to define what Herefordshire requires from commissioning support services the Committee received a proposal for the Provision of Consultancy Services in relation to the Commissioning services the CCG is seeking to procure, prepared by The Commissioning Lab Limited. In light of the amount of work to put in place over the next few months the Committee agreed to the proposal that Herefordshire's submits for authorisation in the second wave September/October 2012. **All proposals were approved.**
13.04/12	**Proposal for the provision of Consultancy Services in relation to procurement of Commissioning Services** • Discussed under item 12.
14.04/12	**Authorisation Process update** Discussed under item 12.
15.04/12	**Operational Plan** The Committee received and update on the Herefordshire CCG Operational Plan and the PCT Cluster Integrated System Plan providing detail on: • the key aims and delivery programmes within the HHCC operational plan • the objectives and content of the PCT Cluster integrated system plan (ISP); and • the process followed in developing the plans, and how it relates to other strategies across Herefordshire Public Services; **The Committee noted the key points with no comments.**
16.04/12	**Health and Well Being Strategy** (extract) pgs 7 – 24 The Committee received for information the vision and guiding principles extract from the Health and Well Being Strategy 2012/13 presented to the

	Health and Well Being Board on 20 March 2012. The Chair confirmed that the next meeting of the Health and Well Being Board plans to discuss its role in developing a more overarching strategy for the community. It was confirmed that the mention in the strategy of commissioning a Family Nurse Partnership Programme in Herefordshire would not require CCG money and would come under the National Commissioning Board. **ATS agreed to update Dr AW on the public health plans already in place.** **It was agreed that a service specification for health visiting would be presented to a future Service Improvement Group.**
17.04/12	**Election process** It was noted that Dr SG had developed the job descriptions since the last meeting and they were discussed at the last GP Parliament on 20 March. The following was agreed: • That 4 GPs should sit on the CCG Board; • That there was some debate over the Deputy Chair position as national guidance suggests that the Deputy Chair should be a lay member so until clarification is received the position will be for a GP Clinical Lead development role (Deputy Chair); • That the timeline had been agreed and job descriptions should be circulated week commencing 9 April; • That the LMC have offered to officiate the counting of votes with CCG admin support; • That the letter inviting applications should come from the COO.
18.04/12	**Cluster update** The Committee received a brief update from Sue Mead member of the Cluster Board and noted: • That there is focus on the integrated plan and an emphasis on milestones within the integrated plan; • That GP leads are a 'helpful voice' at Cluster Board and their attendance is encouraged.
19.04/12	**Risk Proforma** Risks raised during the meeting in relation to risk management were: • WVNHST financial issues; • Concerns around the WVNHST's bid to the Strategic Change Reserve for 2012/13; • Election process – failure to recruit • Frail elderly QIPP delivery • Lack of detail around financial risks 12/13.
20.04/12	**ANY OTHER BUSINESS** No other business was raised.
21.04/12	**CONFIDENTIAL BUSINESS** *Separate minute*

	Date and Time of Next Meeting – note change of meeting time on 1 May 2012. Formal meeting - Tuesday 1 May 2012 at **2pm,** Room 18a, Brockington
	INFORMATION
1.	• **Wye Valley NHS Trust Public Board Papers** Link: http://www.herefordhospital.nhs.uk/tabid/277/Default.aspx • **2gether NHS Foundation Trust Public Board Papers** Link: http://www.2gether.nhs.uk/how-we-make-decisions---trust-board-meetings

AGENDA ITEM 4

RBCCG Board
New Road Surgery, Bromsgrove
Thursday 23rd February 2012, 0830 - 1230

MINUTES

Present	Apologies
Dr Jonathan Wells (JW) – GP/RBCCG Chair	Stuart Bourne (SB) – Assistant Director Public Health NHSW
Dr Richard Davies (RD) – GP/RBCCG Vice Chair	Marion Burrows (MB) – Head of Information NHSW
Tony Hadfield (TH) – Non Clinical Vice Chair/NED NHSW	Dr Edward Barrett (EB) – Board GP
Simon Hairsnape (SHa) – RBCCG Chief Officer	Jan Clossick (JC) – Commissioning Accountant
Andrea Cudd (AC) – RBCCG Manager	Eve Meredith (EM) – PPI Chair and Lay Member
Dr David Law (DL) – Board GP	
Dr Rupen Kulkarni (RK) – Board GP	
Dr Catherine McGregor (CM) Board GP	
Dr Steve Miskin (SM) – Board GP	
Mary Walters (MW) – Chief Finance Officer	
Jo Galloway (JG) – Lead Executive Nurse Quality and Safety	
Linda Pratt (LP) – RBCCG Lead Practice Manager	
Bryan Smith (BS) – West Mercia Cluster NED and Observer	
Sean Pike (SP) – LMC Observer	
Vickie Deacon (VD) – RBCCG PA	
In attendance	
Sam Hill (SHi) – RBCCG Commissioning Manager Sarah Harris (SHar)– RBCCG Information Analyst Hilary Sharpe – Consultant Public Health	

Item	Notes	Action
2	**Declarations of interest** In line with RBCCG Registry of Interests.	
3	**Notification of items of Any Other Business** • Governance training • Audit presentation • Media presentation • Acupuncture • Physiotherapy • Update on Joined up working meeting	
4	**To approve the minutes of last meeting held 19th January 2012** Point 4 – to be moved into the confidential section. VD to amend final version. South Worcestershire Clinical Commissioning Group (SWCCG) has been piloting GP in A&E. RBCCG will take a view upon the deliverables via a meeting is being held next week between SWCCG, RD, LP and AC. Feedback will be via RBCCG Management Team Stroke review 8th April, the Acute Trust cannot continue services on two sites. Need to identify someone to represent RBCCG at the review meeting. AC will add to Management Team agenda. 'Pathway to Recovery' – VD has requested cards/leaflets for all practices. Charlie Twinn from the service has offered to attend a future RBAF meeting to talk about the pathway to recovery service. VD to make arrangements accordingly.	**VD** **AC** **AC** **VD**
Items for decision:		
5	**MSK ICATS 1 year evaluation and recommendations** SHi and SHar presented the 12 month Musculoskeletal Integrated Clinical Assessment and Treatment Services (MSK ICATS) evaluation. The comprehensive evaluation identifies the costs associated with the first 12 months and compares it to the previous 12 months (pre-dating the MSK ICATS service). The headlines are as follows: a. Patient experience relating directly to the MSK ICATS service is very impressive; b. Savings of £863,000 have been recorded over the 12 month period; c. There has been a reduction in secondary care activity and an increase in physiotherapy and diagnostic spends; d. A slight reduction in waiting times at Worcester Acute has also been reported. The MSK ICATS contract is due to expire 30th September 2012 and as	

	such, a decision needs to be taken about the future of the service. RBCCG Board was asked to consider the two following options: **Option 1** – allow the service to cease following expiry of contract – activity would divert to WAT and RoH. **Option 2** – request a review of the original Service Specification, to reflect any potential pathway improvements (progress and sign off to be approved via RBCCG Management Team), re-advertise and procure for a further 12 months (as per 'The Operating Framework for the NHS in England 2012/13' guidance), with clear evaluation points at 6 months and 12 months. <u>Based upon the success of the service in terms of QIPP delivery, RBCCG Board supported the continuation of the service for a further 12 months.</u> The 12 month continuation will allow for whole pathway evaluation i.e. patient experience across Providers. SH suggested that it would be more favourable to extend the existing contract for a further 12 months (in light of the significant changes within NHSW as the CCGs develop). RBCCG Board was in full agreement. AC to discuss with Glyn Wise, the extension will require further price renegotiation. The ongoing process will be monitored via RBCCG Management Team with reporting to RBCCG Board as necessary.	**AC (via Mgt Team)**
6	**Investment in Prevention – follow ups** A number of projects developed which demonstrate the range of activities. a. Bromsgrove – expansion of the 'Trunk Project' which concentrates on activities such as allottments and healthy eating. Consideration is given to a similar hub in Sidemoor. b. Redditch – following on from a 'Joined Up' meeting there is a wish to set up community intervention team in a deprived area. The key focus is to bring together organisations to support the local community which includes mentoring young teenagers etc. c. Home equipment/adaptations – a community team dedicated to support people in their own homes, accessing necessary support to maintain independence and to optimise safety, e.g. minor adaptations such as fire guards, stair gates, carpet mending (preventing falls) etc. d. Engage 50 local R&B businesses to support workplace health. As a fair share charitable project, funding would not be used for food parcels but would contribute towards set-up costs. e. Capital funding projects for rural isolation in and around	

	Bromsgrove. Consideration includes additional buses for the dial-a-ride service, enhancing existing provision. Consideration should be given to criteria for accessing the service i.e. to include clinical need. f. Equipment support such as gym equipment for people with disabilities and healthy eating for particular client groups. There is a very short timescale to secure the best possible deliverables from the non recurrent money available. MW stated that there has been initial contact with joint finance director for councils about setting up a £250k transfer. A suggestion was made to approach the YMCA and Redditch United Football Club with a view to providing additional support for the work already in place around deprived and vulnerable people as do Redditch United FC. Of critical importance is to ensure all plans are costed ASAP with benefits specified. AC to discuss further with Hilary Sharpe. Further discussion /progress via RBCCG Management Team.	**AC (via Mgt Team)**
Items for discussion:		
7	**Joint Services Review** **Feedback from Roadshows and general update** JW has emailed all RBCCG GPs with the Joint Services Review (JSR) Terms of Reference (ToR) and summary paper which was presented at the JSR Public Launch at the end of January 2012. The Redditch public meeting was held last week and the Bromsgrove public meeting is next week. JW stated that the Clinical launch is in March 2012 and that Harmoni will be starting early to enable all GPs to attend. A Clinical Reference Group now meets fortnightly (the 2nd one this afternoon). Four Clinical Working Groups (CWG) for Planned Care; Emergency Care; Womens and Childrens and Elderly Care are being established to consider possible pathway changes and improvements. A range of options will be agreed via each of the CWGs (three x 3 hour sessions). JW stated that RBCCG must secure strong clinical input into each of the CWGs in order to secure the best possible outcomes for Redditch and Bromsgrove. The timeframe is very short, JW will feed back after today's Clinical Reference meeting with more information as to what each CWG will be doing. CWGs will have a facilitator rather than a chair. JW will keep RBCCG Board updated and ask for volunteers to support discussions/options at the CWGs.	**JW**

8	**Month 9, 11/12 Finance Report** MW stated that an SHA exercise was completed back in September 2011 based upon historic spend. The report was submitted and has been published within the last three weeks – it doesn't state what budgets will be for 12/13 nor has it been decided how budgets will be calculated – there will potentially be a new formulae. There is now a requirement to resubmit the exercise – MW is progressing with her team. The determining factor is what the DoH issue as to how they will determine budgets. MW stated that at month 9 RBCCG is forecasting an overspend of £1.9million which shows some deterioration. Included in this forecast is an over spend of £474,573 for Grey Gables. Also, taking the fair share of the centrally held CCG Risk Reserve, the forecast would be reduced to a deficit of £226,664. Overall RBCCG is in a healthy position. MW stated that there are negotiations taking place with both major providers regarding next year's contract. Modelling for next year is based on 5 months of last year and 7 months of this year. The attempt to ensure no patient is waiting over 18 weeks in Worcestershire is likely to be a challenge due to ward closures for Norovirus. There is ongoing analysis to discover the reasons behind the Norovirus outbreak although there is nothing to suggest that anything went wrong in Wrocestershire.	
9	**Finance and Information Subgroup feedback inc FRAP update** Nothing new to report.	
10	**Pharmacy Subgroup Feedback** Full report deferred to next meeting. Dieticans – concerns were raised that although the fortisip project was carried out, dieticians are still asking GPs to prescribe sip feeds. JW requested that this is revisited. DL will contact Mary Shaw to arrange to remind dieticians.	**DL**
11	**Quality and Performance related issues, to include:** • **Feedback on Quality Strategy Implementation Plan** JG informed RBCCG Board that the Quality and Patient Safety Strategy has now been ratified by all CCG Boards and an implementation plan developed. Comments on the implementation plan should be forwarded to JG. CQUINs negotiation continues. The list has been reduced slightly and has been submitted to the SHA. National and regional CQUINs are included. Local influence is encouraged and feedback from RBCCG welcome.	

	The latest draft of the quality schedules will be taken to RBCCG Management Team. Patient experience – a scoping exercise has been carried out and recommendations made regarding work to review engagement activity with some areas of the community. A membership scheme will be developed to ensure the local population are able to engage with the CCG and inform the decision making process in relation to health care. A&E Target – the norovirus outbreak has had an effect on the 95% target which is unlikely to be reached this quarter. Clostridium Difficile – JG stated that there has been very limited uptake for the masterclass at the end of February. She will be setting up a date for a lunchtime session for GPs. PPI presribing – guidance for discontinuation of prescribing PPIs is required. JG will consider masterclass options. JW suggested an information sheet focussing on PPIs. RK suggested using the recently distributed non prescription pads for schools and nurseries when suggesting the use of paracetamol etc.	**JG** **JG**
12	**Reflection on RBCCG Board Development Event and agreement on 'RBCCG vision' and Operating Model** SH gave an overview of the two day event, which was intense but positive. The event looked at work which needs doing before authorisation. The formal authorisation guidance was published last week. AC has captured core outcomes of the two days into a document (circulated with Board Papers). Initial feedback will be reflected in the next version. Any further feedback to AC. RBCCG vision – after discussion it was agreed via RBCCG Management Team to add 'affordable' into the vision and this has been publicised. Further suggestions to AC. Management Team will finalise the document. It was suggested that 'High Quality' should come before 'Affordable' in the vision – AC will amend.	**ALL** **AC**
13	**Communication Strategy (and links with draft PPI Strategy) – updated position** LP, RD, JC and AC met with a local PR company who have come up with a costed plan to produce a Communication Strategy for RBCCG, which will be finalised within 6-8 weeks. Juliet Betterton and Clare Ryan from Better PR, will need to contact members of the Board to do a telephone interview. AC will circulate the questions to Board members within the next two days in preparation for the telephone interview. Board members will be contacted to arrange a date and time for the telephone call. Other stakeholders will also be contacted	

	– these include Frances Martin and Karl Bell from WAHT and Amanda Kimpton and Ian Douglas from WHACT. Also included in the exercise will be local MPs; the Chief Executive of Redditch Borough and Bromsgrove District Councils, Kevin Dicks and Eddie Clarke from Worcestershire County Council. Juliet and Clare will be attending the next Patient and Public Involvement (PPI) meeting at the end of March 2012. The draft PPI strategy will be a central component of the RBCCG Communication strategy. LP, AC and EM will represent RBCCG Board to identify gaps etc and the final draft strategy will be presented to the April or May RBCCG Board.	
14	**RBCCG website** RBCCG has had the current website for some tme and now recognise that it is not particularly easy to navigate nor aesthetically pleasing. LP and AC have met with the communications team at WHACT (with whom a Service Level Agreement is in place) who have designed and maintain websites for both Wyre Forest and South Worcester CCGs. AC has now received a dummy of what the new website will look like which should be up and running by the end of April 2012. AC stated that a newsletter will be produced following each Board meeting. A PPI newsletter will also be produced as well as one for key stakeholders. DL stated that the newsletter needs to be produced with less commissioning speak and more simple headlines, as GPs are unlikely to read the full document at three pages long. AC to take feedback on board for next monthly newsletter and make it 'short and snappy'.	**AC**
15	**Consultant Event update** The Consultant event will be held on Wednesday 14th March 2012. JW stated that he is hoping all Board GPs will attend. AC has written to all practices asking for attendance, so far only three GPs have responded. JW suggested they should receive payment for attending. SH stated that perhaps payment should be made once GPs agree to take on future work. AC agreed to send an email to practices suggesting one GP from each practice attends. There was a suggestion that the CCG should look at holding a further, wider event after this one, to involve Consultants who aren't only based at the Alexandra Hospital. AC will ask Ian Douglas from WHACT to attend. If we are asking for a GP from each practice we need a Consultant from each specialty area. AC will contact Frances Martin and Karl Bell to try to increase interest as only 15 Consultants have responded so far.	**AC** **AC**
16	**Future Zoning visits** There was a suggestion of doing quarterly Zoning visits. Sarah Harris is loading all information onto the Dashboard. AC asked how Board GPs wish to take the Zoning meetings forward. Discussions followed around setting Zoning meetings for certain months so that meetings	

	can be arranged in advance and also around having specific areas to look at during these meetings. RBCCG Management Team will agree the format of the Zoning visits. The next round of visits will be April/May 2012.	**AC (via Mgt Team)**
17	**Update on Shared Management Arrangements and CSS** SH stated that a challenge has been set to have everything in place in April 2012. SH shared the management structure and budget at the RBCCG Board Development Event. 80% of the structure is completed, a few areas are still in discussion such as CHC and where it will sit. SH aims to have the CCG and CSS structures finalised by the end of February 2012. Brian Hanford has been appointed as Managing Director of West Mercia Commissioning Support Services. Brian's appointment provides good leadership with an excellent chance of having a West Mercia rather than West Midlands.	
Items for Noting:		
18	**RBCCG Hospital Services Committee Action Notes**	
19	**RBCCG Community and Mental Health Services Committee Action Notes**	
20	**Management Team Action Notes**	
21	**Pharmacy Subgroup Action Notes**	
22	**AOB** Acupuncture – DL asked whether this is included in the physiotherapy contract. Some people are using acupuncture which is why they need more than 6 physiothereapy sessions. AC stated that acupuncture is not within the current AQP Service Specification. Assura does provide acupuncture and some surgeries offer acupuncture. NICE recommends a maximum of 10 sessions. AC will clarify further with SHi. SH will circulate the PCT commissiong policy for acupuncture. A 'Joined up Working' meeting was attended by AC and RK this week which was run by Kevin Dicks, CEO of Redditch Borough and Bromsgrove District Councils. AC and RK felt that it was a very meaningful meeting with focus on a case study which tracked a patient accessing a wide range of services throughout his life. Final outcome was for RBCCG involvement in a piece of work around Winyates as a pilot. Plans for RBCCG Board going public – SH stated that this will happen after authorisation so the assumption is from October 2012.	**SH**
	Next RBCCG Board: Thursday 22nd March 2012	

Redditch & Bromsgrove Clinical Commissioning Group

RBCCG Board
New Road Surgery, Bromsgrove
Thursday 22nd March 2012, 0830 - 1230

MINUTES

Present	Apologies
Dr Jonathan Wells (JW) – GP/RBCCG Chair	Eve Meredith (EM) – PPI Chair and Lay Member
Dr Richard Davies (RD) – GP/RBCCG Vice Chair	Marion Burrows (MB) – Head of Information NHSW
Tony Hadfield (TH) – Non Clinical Vice Chair/NED NHSW	Dr Edward Barrett (EB) – Board GP
Simon Hairsnape (SHa) – RBCCG Chief Officer	
Andrea Cudd (AC) – RBCCG Manager	
Dr David Law (DL) – Board GP	
Dr Rupen Kulkarni (RK) – Board GP	
Dr Catherine McGregor (CM) Board GP	
Dr Steve Miskin (SM) – Board GP	
Mary Walters (MW) – Chief Finance Officer	
Jo Galloway (JG) – Lead Executive Nurse Quality and Safety	
Linda Pratt (LP) – RBCCG Lead Practice Manager	
Jan Clossick (JC) – Commissioning Accountant	
Stuart Bourne (SB) – Assistant Director Public Health NHSW	
Bryan Smith (BS) – West Mercia Cluster NED and Observer	
Sean Pike (SP) – LMC Observer	
Vickie Deacon (VD) – RBCCG PA	
In attendance	

n/a	

Item	Notes	Action
2	**Declarations of interest** In line with RBCCG Registry of Interests. JW questioned whether Declarations of Interest forms need to be updated from 1st April 2012. VD to email forms round Board members for updating.	**VD**
3	**Notification of items of Any Other Business** • Oncology representation- DL • Choose and Book - DL	
4	**To approve the minutes of last meeting held 23rd February** SWCCG GP in A&E pilot – the meeting planned with Nisha Sankey and Nikki Burger (SWCCG) was cancelled. It was suggested that Richard Morrell and Nisha Sankey be invited to RBCCG Management Team to discuss the GP in A&E pilot – VD to arrange. JW will circulate a 5 page evaluation report produced by SWCCG. Stroke Review – Dr Mark Talbot has agreed to get involved and will attend the Stroke Review meeting on 4th April 2012. Pathways to recovery – leaflets on order. VD to arrange for Charlie Twinn to attend a future RBAF meeting to talk about the service. Procurement of Musculoskeletal Integrated Clinical Assessment and Treatment Services (MSK ICATS) – following discussion with Glyn Wise about procurement options, confirmation has been received to extend the contract to the end of March 2013. RBCCG Management Team will monitor further progress. The next MSK ICATS evaluation point will be October 2012 (18 month service delivery point). Investment in Prevention - Hilary Sharpe (Consultant in Public Health) is attending RBCCG Management Team tomorrow. RBCCG is investing £250k in partnership initiatives to promote good health and preventative measures across Redditch and Bromsgrove. It was requested that Hilary report to RBCCG Management Team on a quarterly (ongoing) basis. Amendment for Item 8, Finance Report – should state that 'Worcestershire is likely to be a challenge', as opposed to 'unlikely to be met'. VD to amend on final version on minutes. Quality – feedback about Clostridium Difficile and PPI prescribing will be discussed at Management Team tomorrow. Communication Strategy – AC will resend email which gives details of who to contact with regards to the telephone interview.	**VD** **JW** **VD** **VD** **VD** **JG**

	RBCCG communication with West Mercia Cluster Board – it has been decided that rather than produce a newsletter following each Board meeting to send to Cluster Board, that minutes of RBCCG Board meeting will be sent instead. Zoning Visits – agreed to add to management team agenda for tomorrow. DL has started booking his next round of visits in and requested feedback from last round. Acupuncture – AC confirmed that acupuncture is not part of the Any Willing Provider physiotherapy service specification.	**AC** **AC**
5	**Childrens Section 75 Annual Agreement** Section 75 is a Partnership Agreement between Worcestershire PCT and the County Council to pool budgets, which will last for an initial period of five years. It is supported by a series of schedules which outlines the budgets to be pooled and the priorities for the use of these funds. Around £12million is pooled by both NHS Worcestershire and the Council. SH stated that in bringing the money together, joint commissioning arrangements work well. SH briefly talked RBCCG Board through the priorities for 2012/13 and stated that the Board will need to formally sign the budget transfer off to the Local Authority. MW informed RBCCG Board that at a recent Countywide CCG Finance meeting discussions took place around which areas of the budget should continue on fair share basis. Agreement was to move away from fair share other than low volume, high cost areas such as the complex children's budget. Recommendation to note and approve the Children's Section 75 Annual Agreement and budget. RBCCG Board was in approval.	
6	**Joint Services Review** **Feedback from Clinical Working Groups and general update** The first four Clinical Working Group meetings were held last week with two GPs from R&B on each. From a process point of view AC felt that it was well planned and thought out. However, there was no preparation time to give full consideration to the evidence which was being discussed. AC felt that it was encouraging that Angus Thompson (Co-chair of the Women's and Children's CWG) was clear that feedback would be at beginning of the second session rather than at the end of the first session. AC approached Angus at the end of the meeting to ask for access to information well in advance of the next session so that we have the option to consult with practices if necessary. The information was received yesterday. DL stated that the basic goal of the co-chair of the planned care group was not to get into site discussions etc but to try and build discussion about ground rules on working together, and to begin to look at	

	pathways, what is good /not so good within the pathways and generate a case for change. DL felt that it was a positive session but came away with concern around a lack of drive for change. There followed a discussion around who is driving the review with concerns that there may not be adequate representation. RBCCG Board felt that as we will be held to account for the outcomes of the JSR, it is important that the commissioning voice is heard. The challenge will be if the process comes up with a solution we don't feel we can support and what we do if this should happen. There was a strong feeling in the group that the issue of transport very much needs to be addressed. SP stated that there had been a Clinical Senate meeting specifically to talk about JSR. There it was stated the the process is absolutely clincally led. SP had a concern that groups were not properly briefed and will feed this back to Clinical Senate.	
7	**Month 10, 11/12 Finance Report** MW reported a slight deterioration on M9 report which is now showing an overspend of £2.34million. This would reduce to £580,000 once you add in fair share of the centrally held risk reserve. JW suggested removing Grey Gables from next report as this would report a virtual break even. Worcester Acute Hospitals Trust (WAHT) is underperforming regarding activity for Redditch and Bromsgrove. The underspend is factored into the budgetary spend for next year. Out of County contracts are near to break even. Continuing Healthcare continues to overspend but hasn't increased on last month. Prescribing is forecast to underspend by £500,000. MW stated that overall NHSW is reporting close to break even, which is a good reflection on work which has been carried out this year. 2012/13 budgets – MW has finalised the contracts for WAHT and Worcestershire Health and Care Turst (WHACT) and those figures will be factored into budgets for next year. The RBCCG current financial position will be approved by West Mercia Cluster Board next week and brought to CCG Boards in April 2012 for approval. There will still be a 1% centrally held risk reserve, and a £1.6million internal risk reserve. Budgets will not be released until end 11/12 and will be based upon historical and fair shares. MW stated that Worcestershire as a PCT is not at its fair share and there has been no movement to fair share in the last few years. MW will present 2012/13 budgets to RBCCG Board in April 2012.	**MW**
8	**Finance and Information Subgroup feedback inc Finance and Information Action Plan (FIAP) update** RD stated that all actions on the FIAP are now complete. He asked for	

	any additional suggestions on the FIAP to be forwarded to him. JC asked RBCCG Board to note the change of name of this item as it is no longer a recovery plan, it is now an action plan. As one of RBCCG's priority areas for 2012/13, a project group is being set up to consider Circulatory Disease. Future progress will be monitored and reported via RBCCG Management Team. DL suggested looking at interpractice referrals for GPs with any kind of special interest and also unifying GP clinical systems. Further discussion will be had via RBCCG Management Team. JW will feedback to RBCCG Board accordingly.	**JW**
9	**Pharmacy Subgroup Feedback** DL stated that the last Pharmacy Subgroup meeting focussed on RBCCG priority areas. Minutes of the last meeting have been circulated and should be noted. Discussions followed about Dabigatran which has now been approved by NICE. EB has agreed to continue as RBCCG Medicines Management Lead.	
10	**Quality and Performance related issues** Quality & Patient Safety Strategy – now ratified by all three CCGs and Clinical Senate. Implementation plan in progress and a number of projects have been initiated. CQUINS – feedback received from NHS Midlands and East SHA who are happy with most of the areas. Further negotiations being undertaken with providers and CCGs to reach consensus of final schemes and to populate the detailed requirements. Outpatient letters – a top priority around improving communication and one of the more debated CQUINs with the acute trust. DL highlighted that an issue is with communications with the outpatient department. DL agreed that he would support development of the finer detail for this CQUIN. JG to ask Karen Hunter to contact DL accordingly. Quality schedules – JG talked the group through the handover report from NHS Worcestershire's Quality and Patient Safety Assurance Committee to West Mercia Cluster Quality, Performance and Resources Committee. The report provides an overview of the top five risks, and a forward plan for reporting Quality and Safety issues for services commissioned by NHS Worcestershire. JG proposed that in future there is CCG involvement Never Event closure as there needs to be a high level of assurance that there will be no future reoccurrence. JG asked for a clinician to review the current never event that is ready to be closed and will take to	**JG**

	Management Team tomorrow. Moving to the future, JG suggests a Quality and Safety Assurance Group is configured from April 2012 to ensure that the current risks regarding quality assurance are addressed, representation to be decided. SH stated that this needs to be considered as part of the wider issue of sub committees to the CCG Board and agreed to bring a proposal through Management Team which will then come to Board in April. JG highlighted that the outstanding Central Alerting System (CAS) alert from October for the acute trust one has now been closed. Accident and Emergency – achievement of the 95% target challenged further during February due to an outbreak of norovirus at WRH. The impact on quality and performance indicators e.g. mixed sex breaches are currently being evaluated. JW highlighted that improving performance at the Alex would have an impact on the stroke target as a whole and the aim should be for performance to be over and above the 95% target. Stroke – improvements have been made but the norovirus outbreak affected the stroke unit. This week there is a further outbreak at the stroke unit in the Alexandra Hospital so continues to be an ongoing issue. Contingency plans are now in place. TIA – JW referred to a recent performance meeting that he had attended at the SHA and asked if GP colleagues were aware that when referred patients should be seen in a TIA clinic within 24 hours? Achievement against this target is only at 60% currently. Need to look at getting referral faxed off faster and ensure GPs are all aware. AC to highlight in the forthcoming newsletter Infection prevention and control – WAHT had 3 cases of MRSA this financial year against a target of 5. NHSW CDifficile target has been exceeded but the issue relates more to primary care as discussed at last month's Board meeting. Clarity around the definition for recording cases has been received from the DH which will address the dual testing issue impacting on performance. West Mercia Quality, Performance and Resources Committee requested that a summary report from NHSW be presented to CCGs and agreement reached regarding picking up of issues and monitoring agreed between CCG and Cluster Committees. The report highlights the top five significant issues. RBCCG Board is requested to support the setting up of a Quality Committee as a formal sub-committee to the Board. The Board is also asked to support a joint quality committee arrangement with Wyre Forest CCG in respect of services commissioned from the same providers and identify a Chair with joint chairing arrangements agreed with WF CCG. Draft Terms of Reference will be prepared and shared with RBCCG Board at the April meeting. SH stated that he is keen to get a Committee up and running and will bring a paper to the next meeting. Clarification is	**AC** **SH**

	required around having joint committees with WF CCG Board.	
11	**RBCCG Board development plans – Audit and Governance Training** Liz Cave and her colleagues in the Audit Commission will potentially be attending RBCCG Board on 26th April 2012 to carry out training. It was agreed to condense the April Board meeting to two hours and to extend the session to 2pm in order for the Audit Commission to complete the training. VD to organise. Media training – SH asked whether RBCCG Board wished to do joint training with Wyre Forest which is due to be held in September. Due to the issues with the JSR and the potential outcomes, it was agreed that media training was a priority area and would need to be arranged ASAP. Further discussion to be had at Management Team. VD to arrange Media Training accordingly.	**VD** **VD**
12	**Communication Strategy (and links with draft PPI Strategy) – updated position** *Betterpr* is currently carrying out telephone interviews with key stakeholders. AC will resend the original email to Board members as there are a number of outstanding interviews pending.	**AC**
13	**Reflections on the RBCCG Consultant Event 14th March 2012** Around 30 WAHT Alexandra Hospital consultants attended the Partnership Event with 6 or 7 from WHACT as well as a number of GPs. There was a presentation on RBCCG progress fro JW, RD and SH which was followed by smaller working groups. Feedback was generally positive. There was also sign up to having an ongoing 6 monthly event. VD to organise. Key learning points – the working group questions were too lengthy and should have been circulated in advance. Tables need to be more mixed (prepared in advance). JW suggested putting together a database of consultants – VD to action. SP suggested that if consultants are unsure what GPs do they are welcome to spend time with GPs Further Partnership Working progress will be monitored via RBCCG Management Team and reported to RBCCG Board wherever necessary.	**VD** **VD**
14	**Update on Shared Management Arrangements and CSS** SH stated that there is a choice about whether to go for 1st wave authorisation or 2nd wave (July or September 2012 applications) which would mean the CCG would be authorised at the end of October or November 2012. RBCCG has had to nominate leadership designates for the future who will go through a diagnostic assessment centre. Proposed West Mercia CCGs and thestructures for the shared management team and Commissioning Support Services (CSS) are out for staff consultation for 30 days. Once the consultation process is	

	complete, SH will be recruiting to the senior posts during April/May 2012.	
15	**RBCCG Hospital Services Committee Action Notes** Noted.	
16	**RBCCG Community and Mental Health Services Committee Action Notes** Noted	
17	**Management Team Action Notes** Noted	
18	**Pharmacy Subgroup Action Notes** Noted	
19	**AOB** Retired Hospital Consultant for RBCCG Board – the original idea was to wait until the final Health and Social Care Bill as there was a suggestion that it may be made easier to find someone. The Health and Social Care Bill was not ultimately changed and the DoH believes that having a retired hospital consultant is the best idea so it will now go out to advert. The ongoing process will be managed via RBCCG Management Team. Oncology representation – DL has been lead for RBCCG on oncology work, supporting Worcestershire Cancer Strategy. The Acute Oncology and Chemotherapy Workstream meeting is asking for representation from CCG on a Monday afternoon which is impossible for most GPs. The meeting would be monthly for around two hours. AC requested further information such as a project plan for that group and then we could attempt to identify a GP to attend. The request will be considered as part of the RBCCG Workstreams Review which is currently underway via RBCCG Management Team. The next strategic partnership board is on 5th April when DL is on leave. SH will attend. Choose and Book – DL is interested to know what the policy is for C&B as CCGs are officially meant to be supporting it. SH informed RBCCG Board that technically it is still one of the priority performance targets and that 90% of referrals should go through C&B. There are 3 options: 1: push the use of C&B, allow it remain as it is (around a third of referrals going via C&B) or pull back from it actively. Around the county there is not a lot of support for pushing C&B utilisation. General view currently is to maintain as it is. R&B currently have around 26% usage. General feeling is that if it works well it will be well used. JSR – there was a question as to how to engage all RBCCG practices within the JSR process. The 1 hour RBAF session, April 17th 2012, will be devoted to discussion around the JSR.	

	Next RBCCG Board: Thursday 26th April 2012

BOARD MEETING – 29 May 2012

TITLE OF REPORT:	Shropshire County Clinical Commissioning Group Board Minutes - 7 March and 4 April 2012
REPORT AUTHOR :	Dr Caron Morton, Chair, Shropshire County Clinical Commissioning Group
PRESENTED BY:	Dr Caron Morton, Chair, Shropshire County Clinical Commissioning Group
PURPOSE OF REPORT:	To receive the minutes of the meetings held on 7 March and 4 April 2012.
KEY POINTS:	• The Performance Report was received which outlined current performance against targets which the PCT would be monitored. • Performance against cancer waiting times was very good, with all of the year-to-date targets currently above the thresholds, apart from the 62 day referral to treatment and screening upgrades. • The 18 weeks Referral to Treatment (RTT) had significantly improved at Shrewsbury and Telford Hospitals NHS Trust (SaTH). The CCG Board noted the current performance and planned actions to deliver the detailed RTT Plans. • The Board received and approved the Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) 18 Week Access Policy and Recovery Action Plan, subject to the completion of an Equality Impact Assessment. • The Board received Financial and Contract Monitoring Reports for Months 10 and 11. • The Board approved the PCT's Financial Budgets for 2012/13. • The proposed framework for the CCG Board Assurance Framework and process for developing a CCG specific framework was approved. • The Board received the results of the 2012 Patient Survey undertaken by the Care Quality Commission. • An update on the current position with regard to the local implementation of Any Qualified Provider (AQP) was received. .

	• The Board supported the proposed Procedures of Low Clinical Value (PLCV) commissioning policy. • The Board received and supported the proposals for the Future Configuration of Hospital Services at SaTH and noted that the Full Business Case would be presented to the CCG Board meeting in May for formal approval. • A progress report was received on the review and development of Shropshire County PCT's and CCG's websites. • An update was received on the roll out of the NHS Equality Delivery System (EDS) and the Board approved the proposed equality objectives. • An update was received on the CCG development, structure and preparation for authorisation.

RECOMMENDATION TO THE BOARD:	The Board is asked to receive and note the minutes of the Shropshire County Clinical Commissioning Group Board meetings held on 7 March and 4 April 2012.

CONTEXT & IMPLICATIONS	
Strategic Objectives	N/A
Financial	N/A
Legal	N/A
Risk & Assurance	As per minutes
HR, Equality & Diversity	N/A
National Policy	NHS White Paper – Liberating the NHS
Carbon/Sustainability	N/A
Partnership	As per minutes

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	The minutes were approved at Shropshire County CCG Board meetings on 4 April and 2 May 2012.

Shropshire County Clinical Commissioning Group

MINUTES OF THE CLINICAL COMMISSIONING GROUP (CCG) BOARD MEETING HELD IN THE SEMINAR ROOM 2, SHROPSHIRE EDUCATION & CONFERENCE CENTRE, ROYAL SHREWSBURY HOSPITAL, MYTTON OAK ROAD, SHREWSBURY AT 9.00AM ON WEDNESDAY 7 MARCH 2012

Present

Dr Caron Morton	*(CCG Chair)*
Dr Bill Gowans	*(CCG Vice Chair)*
Dr Catherine Beanland	*(GP Member) – in attendance up to Minute No 2012.060*
Dr Steve James	*(GP Member)*
Dr Sal Riding	*(GP Member)*
Dr Peter Clowes	*(GP Member)*
Mrs Fran Beck	*(Director of Integrated Care)*
Dr Julie Davies	*(Acting Director of Commissioning)*
Mrs Donna McGrath	*(Chief Financial Officer)*
Mr Alan Healey	*(Non-Executive Director)*
Dr Helen Herritty	*(Shropshire Area Lead Non Executive Director)*
Prof Rod Thomson	*(Director of Public Health)*
Mrs Bharti Patel-Smith	*(Head of Governance)*
Dr Simon Hodson	*(Observer – Local Medical Committee)*
Dr John Snelling	*(Observer)- in attendance up to Minute No 2012.054*
Mr Richard Chanter	*(Shropshire Patient Group – Observer)*
Mr David Beechey	*(Shropshire Patient Group – Observer) – in attendance up to Minute No 2012.061*
Mrs Paula Burton	*(Non-Executive Director - Observer)*
Mrs Tracy Eggby-Jones	*(Corporate Services Officer)*

Apologies

Dr Julian Povey	*(GP Member)*
Mr Paul Tulley	*(Chief Operating Officer)*
Mrs Linda Izquierdo	*(Deputy Director of Nursing, Quality and Patient Safety)*
Mr Eamonn Kelly	*(West Mercia Cluster Chief Executive)*
Dr Leigh Griffin	*(Managing Director, Shropshire County PCT)*
Dr Josh Dixey	*(Observer)*

Dr Morton welcomed everyone to the Clinical Commissioning Group (CCG) Board meeting, in particular Mr Richard Chanter and Mr David Beechey as Patient Group observers and Mrs Paula Burton as Non-Executive Director observer. It was noted that Mr Harmesh Darbhanga had also been invited to attend as a Non-Executive observer.

Minute No 2012.046 - Declarations of Interests

There were no declarations of interest to note at the meeting.

ACTION **Members to complete Register of Interests proforma and return to CCG office.**

Minute No 2012.047 - Introductory Comments from the Chair

Dr Morton had no additional comments to note, other than the welcome at the beginning of the meeting.

ACTION **For information – position noted.**

Minute No 2012.048 - Minutes of Previous CCG Board Meeting : 1 February 2012

Dr Davies reported that there was an inaccuracy on page 4, Minute No 2012.028 – Performance Report. The figures noted under 'Primary Dental Services' were the number of patients and not currency.

Dr Hodson clarified that on page 11, Minute No 2012.041 – Clinical Commissioning Group Structure, the LMC would put forward a formal request to be part of the CCG membership.

BOARD MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the Minutes of the Board Meeting of Shropshire County Clinical Commissioning Group (CCG) held on 1 February 2012, subject to the amendment noted above.

ACTION	**For information – position noted.**

Minute No 2012.049 - Matters Arising from the Previous Board Meetings (not on the agenda)

a) Minute No 2012.028 - Performance Report

Dr Morton reported that the actions recorded in this section would be addressed in April and were outlined below.

ACTION	**Dr Morton to liaise with Mr Tulley with regard to establishing a matrix for 4 or 5 key areas for those patients who fall outside the target area.** **Dr Davies to present summary of lessons learnt from 'look-back' exercise to CCG Board in April.** **Dr Beanland, Professor Thomson and Dr Davies to discuss developing local outcome measures.**

b) Minute No 2012.033 – NHS 111

Dr Morton advised that the NHS 111 costings and service specification were not available at present, however, an update would be presented to the April Board meeting.

ACTION	**Dr Morton to present update report on NHS 111 costings and service specification to the CCG Board meeting in April.**

c) Minute No 2012.041 – Clinical Commissioning Group Structure

Dr Morton advised that she had met with Mrs Joanna Newton, Chair, West Mercia Cluster, to discuss the CCG sub-committee proposed structure and would present feedback to GP Members and CCG Executive Team.

ACTION	**For information – position noted.**

d) Minute No 2012.042 - Clinical Commissioning Group Board representative at Foundation Trust Stakeholder meetings

Dr Morton reported that Dr Steve James expressed an interest in becoming a CCG representative at Shropshire Community Health NHS Trust Foundation Trust Stakeholder meetings. It was noted that other CCG representatives would be required in order to respond to the requests from other Trusts.

ACTION	**Members to forward areas of interest for attendance at Foundation Trust Stakeholder committees/reference groups to Dr Morton.**

Minute No 2012.050 - Update from the Chair

Dr Morton gave a verbal update on current national and local issues. The following specific comments were noted:

National Developments

- Authorisation Application Guidance - had been published and it was noted that the CCG would need to further develop and concentrate on domain 4 (Governance), in order to apply for authorisation in Wave 1 in July 2012. Dr Morton advised that she would present a briefing paper to the April CCG Board meeting on what documentation was required in the timeframe leading up to authorisation.

- General Medical Council (GMC) – New guidance published acting on cancers.

- Payment by Results (PBR) Tarriff – 2012/13 published.

- CQUINs Scheme – Published.

Cluster Developments

- West Mercia Commissioning Support Services – Mr Brian Hanford, Cluster Director of Finance, had been appointed as Interim Managing Director for the West Mercia Commissioning Support Services.

- West Mercia Cluster Board – items discussed at 28 February 2012 Cluster Board meeting included:

    - Pending patients at Shrewsbury & Telford Hospital NHS Trust (SaTH)
    - 18 week pending breach and constitutional rights (although it was noted that the position had now significantly improved)

- SHA Assurance and Safeguarding visit – scheduled for 12 March 2012

Local Developments

- SaTH Chief Executive – Noted that Mr Adam Cairns would be leaving his post as Chief Executive of SaTH to take up a new position in Cardiff.

- Future Configuration of Hospital Services (FCHS) – capital of £35m had been approved for reconfiguration of hospital services at SaTH.

- CCG Constitution – work to progress the development of the CCG Constitution was underway, and an update was noted under Minute No 2012.060 – CCG Development.

- QIPP – updated version had been issued, with key start dates noted as follows:

    - July – RAID
    - October – Long Term Condition Strategy
    - October – Frail and Complex Cases

- 2% Non-recurrent bid – work was progressing on developing the bids, but not submission date had been received.

- Contract Negotiations – had been completed with QIPP savings attained.

- Shropshire Community Health NHS Trust - PAM (Price Activity Matrix) – discussion underway but no final position agreed.

- Local Health Economy 5-10 year sustainable plan – Finnamore were working with the local health economy to develop a sustainable plan for the next 5-10 years, which would be available at the end of April 2012.

Dr Herritty raised concern that she and other CCG Members had not been involved in the work being undertaken by Finnamore. Dr Morton advised that she had a meeting scheduled later in the week and it was envisaged that CCG Members would be contacted thereafter.

Dr Gowans believed that the Cluster Board was trying to empower CCGs by offering help and guidance on their authorisation applications and felt it would be sensible to take up their offer for the benefit of the CCG. Dr Beanland asked if there would be backing and support for education at Cluster level? If so, could she be put in touch with the relevant person.

THE BOARD FORMALLY NOTED the Chair's update on national, regional and local developments.

ACTION	**Dr Morton to present briefing paper on Authorisation Application Guidance to April CCG Board meeting.** **Mrs Patel-Smith to establish name of Educational person at the Cluster and feedback to Dr Beanland.**

Minute No 2012.051 - Patient Story

Firstly, Dr Davies recorded her thanks to Dr Gowans for his help in obtaining the patient's consent and constructing the patient story.

The patient story, presented by Dr Davies, focused on a patient's journey from prostate cancer screening, diagnosis, through to surgery, which overall took 423 days from referral and involved numerous healthcare professionals, from the GP to an out-of-county consultant. The story highlighted the complexity and uncertainty facing the patient at each stage of his assessment/treatment and only by carrying out his own research he was able to make an informed choice in relation to what treatment he wished to undertake. The patient was now three months post-operative and making an uneventful recovery.

Members felt this illustrated how those patients who were knowledgeable and carried out their own research were able to make informed choices about their treatment, which may leave other patients making uninformed choices. It was noted that perhaps more information about conditions, treatments and services should be made readily available to all patients. It was also highlighted that an appropriate pathway needed to be established involving all healthcare professionals, including out-of-county providers, which would enable consultant to consultant referrals.

Dr Morton asked for a volunteer to present a patient story at the April CCG Board meeting.

ACTION	**Volunteer required to present a patient story at the April CCG Board meeting.**

MANAGING DELEGATED RESPONSIBILITIES: CURRENT PERFORMANCE

Minute No 2012.052 - Performance Report (Against vital signs/outcome measures and Contract Management Report

Dr Davies presented the Performance Report which outlined current performance against targets linked to the Vital Signs assessment produced by the Care Quality Commission. Appendix A outlined the status of all targets and reflected the Performance Measures for 2011/12, which the PCT would be monitored against. The report had been updated to reflect the new ambulance indicators (where data was available).

Appendix B summarised actions for vital sign indicators, where the targets were not currently being achieved. Dr Davies advised that there had been significant improvement and change in direction of performance since the last report, with the exception of Delayed Transfers of Care (DToC). Although the hard work of Mrs Christine Morris and Mrs Elaine Hodson in establishing a process for DToC was acknowledged. Mrs Beck reported that the position had now been recovered and that there was a better understanding of systems, which enabled complex problems to be resolved.

Dr Herritty raised concern that there appeared to be an increase in the number of Healthcare Acquired Infections (HCAI). Dr Davies advised that there had been a change in the way in which tests for infection were carried out, which had resulted in more cases being reported. However, reporting had leveled out and the numbers had now fallen. Prof Thomson confirmed that previously the PCT had good compliance against the target, which inevitably meant the target was tightened, and predictably a higher numbers of cases were identified. Dr Morton suggested that an article be drafted for the next edition of Magpie in order to highlight the issue to GPs and practices and ask for their continued support in reducing the numbers of HCAIs.

It was noted that Appendix C summarised the performance against the Cancer target and a full report was received under Minute No 2012.053.

In addition, Dr Davies advised that she would present an Ambulance Performance Report at the April CCG Board meeting.

THE BOARD FORMALLY RECEIVED AND NOTED the performance report against vital signs/outcome measures and contract management, as presented by Dr Julie Davies.

ACTION	**Dr Morton, Prof Thomson and Dr Beanland to liase with regard to producing an article on HCAIs for the next edition of Magpie.** **Dr Davies to present Ambulance Performance Report to CCG Board meeting in April.**

Minute No 2012.053 - Cancer Performance Report

Dr Davies presented the Cancer Performance Report, produced by Mr David Whiting, Commissioning Manager – Cancer.

Dr Davies reported that cancer waiting times performance remained very good, with all of the 'year to date' targets currently above the thresholds, apart from 62-day referral to treatment and screening upgrades. Overall, SaTH, the main provider, was compliant with the target and was forecast to still achieve the 62-day target for the year. The good performance was due to improved and updated procedures within SaTH.

It was also noted that some of the targets involved very small numbers and that a single breach could sometimes mean that a target failed. Dr Davies advised that some of the breaches were due to out-of-county providers and she assured the Board that discussions were taking place with University Hospital North Staffordshire (UHNS) to resolve these complex cases.

In addition, a workshop had taken place on 23 February with all key stakeholders from clinical, management and commissioning sides to monitor progress and use of 2-week referrals. Another workshop would be convened to look at all other specialties, including large capacity areas such as breast and skin.

Dr Morton confirmed that the CCG Board would be looking at championing three key indicators and cancer may be one. Dr Morton would be putting together a proposal for the Board to consider at its next meeting in April.

Mrs Patel-Smith advised that the Cancer Local Implementation Team (LIT) was currently undergoing a review of their work and felt it would be appropriate to use this forum to feedback issues, particularly in relation to 62-day referral to treatment.

THE BOARD FORMALLY RECEIVED the Cancer Performance Report and NOTED the current good performance against targets.

ACTION	**Dr Morton to draft proposal on three key indicators to be championed by the CCG Board and present to Members at the meeting in April.** **Dr Davies to liaise with Cancer LIT with regard to current issues in relation to 62-day referral to treatment.**

Minute No 2012.054 - Finance Report

Mrs McGrath presented the Financial and Contract Monitoring report for Month 10 (to 31 January 2012), which sets out the PCT's financial position from the Commissioning Arm perspective.

Mrs McGrath reported that the PCT's cumulative position showed a £749,998 surplus, which was higher than the planned position of £700,000 surplus. The position included an adverse variance of £3,264,643 in respect of Shropshire County Clinical Commissioning Group; offset by favourable variances in other areas.

The PCT was currently forecasting achievement of the control total of £1,000,000 surplus and the 1% contingency reserve was fully committed.

Mrs McGrath advised that Appendix B identified the movement between the Initial Revenue Resource Limit and the latest position in line with in year adjustments and assumptions around anticipated allocations. Where as Appendix C showed the cumulative Month 9 position of £3,264,643 deficit. This was a reflection of a significant adverse variance relating to SaTH and other NHS out-of-county contracts, partially offset by favourable variances in other areas, notably RJAH and GP Prescribing.

Dr Herritty asked Dr Davies if she was confident that contracts would be achieved next year? Dr Davies advised that she would be drafting a paper outlining the QIPP savings and contract output, which she planned to present to the CCG Board in April.

Dr Beanland welcomed the Finance Report and asked if it would be possible to have an overarching spreadsheet of where resources were spent, including the 2% non-current funding, similar to the one presented to the Quality, Performance & Resources (QPR) Committee. Mrs McGrath agreed to circulate the QPR paper to Board Members and reported that she would also be presenting a budget-setting paper to the April CCG Board meeting.

Mrs Burton raised concern with regard to the increasing demand on the Continuing Healthcare budget and asked whether this had been reflected in the budget for 2012/13. Mrs McGrath confirmed that the proposed budget was challenging but a growth element, attached to QIPP savings, had been factored into the budget for 2012/13.

THE BOARD FORMALLY RECEIVED AND NOTED the Financial and Contract Monitoring report for Month 10 (to 31 January 2012),

ACTION	**Dr Davies to present briefing paper outlining QIPP savings and contract output to April CCG Board meeting.** **Mrs McGrath to circulate QPR Committee Financial Report to CCG Board Members.** **Mrs McGrath to present Budget-setting paper to April CCG Board meeting.**

Dr Snelling left the meeting at this point.

Minute No 2012.055 - SaTH 18 Week Referral to Treatment (RTT) update

Dr Davies presented her report which provided Members with an update on the 18 Week Referral to Treatment (RTT) at SaTH and advised that both local PCTs continued to work closely with SaTH to monitor their delivery against their current detailed RTT plans. The current target was to achieve the admitted (90%) and non-admitted (95%) targets for the Trust by the end of March 2012.

Dr Davies reported SaTH now had an admitted backlog down to 420 for all commissioners, of which 220 were Orthopaedics, which was a significant improvement compared to a high 1,586 patients in August 2011. The current non-admitted backlog was down to 381 from a high of 4,095 patients in July 2011. Also, since June 2011 the number of incomplete pathways over 18 weeks had fallen from a high of 6,175 at SaTH to 801 as of last week.

Dr Davies was confident that the Trust would achieve the non-admitted target during March 2012, and the admitted target by the end of March 2012. The specialty that gave the main cause for concern was Orthopaedics, as this would be the last specialty to achieve the target by the end of March. SaTH had already achieved the incomplete target in November 2011.

In addition, a cohort of Orthodontic patients had been given to the PCT to assess and, if necessary, develop treatment plans for, by the end of March. A cohort of Oral Surgery patients would also have had all their treatment by the end of March.

Dr Morton, on behalf of the Board, recorded her thanks for the hardwork and continued support Dr Davies and the Commissioning Team had provided to SaTH. Dr Herritty asked if there was anything else the CCG could do to ensure the targets were met. Dr Davies advised that all the additional capacity purchased had been fully utilised and no further contingency was available.

THE BOARD FORMALLY RECEIVED AND NOTED the update report from Dr Davies on the current performance and planned actions to deliver the 18 Referral to Treatment (RTT) improvement.

ACTION	**For information - position noted.**

Minute No 2012.056 - Locality Updates

Dr Gowans and Dr Morton gave a verbal update to the CCG Board on Locality issues and development of Locality Boards.

Dr Gowans announced that Dr Ruth Clayton, Chair - North Locality, had agreed to undertake the role of Vice-Chair of the Clinical Advisory Panel (CAP). Dr Gowans welcomed this appointment and felt it was a positive step to local engagement.

Dr Morton advised that she had regular meetings with the Chairs of the Locality Boards and noted the three workstreams currently being undertaken:

- Organisational Development (OD) planning, with support from Ms Karen Yates.
- Development of CCG Constitution, outlining organisational functions and accountability.
- QIPP – specific areas identified for review (North – Dementia Care, South – Long Term Conditions and Shrewsbury & Atcham – the management of patients out of hospital settings, ie care homes)

Dr Morton reported that she would be giving presentations to the Practice Nurse and Practice Manager Forums around the county to promote membership of the CCG Board and Sub-committees.

Dr Beanland asked how non-principals would be engaged in locality development, particularly as they do not necessarily work within one particular area. Dr Morton advised that this would need to be explored further, but noted that the CCG would be willing to fund and support a Non-Principals Group if this was felt to be appropriate. Dr Beanland reported that a non-principals COPE event was planned for later in the year and it may be something that would be explored then.

THE BOARD RECEIVED AND NOTED the verbal update on Locality issues and development of Locality Boards as presented by Dr Gowans and Dr Morton.

ACTION **For information – position noted.**

Minute No 2012.057 - Board Assurance Framework

Mrs Patel-Smith presented the revised Shropshire County and Telford & Wrekin Board Assurance Framework (BAF), noted as Appendix 1 of the report, and advised that it had also been presented to the West Mercia Cluster Board meeting on 28 February 2012.

It was noted that the current BAF had been simplified to reflect the top risks identified by both PCTs and Mrs Patel-Smith highlighted the importance of maintaining the existing PCT BAF until an the CCG had an agreed CCG BAF. Therefore, it was suggested that the framework be used as a basis for the development of the Shropshire County CCG's BAF, and be used to outline specific risks associated with the achievement of the CCG's duties and principles that were not included in the PCT's BAF.

In order for the Board to discuss the process for developing a CCG specific Assurance Framework it was proposed that a Board workshop be held in April. Board Members welcomed the simplified approach of the BAF, which identified the high level risks for which the Board sought assurance and supported the proposal to hold a workshop specifically aimed at developing a CCG Assurance Framework.

In addition, Dr Beanland suggested an amendment to the wording under Key Principle 2 – Develop a 'true membership' organisation (page 3), to include 'GP member practices and individual GPs'.

THE BOARD APPROVED the proposed framework for the future CCG Board Assurance Framework report and AGREED that the process for developing a CCG specific Assurance Framework should be discussed at a Board Development workshop.

ACTION **Mrs Patel-Smith to set up CCG Board Workshop in April for the development of a CCG specific Assurance Framework.**

Minute No 2012.058 - Care Quality Commission (CQC) Patient Survey

Mrs Patel-Smith, on behalf of Mrs Izquierdo, presented the results of the 2012 Patient Survey undertaken by the Care Quality Commission (CQC). The survey undertaken related to patient views on their experience in secondary care hospitals and the results showed a comparison of the main providers across the West Mercia Cluster.

It was noted that Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH) performed significantly better than other organisations in several areas. However, performance in the "Time waiting for an appointment" was comparatively worse. This was an area that had been identified as requiring improvement previously by both the Trust and local Commissioners. The Trust had a proven track record of developing processes and care pathways to consistently improve patient experience. Actions taken by the Trust to improve patient experience would continue to be monitored via the Clinical Quality Review (CQR).

Mrs Patel-Smith reported that SaTH's performance was worse than other organisations in four elements, which were shown in 'red' in Appendix 1 of the report. The Trust had over recent months demonstrated its commitment to improving patient experience in all the areas indicated and were taking measures to seek real time patient feedback to improve services. These measures and wider patient experiences would continue to be monitored through the CQR process.

Mrs Patel-Smith advised that the results from the survey would be triangulated with the number of incidents and complaints received by the Trusts, In addition, Dr Davies stated that the results would be used to develop the Trusts' CQUIN measures.

Mr Chanter asked if the same survey was carried out for primary care providers? Dr Morton confirmed that there was and the questions were similar. It was noted that a comparison of results from both secondary care and primary care providers for 2012/13 would be undertaken. It was also noted that no Mental Health Trusts featured in the results and that explained why South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) did not appear.

Members acknowledged the good work, leadership, moral and partnership working in secondary care and felt that the survey did not reflect this and people would need to be mindful that a survey is a person's personal opinion and perspective of a service.

THE BOARD RECEIVED AND ACKNOWLEDGED the key points from the results of the 2012 Patient Survey undertaken by the Care Quality Commission (CQC).

ACTION For information – position noted.

MANAGING DELEGATED RESPONSIBILITIES: PLANNING FOR 2012/13

Minute No 2012.059 - Any Qualified Provider (AQP)

Dr Davies presented her briefing paper which provided an update on the current position with regard to the local implementation of Any Qualified Provider (AQP).

Dr Davies reported that PCTs/CCGs were required to have implemented 3 services on an AQP process by September 2012. The services selected for Shropshire County PCT/CCG were podiatry, adult hearing and wheelchairs. It was noted that nationally produced specifications for these services were currently being reviewed, in conjunction with the other West Midlands Clusters, and the process had identified potential clinical and financial risks.

Dr Davies advised that AQP was a national priority and performance would be managed closely, however, participation should not be at the expense of an unsuitable service specification or expensive tariff which could create a clinical and/or financial risk for the CCG. With this in mind, Dr Davies assured the Board that any decisions to commence the qualification process for any of the 3 services would be made on the basis of a proper analysis of the risks involved. Although the timescales involved in making appropriate decisions were tight and Dr Davies proposed that the Acting Director of Commissioning, in conjunction with the CCG chair, be authorised to take the action necessary to determine whether or not to participate in the qualification process and to determine the appropriate route for doing so.

Members discussed and acknowledged the challenges facing the CCG in implementing AQP locally, but maintained that being a responsible commissioners and mitigating risks was their main priority. Therefore, it was agreed that Dr Davies and Dr Morton be authorised to take any necessary action in relation to the AQP qualification process.

THE BOARD NOTED the current position in developing AQP and SUPPORTED the proposal for the Acting Director of Commissioning, in conjunction with the CCG chair, to take the action necessary to determine whether or not to participate in the qualification process and to determine the appropriate route for doing so.

ACTION For information – position noted.

CLINICAL COMMISSIONING GROUP (CCG) DEVELOPMENT

Minute No 2012.060 – Clinical Commissioning Group (CCG) Development

Mrs Patel-Smith, on behalf of Mr Tulley, presented the summary report on progress and plans in relation to the development of the Clinical Commissioning Group (CCG) and preparation for authorisation.

Dr Morton advised that the CCG was required to develop and agree a Constitution as part of it's governance arrangements, even though it was anticipated that a model constitution document would be published by the NHS Commissioning Board shortly. Dr Morton drew Members attention to Table 1 of the report, which outlined the proposed process and timeframes for progressing the work locally. Dr Morton acknowledged that the timeframes were challenging, but felt that by developing a Constitution now would create an opportunity for member ownership before application for authorisation in Wave 1.

Board Members supported the proposal to develop a CCG Constitution, however thought it would be beneficial to obtain LMC feedback on the first draft as soon as possible, particularly in light of the tight timescales. Dr Morton agreed to speak to Dr Mary McCarthy (LMC Chair) and Dr Ian Rummens (LMC Secretary) with regard to establishing a small working group of LMC representatives to scrutinise and comment on the first draft of the Constitution.

Dr Beanland also asked for a copy of the Constitution in order to provide her comments. It was noted that the Constitution was still in the process of being written and a copy would be issued to GP and Executive Members as soon as it was available.

THE BOARD RECEIVED AND NOTED the update on the plans for CCG Development, which focussed on the six domains against which the authorisation proposals would be assessed.

THE BOARD FORMALLY APPROVED the process for the development of the CCG Constitution, as set out in Table 1 of the report.

ACTION	**Dr Morton to liaise with Dr McCarthy and Dr Rummens with regard to obtaining LMC feedback on the first draft of the CCG Constitution.**

Dr Beanland left the meeting at this point.

UPDATES FROM SUB-COMMITTEES OF THE PCT TRUST BOARD

Minute No 2012.061 – Report from Quality, Performance & Resources (QPR) Committee

Mr Healey reported that the Quality, Performance & Resources (QPR) Committee meeting scheduled for 29 February 2012 had been cancelled, due to contract negotiations. However, Mr Healey presented a briefing paper which outlined the issues that would have been discussed at the meeting. Key points were noted as follows:

- **Cluster QPR Committee Terms of Reference** - were revised at its first meeting and would be considered by the CCG QPR Committee at its next meeting and a decision taken on whether any consequent changes were needed to the CCG QPR Terms of Reference.

- **Finance -** the PCT remained on target to achieve its year-end financial targets (as noted in Minute No 2012.54.

- **Budget Setting** – a draft budget setting paper would be considered at the next meeting.

- **Ambulance Performance** – an update report would be presented to the next meeting.

- **Performance** - exception reports for which the year to date indictor was not green would be discussed at the next meeting.

- **Delayed Transfer of Care (DToC)** – For February, the end of month census figure for DToC had substantially improved for Shropshire responsible patients. However, the target was based on overall SaTH performance and the high number of Powys patients continued to impact on achievement of the

national standard (delays < 3.5% of available acute beds). The issue had been escalated to the cluster, who have contacted Powys Local Health Board to raise the issue as a serious area of concern.

- **Quality** – Appendix 1 of the report comprised the quality risks report as presented to the cluster QPR meeting, which highlighted key quality issues for Shropshire services

- **Primary Care Contracts** – as the QPR Committee meeting had been cancelled, Chairman's action was taken to approve contractual action in relation to a dental contract.

Dr Davies advised that she was the CCG representative at the new Welsh & Borders Stakeholder Group and she would raise the issue of DToC at their next scheduled meeting in April. Dr James offered his help and support in relation to border issues.

ACTION **Dr Davies to raise performance issue in relation to DToC at the next meeting of the Welsh & Borders Stakeholder Group in April.**

Minute No 2012.062 – Report from Clinical Assurance Panel (CAP)

Dr Gowans presented the summary of the Clinical Assurance Panel (CAP) meeting held on 8 February 2012. He advised that the Committee was evolving and due to the number of service developments received and limited capacity, it had been agreed to establish a Service Review and Procurement Group, which would report to the CAP, who in turn would provide assurance to the CCG Board.

In addition, Dr Gowans reported that shared governance was developing across the Local Health Economy, which would enable transformational change and integration. Members welcomed the move to shared governance and felt this would be beneficial for developing a more formal process for service redesign and accountability, particularly around risk and quality.

THE BOARD RECEIVED AND NOTED the summary of the Clinical Assurance Panel (CAP) meeting held on 8 February 2012.

ACTION **For information - position noted.**

Dr Beechey left the meeting at this point.

ITEMS FOR INFORMATION

Minute No 2012.063 – Downham Market Report

Dr Morton advised that she had been unable to present a briefing paper on the recommendations from the Downham Market report, as it was still being reviewed at the Cluster. It was hoped the paper would be available for the April CCG Board meeting. However, Dr Morton gave assurance that all policies and processes were in place for locums working in Shropshire.

ACTION **Dr Morton to present briefing paper on Downham Market recommendations to CCG Board meeting in April.**

ANY OTHER BUSINESS

Minute No 2012.064 – Assurance Pro-forma

Dr Morton tabled a copy of the assurance pro-forma used by the Cluster to identify any risks by Board Sub-committees. Dr Morton advised that the pro-forma should be used in conjunction with the Burdett checklists, that had also been tabled.

Dr Morton asked that all Sub-committee Chairs complete the pro-forma for each meeting and return completed forms to the CCG office for monitoring.

ACTION **Board Sub-committee Chairs to complete assurance pro-forma for each Sub-committee meeting and return to the CCG office.**

Minute No 2012.065 – Change of CCG Board Meeting Dates

Dr Morton drew Members attention to the change in CCG Board meeting dates from June 2012. The CCG Board would now meet on the second Wednesday of the month, and CAP on the first Wednesday. This would allow for more timely reports on quality, performance and finance to be presented. The revised dates were noted on the agenda.

ACTION	**Members to note change of CCG Board meeting dates from June 2012, as noted on the agenda.**

Minute No 2012.066 –Board Development Away Day

Dr Morton proposed holding a Board Development Away Day week commencing 9 April 2012, to particularly look at the CCG Constitution and Board Assurance Framework. Members were asked to forward their availability to the CCG office.

ACTION	**Members to inform the CCG office of their availability to attend a Board Development Away Day during week of 9 April 2012.**

There were no other items of any other business to note.

DATE OF NEXT MEETING

The next scheduled meeting of the CCG Board would take place on Wednesday 4 April 2012, 9.00am at Shrewsbury Town Football Club, Oteley Road, Shrewsbury.

SIGNED …….. DATE ……

Shropshire County Clinical Commissioning Group

MINUTES OF THE CLINICAL COMMISSIONING GROUP (CCG) BOARD MEETING HELD IN THE SOVEREIGN SUITE, SHREWSBURY TOWN FOOTBALL CLUB, OTLEY ROAD, SHREWSBURY AT 9.00AM ON WEDNESDAY 4 APRIL 2012

Present

Dr Caron Morton	*(CCG Chair)*
Dr Bill Gowans	*(CCG Vice Chair)*
Dr Catherine Beanland	*(GP Member)*
Dr Steve James	*(GP Member)*
Dr Peter Clowes	*(GP Member)*
Dr Kieran McCormack	*(GP Member)*
Mr Paul Tulley	*(Chief Operating Officer)*
Mrs Fran Beck	*(Director of Integrated Care) – in attendance up to Minute No 2012.085*
Dr Julie Davies	*(Acting Director of Commissioning)*
Mrs Donna McGrath	*(Chief Financial Officer)*
Prof Rod Thomson	*(Director of Public Health) – in attendance up to Minute No 2012.085*
Mr Alan Healey	*(Non-Executive Director)*
Mrs Bharti Patel-Smith	*(Head of Governance)*
Dr Josh Dixey	*(Observer)*
Dr Simon Hodson	*(Observer – Local Medical Committee)*
Mr Richard Chanter	*(Shropshire Patient Group – Observer)*
Mr David Beechey	*(Shropshire Patient Group – Observer)*
Mrs Paula Burton	*(Non-Executive Director - Observer)*
Mrs Tracy Eggby-Jones	*(Corporate Services Officer – Minute Taker)*

Apologies

Dr Julian Povey	*(GP Member)*
Dr Sal Riding	*(GP Member)*
Dr Helen Herritty	*(Shropshire Area Lead Non Executive Director)*
Mrs Linda Izquierdo	*(Deputy Director of Nursing, Quality and Patient Safety)*
Mr Eamonn Kelly	*(West Mercia Cluster Chief Executive)*
Dr Leigh Griffin	*(West Mercia Cluster Deputy Chief Executive)*

In Attendance

Mr David Naylor	*(OD Programme - Observer)*
Mr Neil Nisbett	*(Director of Finance, SaTH) - Minute No 2012.082 only*
Mrs Kate Shaw	*(Programme Manager, SaTH) - Minute No 2012.082 only*
Mrs Jenny Stevenson	*(Clinical Governance Facilitator) - Minute No 2012.085 only*

Dr Morton welcomed Members to the Clinical Commissioning Group (CCG) Board meeting, in particular Dr Kieran McCormack, newly appointed GP Member for Quality and Mr David Naylor, who was in attendance to observe the Board as part of the organisational development (OD) programme.

Minute No 2012.067 - Declarations of Interests

Professor Thomson reported that he was a Foundation Governor at Alder Hey Children's NHS Foundation Trust.

Minute No 2012.068 - Introductory Comments from the Chair

Dr Morton had no additional comments to note, other than the welcome at the beginning of the meeting.

Minute No 2012.069 - Minutes of Previous CCG Board Meeting : 7 March 2012

Dr Davies reported that there was an inaccuracy on page 6, Minute No 2012.054 – Finance Report. The briefing paper outlining the QIPP savings would be presented to the May CCG Board meeting and not April as stated.

BOARD MEMBERS FORMALLY RECEIVED AND APPROVED as an accurate record the Minutes of the Board Meeting of Shropshire County Clinical Commissioning Group (CCG) held on 7 March 2012, subject to the amendment noted above.

Minute No 2012.070 - Matters Arising from the Previous Board Meetings (not on the agenda)

a) Minute No 2012.028 - Performance Report

Dr Davies advised that the briefing paper on the 'look-back' exercise would be presented to the May CCG Board meeting.

ACTION **Dr Davies to present summary of lessons learnt from 'look-back' exercise to CCG Board in April.**

b) Minute No 2012.063 – Downham Market Report

Dr Morton reported that she was unable to present the report on the Downham Market recommendations, as feedback from the Cluster and Strategic Health Authority (SHA) had not been received, therefore, this would be presented to the May CCG Board meeting.

Dr Morton reassured the Board that work was progressing in the CCG/PCT following the publication of Downham Market report and that in Shropshire all locums had to be on the Shropshire Performers List and received induction packs and regular appraisals.

ACTION **Dr Morton to present briefing paper on the Downham Market recommendations to the CCG Board meeting in May.**

Minute No 2012.071 - Update from the Chair

Dr Morton gave a verbal update on current national and local issues. The following specific comments were noted:

National Developments

- National Commissioning Board (NCB) – Sir Bruce Keogh, NHS Medical Director, was focusing on the role of Medical Directors in light of the development of the NCB and CCGs.
- Atlas of Variation 2011 – Now published and showed variation in child health improvements, particularly Asthma and Epilepsy.
- 'Let's Get Moving' Campaign – had been launched, which would be taken forward by the CCG and Public Health.
- National Cancer Awareness Campaign - to be launched in May.
- Health and Social Care Act – the Act had now been passed through Parliament and Mr Andrew Lansley, Secretary of State for Health, had written to all CCG Chairs outlining the expectation of CCGs.
- National Challenge on Dementia – the government had outlined plans to increase spending to £66m by 2015 on dementia research, which would include memory clinics and dementia friendly communities.
- David Flory report – The Quarter (Oct – Dec 2011) – had been published. Key highlights included the reduction in the number of Health Care Acquired Infections (HCAI), particularly MRSA and C-Difficile, and breaches of mixed sex accommodation. Both SaTH and RJ&AH had been identified in the poorest performing Trusts league table for Referral to Treatment (RTT), which had led to the local health economy being performance managed by the Strategic Health Authority (SHA).

Cluster & CCG Developments

- Shropshire County CCG – was now operating in full shadow from 1 April 2012. The PCT Managing Director role had ceased to enable CCG Executive Directors to report directly to the Cluster.

- Authorisation Application Process – the Cluster had given their agreement for the CCG to proceed in Wave 1 of the authorisation process. This item was discussed in detail under Minute No. 2012.084.

- CCG Recruitment – Dr Kieran McCormack had been appointed as Lead GP Member for Quality. Further appointments had also been made to the quality and safeguarding directorate.

THE BOARD FORMALLY NOTED the Chair's update on national, regional and local developments.

ACTION Position noted – for information.

Minute No 2012.072 - Patient Story

Mr Healey recorded his thanks to colleagues for obtaining the details relating to the patient story.

The patient story, presented by Mr Healey, focused on a patient's treatment for cataract surgery. The patient had already undergone private treatment on their left eye and, due to sight deterioration in the right eye, underwent NHS funded cataract surgery. Initially the patient had their pre-operative assessment where the lense strength was determined. However, following the procedure the patient experienced severe pain and was referred back to the Consultant Ophthalmologist. At this point it was established that the incorrect lense strength had been inserted. Corrective surgery was not an option and the patient was provided with alternative eyewear. The patient expressed their concern at the way in which they had been treated following the procedure, the fact they were not acknowledged appropriately, the lack of openness and the arrogance of the consultant.

Dr Morton advised that the incident was logged as a 'Never Event' and a Root Cause Analysis (RCA) was undertaken. It transpired that this incident was not isolated and that several other similar incidents had occurred within the department, all of which were subject to a RCA. It was established that they had occurred due to both software and human error. Therefore, the decision had been taken to suspend the ICAT service and temporarily close the ophthalmology theatres. Dr Davies reported that commissioners were in discussion with the Nuffield with regard to providing the service in the interim, although it was noted that they would not be able to fully meet demand. However, Dr Davies was hopeful that the theatres would reopen after 16 April 2012.

Members discussed how staff attitudes were addressed and monitored. Dr Morton advised that robust systems were in place, ie disciplinary procedures, and that patient complaints formed part of the new healthcare professionals appraisal system and revalidation. In addition, Dr Morton confirmed that a CCG GP Member was part of the RCA panel for each 'Never Event'.

Dr Morton asked for a volunteer to present a patient story at the May CCG Board meeting.

ACTION Volunteer required to present a patient story at the May CCG Board meeting.

MANAGING DELEGATED RESPONSIBILITIES: CURRENT PERFORMANCE

Minute No 2012.073 - Performance Report (Against vital signs/outcome measures and Contract Management Report

Minute No 2012.074 - Cancer Performance Report

Minute No 2012.075 - Ambulance Performance Report

Minute No 2012.076 - Finance & Contract Management Report

Mr Tulley advised that the Quality, Performance & Finance (QPR) Committee had already discussed the four performance and contract monitoring reports (outlined above) and that the reports had been circulated with the

CCG Board agenda for information. Key highlights from the reports were noted in the QPR briefing paper presented under Minute No. 2012.087.

It was agreed that in future detailed performance reports would be presented and discussed at the QPR Committee and that only a summary report of key issues would be received at Board meetings.

THE BOARD FORMALLY RECEIVED AND NOTED for information the:

- ***Performance report against vital signs/outcome measures and contract management.***
- ***Cancer Performance report against cancer waiting times target***
- ***Ambulance Performance report***
  Financial and Contract Monitoring report for Month 11 (to 29 February 2012),

Minute No 2012.077 - Budget Setting

Mrs McGrath presented the proposed PCT Financial Budget report for 2012/13, which had been produced following contract negotiations. Mrs McGrath reported that the Quality, Performance & Resources (QPR) Committee had reviewed the report at their meeting in March and recommended approval to the Board.

Mrs McGrath drew Members attention to key points within the report as follows:

- **PCT Allocation uplift for 2012/13** - had been announced at 3% (£13m). The allocation does not take into account any movement towards the PCT's weighted capitation target. The PCT was currently 2.8% (£12.7m) below it's weighted capitation target.

- **QIPP** - the SHA had recommended that PCTs identify a further 25% of contingency savings over and above those needed to deliver the control totals. For Shropshire PCT this would amount to £2.6m further savings to be identified. Against this target the PCT had already identified a small (£347k) contingency. The Supporting Delivery Group (SDG) would have the remit of identifying additional contingency schemes and actioning the savings schemes as required.

- **Health Economy Sustainability** - in addition to the commissioner QIPP Programme providers within the health economy had internal efficiencies that needed to be met. The value of these efficiencies would amount to at least 4% of their turnover. In order to ensure financial stability across the health economy the providers plans must be reviewed alongside the commissioners plans to ensure that they were sufficiently robust to realise efficiency savings while still delivering a quality service.

- **Nationally Mandated Programmes** - there were some nationally mandated programmes (eg Any Qualified Provider and NHS 111) that were going to have a financial impact on the organisation during 2012/13. As at that stage the programmes were not advanced enough to evaluate the financial implications to the CCG and they had not, therefore, been factored into the budgets. As soon as the financial modelling on the schemes had been completed the Board, via the QPR Committee, would be updated.

Mrs McGrath emphasised that during a period of rapid change it would be important to maintain an audit trail of budget transfers and responsibilities to successor organisations. Similarly it would be important to ensure organisational knowledge was not lost during transition as key staff were transferred into new organisational structures.

Mr Healey stressed that the QPR Committee and SDG would be stringently monitor the cost improvement programmes (CIPs) and contingency schemes and provide assurance to the Board on a regular basis.

Members enquired if the CCG's budget would make up for the shortfall, particularly as the PCT was still below its weighted capitation target. Mrs McGrath advised that there was no move towards the fairshare target, equally there was no move away either.

THE BOARD FORMALLY RECEIVED AND APPROVED the 2012/13 proposed budget as set out in Appendix 4 of the report.

THE BOARD NOTED that the budget may require further amendments, once contract values were finalised and the nationally mandated programmes implemented.

Minute No 2012.078 - SaTH 18 Week Referral to Treatment (RTT) update

Dr Davies presented her report which provided Members with an update on the 18 Week Referral to Treatment (RTT) performance at SaTH and the proposed actions required to deliver the national targets during 2012/13.

Dr Davies advised that both local PCTs continue to work closely with SaTH to monitor their delivery against their current detailed RTT plans. The target was to achieve the admitted (90%) and non-admitted (95%) targets for the Trust by the end of March 2012. It was noted that SaTH now had an admitted backlog down to 369 for all commissioners, of which 136 were Orthopaedics and 102 Ophthalmology. This compared to a high in August 2011 of 1,586. The admitted target would not be achieved in March.

The current non-admitted backlog was 377 down from a high in July 2011 of 4,095. It was envisaged that the non-admitted target of 95% should be achieved from March onwards inclusive of the routine month end validation. Since June 2011 the number of incomplete pathways over 18 weeks had fallen from a high of 6,175 at SaTH to 583. SaTH had already achieved the incomplete target and had done so since November 2011.

The original cohort of Orthodontic patients that had been given to the PCT were being assessed, with treatment plans in place by the end of March. It was noted that follow-on cohorts would not be cleared by the end of March but would be assessed and treatment plans agreed during April. The cohort of Oral Surgery patients will have had all their treatment by the end of March except 4 patients who had chosen to have their treatment in April.

THE BOARD FORMALLY RECEIVED AND NOTED the update report from Dr Davies on the current performance and planned actions to deliver the 18 Referral to Treatment (RTT) improvement at SaTH.

Minute No 2012.079 - RJ&AH 18 Week Access Policy and Action Plan

Dr Davies tabled her report which provided Members with an update on the 18 Week Referral to Treatment (RTT) performance at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJ&AH) and the proposed actions required to deliver the national targets during 2012/13.

Dr Davies advised that the Intensive Support Team (IST) visit found that the current Access Policy was not fit for purpose and a number of the 18wk RTT rules had not been interpreted and applied correctly. It recommended that the Trust rewrote its Access Policy in line with existing RTT rules and reviewed its waiting list to ensure clock pauses were being applied correctly and correct those where it had not been applied correctly. As a result of this review and subsequent correction the Trust was asked to withdraw its formal reporting of 18wks RTT from December 2011. It would be resubmitting its corrected data for December, January and February in the near future and this would show a failure of the admitted RTT for that period.

It was noted that both RJAH and commissioners had been working to rewrite the Access Policy and draw up an Action Plan to recover the 18wk RTT performance to the current waiting time targets. The plan was at a sub-speciality level and comprised actions to clear the backlog of patients with a combination of more efficient use of current resources, additional clinical capacity and commissioner support to redirect patients in the short term where possible and redesign specific pathways (eg spinal and upper limb). Dr Davies advised that as the backlog of patients would be treated in line with the action plan then the Trust's 18wk RTT performance, for both non-admitted and admitted, would get worse before recovering after the elimination of the backlog.

Members were in support of the implementation of the Patient Access Policy, however, raised concern that an Equality Impact Assessment (EIA) had not been completed. Dr Davies acknowledged that that EIA had not been undertaken at this stage, but advised the Board that she would feed this back to the Trust. The Board also confirmed their support of the Recovery Action Plan, including the additional commissioning support where necessary.

THE BOARD FORMALLY RECEIVED AND APPROVED the Patient Access Policy (Appendix 1) for immediate implementation at RJ&AH, subject to the completion of an Equality Impact Assessment (EIA).

THE BOARD AGREED the Recovery Action Plan (Appendix 2) and the necessary commitment of commissioning support required to deliver it.

ACTION	**Dr Davies to feedback to RJ&AH the Board's support of the Patient Access Policy, subject to the completion of an Equality Impact Assessment (EIA).**

Minute No 2012.080 - Locality Updates

Dr Morton advised that a Locality update would not be required as Locality Board minutes would be circulated with the Board Agenda in future. The North Locality Board minutes were received and noted under Minute No. 2012.089. Dr Morton agreed she would check with Locality Chairs if they were happy with this position or whether they would wish to present them personally.

THE BOARD NOTED that verbal updates on Locality issues would not be required in future as Locality Board minutes would be circulated with the CCG Board agenda.

ACTION	**Dr Morton to check with Locality Chairs if they would be happy for Locality Board Minutes to be issued with the Board agenda for information, or whether they would wish to present the minutes personally.**

Minute No 2012.081 - Procedures of Low Clinical Value (PLCV)

Dr Davies presented the revised policy on Procedures of Low Clinical Value (PLCV) and advised that a review of the current Shropshire policies was undertaken against the policies approved in Herefordshire, following agreement from the Clinical Advisory Panel (CAP) and Joint Committee on Priorities and Policies.

The revised policy demonstrated a potential to improve the current understanding and impact of policies by ensuring all polices were contained in one document, were reviewed with clinical colleagues across primary and secondary care for potential new areas for policy implementation and emerging evidence of clinical and cost effectiveness and incorporated coding against each policy to enable improved monitoring

Dr Davies confirmed that that the PLCV policy had been reviewed clinically by the CCG lead on scheduled care, CCG Locality Boards, clinicians from SaTH and RJ&AH. It was estimated that £250,000 would be saved in 2012/13 to be reinvested into other services as part of the QIPP challenge for the CCG.

Dr Morton reported that the CCG did not have delegated authority and was, therefore, unable to approve the policy but could recommend it to the PCT Cluster Board for approval.

Mrs Burton sought assurance with regard to the appeals process for those patients who did not meet the criteria. Dr Davies advised that these applications would be considered through the PCT's Individual Funding Request (IFR) process.

In addition, Members discussed patient and public involvement in the development of the policy. Dr Morton advised that no formal public involvement had been undertaken, although the Locality Boards and Local Medical Committee (LMC) had seen the document, and suggested that the newly established Patient & Public Member Board, chaired by Mrs Burton, could take forward.

***THE BOARD SUPPORTED** the proposed Procedures of Low Clinical Value (PLCV) commissioning policy and RECOMMENDED it be submitted to the PCT Cluster Board for approval, once further patient and public engagement had been undertaken.*

ACTION	**Mrs Burton to take forward further patient and public engagement in relation to the PLCV policy, before it was submitted to the PCT Cluster Board for approval.**

Minute No 2012.082 - Future Configuration of Hospital Services (FCHS)

Mr Neil Nisbett, Director of Finance and Mrs Kate Shaw, Programme Manager, SaTH were in attendance to give a presentation on the Future Configuration of Hospital Services (FCHS), in particular the development of the Full Business Case (FBC). A copy of the presentation is attached as Appendix 1 of the minutes.

Mr Nisbett initially briefed Members on the key points of the Outline Business Case (OBC), which included the proposed services for the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital (PRH). Mr Nisbett confirmed that capital dividend funding of £35m had been received from the Department of Health to proceed with the development. Mrs Shaw spoke on the proposed sites plans for both hospitals.

Dr Clowes asked how SaTH would ensure that appropriate procedures were in place for patients to access the Paediatric Assessment Unit (PAU), particularly those patients who live in SY4, SY6 and SY7 postcodes. Mrs Shaw advised that Mr Andrew Stenton and Mr Kevin Eardley were leading on patient-flow and gave assurance that robust processes were in place.

Dr Davies raised concern with regard to ambulance performance, in particular response times. Mrs Shaw reported that the Trust was working with the Lead on Governance and Safety at the Ambulance Service and offered to clarify Dr Davies' concerns in more detail outside the meeting.

Dr Beanland expressed her interest in establishing a link with the Trust's Education Lead in order to take forward the development of patient pathways Mrs Shaw agreed to forward the contact details of the Consultant Lead for education.

Professor Thomson enquired where Tele-healthcare fitted in with the current proposals, particularly within paediatrics. Mr Nisbett confirmed that a site-to-site facility had been tested, but acknowledged that it was not an explicit model and required further development. Mrs Shaw advised that an IT Strategy was in the process of being implemented and internal discussions were ongoing.

Dr Morton stated that the presentation received was an update on the development of the FBC and that the Board was asked to show its support at this stage, as the FBC would be presented to the CCG Board meeting in May for formal approval.

THE BOARD RECEIVED AND SUPPORTED the proposals for the Future Configuration of Hospital Services at SaTH and NOTED that the Full Business Case would be presented to the CCG Board meeting in May for formal approval.

ACTION	**Dr Davies to meet with Mrs Shaw in order to seek assurance with regard to ambulance performance and response times.** **Mrs Shaw to provide Dr Beanland with contact details of the Trust's Lead Consultant for Education.** **Mrs Eggby-Jones to note Future Configuration of Hospital Services – Full Business Case as agenda item for 2 May CCG Board meeting.**

MANAGING DELEGATED RESPONSIBILITIES: PLANNING FOR 2012/13

Minute No 2012.083 - Quality, Innovation, Productivity and Prevention (QIPP)

Dr Davies advised that an update on the QIPP would be presented to the CCG Board meeting in May, this would include the QIPP savings and contract output.

ACTION	**Dr Davies to present briefing report on the QIPP to CCG Board meeting in May.**

CLINICAL COMMISSIONING GROUP (CCG) DEVELOPMENT

Minute No 2012.084 – Clinical Commissioning Group (CCG) Development

Mr Tulley presented his summary report on progress and plans in relation to the development of the Clinical Commissioning Group (CCG), the recent guidance on the application process and an update on the development of the West Mercia Commissioning Support Organisation (CSO). Key points from the report were noted as follows:

- **Authroisation Process** – Mr Tulley had attended a Commissioning Board workshop on the authorisation process, where the application wave timescales were confirmed. The wave 1 application deadline was 1 July 2012 and it was expected that first wave applicants might have more conditions applied to their authorisation, as it was thought their aspects of readiness may be difficult to have been fully ready within the wave 1 deadline (eg development of Health & Wellbeing strategy, commissioning intentions for 2013/14 and CSO authorisation).

  Mr Tulley felt that there would be benefits for Shropshire County CCG to proceed in wave 1, as applicants would have more time, post authorisation, to discharge their conditions before April 2013, although it was noted that the SHA would liaise with CCGs and PCT clusters during April to agree which application wave each CCG would work towards. Mr Tulley drew Members attention to Section 9 of his report, which outlined the list of documentation that would need to be submitted with the CCG's authorisation application.

Dr Morton added that she and Mr Tulley would be working closely with the SHA and PCT Cluster to take forward the CCG's application for authorisation. The Board supported the proposal for the CCG to apply to be in the first wave of applicants.

- **Commissioning Support Organisation (CSO)** - The West Mercia CSO had submitted a business plan to the Commissioning Board's Business Development Unit (BDU), where it would be subject to the Gateway 2 assessment process (during April). To support the process a Service Level Agreement (SLA) had been agreed between the CCG and the CSO. Mr Tulley advised that the CCG had also been asked to complete a stakeholder survey to inform the BDU assessment of the West Mercia CSO proposal.

  Members discussed the risks associated with the development of a CSO, but Dr Morton assured the Board that she would be on the Gateway 2 Assessment Panel and would be assessing CSO proposals.

THE BOARD RECEIVED AND NOTED the update on the plans for CCG Development and SUPPORTED the proposal for Shropshire County CCG to apply to be in the first wave of applicants for authorisation.

ACTION	**Dr Morton and Mr Tulley to take forward proposal for Shropshire County CCG to apply to be in the first wave of applicants for authorisation.**

Minute No 2012.085 - Website Developments

Mrs Jenny Stevenson, Clinical Governance Facilitator, attended for this item.

Mrs Patel-Smith introduced Mrs Stevenson, who was in attendance to update the Board on progress around the review and development of the Shropshire County websites, which included the:

- Development of a Clinical Commissioning Group (CCG) website
- Review and updating of the Primary Care Trust (PCT) website
- Updating of the Independent Contractor Zone section of the PCT website

Mrs Stevenson advised that at the Shropshire County CCG Board meeting in December 2011 it was agreed to proceed with the development of a separate CCG website rather than updating the PCT site, as a result it was decided that a workshop should be arranged to inform a specification for the site. The workshop took place on 24 February to get input from a range of interested parties, ie PCT/CCG staff and GPs, member practices and patients. The group looked at some existing CCG websites and commented on what they liked and disliked about the sites, as well as thinking generally about what is important when it comes to the content and layout of websites.

The consensus was that the CCG website should be structured around service delivery and not the organisation, focusing on the user rather than how the CCG was organised and managed. Mrs Stevenson drew Members attention to Appendix 1 of her report, which outlined the proposed structure. It was recommended that a small group be set up to progress this work over the next 12 months. It was felt that it would be beneficial to invite someone from an external (preferably local) web design company to the next meeting, to discuss options and bring fresh ideas to the group. GP input into this group was also being explored. The aim would then be for the website to be launched at the end of March 2013 in time for the CCG being fully operational and accountable from 1 April 2013. The PCT website would be 'turned off' at the same time.

In addition, Mrs Stevenson advised that work was ongoing to update the content of the PCT website. A CCG page had been added to the site, as well as updated information about the structure of the PCT and West Mercia Cluster. It was noted that Mrs Stevenson and the Communications Officer were working with the website developer (employed by Shropshire Community Health NHS Trust) to keep the site up to date and continue to remove what remained of the provider information, which should now sit solely on the Community Trust's website.

Members discussed how the site could be further improved, in order to ensure the content was up to date and useful for GP colleagues. It was felt that input from a GP from the CCG Board would be beneficial and Dr James was nominated, along with Dr Beanland who had already carried out a lot of work to update and improve the education section of the Independent Contractor Zone.

Professor Thomson nominated a Public Health representative (Dr Kevin Lewis) to also help with the reviewing and development of the websites, particularly with the partnership working and transition of Public Health to the local authority.

Discussion took place with regard to the launch date of the newly developed CCG website, which was proposed to be the end of March 2013. Some Members felt that as the CCG was be going forward for authorisation in Wave 1, then the launch of the website could be earlier (ie October 2012). However, there was concern that if the date was brought forward then the content may not be to a high standard. It was, therefore, agreed to work towards the proposed launch date of March 2013.

THE BOARD FORMALLY RECEIVED AND NOTED the progress around the review and development of the Shropshire County websites and AGREED that the CCG website should be launched at the end of March 2013, in time for when the CCG became fully operational on 1 April 2013.

THE BOARD SUPPORTED the resourcing of GP input into a working group for the development of the CCG website, including the updating and maintenance of relevant sections of the Independent Contractor Zone.

ACTION **Mrs Stevenson to liaise with Dr James, Dr Beanland and Dr Kevin Lewis with regard to the reviewing and development of the Shropshire County websites.**

Mrs Beck and Professor Thomson left the meeting at this point.

Minute No 2012.086 - Equality Delivery System (EDS) Objectives

Mrs Patel-Smith presented her briefing paper which provided an update to the Board on the roll out of the NHS Equality Delivery System (EDS), thus ensuring that the CCG's obligations under the Public Sector Equality Duty were met, this included undertaking a self assessment against the 18 EDS standards.

Mrs Patel-Smith reported that a local health economy event had taken place on 22 March at which the PCT /CCG, the local acute Trust and Community Health Trust met with service users and community interest groups to review progress and inform the setting of equality objectives by the NHS organisations. The objectives were noted as follows:

1) Targeted review of what support is available for patients from the protected characteristics to access equitable healthcare services. In the first instance the review will focus on a small number of protected characteristics based on the current information we have about the protected characteristics within our communities. Potentially a protected characteristic could include the most vulnerable people in our community (e.g. people with mental health needs, homeless people etc.).

2) Review:

- the mechanisms that service providers use to capture feedback from patients who fall within the protected characteristics
- the accessibility of these mechanisms for patients from protected characteristics
- how many patients from the protected characteristics provide feedback and how service providers respond to the their feedback

3) Establish mechanisms for staff to have access to information on protected characteristic groups within the community and an opportunity to learn from them directly.

4) Incorporate the principals of the Competency Framework for Equality and Diversity Leadership into the PCTs /CCGs new appraisal system during the next 6 to 12 months.

It was noted that further dialogue was required with the community interest groups to define the objectives for the PCT /CCG, so that they were specific, measureable, attainable, relevant and time- bound.

In addition a Health and Social Care economy-wide task and finish group had been established to agree mechanisms for ongoing monitoring of implementation of the objectives by the community interest groups.

Dr Gowans advised that Shropshire was ahead of the game nationally on the implementation of EDS and. on behalf of the Board, thanked Mrs Patel-Smith for the work she had undertaken to progress the EDS and develop the objectives for the local health economy.

THE BOARD FORMALLY RECEIVED AND NOTED the content of the report and APPROVED the proposed equality objectives (noting that further work was necessary to make the objectives specific, measureable, attainable, relevant and time-bound) and AGREED that the objectives would be integrated in the business planning process.

UPDATES FROM SUB-COMMITTEES OF THE PCT TRUST BOARD

Minute No 2012.087 – Report from Quality, Performance & Resources (QPR) Committee

This item was taken earlier on the agenda and in conjunction with the Performance, Contract Management and Finance reports (Minute Nos. 2012.073-76).

Mr Tulley, on behalf of Mr Healey, presented the briefing paper which provided an update on issues discussed at the meeting of the QPR committee held on 28 March 2012 and included an update key issues as follows:

- **Finance and Contracting** - the report confirmed that the PCT remained on target to achieve its year-end financial targets and there were no significant changes to the position reported in the previous month.

- **Performance** - exception reports were presented for performance targets for which the year to date indictor was not green. It was the first month when all cancer targets had been achieved, although the year-to-date performance against the 62 day target was not achieved. The SaTH RTT position had been reported under Minute No. 2012.78.

- **Ambulance Performance** - two reports were received, the first had been commissioned from West Midlands Ambulance Service (WMAS), where areas of potential improvement had been identified, which included improving performance in SY4, SY5 and SY7 postcodes, increased use of alternative pathways and improving hospital turnaround.

  The second report was commissioned from an independent third party and provided a more detailed analysis of current areas of under-performance and suggested that alternative solutions being utilised in other areas might provide a more sustainable way of improving local performance.

- **Quality** – report received on the quality risks presented to the cluster QPR meeting and report on infection prevention and control. The Deputy Director of Nursing, Quality and Patient Experience provided a verbal update on action taken in response to a number of Never Events that had occurred in the ophthalmology service at SaTH.

- **Safeguarding** - an internal audit report was received which gave moderate assurance in relation to systems and processes for adult safeguarding. An action plan had been agreed to address the recommendations made in the report. It was noted that Adult safeguarding was already recorded as a risk on the PCT risk register and that the QPR committee would receive a monthly update on progress against the implementation of the action plan.

- **Primary Care Premises** - the committee agreed a preferred approach to the resolution of a legacy issue relating to primary care premises.

- **Budget Setting** - the committee approved the proposed budget, noting that it may require further amendments as contract values were finalised. (This report was also approved by the CCG Board see Minute No. 2012.077).

- **Supporting Delivery** - the committee received a report from the Supporting Delivery Group. The group was only able to provide limited assurance that the overall QIPP programme would be achieved in 2011/12. This would be reviewed for the following month when the impact of the pending activity at SaTH had been removed from the QIPP figures.

- **Risk Assurance update** - the Board Assurance Framework (BAF) would be amended to reflect the following:

  - Financial risk in relation to the 2012/13 (in particular the need for additional local contingencies to be identified)
  - RJAH 18 weeks performance
  - WHO checklist compliance for all providers
  - Adult safeguarding (to reflect audit report and action plan)

Mr Healey stated that the key objective of the QPR Committee was to provide assurance to the CCG Board and it was important to ensure appropriate processes were in place and fit for purpose, particularly with regard to quality.

Members welcomed the report and felt it was clear, concise and provided the necessary level of information in order to provide assurance regarding financial management, quality and performance. Members felt that Ambulance performance provided a significant risk to the PCT/CCG and recognised the need for a independent third party commissioned report to look in to issues in relation to under-performance and actions required to improve it.

Professor Thomson clarified the figures in relation to childhood immunisation and advised that the PCT was hitting all the targets, with the exception of the MMR target for 5 year olds, which was 2% below target.

Mrs Burton sought clarification with regard to the robustness of adult safeguarding procedures, particularly in residential and nursing homes. Dr Morton gave assurance that processes were improving and that Mrs Joy Henry had now been appointed as Adult Safeguarding Lead Nurse and she would be attending announced and unannounced visits to the homes.

THE BOARD FORMALLY APPROVED the Quality, Performance & Resources (QPR) Committee report as providing assurance regarding the oversight by the QPR committee of quality, performance and financial management of the CCG's delegated responsibilities.

Minute No 2012.088 – Report from Clinical Assurance Panel (CAP)

Dr Gowans presented the summary of the Clinical Assurance Panel (CAP) meeting held on 14 March 2012 for information. Dr Gowans reported that there would be no CAP meeting in April due to the CCG Board development day, therefore, to take account of this the CAP agenda for May had been extended.

THE BOARD RECEIVED AND NOTED the summary of the Clinical Assurance Panel (CAP) meeting held on 14 March 2012.

ITEMS FOR INFORMATION

Minute No 2012.089 – Locality Board Minutes

Dr Morton presented the North Locality Board minutes from the meeting held on 12 January 2012 for information and advised that she would check with Locality Chairs if they were happy with this position or whether they would wish to present the minutes personally (as noted under Minute No. 2012.080 – Locality Issues).

THE BOARD RECEIVED AND NOTED the minutes of the North Locality Board meeting held on 12 January 2012.

ACTION	**Dr Morton to check with Locality Chairs if they would be happy for Locality Board Minutes to be issued with the Board agenda for information, or whether they would wish to present the minutes personally, as noted under Minute No. 2012.080.**

ANY OTHER BUSINESS

There were no items of any other business to note.

DATE OF NEXT MEETING

The next scheduled meeting of the CCG Board would take place on Wednesday 2 May 2012, 9.00am at Shrewsbury Town Football Club, Oteley Road, Shrewsbury.

SIGNED …….. DATE ……

BOARD MEETING

TITLE OF REPORT:	Minutes of the South Worcestershire Clinical Commissioning Group Board Meeting
REPORT AUTHOR :	Simon Trickett – Chief Operating Officer – South Worcestershire Clinical Commissioning Group
PRESENTED BY:	Eamonn Kelly – Chief Executive – West Mercia Cluster PCT
PURPOSE OF REPORT:	To receive the minutes of the meetings held on 8 March 2012 and 12 April 2012
KEY POINTS:	The main topics discussed at the meeting held on 8 March 2012 were the draft staffing structures for the CCG's and the authorisation process. An update on the Joint Service Review was given which outlined the proposed workstreams. Both the Finance and Quality & Patient Safety reports were discussed and received. Finally, the Board were briefed on the visit the management team had from Ros Roughton (Deputy of Dame Barbara Haiken). The Board held a facilitated development session on 12 April 2012, although time was dedicated to discussing the Operational Plan, the Collaborative Agreement and the 2012/13 CCG Budgets.
RECOMMENDATION TO THE BOARD:	The Board is asked to note the minutes of the meeting held on 8 March 2012 and 12 April 2012

CONTEXT & IMPLICATIONS	
Strategic Objectives	None
Financial	None
Legal	None
Risk & Assurance	None
HR, Equality & Diversity	None
National Policy	None
Carbon/Sustainability	None
Partnership	None

GOVERNANCE	None
Committee/Approval Process (with dates) *as appropriate*	

South Worcestershire Clinical Commissioning Group
Board Meeting

Minutes of the meeting held on Thursday 8 March 2012
at Elbury Moor Medical Centre, Worcester

Present:	
Carl Ellson (CE) Chair	Felix Blaine (FB)
Simon Trickett (ST)	Nikki Burger (NB)
Rosemary Williams (RW)	David Farmer (DF)
Mary Walters (MW)	George Henry (GH)
Margaret Jackson (MJ)	Jonathan Thorn (JT)
Rob Parker (RP)	Richard Allen (RA)
Karen Hunter (KH)	Mike Arnold (MA)
Stuart Bourne (SB) (part)	Christine Parker (CP)
Jayne Grainger (Notetaker) (JGr)	
Apologies: Dr A Kelly, Philippa White and Jo Galloway	

1. Welcome and apologies CE welcomed everyone to the meeting and accepted apologies from Dr Kelly, Philippa White and Jo Galloway. Karen Hunter was deputising for Jo Galloway	
2. Declaration of Interests ST declared that he is currently employed by Worcestershire Health & Care Trust.	
3. Updates **3.1 CCG Support** – It was reported that the draft staffing structures were to be published the following day and the consultation document circulated to all staff in the West Mercia PCT. Staff were to be encouraged to come forward with questions and comments. Following the 30 day consultation period it was expected that by mid April the appointment process for the senior posts could be started with the remainder being completed by the end of June 2012. Work is ongoing with finalising the Commissioning Support Organisation structure and the CCG is supportive of promoting the West Mercia option although there is talk from the Centre that these organisations need to be larger in scale and may need to be within a West Midlands footprint. **3.2 Authorisation** – Recently issued guidance has been reviewed and plans are in place to deal with the volume of work which will need to be undertaken. **3.3 Visit by Ros Roughton** – The CCG had recently hosted a visit by Ros Roughton who is deputy to Dame Barbara Haiken. Positive messages were taken back and she was encouraged by the work	

and ideas of the CCG. Thanks were expressed to FB and AK for their contribution on the day. **3.4 Joint Service Review** – The 4 identified workstreams were being populated with GPs from the CCGs and we were able to put forward : NB and CE – Unplanned & Emergency Care FB - Elderly and EOL John O'Driscoll – Planned Care Gemma Moore – Women & Children's This is a well managed process with the workstreams meeting on three occasions at the same time and venue, giving the opportunity for some joined up working when needed. It was recognised that some issues are very important and we cannot await the outcome of the Joint Service Review so work is ongoing with the Walk In Centre, NHS111, stroke and A & E targets. FB highlighted that the Out of Hours Monitoring Board needs to closely oversee the service provider. Finally, the concern from the localities about reducing the monthly meetings was discussed and it was agreed that this would continue in the present format and both CE and ST would endeavour to attend meetings over the coming months.	
4. Board Structure, Operating Model and Development Following on from the Board meeting held in February, ST presented the latest version of the structure and operating model although it was noted that these may be updated as requirements may force changes over the coming months. We continue to be a clinically led organisation and this is reflected in the paper presented. The role of the practice manager was discussed and ST stressed that this is seen as an important function within the organisation as they give us a clear lever in getting things done. The 6 GP leads represent the localities and they will each be given lead roles, although the GPs will need to let ST know their time commitments so that they can be used effectively. National Guidance issued for the role of the Accountable Officer has shown that this can be a GP and CE is keen to assume this role. However that will result in him stepping down as chair and one of the remaining GPs being Chair of the Board. RP commented that this was a very good paper and that peoples thoughts had clearly been listened to and taken on board. He was supportive of it moving along although suggested that Terms of Reference for the committees be in draft form and let them evolve over time. During the discussion it was clear that the identity of the new organisation was not to be a replication of the PCT and that we need to be clear about what we are doing differently. Discussion at the development session in April could be around identifying the 5 most important things to the CCG. MA expressed his concerns about the Practice Managers Group and ST	**GP Leads**

acknowledged this, advising that he and CE are attending a Practice Managers Group meeting on 29th March to listen to those concerns and also put forward the vision for the new Practice Managers Group. All Board members were given the opportunity to raise any concerns which were addressed after which the Board approved the proposed operating model and associated changes to the membership of the board from 1 April 2012. CE proposed AK as chair of the Board and DF seconded. It was agreed that ST would discuss the position of vice chair with MJ and RP outside of the meeting, as it was noted that the process for electing lay members to the Board would be published shortly. Expressions of interest from Board members were invited on the proposed GP clinical lead roles and practice manager representative roles. Please submit to ST. Finally it was agreed that ST would carry out further work so that the proposed clinical lead roles and new committees and forums can develop appropriate terms of reference and meeting dates.	**ST** **ALL** **ST**
5.QIPP RW reported that whilst we had a Business Plan which has been useful during 2011/12 we need to produce an Operational Plan for 2012/13. This is one which we as a Board and Management Team will use on a day to day basis as it shows priorities and timescales. This is currently being worked on with Deloittes and the initial document should be ready for circulation by 15 March 2012. This will be shared with the Board with comments being needed by 20 March. It is key that GPs and Practice Managers spend some time reading and commenting on this document and we need to ensure we engage localities so that they can take ownership of the plans RP commented that as the major part of this document would be around QIPP an Executive Summary would be helpful and this will be explored once the final document is ready.	**RW**
6. Draft minutes of the Board meeting held on 9 February 2012 Page 3, item 5 was amended to read: ST reported that due to additional resources there is flexibility in the system. Pages 5 and 6, items 8.1, 8.2, 8.3 and 8.4. All amends proposed by JG were accepted.	
7. Matters Arising **7.1 Herefordshire PCT Overspend** – MW reported that the overspend had been identified as relating to three long stay patients. The practices had now been contacted and were aware of the situation which was being rectified. **7.2 Grey Gable Surgery** – CE gave an update on Grey Gable Surgery	

advising that Dr Paton is due to retire later this year when the future of this surgery will be finalised. **7.3 ICATS service – costs** – It was confirmed that the paper presented to the last Board meeting had been updated. It was noted that the data around the ICATs service is problematic however, Natalie Liao, our Senior Information Analyst is reviewing the data and it is expected we shall have more robust information in the future. **7.4 Medicines Management** – FB reported that a prescribing decision support software option appraisal is being carried out which will be circulated for comments prior to being reviewed at the Medicines Management Committee. CE reported that at the recent Roadshows many practices had expressed the wish to manage their own prescribing budgets. RW added that feed back from the Roadshows had been captured and it was agreed that this would be circulated with the minutes of this meeting.	**JGr**
8 Quality & Patient Safety Report KH presented her report advising that following ratification by all three Worcestershire CCGs and Clinical Senate, work has started on the implementation plan for the Quality & Patient Safety strategy. KH reported that feedback is awaited from the SHA regarding NHS Worcestershire's shortlist of CQUINS (Commissioning Quality Innovation) but in the meantime, details are being put into the schemes and contracts. Concern was raised around the stroke, A & E targets and TIA and it was noted that the stroke option work was being carried out due to the concerns across Worcestershire. The remainder of the paper was discussed, following which: • The report was noted • CE and DF agreed to be involved in the closure of "Never Events" • The Board agreed to the setting up of a Quality Committee and the chair would be identified.	
9 Finance Report MW presented the Month 10 Finance Report, which shows a forecast overspend of £1,697,925. It was reported that contract negotiations with the Acute Trust are almost finalised. It was to be noted that budget setting for 2013/14 will be later in the year. MW advised that the mental health placement budget (£2m) is to be transferred to the Joint Commissioning Unit and whilst this is currently overspent, the deficient will be taken from the internal risk reserve. ST asked if the process for allocating the 2% reserves had been finalised. MW responded that negotiations with the Acute Trust will result in them receiving some of the funding but that discussions are ongoing about opportunities for retaining some which can be accessed for the benefit of Worcestershire patients.	

10. Items for Information **10.1 Breast Screening: Future Developments and Screening Sites** – SB presented his report, reminding the Board that this service operates jointly with Herefordshire and mammograms are carried out at both static and mobile locations. Presently screening is carried out at 9 locations across Worcestershire however with the introduction of digital mammography, it is proposed to reduce the locations to 8 sites. For SWCCG this will result in the removal of the mobile site in Droitwich from Autumn 2012. CP asked what consultation had been carried out as she was concerned that patients could be discouraged by having to travel further. SB responded that leaflets will be distributed to practices and local events will be held for both patients and primary care staff. The Herefordshire & Worcestershire Breast Screening Programme currently has the highest uptake in the country so these changes will be closely monitored and appropriate action taken if necessary. **10.2 Child & Adolescent Mental Health Services (CAMHS)** – It was agreed that this update should be presented to the Health & Care Trust Liaison Board. **10.3 Accommodation** – JG informed the Board that the SWCCG office, currently located at Elbury Moor Medical Centre would be moving on Thursday 15 March to Droitwich Medical Centre. The office at Elbury Moor would be retained as a meeting space. **10.4 Board Development** – The Board would be meeting on 12 April for a Development Session and RW and MJ will develop the agenda with Barbara Scott, who will be delivering the session. CE proposed a 2.30pm start in the future and all agreed. Finally, as this would be the final meeting when all practice managers would be in attendance, CE thanked them for their input and continued support.	**RW/MJ**
10 Dates of next meetings 12 April 2012 – Board Development Session 10 May 2012 – Board meeting Both meetings to be held at Elbury Moor Medical Centre, commencing at 2.30pm (**Please note revised start time**)	

South Worcestershire Clinical Commissioning Group
Board Meeting

Minutes of the meeting held on Thursday 12 April 2012
at Elbury Moor Medical Centre, Worcester

Present:	
Anthony Kelly (AK) - Chair	Rosemary Williams (RW)
Carl Ellson (CE)	Lucy Noon (LN)
Simon Trickett (ST)	Jo Galloway (JG)
Jonathan Thorn (JT)	Mary Walters (MW)
David Farmer (DF)	Rob Parker (RP)
Nikki Burger (NB)	
Apologies:	
George Henry (GH)	Jayne Grainger (JGr)
Felix Blaine (FB)	Margaret Jackson (MJ)
Stuart Bourne (SB)	

1. Board Development The majority of the meeting was devoted to Board Development with the session facilitated by Barbara Scott. The session was not minuted.	
2. Operational Plan The draft Operational Plan was discussed and some minor amendments agreed. RW to forward amendments to David Mehaffey. MW to provide revised budget information & JG to forward corrected C Diff data to DM. The Plan was otherwise approved as a living document which will be used to monitor progress and revised accordingly throughout the year. Jayne Grainger to be asked to post on the members section of the SWCCG website.	RW MW, JG JGr
3. Collaborative Agreement The draft Collaborative Agreement was approved by the Board subject to completing the consultation process with practices through the locality meetings. Document to be finalised and signed by practices by the end of April.	LN / RW
4. Budgets MW led a discussion of the 2012/13 budget papers. Key issues were: • 2012/13 budgets will require formal approval at the May Board meeting. • Apportionment of internal 1% risk reserve (para 9) was noted and the effect on the 3 CCGs. This is currently being discussed between the CCGs. • Noted that 2013/14 budgets are not expected to be known before December '12. They will not be based on the current formula – either based on historic spend or a new formula. Thus, the financial position of the 3 CCGs could change substantially. • Noted that majority of spend is based on actual spend and not	

apportionment, but 3% inaccuracy could have major impact on risk reserve. • Noted that it is difficult for all 3 CCGs to develop project work against the backdrop of uncertainty. • CE suggested holding a substantial Worcestershire reserve in order to mitigate against any extreme impact of budget changes. The Board agreed to support CE and ST in brokering a Worcestershire agreement. The meeting discussed the use of the 2% transformational fund. Agreed that SWCCG should prepare good bids for submission. MW to forward bid criteria. Also agreed that any funding for WAHT should be linked to support for SWCCG Urgent Care objectives.	CE / ST
5. Date of Next Meeting 2.30pm Thursday 10 May 2012 – Elbury Moor Medical Centre	

Telford and Wrekin Clinical Commissioning Board

Minutes of the Meeting held on
Tuesday 20th March 2012
The Aldridge Room, Halesfield 6, Telford, TF7 4BF

Present:

Dr Mike Innes	MI	Chairman
Dr Karen Stringer	KS	GP CCG Member
Dr Jim Hudson	JH	GP CCG Member
Dr Andy Inglis (attended part of the meeting)	AI	GP CCG Member
Dr Stefan Waldendorf	SW	GP CCG Member
Peter Price	PP	CCG Project Director
Geoff Braden	GB	Local Support Member
Dylan Harrison	DL	Local Support Member
Andrew Mason	AM	Cluster Non-Executive Director
Miss Laura Boden	LB	Chief Finance Officer
Nicky Wilde	NW	Clinical Commissioning Manager
Karen Kalinowski	KK	Head of Care and Support – Telford and Wrekin Council

Also in Attendance:

Dr Chris Weiner – representing Dr Catherine Woodward	CW	Consultant in Public Health – NHS Telford and Wrekin
Karen Ball	KB	Secretary to the Clinical Commissioning Board (Minute Taker)
Craig Kynaston	CK	Head of Contract Management & Business Intelligence - HCS
Mark Hoult	MH	Head of Application Development
Nigel Meehan	NM	Graphnet
Sharon Clennell	SC	TRAQS Project Manager

27.12 **Apologies:** Dr Catherine Woodward, Miss Alison Smith, Mr Paul Clifford **Actions**

28.12 **Members' Declaration of Interest**

Document has been circulated to members for completion. Dr Innes informed members that it is the intention of the Government to have a more formal approach to declaration of interests and in the future it is expect that a template will have to be completed which the public will have access to view.

29.12 **Minutes of the meeting held on Tuesday 21st February 2012**

The minutes of the meeting were agreed as a true record.

30.12 **Matters Arising**

The members went through the action list from the last meeting:

33.11.1 Review of Committees
21.02 – Mr Price confirmed that a letter would be sent to PCT officers to confirm that no old PCT sub-committees should meet without full justification.
20.03 – Mr Price reported that Miss Smith is in the process of producing a letter which will be signed by Mr Price.

		Actions
3.12	Minutes of meeting held on Tuesday 20th December 2011 21.02.12 – Pen Portrait included within the papers of the meeting • Dr Woodward recommended an update on the work of the Clinical Quality Group chaired by Dr Jo Leahy and get clarity on work already being done. Dr Woodward, Dr Innes to meet with Dr Leahy to discuss a way forward 20.03 – Dr Innes has met with Dr Leahy, unfortunately Dr Woodward was unable to attend. Discussed where clinical quality will sit, which needs to be demonstrated as a CCG development. Discussions taking place at both SHA and Cluster level. Members recognised that quality is a standing Board agenda item.	
18.12.1	Outline Business Case Telford Referral and Quality Services (TRAQS) 21.02.12 • Headlines from the Project Plan will be shared with the CCG Board and future meetings will receive a more formal project update which will be scheduled within the agenda for the beginning of the meeting • Mrs Clennell to strengthen the wording in the terms of reference to reflect the need to improve quality as a primary aim of the project 20.03 – Dr Woodward has spoken to Dr Chris Weiner regarding 'unwanted variation' with reference to linking his work into TRAQS and amending the terms of reference accordingly.	
18.12.2	• Dr Woodward to produce a regular update around public health for the monthly GP Clinical Commissioning Newsletter • Dr Woodward to provider Dr Inglis with a copy of last years Annual Health Report 20.03.12 • Dr Innes reported that he is a member of the Shadow Health and Wellbeing Board and will be attending their next meeting which takes place tomorrow. As part of the agenda they will be looking at the development of the Health and Wellbeing Strategy and JSNA. • Update on the Strategy to be an agenda item, under Collaborative Arrangements, at the next board meeting, will then become a standing item.	**MI / KB**
20.12.1	Financial Position 2011 – 12 – Month 10 • Budget deficit to be reflected in the Corporate Risk Register 20.03 – this action has been completed.	
20.12.3	Clinical Commissioning Working Plans Operational Plan 2012/13 • Need to reduce the number of priority areas and clarify targets in Appendix 2. • It was felt improving life changes for children and young people isn't manageable, need to clarify with smarter targets / objectives • Need to include longer term plans.	

- It should be articulated within the Plan that there will be tie in with the Health and Wellbeing Strategy once it is developed
- Need to include measureable targets around outcomes
- Need to re-focus text at beginning to put into context.

Actions

Communications and Engagement Strategy
- Reduce the number of bullet points on page 7, to be clustered into a smaller number of points
- Need to emphasise areas the CCG think are important
- Strengthening patient engagement.

20.03 – this action has been completed.

31.12 Strong Clinical Focus

31.12.1 Risk Stratification Assurance

Craig Kynaston, Mark Hoult and Nigel Meehan attended for this agenda item.

The report submitted for this agenda item highlighted a number of issues

- Neither NHS Telford and Wrekin or Shropshire County PCT are using the outputs from the BUPA Risk Stratification tool due to issues with the primary care data submission
- These issues are mainly around the way the data extraction company, Graphnet, extract and process the data from GP practices within the PCTs
- There are four main issues relating to HCS, BUPA, Graphnet and NHS Telford and Wrekin:
  - Graphnet are not extracting flags within the data that highlights when patients have left the practice or died – Graphnet has now tested a new extraction which collects the data for deceased patients and those who have left the practice.
  - Clearing down of the BUPA tool as the data is large in volume and the risks of the clear down affecting other West Midlands PCTs – two options have been proposed for rectifying this issue
  - There are also data quality issues which are being investigated by NHS Telford and Wrekin – HCCS have issued NHS Telford and Wrekin with a list of issues identified so that NHS Telford and Wrekin can investigate and inform HCCS if any action is necessary
  - The uploaded data also has various other issues e.g. data in the wrong fields – a list of these issues has bee sent to Graphnet and they are currently under investigation

Members discussed the issues and the following points were highlighted:

- PCT are purely hosts for the risk stratification tool which has been commissioned by the Strategic Health Authority who hold the contract
- The risk stratification tool has been developed to marry primary care and secondary patient data to inform future planning for unplanned care and admissions to hospital and to improve care
- Development of the risk stratification tool has been underway for the past 2 years within Shropshire, however as yet no data

has been produced in report form for either the PCT or practices as they haven't been successful in getting an output

- Graphnet have been working closely with HCS to iron out the anomalies. Expecting to get output from the system next week
- Shropshire is the first area to use the BUPA extraction tool
- Mr Mason questioned whether, due to the issues highlighted, there would be further financial costs incurred by NHS Telford and Wrekin. Mr Mason was assured that the PCT would not incur financial costs for the delay in getting the risk stratification tool up and running.
- Dr Hudson felt there is a risk with the system not being up and running that high risk patients can't be targeted and this was a hidden challenge to their health
- Data will be extracted from practices nightly and used to inform monthly reports which are produced by HCS. This is currently happening with the two pilot practices within Telford
- HCS and BUPA are currently clearing down the data for the PCT and reloading, it is expected that this will take 2-3 weeks
- Graphnet and HCS will be visiting one of the pilot practices next week to look at the data
- Mrs Wilde highlighted that risk stratification is a standing agenda item of the Commissioning Intelligence Group. There is practice manager representation on this group so they are aware of the data issues
- EMIS web, which is being introduced to all EMIS practices in the CCG over time is an issue as it is not compatible with the risk stratification tool, however, work is ongoing to rectify this situation
- Mrs Wilde commented that one QIPP scheme is reliant on the risk stratification tool working and reassurance that it will work is required
- Mr Meehan stated that he would expect the validation tool would be working correctly within the next 6 weeks. Members raised reservations on whether this would be achievable
- Dr Weiner raised concerns with regards to the issues raised and what effect they might have on the Healthcheck programme data. Dr Weiner also asked how the risk stratification tool would be paid for in the future; Mr Price responded by saying that it was included within the SLA with informatics and will be split between public health and commissioning
- Members felt that issues raised at this meeting should be highlighted to the West Mercia Cluster

Actions: **Actions**

- **Dr Innes to speak to Mr Jarman-Davies with regards to arranging a meeting with representation from the PCT; Mr Jarman-Davies, Mrs Tracey Jones and Dr Chris Weiner , HCS and Graphnet to discuss the contract and a commitment to assure NHS Telford and Wrekin that the issues will be addressed within a specific timeline. Status of the contract needs to be looked at before the meeting** **MI**
- **Update from HCS on progress of the risk stratification tool to be shared at CCG Board meeting taking place in May 2012, exception report to come to the June 2012 meeting if the issues have not been resolved** **HCS**
- **Mrs Wilde to request Mrs Tracey Jones, to complete a Risk** **NW**

31.12.29 TRAQS Update

Mrs Sharon Clennell attended the meeting for this agenda item.

Verbal update given by Dr Inglis on the progress of the TRAQS project and the following points were raised:

- The job description for the GP sifter roles has been passed by HR
- A phased approach to the implementation of TRAQS, across GP practice, will take place starting on the 14 June 2012 and will hopefully be completed by October 2012
- Will be beginning with 10 /11 Pathways, six of which have been developed through the QP work of GP
- The GP Commissioning Forum have been involved in the development of four pathways: urology, dermatology, ophthalmology and MSK. Will also look, at the next meeting, at the development of varicose veins and heart failure pathways
- Mrs Clennell is shortly to start a programme of visits to GP practices and currently has nine appointments booked. Mrs Clennell has produced a presentation for the visits
- Dr Inglis will be undertaking a lunchtime session around TRAQS in April 2012 and a PLT event will take place in May 2012 with Dr Louise Warburton and will include managing MSK
- Currently looking at software requirements. Mr Mason requested that assurance could be given that the specification for software requirements could be met and the contract must include on going support of the software. Mrs Clennell replied that she is in discussions with Mr Andy I'Anson, IT Programme Manager, on suitable software and also mentioned that the software they would look to use would either be VEDAS as used by Brighton referral hub or EPEX as used by Sentinel the Devon referral hub
- Systems will be piloted before going 'live'
- Capital spend is available to purchase hardware, which would need to be ordered and received before the end of March 2012. Miss Boden also highlighted that there is capitol available for 2012/13
- A company called Patient Opinion has been commissioned by the PCT to look at tracking patient feedback and will inform next years commissioning round
- Currently look at how the administration roles will be filled and leadership of TRAQS going forward
- Members discussed issues around the Choose and Book LES. Mr Price is meeting with Mrs Anna Charalambous-Green and will discuss
- Dr Weiner discussed tackling "unwanted variations" through TRAQS.

32.12 Meaningful Engagement

32.12.1 Report from the GP Clinical Commissioning Forum

The following points were highlighted from the report to members:

- At the March 2012 meeting members received a presentation on Summary Care Records (SCR) which will be rolled out once

EMIS Web is available across practices

Actions

- GP Board members gave a presentation of their work, which included their achievements over the past year. Members of the Forum had found it be very informative.
- Members of the CCG Board questioned how information, which is shared at the GP Forum, is filtered through to GPs who aren't Forum members. Mrs Wilde responded that all papers, including the minutes of meetings, are forwarded to all GP practices
- The ophthalmology group gave a presentation of the progress of their work
- Members agreed to continue direct access to MRI scans for a further 12 months. It was also agreed that APCS would refer rather than individual GPs
- Members noted that GP and Practice Manager attendance at Forum meetings is very good and engagement with GPs is improving
- Mrs Jo Chambers, CEO of the Shropshire Community Healthcare NHS Trust is to be invited to attend a Forum meeting in May 2012
- Members were advised by Dr Waldendorf that he would be resigning as the CCG Board Member and the Chair of the GP CC Forum as from the end of March 2012, however he will continue to Chair the Forum until a new Chair is in place. CCG Board Members wished their thanks to Dr Waldendorf to be recorded
- Discussions continued on possible options for filling the role; four possible proposals were discussed, final decision to be made by Forum members:
  - Nominations from Forum members; members of Forum to elect Member
  - Practice Manager to take on the role; they would also act as Practice Manager Member of the CCG Board
  - The four remaining GP CCG Board Members to take on the role of Chair Forum meetings
  - Forum members elect a Chair who doesn't sit on the CCG Board
- Paper to be developed by Dr Innes, on the options for appointing to the CCG Board member role vacated by Dr Waldendorf, which will be discussed by the GP CC Forum **MI**
- Dr Inglis informed members that the Audit Committee require a GP Forum member to sit on the Committee; election process will need to be undertaken to fill this role.

Recommendation:

- **Members noted the content of the report**

33.12 Service and Financial Planning

33.12.1 Financial Position 2011-12 – Month 11

Miss Boden updated members on the PCT and CCG financial budget. Still anticipated an under spend of £1m on the PCT budget. As at January 2012 QIPP savings were falling short of plan by £256,691. This won't affect year end but is a risk to achieving QIPP savings. Dr Hudson mentioned that the process has begun to look at QIPP initiatives for 2012/13. Schemes that don't look like they will achieve will be stood down and others will be brought on stream.

Miss Boden commented that due to the timing of Board meetings financial reports will run a month behind.

Risks for the coming financial year include SaTH overspend.

Recommendations:

- **Members noted the latest revenue resource limit including notified and anticipated allocations**
- **Members noted the latest financial position**
- **Members noted the latest savings target position.**

33.12.2 Budget Setting 2012/13

Miss Boden informed Members that the report she was presenting to the CCG Board had formed part of the West Mercia Cluster proposed financial budget 2012/13 which was presented to the Cluster Quality Performance and Resources Committee on 14th March 2012. The report is linked to the overall five year financial plan for the CCG and will be updated following approval of the 2012/13 budgets. Attachment 6 of the report highlighted the bids put forward to the Cluster for the 2% contingency fund. As yet confirmation of which bids have been successful has not been received.

1% has been earmarked for CCG risk reserve.

Members continued by discussing concerns with regards to the financial position going forward and whether disinvestment in services may have to be considered in the future. Members continued by highlighting that QIPP schemes and TRAQS will be areas where savings can be found. Dr Weiner mentioned tackling variations in healthcare which will be invaluable in saving money, however it will take time to see savings coming through.

Recommendations:

- **Members approved the proposed sources and applications of funds at attachment one**
- **Members approved the 2012-13 proposed budgets as set out at attachment two pending the outcome of service level agreement negotiations**
- **Members approved the planned QIPP schemes, disinvestments and investments as set out in attachments three to six**
- **Members noted the key risks and mitigating actions in section five**

33.12.3 CCG Authorisation Update

Mr Price reported that further guidance on Authorisation had been received; with this in mind an Action Plan has been developed which has been shared with key managers. Hoping to be in first phase applications but if not will go for second phase. Model Constitution is due out in the next couple of weeks.

Mrs Wilde gave a verbal update on some issues, to note - Clinical Quality Framework – need to have a CCG lead officer to put evidence together for Authorisation. Mr Mason mentioned that Herefordshire

have produced a Framework and will forward to Mrs Wilde. Members questioned whether there would be a CCG Member on the QPR Committee as yet no invite has been received from the Cluster. **Actions**

Clinical Engagement – wide clinical engagement across areas. Need to give formal consideration to a local clinical senate.

Long Term Plan – a Long Term Plan will be produced when the JSNA has been refreshed and the Health and Wellbeing Strategy is in place. The current 12 month strategy will enable development in the mean time.

Case studies – need to put five case studies together.

Have received pre-application planning documentation, need current position by the end of March 2012. Will make an assessment of where we think we are and will discuss with the Cluster.

Draft authorisation documentation needs to be formalised.

The Cluster will discuss the possibility of CCG's assessing other CCGs Authorisation documentation as a test exercise.

33.12.4 Operation Plans

Mrs Wilde reported that verbal feedback on the plans had been received this morning from the West Mercia Cluster. As a whole the feedback had been very positive. A few areas needed strengthening, to support authorisation, but as a whole the feedback had been very positive. Mrs Wilde will share comments with the authors and Local Support Members.

Mrs Wilde asked members how they wished progress on the Plans to be reported to the Board. Members agreed that regular updates were not required – reporting by exception only.

34.12 Governance Arrangements

34.12.1 Risk Assurance Proforma

At the February 2012 West Mercia Board Cluster meeting it was agreed that each CCG Board would add risk assurance on to their agenda as a standing item. This will ensure that risks identified during discussion of CCG Board agenda items are captured, risk rated and a risk owner is identified so that this information is passed onto the Risk Manager for each PCT. For NHS Telford and Wrekin this is Lezli Feeney.

A proforma, which was attached with the papers for the meeting, has been developed for capturing this information and approved by the PCT Board.

Recommendations:

- **Members noted the addition of a risk assurance item as a standing on the Board agenda under Governance Arrangements**
- **Members agreed that risks need to be captured on the**

proforma from this meeting. **Actions**

35.12 Quality and Safety

There were no items under Quality and Safety for discussion.

36.12 Collaborative Arrangements

There were no items under Collaborative Arrangements to report.

37.12 CCG Leadership

37.12.1 Appointment of Chief Operating Officer

Dr Innes reported that the successful candidate had provisionally accepted the appointment. Two references have been received, awaiting a further reference, which Dr Innes has chased. The candidate has indicated that they will be able to take up the post as from the beginning of May 2012, however would be willing for handover arrangements to start during April. Once all the reference have been received a press statement will be issued.

38.12 For Information

There were no items for information to report.

39.12 Any Other Business

There was no other business to report.

40.12 Date and Time of Next Meeting

Tuesday 17th April 2012 – 12.30pm – The Aldridge Room, NHS Telford and Wrekin, Halesfield 6, Telford TF7 4BF

Telford and Wrekin Clinical Commissioning Board

Minutes of the Meeting held on
Tuesday 17th April 2012
The Aldridge Room, Halesfield 6, Telford, TF7 4BF

Present:

Dr Mike Innes	MI	Chairman
Dr Karen Stringer	KS	GP CCG Member
Dr Jim Hudson	JH	GP CCG Member
Dr Andy Inglis	AI	GP CCG Member
Peter Price	PP	CCG Project Director
Dylan Harrison	DH	Local Support Member
Andrew Mason	AM	Cluster Non-Executive Director
Laura Boden	LB	Chief Finance Officer
Nicky Wilde	NW	Clinical Commissioning Manager
Paul Clifford	PC	Corporate Director – Telford and Wrekin Council

Also in Attendance:

Dr Chris Weiner – representing Dr Catherine Woodward	CW	Consultant in Public Health – NHS Telford and Wrekin
Alison Smith	AS	Head of Governance
Karen Ball	KB	Secretary to the Clinical Commissioning Board (Minute Taker)
Kate Shaw	KS	Programme Manager, Future Configuration of Hospital Services
Neil Nisbet	NN	Director of Finance – Shrewsbury and Telford Hospital NHS Trust
Sharon Clennell	SC	TRAQS Project Manager

41.12 **Apologies:** Dr Catherine Woodward, Geoff Braden **Actions**

42.12 **Members' Declaration of Interest**

Item 48.12.2 – Mr Mason, Cluster Non-Executive Director and Mr Harrison, Local Support Member declared an interest in this item as Members of the CCG Board.

43.12 **Minutes of the meeting held on Tuesday 20th March 2012**

The minutes were agreed as a true record.

Dr Innes and members of the CCG Board thanked Mr Price for the enormous support he has provided to the CCB Board and wished him well in his retirement.

44.12 **Matters Arising**

The members went through the action list from the last meeting:

Review of Committees

33.11.1
- Agreed to further work being undertaken and a further report including detailed proposals for streamlining committees / groups is undertaken by the Executive Leads, once appointed and brought to a future CCG Board meeting for consideration.

21.02 – Mr Price confirmed that a letter would be sent to PCT officers to confirm that no old PCT sub-committees should meet without full justification. **Actions**

20.03 – Mr Price reported that Miss Smith is in the process of producing a letter which he will sign.

17.04 – Miss Smith reported that the letter had been done.

JSNA Update

- JSNA will be part of the authorisation documentation for the CCG
- Dr Woodward to produce a regular update around public health for the monthly GP Clinical Commissioning Newsletter

18.12.2
- Dr Woodward to provide Dr Inglis with a copy of last years Annual Health Report

20.03 – Update on the Health and Wellbeing Strategy will be an agenda item under "Collaborative Arrangements" at the April 2012 Board meeting, will then become a standing agenda item.

17.04. – This action was agenda item 50.12.1 at this meeting.

CCG Authorisation Update

20.12.2 It was agreed that the T&W CCG should aim for application submission in July 2012 with as early assessment as possible.

Risk Stratification Assurance

- Dr Innes to speak to Mr Jarman-Davies with regards to arranging a meeting with representation from the PCT; Mr Jarman-Davies, Mrs Tracey Jones and Dr Chris Weiner , HCS and Graphnet to discuss the contract and a commitment to assure NHS Telford and Wrekin that the issues will be addressed within a specific timeline. Status of the contract needs to be looked at before the meeting

31.12.1

- Update from HCS on progress of the risk stratification tool to be shared at CCG Board meeting taking place in May 2012, exception report to come to the June 2012 meeting if the issues have not been resolved
- Mrs Wilde to request Mrs Tracey Jones, to complete a Risk Proforma – 17.04.12 – This action has been completed.

Report from the GP Clinical Commissioning Forum

- Dr Innes to develop a paper on the options for appointing to the CCG Board member role vacated by Dr Waldendorf, for discussion at by the GP CC Forum

32.12.1

17.04. – This action has been completed.

45.12 Strong Clinical Focus

45.12.1 SaTH Full Business Case

Ms Kate Shaw and Mr Neil Nisbet attended for this agenda item.

Mr Nisbet gave a presentation entitled "Future Configuration of Hospital Services Full Business Case". Members had previously received a copy of the Full Business Case (FBC) Summary with the papers for this meeting. **Actions**

A number of key points were highlighted within the presentation:

- The timetable for approval of the FBC was that the ultimate decision would be taken by the Strategic Health Board at their Board meeting on 24 May 2012
- Travel and Transport Plan is currently being developed and will be completed by July 2012
- Changes that have been made since the Outline Business Case actively improve the Trust's preferred option
- The Trust has pursued a different source of funding for the scheme from the Department of Health (DH). And the DH has confirmed £35m of Public Dividend Capital (PDC) funding has been made available
- Scheme remains affordable at circa £35m
- The main building contractor for the works is Belfour Beatty
- Guaranteed Maximum Price will be agreed for all design and construction work prior to main works commencing
- Summary of PDC verses Loan highlighted within the presentation
- Assurance has been sought for the proposed reconfiguration which includes four key elements. One of these elements is a Gateway Review which took place in March 2012. After assessment the plan was rated as green / amber; the review team had been particularly impressed with the clinical engagement that had taken place
- The presentation included the long term financial position for the next 5 years.

Members continued by discussing the FBC and the following points were highlighted:

- Clinicians are satisfied that the proposals meet requirements
- There will be no cost implications for the CCGs as activity carried out by SaTH is covered by the tariff system of payment
- Value of the land to be used at the PRH for the new build has been included as a capital cost of £374k, paid to the DH as if it hadn't been used for redevelopment purposes it could have been sold. The land will be transferred from the PCT to SaTH
- It is anticipated that some services, including certain paediatric services, which are no longer carried out at SaTH but done out of county could return, as a result of reconfiguration
- Mr Price asked if there are risks around the £35m spend on the project and would it be likely that costs could rise. Mr Nisbet stated that as guaranteed maximum price will be agreed prior to the work starting this wouldn't be an issue. If the cost of the project came to under £35m, the savings would be shared between SaTH and the contractor Belfor Beattie
- Services, that are to be housed within existing accommodation, would begin to move once the FBC has been approved
- As the project is being funded by PDC SaTH will not have to pay interest as it is not a loan, however, the dividend paid to the DH will however increase to £1,172m per year as opposed to the equivalent of £55k if it had been a loan

- Mr Nisbet discussed delivering savings including internal efficiencies and changes to working practices
- Members raised their concerns that the window in which appointments can be booked via Choose and Book had recently been reduced from 11 weeks to 6 weeks, therefore there are concerns that this may end in another pending list situation occurring. Although this issue has already been raised with SaTH Mr Nisbet was asked if he would convey the concerns of the CCG Board to the CEO and directors of SaTH; Mr Nisbet responded by saying that he would
- Dr Innes questioned whether having two A&E units would continue to be viable, not withstanding that the hospitals will be providing different services. If PRH's A&E were to close would paediatrics need to relocate to the RSH? Mr Nisbet responded by saying that the assumption is that neither A&E department would close. If it was a decision that was taken in the future, options for how services would be provided would have to be looked at
- Ms Shaw reassured members that future proofing around pathways had been carried out and that they did not foresee the need to close either A&E unit

Recommendations:

- **Members approved the Full Business Case for the future configuration of hospital services; specifically the preferred capital options for both RSH and PRH, the requirement for the Department of Health Public Dividend Capital investment of £34.873m**

45.12.2 TRAQS Update

Mrs Sharon Clennell attended the meeting for this agenda item.

An update on the progress of the TRAQS Project was included with the papers for this meeting. Dr Inglis and Mrs Clennell also gave a verbal update on the progress of the TRAQS project and the following points were highlighted:

- Dr Rohit Mishra, GP at Hollinswood Medical Practice and Mrs Lisa Baldwin, Practice Manager at Donnington Medical Practice had given a very good presentation on QP Cardiology at the last Practice Forum meeting
- Varicose Veins Pathway has been developed by Dr Inglis and Heather Griffiths, Vascular Nurse Practitioner at SaTH which was agreed by the Practice Forum at their meeting on 3 April 2012, and shared with members at this meeting
- Mrs Clennell has had positive engagement with GP practices around the introduction of TRAQS and was able to share the proposed phased roll out to practices with members, which will happen in four phases. In order to complete phase four Mrs Clennell needs to visit the practice who will be included within this phase, on the whole these are small practices. Fourth and last phase will be rolled out on 12 October 2012
- Practice Managers will be invited to the weekly TRAQS Project meetings prior to their practices going live
- Algorithms for practices have been developed by Mrs Baldwin
- Dr Inglis and Dr Louise Warburton, a GP with an interest in MSK, are to hold a GP learning session around TRAQS on 26

April 2012. A further PLT event is to be held in May 2012 **Actions**

- There is a patient representative on the TRAQS Project Team
- Accommodation has been identified for the TRAQS services to operate within Halesfield 6
- VEDAS has been chosen as the software system to run TRAQS and currently the contract is being developed by IT services. Mr Mason commented that it needs to specify in the contract what is required from the onset and that "tweaking" to the system should be kept to a minimum once the software is up and running. Mr Mason also asked whether metrics have been developed to measure success of TRAQS and whether the software will generate these. Ms Boden to speak to Mr I'anson to address this **LB**
- Patient leaflets are currently being developed and will be shared with patients for feedback
- TRAQS will not include mental health service referrals or 2 week wait referrals
- Laminated sheet will be produced for GP practices on the TRAQS process and what pathways are included
- Mrs Clennell confirmed that the window of time to be able to book appointments through Choose and Book has reduced from 11 weeks to 6 weeks. She had been assured by SaTH that this change will not create a new hidden pending list.
- A document was shared with members showing waiting times for appointments at neighbouring acute Trusts. Members asked for clarification from Mrs Clennell on whether they showed the number of slots or days. Mrs Clennell confirmed it was days
- Process for recruiting GP sifters is underway, a number of GPs have shown an interest in the role
- The Risk Register was shared with members and is updated on a regular basis
- Currently developing a TRAQS logo
- Still on track to go live on 14 June 2012
- Mr Mason asked if a set of metrics was being developed to monitor TRAQS once operational. Dr Inglis responded by saying that VEDAS comes with a standard set of reporting formats however, reports out side the standards could be added. Reports will be shared with GPs on a quarterly basis. Mr Mason commented that it would be worthwhile have a paper at a forthcoming Board meeting which defines the metrics against which the success of TRAQS will be measured
- Dr Inglis suggested that the metrics should be developed externally. Mr Mason said he would be happy to contribute regarding suggestions on what these should include **AM/AI**
- Members discussed the Hip and Knee Pathway which is on the Map of Medicine
- As Dr Weiner hasn't been sighted on the "benefits" paper Mrs Clennell will email him a copy **SC**
- Mrs Clennell report that she had given an update on TRAQS at the last Practice Managers meeting
- The Choose and Book LES will discontinue on 31 May 2012 and will be replaced by the TRAQS LES for all practices regardless of which phase of roll out they are in
- Mr Price reported that a Single Source Arrangement has been completed for the VEDAS software as there are no other companies able to offer the software that is required

- Mr Mark Cheetham and Mr Steve Peak of SaTH have be updated on the proposals for TRAQS

Actions

Recommendations:

- **Members noted progress to date.**

45.12.3 Early Implementation of Personal Health Budgets

Mrs Susan Spence attended the meeting for this agenda item.

Mrs Spence reported that the Department of Health (DH) are keen to role out health budgets as soon as possible for all NHS CHC eligible patients. However, learning experience from pilot sites, which have been up and running since 2010, show that it is not fully understood how it will work. The DH are keen to recruit as many new pilot sites (with direct payment powers) to the existing pilot programme, and expressions of interests need to be submitted by 30 April 2012. It is recognised that Telford and Wrekin would not be in a position to expression an interest in joining the pilot programme at this time. Raising patient awareness of Personal Health Budgets will be a considerable piece of work before April 2014.

Following discussion members agreed that it would not be the correct time to become a pilot site. Mrs Spence continued by saying that a multi-agency working group will be established that will feed back to the CCG Board on progress.

Recommendations:

- **Members noted that being considered for access to Public Health Budgets PHBs) will become a patient right from April 2014 for all NHS CHC eligible patients and is likely to be rolled out to all patients thereafter**
- **Members noted that there is significant level of preparatory work that is required to be undertaken in order to achieve a state of readiness to offer PHBs from April 2014 and that outline plans have already been considered**
- **Members agreed that the timeframe set down by the DH to be approved to join the pilot programme is too onerous to achieve within existing resource capacity**
- **Members agreed to receive an update report in six months time.** **SS**

45.12.4 Integrated Community Based Sexual Health Services Tender

Ms Emma Pyrah attended the meeting for this agenda item.

Ms Pyrah reported that the Shropshire Community Health Trust has been formally notified that the decision has been made to tender sexual health services jointly with Shropshire County PCT. SHA approval is required for the extension of the contract duration to 3 years from the 1 year NHS Operating Framework 2012-13 default position.

Ms Pyrah highlighted that service user involvement will be incorporated into the tender bid assessment and contract award stages. Members recognised that there isn't a need to have Board representation on the Tender Evaluation Panel but there was a need for a reporting process to the CCG Board. Chair of the Panel is Professor Rod Thomson, Shropshire County PCT, Director of Public

Health. Mrs Wilde questioned whether members of the GP Clinical Commissioning Forum should be sighted on the tender process. Ms Pyrah agreed that they should. Mrs Wilde to invite Dr Melanie Abey, T&W GP Lead Sexual Health and Ms Pyrah to attend the GP CC Forum meeting on 29 May 2012. **Actions** **NW**

Dr Innes, on behalf of Telford and Wrekin CCG, signed the "GP statement of Support for the Integrated Community-based Sexual Health Services Procurement".

Recommendations:

- **Members noted the content of the report.**

46.12 Meaningful Engagement

46.12.1 Report from the GP CC Forum

Items at the GP CC Forum meeting, which was held on 3 April 2012 included:

- Mr Mark Smith, Consultant at SaTH gave an update on direct access endoscopy
- Update on TRAQS
- QIPPS presentation by Dr Hudson
- Members of the Forum discussed the recruitment of the fifth Clinical Commissioning GP Board member. As yet there had been no interest shown from GP Forum members. Mrs Wilde will email practice managers requesting that any GPs who may be interested contact Mrs Wilde. Post will be for 3 sessions per week. In the interim Dr Innes will continue to chair the GP Forum meetings. **NW**

47.12 Service and Financial Planning

47.12.1 Financial Position 2011-12 – Month 12

Ms Boden tabled a Draft Financial Summary Position as at Month 12.

Miss Boden shared the 2011/12 draft financial summary position as at month 12 with member, which shows the predicted under spend of £1m. Currently working on the 2012/13 budgets; hope to have these available shortly.

QIPP year end report will be available shortly.

Dr Innes report that whilst there is an identified the £2.4m overspend on the clinical commissioning budget in the past year, it is accounted for in next year's financial budget.

47.12.2 Performance Report

Miss Boden informed members that the Performance Report Against Vital Signs report had previously been presented to the Quality, Performance and Resources Committee (QPR) and also received by the Professional Executive Committee (PEC) for information. Included within the report is an improvement plan for targets that are under-performing. Since the QPR has been stood down reports will come to CCG Board meetings. Members went on to discuss the role

of the West Mercia Cluster QPR Committee that is now in place. Members agreed that the Telford and Wrekin element of the report which is submitted to the Cluster QPR Committee should come to the CCG Board meeting first. Although Dr Innes and Mr Mason see the full Cluster Board report other members of the CCG Board are not sighted on it. Dr Innes said it was important to be sighted on the Vital Signs and how they are achieving.

Actions

Dr Inglis said that there needs to be a focus on areas that aren't achieving, with updates to the Board from those responsible for the Vital Sign, along with actions to be taken. Miss Smith, Dr Innes and Dr Inglis to meet and bring suggestions on how this can be achieved.

AS/MI/ AI

Dr Weiner mentioned that Public Health service governance arrangements are being looked at. It has been suggested that the Health and Wellbeing Board will monitor Public Health performance.

Mrs Wilde reported that she had, had discussions with public health and Ms Helen Morris, Senior Information Analyst, with regards to input into the authorisation documentation. Members also discussed whether the Health and Wellbeing Board should be setting outcomes. Dr Innes stated that there needs to be a process to manage performance on Vital signs in the coming interim year.

Members recognised that the data shared at this meeting was for January 2012.

Recommendations:

- **Members noted current performance and supported the proposed actions set out in Appendix B**

48.12 Governance Arrangements

48.12.1 Management of SHA and PCT Administrative Estate

Members had received a report for the papers of the meeting which summarised DH guidance on the proposed management of estates that should be retained by PCT's. Mr Price informed members that a mapping exercise for the use of PCT Headquarters, Halesfield 6 had been carried out and discussed informally.

Following discussion of the report the following recommendations were agreed.

Recommendations:

- **Members noted the content of the guidance**
- **Will formalise their position on their future property requirements so that proposals can be discussed and business cases, where required, can be submitted to the SHA for the approval to proceed.**

48.12.2 Draft Role Board Members

The report received by members highlighted the make up of the CCG Board including membership that is a statutory requirement according to the NHS Commissioning Board Body and additional roles which have been decided following informal discussions.

Mrs Wilde said that the role of registered nurse and secondary care specialist doctor are not attributable to the running costs of the CCG.

Members continued by discussing the report and the outline job roles, including person specifications included as appendices. Also included within the report are draft costing for each role. For Authorisation purpose an appointment process to these roles will need to be put in place. Would also make sense to have all roles in place for the transition period however, this is not a requirement of the DH. Tenure for each role within the report will be for 12 months designate basis.

Secondary care specialist doctor needs to work for an organisation which is not the Trust's main acute provider of services.

Members agreed that the outline job roles were good. Mrs Wilde commented that 50% of the job roles were prescribed. Mrs Wilde continued by asking members to let her know if they are happy with the proposed additional representation of the Board and did they feel each role had been allocated the correct number of sessions. With regards to the patient representative member of the Board, members agreed that GP practice patients groups could be asked to jointly elect a patient member of the Board. Mr Mason commented that they would need training and support to undertake this role.

Outline role for the practice manager member will be shared with practice managers, for them to agree. This role would also be expected to chair the monthly practice managers meetings. Members agreed that the sessions for the practice manager member should be set at 2 or 3 sessions per month.

Members agreed that a report would come to the May 2012 CCG Board meeting outlining the timeline and process for recruitment. **NW**

Recommendations:

- **Members agreed the future membership of the CCG Board**
- **Members agreed the content of the job roles including the amendments mentioned above**
- **Members agreed the number of sessions for each Board member; apart from the Practice Manager role which will increase to 2-3 sessions per month**
- **Members approved the commencement of the recruitment process**

49.12 Quality and Safety

49.12.1 Adult Safeguarding

Mrs Linda Izqueirdo attending the meeting for this agenda item.

Mrs Izqueirdo reported that an internal audit review of Adult Safeguarding was carried out as part of the 2011/12 internal audit plan as agreed by the Audit Committee.

In response to a question from Mr Mason Mrs Izqueirdo reported that Mr John Snell had been nominated as Non-executive Director for Child Safeguarding and members agreed that it would be also

acceptable for Mr Snell to cover Adult Safeguarding. This will be an interim arrangement until March 2013. **Actions**

Recommendations:

- **Members noted the content of findings of the report**
- **Members accepted the supported the delivery of the agreed actions to move the assurance from Moderate to Full**
- **Monitor the delivery of actions contained within the report by receiving quarterly updates**

50.12 Collaborative Arrangements

50.12.1 Shadow Health and Wellbeing Governance Report

Members discussed the report which had been shared with members. Mr Clifford highlighted that the Health and Wellbeing Board becomes a statutory committee of the Local Authority in April 2013, however agreement was being sought on whether a Shadow Health and Wellbeing Board (SHWBB) should be set up as an 'arms length' committee of the Local Authority until April 2013, although it won't have formal decision making powers until April 2013. Members continued by discussing membership; Dr Leigh Griffin will be asked if he would be happy to remain a member of the SHWBB. Keen to develop sub committees of the Board. Currently developing the Health and Wellbeing Strategy which will be shared with the CCG Board. Members looked at the Terms of Reference and agreed that there needed to be a two way process between the CCG Board and the SHWBB. Members highlighted points 6 and 7 and agreed the need to ensure that there isn't an overlap of the roles of the SHWBB and the CCG Board. Mr Harrison, who will be a member of the SHWBB, commented that there was no reference to health inequalities within the ToR; Mr Clifford agreed and said that this would be rectified. In addition to including health inequalities the ToR should also include the need of the Board to address the public duty under the Equality Act 2010. Dr Inglis commented that there needs to be a clear line between the Board being strategic and not becoming operational.

Members questioned the quoracy of meetings, which is one quarter, and agreed that this needed to be made up of representatives of each area on the Board – CCG, PCT, LA and LINks. Miss Smith commented that the JSNA would need to including the 9 strands of equality.

Recommendations:

- **Members agreed the proposed Terms of Reference including amendments to the quorum and the addition of health inequalities**
- **Members agreed the proposed membership, including Cabinet Member representation**
- **Members agreed that the SHWBB is set up as an 'arms length' committee of the LA, until the Board becomes a statutory committee of the LA in April 2013**
- **Members agreed that meetings will be held in public from April 2011, although the press and public may be excluded**

during consideration of any matter which would involve the disclosure of confidential or exempt information **Actions**

- **Members noted the proposed structure of the Shadow Board, subject to further engagement and consultation with providers, service users and stakeholders.**

51.12 CCG Leadership

51.12.1 Progress Report on Authorisation

Mrs Wilde informed members that with regards to the RAG ratings 8 areas were judged to be red, 19 green and 25 amber. Those areas judged to be red were for one of two reasons, which were either because they were outside the CCGs control or the deadline that had been set had passed. Mrs Wilde went on to say that the "Readiness for Authorisation" template had been received last week. Meeting has been arranged next week to discuss Authorisation but going in the right direction.

Dr Innes said that the CCG Board are keen to be in wave one of authorisation but likely to be in wave two. It is likely that most CCGs will opt to be in wave two.

Recommendations:

- **Members considered the content of the report**

52.12 For Information

There were no items for information to report.

53.12 Any Other Business

53.12.1 Report on the Outcomes of the Equality Delivery System Event

Members were updated, via a report, on the outcomes of the Equality Delivery System Event which had taken place on 22 March 2012. A meeting is being arranged for the Chair of the CCG, GP Lead for Patient Engagement, Lead Commissioner for Patient Engagement and Local Support Member with lead role for equalities to agree the actions that need to be taken in response to the outcomes of the event. A future community event will take place in June 2012. Dr Innes commented that he had attended the event which was very good.

Recommendations:

- **Members noted the actions already taken place.**

54.12 Date and Time of Next Meeting

Tuesday 15th May2012 – 1.15pm – Room F, NHS Telford and Wrekin, Halesfield 6, Telford TF7 4BF

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Minutes of the Wyre Forest Clinical Commissioning Group
REPORT AUTHOR :	Dr Simon Gates (Chair) Wyre Forest Clinical Commissioning Group
PRESENTED BY:	-
PURPOSE OF REPORT:	To receive the minutes of the meeting held on 6 March 2012
KEY POINTS:	Key discussion areas: Finance Quality & Safety Patient & Practice Involvement Holding Board to Account: ➢ Mental Health ➢ Virtual Ward ➢ Sexual Health ➢ Increased Focus on General Practice ➢ Community Nursing
RECOMMENDATION TO THE BOARD:	The Board is asked to note the minutes of the meeting held 6 March 2012
CONTEXT & IMPLICATIONS	
Strategic Objectives	N/A

Financial	As outlined in the minutes
Legal	DoH Legal Framework
Risk & Assurance	As identified in the minutes
HR, Equality & Diversity	N/A
National Policy	NHS White Paper/ Health & Social Care Bill/Operating Framework 2012/13 Authorisation Toolkit
Carbon/Sustainability	N/A
Partnership	N/A

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Wyre Forest Clinical Commissioning Group 3 April 2012

"Working together for a healthier future"

MINUTES OF THE WYRE FOREST CLINICAL COMMISSIONING BOARD MEETING

Held at the Education Centre, Kidderminster Treatment Centre
9am until 12.30pm
Tuesday 6 March 2012

Present:

Dr Simon Gates	(SG)	Chair
Stella Baldwin	(SB)	PPI/Advisory Group Chair
Dr Tony De Cothi	(TDC)	Vice Chair / Lead for Unscheduled Care
Simon Hairsnape	(SH)	Chief Operating Officer
Clare Nock	(CN)	Practice Liaison and Support
Dr Paul Williams	(PW)	Lead for Scheduled Care
Jo Galloway	(JG)	Lead Nurse Quality & Safety
Mary Walters	(MW)	Chief Finance Officer
Tony Hadfield	(TH)	Representing Bryan Smith

In Attendance:

Dr Ashis Banerjee	(AB)	Consultant in Public Health
Toni Bellfield	(TB)	Commissioning Accountant
Rachael Blundell	(RB)	Community Services Commissioning Support Manager
Dr Stuart Bourne	(SBo)	Assistant Director of Public Health Consultant in Public Health
Philip Daniels	(PD)	Specialty Registrar Public Health
Heather Macdonald	(HM)	Deputy Chief Officer
Anita Roberts	(AR)	Lead Commissioner for Community Services
Lakhbir Virk	(LV)	Senior Information Analyst

Minutes:

Julie Bishop	(JB)	Board Secretary

Apologies:

Steve Booth	(StB)	Hospital Consultant
Bryan Smith	(BS)	NED West Mercia Cluster
Alex Hill	(AH)	Acting Head of Performance

6.03.1 **Welcome and Introductions**
SG as chair welcomed everyone to the meeting. It was noted that Tony Hadfield was representing Bryan Smith.

6.03.2 **Apologies**
Apologies noted as above.

6.03.3 **Minutes of the last meeting**

The minutes of the last meeting 7 February 2012 were agreed as a true and accurate record with the exception of the following amendment:

*Item 7.02.9 Update on budgets - The budget would go to the West Mercia Cluster Board in **March** and to the Wyre Forest CCG Board in **April**.*

6.03.4 **Declarations of Interest:**
No new declarations of interest were reported.

Declaration of Communication:
No declaration of communication was reported.

6.03.5 **Finance Update**
MW provided an update.

Overall PCT position
The finance team is working on finalising next year's budgets. The current position for the PCT still shows a surplus around £5m but this will deteriorate to £4 - £5m with sign off of contracts. The surplus carried forward agreed by the SHA will be £3m.

The Mental Health placement budget is moving back from Worcestershire Health and Care NHS Trust (WHCT) to the PCT to manage. Sue Harris Joint Commissioning Manager for Mental Health is leading on this. Sue will be leaving the JCU to take up a new role with WHCT as Director of Strategy and Business Development. A start date has not yet been confirmed but it is likely to be mid May.

Wyre Forest CCG position as at 31st January 2012
As at month 10 Wyre Forest CCG is forecasting an underspend of £4,170,368 this is £187,007 more than last month.

6.03.6 **Quality & Safety, PPI, Advisory Group**
Quality & Safety Report
JG presented the report.
The Commissioning Quality and Patient Safety Strategy
This has now been approved by all three Worcestershire CCGs and Clinical Senate. An action plans is in place and a number of projects have been initiated including the development of:

- A strategy for care homes;
- A quality assurance framework and quality dashboards for CCGs;
- A single repository to report, monitor and feedback regarding concerns;
- An options appraisal for membership schemes.

Commissioning Quality Innovation (CQUIN)
Feedback has been received from NHS Midlands and East SHA on the shortlist of CQUINs and they are being updated and to include more detail. Further discussions will take place with providers and CCGs in order to reach consensus of final schemes and to populate the detailed requirements.

Quality Schedules
Schedules on going and will be much more outcome focussed ensuring

improved quality.

Provider Variance Report (key issues for consideration)
Work is continuing to develop a quality dashboard for CCGs, a draft of which will go to the quality committee in April.

Areas rated 'green' (on track against target) and 'red' (off target). Areas rated 'purple' are for information only. Amber is where performance is declining on a green rating or a red rating where performance is improving.

RAG Rated green areas:

- Safeguarding
- VTW
- SHMI
- 18 week referral to treatment
- Cancer 2 week wait
- Delayed transfer of care
- Readmissions

RAG Rated red areas were discussed in more detail.

Never Events
Never Events are significant incidences that should not happen. In Worcestershire there have been two this financial year, a retained swab and a wrong-site surgery. A number of never events have occurred within West Mercia Cluster and the wider SHA and there is a current focus on use of the World Health Organisation Surgical Checklist and ensuring compliance is maintained at a consistently high level. The board was asked to agree CCG involvement in the closure of Never Events. TDC, PW and CN agreed to be the CCG contacts for sign off of closure of the retained swab Never Event which has been submitted for closure. It was also agreed that these would be closed at Quality Committee in the future.

Action:
JG to circulate the root cause analysis report to TDC, PW and CN for their comment prior to closure of the retained swab never event.

The Central Alerting System (CAS)
The Central Alerting System (CAS) is a web-based system for issuing patient safety alerts and other safety critical guidance to the NHS and other health and social care providers and is maintained by the Department of Health. There is currently one outstanding alert in Worcestershire which has been entered on local risk register and will be reported at CMB on Friday. An update is expected from WAHT in a week's tine regarding the outcome of a quality committee meeting where the status of the alert will be reviewed and closure is anticipated.

A & E 4 hour performance target
There have been numerous discussions about finding a solution to the poor performance of WAHT in meeting the four hour target for A & E of 95%. The target was further challenged during an outbreak of the norovirus infection at

Worcester Royal Hospital (WRH) with all eight medical wards closed that resulted in escalation to a Major Incidence. The Major Incidence has now been stood down and is in the recovery phase. The SHA is expecting WAHT to reach the target of 95% in March.

As commissioners everything possible has been done with good MIU and good Out of hour's service in place. A further meeting with WAHT, WHCT, Adult and Social Care and the PCT took place on Friday. It has been agreed for the extra winter initiatives to continue until the end of March.

The SHA and PCT have put to WAHT a whole host of actions to address. Chris Emerson, Head of Acute Commissioning (NHSW) has set up regular meetings in order to monitor the action plan and it was accepted that it would be useful to have CCG input. It was agreed that JG would send the action plan to TDC to make a judgment as to whether he attended the meetings.

Action:
JG to forward the emergency services action plan to TDC and advise regarding the meeting to review the action plan.

SG questioned if there was anything primary care could do to alleviate the pressure on WRH, i.e. as a CCG divert patients away from A & E.

The issue was that the A & E was tight on capacity it was a small unit and coped with 'peaks' badly and tended to take days to recover after peak. The numbers of attendees were not high it was not the minors that breached. SW CCG currently support a GP working alongside A & E staff as part of the winter pressures schemes.

A bed bureau capacity hub is being developed and an appointment has been to manage it and David Sykes, Project Director Worcestershire Hub started yesterday.

PW suggested having a protocol flowchart at primary care level and review of patient's history to see why they were referred to A & E. The impact on quality and performance indicators is currently being evaluated i.e. Mixed sex breaches.

Stroke care
Performance continues to be a concern against the target for the proportion of people who spend at least 90% of their time in hospital on an acute stroke unit. The outbreak of the norovirus infection at both hospital sites has further affected performance.

On the 4th April a meeting is taking place to look at an options appraisal for stroke services. CCGs have been invited to attend.

The West Mercia Cluster Quality, Performance and Resources Committee
The first meeting was held in February. The board was asked to agree to set up a Quality Committee as a formal sub committee to the board with effect from April 2012. The board agreed to a joint quality committee arrangement with Redditch and Bromsgrove (R & B) CCG in respect of services commissioned by

the same provider. A chair would need to be identified for the committee and joint chairing arrangements agreed with R & B CCG. The meetings will take place every couple of months.

It was recommended that Steve Booth would be an ideal chair and SG would contact him once he returns from annual leave. In the meantime JG would start drafting the terms of reference and set up the first meeting to take place in April.

It was decided that a patient representative should be on all committees.

Action:
JG

It was accepted that it would be a challenge for the board to make sure they are sighted on issues they need to be sighted on and it will be necessary to have a number of committees to support the board. The board will need to decide whether to share arrangements with R & B or even across the county.

The board noted the report, and agreed it was important to be aware of issues and concerns that may potentially impact on quality and patient safety.

PPI
SB provided a summary and presented the report setting out the final draft of the PPI membership scheme prepared by Jane Hulley, Consultant. The board noted that the report was very thorough and was an excellent piece of work.

The report has been written for all three Worcestershire CCGs however, Wyre Forest was in a position to go ahead now however, the other two CCGs were not yet in this position.

The board wholly supported the scheme and was keen to see this in place in Wye Forest.

JG referred to governance arrangements and resourcing the scheme appropriately. She suggested that consideration should be given to commissioning Jane to lead on this piece of work.

It was agreed that the scheme would be promoted at the CCG launch with leaflets available to encourage Wyre Forest residents to volunteer to sign up to become a member of the scheme now or as a potential member in the future.

It was further agreed to establish a steering group to be fully set up by October and review of the level of membership. SB, JG and Jane to discuss this further.

Action:
SB/JG

Advisory Group
The next meeting is taking place 28th March. The election of chair /vice chair and terms of reference are on the agenda for discussion. SH was attending the next meeting to provide an overview of progress as the CCG moves towards authorisation.

6.03.7 **"Holding to Account" (as a board)**

Mental Health

PW gave an update on progress with the mental health project and included:

- GPA Meeting 21st February clarified outcomes expected from planning phase.
- Planning underway to pilot mental health professionals within two GP practices from April.
- Agreed time for daily Psychiatrist telephone availability.
- Talking Therapies workshop held. Workshop provided capacity, demand and waiting list data for all talking therapy services within Wyre Forest. This will be used to develop pathway and commissioning options.
- Workshop booked for 27th March to present options from planning phase to clinicians who attended original workshop in December for sign up before presentation to CCG Locality Board in April.

PW pointed out that the two pilots will required funding to release GP time and The board agreed to support financial commitment.

It was agreed that PW and TB will look at the costings for the two pilots. An evaluation of the pilots will be reported back to the board at the May meeting.

Review of Community Nursing

AR presented the report to the board. The CCG has identified community services as a priority which includes community nursing services. The model needs to integrate fully into other extended services in the community including the Admission Prevention Team (APT) and GP practices/staff.

A project team has been established (Anita Roberts, Alison Field Practice Manager, Jan Austin Locality Manager, representatives of the community nursing teams, Dr Tony Carter and Dr Nigel Cockrell).

At a GPA meeting in October practices were asked to feedback on what worked well and how they thought the service could be improved. Additionally, the district nurses were asked for their comments too. The GPA agreed that the locality group will be the conduit for monitoring progress against timescales.

A Project Initiation Document (PID) has been developed.

The project team will be meeting shortly to discuss the service specification, to reach joint agreement around the extent of the review, the key priorities and key outcomes to be achieved. The timescale for agreeing this is expected to be the end of March however, it is recognised that the timeframe may need to be adjusted if further discussion and consultation with relevant colleagues is necessary to ensure the service specification is 'fit for purpose'.

The board was very keen to see an increase in the number of nurses in Wyre Forest i.e. palliative care. SG pointed out that support to patients in care homes needed to be considered as part of the review.

A full update will be provided to the board at the May meeting.

Action:
AR

Sexual Health
It was noted that this paper had been pulled together by Rachael Blundell (Commissioning), Ash Banerjee (Public Health) and Philip Daniels (Public Health). AB presented the report to the board. From April 2013, all sexual health services will be commissioned by Public Health (PH) in the Local Authority (LA) with the exception of abortion services which is likely to be commissioned by CCGs and SARCs (Sexual Assault Referral Centres) which will be commissioned by the NHS Commissioning Board (NHSCB).

Public Health will be undertaking a full needs assessment of sexual health services across the county. Poor GUM access in Wye Forest may well be picked up in this review and it is quite feasible that a GUM clinic in Wye Forest will be recommended.

In the report options were proposed for Wyre Forest CCG to consider:

1. To decide whether to continue investing in sexual health services funding 2012/13 given that they will not be responsible for commissioning.
2. If it does decide to commission the CCG will be unlikely to sustain recurrent funding g in 2013/14 and beyond and this could be potentially damaging from a public perspective.

The report put forward options to consider if the CCG wishes to invest to improve services locally page 5 of the report i.e. improve abortion series; discreet one year projects for e.g. sexual health training for GP practice staff, capital set up for a GUM clinic and improved Time4U services.

The board decided after a lengthy debate to review the changes to sexual health services at the April meeting and decide whether to keep sexual health as a priority bearing in mind that the CCG will not be commissioning the service and therefore will not be able to influence decisions.

Action:
Voting board members

Increased Focus on General Practice
CN provided a summary of the report presented to the board. The board acknowledged that efficient, effective General Practices engaged with their CCG is essential for the success of clinical commissioning. There are many demands & challenges facing general practice of which clinical commissioning is only one.

A number of steps have been taken in Wyre Forest to support general practices' participation in clinical commissioning and these have been well

received by practices i.e. improved communication (website, newsletter, practice manager meetings, reports to GPA); increased data resources (dashboard, reports, activity data); funding by incentivising practices to engage and perform through the CCG's investment in a Commissioning LES; training via NHS Alliance. Practices feel engaged in decision making and value stakeholder events

There has been a marked increase in engagement from practices i.e. being part of committees and project groups. There has been a strong buy in from GPs expressing an interest in being involved in GP/Consultant pairings.

The board reaffirmed their continued support to the practices and recognised that good engagement was key to the success of the CCG.

Virtual Ward

TDC presented the report and service specification to the board. He reported that this was a pleasing project and congratulated HM, the clinical team and WHC T for their hard work in making the project possible.

In terms of outcomes, it was good to see a reduction (10%) in non-elective admissions. The next step was to focus on elective admissions. Work was continuing with practices to look at patients with a risk score of 6 and 7 and this piece of work is expected to be completed by the end of March

Funding agreed by the board previously for additional nursing resource to support the APT will increase capacity within the team. This will allow the team to support both the proactive case management and increased reactive 'admission avoidance' patients. The additional staff will start in April.

There were still challenges in the system i.e. low numbers of patients discharge resulting in higher numbers remaining on the ward than was envisaged. Work to address this was the next step i.e. look at how practice based nurses can play a role.- delete this sentence

It was expected that with the additional nurses in place the team will be able to maintain the10% reduction. The board asked for reassurance that the virtual ward would be 'fit for purpose' in 2013 and to make sure that any requests for additional capacity is put to the board early on as there will be budget constraints next year.

SBo gave an update on the full evaluation undertaken by Public Health. The evaluation covered the experience of patients, GPs and APT staff. SBo pointed out that the sample numbers were low and therefore interpretation of the results would need to be treated with caution.

The results highlighted:

- Patients - admission to the ward coincided with improvements in health status for the majority of patients with the most notable achievement being the reduction in levels of anxiety/depression. Anxiety is a major

risk factor for unnecessary hospital admission;
- GPs - overall the majority of GPs supported the virtual ward;
- APT - staff believed the virtual ward was making a positive impact on patient care.

HM added that there was nothing unexpected in the report and an action plan was in place to look at comments and issues with the team.

SG referred to previous discussions considering a clinical leader of the virtual ward and HM reported that this was being progressed.

MW asked if there was a forum whereby good practice and projects i.e. the virtual ward could be shared with the other two CCGs. TDC confirmed that he has presented across the county and the virtual ward documentation shared with R & B CCG.

It was concluded that a report/update would be presented to the board in four months (July) setting out the level of investment, if needed to ensure the virtual ward is fit for purpose in 2013.

Action:
TDC/HM

SG as chair on behalf of the board proposed writing individually to the virtual ward staff acknowledging their hard work and achievements so far.

Egton Medical Information Systems Ltd (EMIS)
SG provided an update on the proposal to move practices in Wyre Forest on to one IT system. The system proposed is EMIS Web. This system offers more timesaving and patient care features providing the GP practice with modules from a leading clinical system: medical record summary, prescribing, appointments, searches and consultation mode etc. and maximises QOF points.

There is no need to go down the procurement route as practices can choose their own IT system they wish to have in place.
The proposal has been discussed with John Thornbury Director of IT (WAHT) and Lynda Dando Head of Primary Care (NHSW) who both support the process Lynda has offered to support practices to ensure that they will not be penalised i.e. loss of QoF points during the move onto the system. They will both be attending the next GPA meeting where EMIS will be discussed to get a steer from practices.

Richard Jarman, Practice Manager, York House surgery has agreed to lead the process from the practice side. Stourport and York House practices are moving onto EMIS from the 1st May 2012.

6.03.8 **Review of communications/key messages:**
- Quality & Safety;
- PPI Membership Scheme;
- Holding to Account Updates;

- EMIS;
- Budget update.
-

6.03.9 **For Information and items to note:**

- Wyre Forest Management Team Action Notes & Invest to Save Summary (14 & 28 February 2012);
- Wyre Forest Locality Board Minutes (9 February 2012);
- Wyre Forest CCG Board Action Plan (7 February 2012);
- Month 10 Finance Report.

6.03.10 **Date of the Next Meeting:**

Tuesday 3 April 2012 at 9am until 12.30pm in Room 3 Education Centre, Kidderminster Treatment Centre.
Commission Academy session to follow this meeting (lunch provided)
Agenda Items:

- Finance;
- Commissioning;
- Health & Wellbeing (Dr Jim Goodman & Marcus Hart attending).

Forthcoming agenda items:

- June board meeting – Radiotherapy full business case.

Signed Dr Simon Gates **Date 3 April 2012**

Dr Simon Gates Chair Wyre Forest CCG Board

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Minutes of the Wyre Forest Clinical Commissioning Group
REPORT AUTHOR :	Dr Simon Gates (Chair) Wyre Forest Clinical Commissioning Group
PRESENTED BY:	-
PURPOSE OF REPORT:	To receive the minutes of the meeting held on 3rd April 2012
KEY POINTS:	Key discussion areas: • Health & Wellbeing Board Overview • Sexual Health • Acute Commissioning • Community Services • Finance • Review of Strategy
RECOMMENDATION TO THE BOARD:	The Board is asked to note the minutes of the meeting held 3rd April 2012
CONTEXT & IMPLICATIONS	
Strategic Objectives	N/A

Financial	As outlined in the minutes
Legal	DoH Legal Framework
Risk & Assurance	As identified in the minutes
HR, Equality & Diversity	N/A
National Policy	NHS White Paper/ Health & Social Care Bill/Operating Framework 2012/13 Authorisation Toolkit
Carbon/Sustainability	N/A
Partnership	N/A

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Wyre Forest Clinical Commissioning Group 1st May 2012

"Working together for a healthier future"

MINUTES OF THE WYRE FOREST CLINICAL COMMISSIONING BOARD MEETING

Held at the Education Centre, Kidderminster Treatment Centre
9am until 12.30pm
Tuesday 3 April 2012

Present:

Dr Simon Gates	(SG)	Chair
Steve Booth	(StB)	Hospital Consultant
Dr Tony De Cothi	(TDC)	Vice Chair / Lead for Unscheduled Care
Simon Hairsnape	(SH)	Chief Operating Officer
Clare Nock	(CN)	Practice Liaison and Support
Dr Paul Williams	(PW)	Lead for Scheduled Care
Jo Galloway	(JG)	Lead Nurse Quality & Safety
Mary Walters	(MW)	Chief Finance Officer
Bryan Smith	(BS)	NED West Mercia Cluster

In Attendance:

Dr Ashis Banerjee	(AB)	Public Health Consultant
Rachael Blundell	(RB)	Community Services Commissioning Support Manager
Dr Stuart Bourne	(SBo)	Public Health Consultant
Dr Jim Goodman	(JGo)	CCG rep HWB Board/ GP York House Surgery
Dr Richard Harling	(RH)	Director of Public Health
Cllr Marcus Hart	(MH)	Chair of Worcestershire Health and Well-Being Board (HWB)
Heather Macdonald	(HM)	Deputy Chief Operating Officer
Anita Roberts	(AR)	Lead Commissioner for Community Services
Lakhbir Virk	(LV)	Senior Information Analyst

Observers

Janice Smith	(JS)	Consultant - Capsticks
John Bullivant	(JBu)	Consultant – Good Governance

Minutes:

Julie Bishop	(JB)	Board Secretary

Apologies:

Stella Baldwin	(SB)	PPI/Advisory Group Chair
Toni Bellfield	(TB)	Commissioning Accountant
Alex Hill	(AH)	Acting Head of Performance

03.04.1 **Welcome and Introductions**

SG as chair welcomed everyone to the meeting in particular Dr Richard Harling, Director of Public Health, Councillor Marcus Hart, Cabinet Member with Responsibility for Health and Wellbeing/Chair of Worcestershire Health and Well-Being Board (HWB), Dr Jim Goodman who represented the CCG on the HWB were attending to provide an overview on the Health and Wellbeing Board. Janice Smith Consultant, Capsticks (healthcare specialists) and John Bullivant Consultant, Good Governance attended the meeting as observers to advise and support the CCG with the authorisation process.

SG reflected on the past financial year since having responsibility for the 'shadow' budget. Wyre Forest was in a very good financial position He acknowledged the PCT's good financial and quality legacy which has been key to Wyre Forest CCG's (WF CCG) achievements (reduction in referrals and healthy underspend) and thanked PCT staff.

03.04.2 **Apologies**

Apologies noted as above.

03.04.3 **Minutes of the last meeting**

The minutes of the last meeting 6 March 2012 were agreed as a true and accurate record.

03.04.4 **Declarations of Interest:**

There were no new interests declared in respect of the agenda.

Declaration of Communication:

There were no communications declared.

03.04.5 **Commissioning:**

(i) Health & Wellbeing Board (HWB) Overview

RH, JGo and MH presented the papers. From April 2012 HWBs are being formally established across England with a view to them becoming statutory from April 2013. As an 'early implementer' Worcestershire County Council has established a HWB in shadow form since May 2011.

Worcestershire's HWB aims to develop collective local leadership and partnership with the core purpose of integrating public services in order to secure better health outcomes, better quality of care and better value for money. To do this it will undertake four main functions:

- To oversee the production of the statutory Joint Strategic Needs Assessment (JSNA) by the local authority and CCGs, to provide a clear statement of the health and wellbeing needs of the local population;
- To develop the statutory Joint Health and Wellbeing Strategy (JHWS) on behalf of the local authority and CCGs to provide a framework for how population needs are to be addressed;
- To consider whether the commissioning plans of the local authority and

CCGs are consistent with the JSNA and JHWS;

- To support the development of joint commissioning and pooled budgets.

The aim is for HWBs to make a "real difference" focusing on improving outcomes, rather than improving services. All HWBs are required to identify and focus on a small number of priorities. In Worcestershire these priorities are: Obesity, Alcohol, Mental Health, Acute Services, Older People and Long Term Conditions.

As part of the authorisation process the CCGs will need to show evidence of being actively engaged in partnership work such as the JSNA. Future commissioning plans will need to demonstrate a clear link back to the JSNA, and to joint health and wellbeing strategies.

SG pointed out that the HWB priorities mirrored WF CCG's priorities decided at the away day with practices last September. Public Health provided a steer and SG was keen that this would continue in future years.

The duration of the strategy will be three years. The strategy will be a high level document. The HWB wants to provide outcome measures that will enable monitoring and impact. The board agreed that It was important that CCGs are a very visible element of the localism agenda. RH added that the HWB as a whole including CCGs was instrumental in agreeing the strategy and action plan.

The next step for the HWB was a Stakeholder event which is taking place 30th May 2012 and CCGs are invited to attend followed by the first HWB public meeting. The consultation on the draft strategy will run until September 2012.

RH and MH reported that they were attending the other two CCG boards and were keen to move HWB around the county as meetings taking place at County Hall were often viewed as too remote. The HWB was keen to encourage public attendance.

JGo was positive about the function of the HWB. The multi agency membership of the HWB provides opportunities to improve health outcomes, tackle health inequalities, and address the many issues that impact on people's wellbeing.

HealthWatch

JGo gave a briefing on the establishment of HealthWatch in Worcestershire. The group chaired by Peter Pinfield was seen as very positive by JGo. HealthWatch is an independent consumer champion for the public - locally and nationally - to promote better outcomes in health for all and in social care for adults. Local HealthWatch will also provide information and advice to help people access and make choices about services. HealthWatch will be operational by April 2013 but Worcestershire has pilot status to proceed early and plans to be up and running by October 2012.

SG thanked the HWB attendees and acknowledged the HWBs good progress and looked forward to HWB attendance at the Wyre Forest CCG planning session in the Autumn.

(ii) Sexual Health Discussion

The board at the meeting in March discussed the decision by the DoH that Local Authorities will commission the following sexual health services (as part of public health) from April 2013:

- Contraception (outside of the GP contract);
- Sexually Transmitted Infection (STI) testing and treatment;
- Sexual health promotion;
- HIV prevention.

CCGs will commission abortion and vasectomy services from April 2013.

The National Commissioning Board (NHS CB) will commission the following sexual health services from April 2013:

- HIV treatment and care;
- Contraception through primary care (GPs);

As Wyre Forest CCG identified Sexual Health as a priority last September it was agreed to revisit that decision at the meeting today to decide whether to down grade it and opt for a new priority.

The board members discussed this option in detail noting that it was no less of a priority than it was six months ago and agreed that it was important to achieve the best outcome for the Wyre Forest Locality.

It was decided that engaging with Public Health and the Joint Commissioning Unit (who will be responsible for commissioning the majority of sexual health services) and being able to influence decision making for investment in Wyre Forest sexual health provision was good for the Wyre Forest population. It was also acknowledged that the Health and Wellbeing Board (HWB) was disappointed that the other two CCGs had not identified sexual health as a priority.

Action:

It was agreed that RB and AB will work together in order to influence the Public Health review of Sexual Health services across the county as a whole. RB will share the Wyre Forest Sexual Health Proposal paper and information with the new Sexual Health Commissioning Manager at the JCU and will report back to the Board with details of the future plan of the PH review, together with the structure of the Project groups and timescales.

(ii) Acute Commissioning Update

The 2012/13 contract with Worcestershire Acute Hospitals NHS Trust (WAHT) was signed off on Friday 30th March 2012. The contract value equates to £249,891,794 of which the Wyre Forest element is £55,232,266 (22%). The contract is available to view if board members wished to see the detail. It was agreed by the PCT on behalf of the CCGs.

The acute trust has made an application to the West Mercia Cluster for circa £10m from the 2% transformational change resource allocation. This is non recurrent money and is to be used to support the trust in the implementation

programme as it is accepted that service redesign productivity gains are not immediately achievable without this support.

TDC added that it was important for CCG involvement in the contract process this year early on as CCGs will ultimately be responsible for the contract when the PCT is abolished. TDC pointed out that capacity was an issue and adequate notice of meetings was needed.

HM suggested that it was of more value to make sure Wyre Forest's priorities are included in the Commissioning Intentions rather than clinicians' attendance at Contract Management Board meetings.

Clinical involvement in reviewing readmissions was proposed as a good area to focus on in-year.

SH stated that over the next few months it was necessary to look at processes which were working well to be mapped across to CCGs. There would be less staff in the CCGs and where best to use clinicians needed to be thought through.

Action:
It was agreed that SH, MW and HM would discuss this further. The CCG shared commissioning team should be in place by June and it was decided that it would be reviewed at Management Team in June.

The board was also keen for clinical engagement at WAHT in terms of performance managing the contract. PW suggested embedding it into the contract i.e. the GP/Consultant pairings.

Action:
It was agreed to discuss this at the next GP/Consultant Pairings event.

Action:
The Commissioning for Quality and Innovation (**CQUIN**) final schemes delivered to be circulated by AR to the board members.

(iv) Community Services Update

This is the final year of a three year contract with Worcestershire Health & Care NHS Trust (WHCT). A decision was made to continue with two separate contracts for WHCT for community services and mental health for this year.

The contract value for 2012/13 for community services was £92,738,909.

The Deed of Variation for both community services and mental health has been signed off by both parties with CCGs as signatories.

The 2012/13 community services contract is structured in a similar way to the 2011/12 contract with some elements of Payment by Results (PbR) and block contracts.

The Information Team has been working on splitting out block to fair share activity for CCGs and this will be available from Month 1.

SG referred to the QIPP 4% target and reiterated that community staff appointed for Wyre Forest must be for Wyre Forest and not for the county. He wanted to see an increase in community staff and did not want a reduction as part of the QIPP savings.

AR responded saying that it was about clear indicators and how we expect them to perform i.e. incentivise them. In terms of staff appointed to the virtual ward it has been made very clear to WHCT that these staff will remain in Wyre Forest and will be performance managed.

MW pointed out however, that Robert Mackie, Director of Finance WHCT argument would be that we should be commissioning outcomes.

AR reported that she was meeting with the project team (includes two GPs and Practice Manager) next week. This team has been set up to undertake a review of community nursing in Wyre Forest. The problem at present was that we are working to the old specification. The new specification will increase capacity and make sure the outcomes for staff and patients are what we want.

Action:
AR will provide a full report to the May board meeting.

With regard to the major change in the way mental health care is currently funded i.e. a shift from block grants to Payment by Results (PbR) currencies the timeline initiated by he Department of Health (DoH) has slipped.

WHCT has made excellent progress with PbR clustering. Clustering is where funding is aligned with 21 "clusters" or care groups. Each cluster describes a group of individuals according to their needs and difficulties. These groupings have been developed nationally.

Action:
AR will circulate to board members the list of CQUINS and the Quality Schedule will be available at the May board meeting.

03.04.6 **Finance:**

(i) Month 11 Finance Report
MW presented the report. There has been a significant improvement in respect of Month 10 to Month 11 with WF CCG forecasting an underspend of £4,866,907; this is an increase of £696,539.

The remainder of the report was fairly consistent with Month 10.

The hard work in terms of QIPP i.e. virtual ward contributed to this healthy position.

(ii) 2012/13 Budgets
The board acknowledged that MW as Wyre Forest Chief Finance Officer was not involved in the recent discussions with the three CCGs regarding WF CCG

budget concerns i.e. historic spend or 'fair share' budget allocation. This was on the advice of Brian Hanford who acknowledged MW could be put in a difficult position.

It was also noted by the board that JG sat on all three CCG Boards in Worcestershire as Lead Nurse Quality & Safety.

The West Mercia Cluster Board approved the Worcestershire PCT 2012/13 budgets at its meeting Tuesday 27th March 2012.

The board was asked to approve the 2012/13 budget for Wyre Forest CCG.

A short briefing paper provided the background as to how the budgets are set and MW referred to each section Points to note included:.

- A 3.6% uplift has been applied to CCGs budget allocation;
- WAHT split is factored in to the budgets going forward;
- Wyre Forest demography higher than the rest of the county (1.24%).

MW pointed out that the finance team has made good progress in identifying expenditure to specific CCGs however, it is not mandatory for secondary healthcare providers to provide this until 2013. This could have a considerable impact on the budget as a 1-2% shift on £130m budget is a sizeable amount.

W F CCG against a planning target of a 1% internal Operational Reserve of £1.3m has £6.5m of currently uncommitted resources i.e. £5.2m above the requirement. This is on a "fair share" budget of £130.4m. This puts Wyre Forest in a very strong position. This was a combination of hard work and gains in terms of the 'fair share' formula

The board formally accepted the 2012/13 budget allocation for WF CCG.

03.04.6 **Review of Strategy:**

The board reviewed 2011/12 and 2012/13 priorities to make sure there were no concerns that needed to be addressed:

2011/12

Priority One - Ensuring Financial Balance

Achieved for this year. Ongoing.

Priority Two - Developing alternatives to unscheduled care and reducing unnecessary admissions

Virtual Ward up and running and performing well. New staff in post which is a significant achievement.

TDC referred to work Dr Felix Blaine was doing in terms of high risk patients in care homes and how the care home LES/project can link to the virtual ward. TDC is meeting with John Thornbury re an integrated health record and how communications with the virtual ward and the whole health community a=could be improved.

To achieve the QIPP savings the virtual ward has to keep delivering for the foreseeable future.

SG pointed out that investing in community care was key to delivering QIPP savings.

MW added that she was meeting with Peter Fryers to look at his recommendations as a follow up to his QIPP presentation to the board.

Priority Three - Managing elective care to ensure the appropriate use of hospital based services
The Integrated Clinical Assessment and Treatment Service (ICATS) set up. Ongoing.

Priority Four - Developing clinical engagement and service integration
GP/Consultant Pairings for most specialities and regular events over the past year. Ongoing.

2012/13
Priority One - Re-commission Psychiatric Services, in partnership with the combined community and mental health trust
PW referred to a problem in Wyre Forest with only 60/70% practices having access to the Improving Access to Psychological Therapies Programme **(**IAPTS). Jenny Dalloway, Mental Health Project Lead Adults JCU, Worcestershire County Council was looking into the cost of making it available to all Wyre Forest GP practices.

Priority Two - Look to commission a coherent sexual health service for the Wyre Forest
This item was covered under agenda item 03.04.5 (ii).

Priority Three - Complete the commissioning of community services to ensure a specification matches the needs of a modern health service
Report to be presented to the board next month.

Priority Four -Support General Practices to release more clinical time for commissioning and primary care
No issues or concerns raised.

Priority Five -Implement a Quality and safety strategy
Quality and Safety strategy in place. Medium term strategy to be developed.

The board discussed future investment. JG referenced the lack of significant investment into residential care i.e. review admissions from care homes to WAHT.

TDC referred to an Urgent Care Centre which could be situated in

Kidderminster Treatment Centre within six months offering convenient access to a range of treatment for minor illnesses and injuries.

It was decided that it would be useful to consider a report on investment and next steps going to a future board meeting for further discussion.

03.04.7 **Review of communications/key messages:**

- Health & Wellbeing;
- Acute Commissioning;
- Community Services Commissioning;
- Finance;
- Review of Strategy;
- Away Day for GP Practices;
- Sexual Health Priority.

03.04.8

- **For Information and items to note:**
- Wyre Forest Management Team Action Notes & Invest to Save Summary(13.03.2012);
- Wyre Forest Locality Board Minutes (08.03.2012);
- Wyre Forest CCG Board Action Plan (06.03.2012);
- Equality & Diversity documents.

03.04.9 **Date of the Next Meeting:**

Tuesday 1st May 2012 at 9am until 12.30pm in Room 3 Education Centre, Kidderminster Treatment Centre. Joanna Newton, Chair West Mercia Cluster will be attending this meeting.

Agenda Items:

- Holding to Account;
- Quality & Safety, Performance;
- Wyre Forest Advisory Group Update;
- PPI update.

Forthcoming agenda items:

- Tuesday 12th June board meeting – Radiotherapy full business case.

Signed ..... **Date .....**

Dr Simon Gates Chair Wyre Forest CCG Board

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	Update Report from Audit Committee
REPORT AUTHOR :	Brian Hanford, Director of Finance
PRESENTED BY:	Brian Hanford, Director of Finance
PURPOSE OF REPORT:	To advise the West Mercia Cluster of PCT Boards of the recent Audit Committee held on 3 May 2012. The ratified minutes of the previous Audit Committee meeting held on 12 March 2012 are attached for information:
KEY POINTS:	• IM&T Disaster Recovery – Shropshire County PCT • Board Assurance Framework and Risk Management logging • Development of CCG Audit and Assurance Arrangements • External Audit Reports – progress report and the national Payment by Result Audit • Internal Audit Reports – progress report; Continuing Healthcare in Worcestershire • Counter Fraud
RECOMMENDATION TO THE BOARD:	The Board is asked to note the contents of the report

CONTEXT & IMPLICATIONS	
Strategic Objectives	To inform the Annual Governance Statements and provide assurance to the Board on financial systems and controls
Financial	Internal Audit Reports/External Audit Reports
Legal	Complies with relevant legislation
Risk & Assurance	Risks identified during the meeting have been captured on the Assurance Pro-Forma and considered for entry on directorate risk register
HR, Equality & Diversity	No Equality and Diversity issues identified but recognition of the importance for strong Equality and Diversity processes in relation to effective governance.
National Policy	Department of Health National Policy
Carbon/Sustainability	Not applicable
Partnership	Risk to Partnership arrangements identified in directorate risk registers and escalated to BAF as appropriate
GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	Audit Committee minutes of meeting on 12 March approved by the Committee and signed by the Chair subject to minor amendments.

Audit Committee Update Report

Introduction

The Audit Committee has met on the 2n d May and detailed below is a summary of the substantive issues discussed.

IM&T Disaster Recovery – Shropshire County PCT

The Committee noted receipt of Shropshire Community IM&T Disaster Recovery plan which was required under the recommendation tracking system of past Internal Audit Reports. The Committee discussed the need to follow up the gaining of assurance in all areas of the Cluster and the Director of Finance confirmed that he was putting in place a Cluster wide ICT Programme Board which would include review of IM&T issues such as disaster recovery within its remit.

Board Assurance Framework and Risk Management Logging

The Committee discussed the process established for tracking risks raised by sub committees of the Board and the importance of Committees logging even nil returns. A future Audit Committee will review all submissions to date formally but it was noted that at this time there were no specific issues that required highlighting to the Board that were not on the Boards agenda. The Committee also noted that the draft Cluster Corporate Objectives were scheduled to be presented to the Cluster Board at the May Board and agreed that the Audit Committee would usefully review the Risk Assessment of the objectives signed off at the Board prior to there representation to a future Board meeting.

Development of CCG Audit and Assurance Arrangements

The Committee discussed at length the development of Audit arrangements to underpin the delegated relationship with the Cluster Board. The Committee noted that particularly in Worcestershire External Audit colleges from the Audit Commission had held a number of successful developmental sessions with CCG Boards which had explored general governance issues and in particular issues such as conflicts of interests.

The Committee agreed to set up a small Task & Finish Group to propose how best to support CCG colleagues in their development of Audit arrangements and this met on the 11th May in support of their authorization process and to assure itself on behalf of the Board that sound governance is progressing under the delegated arrangements.

The T&F Group proposed to meet each CCG Board in an informal setting to present key Audit Committee issues and approaches before engaging more substantively with key individuals within each CCG that would be instrumental in establishing Audit arrangements e.g. Audit lay members, CFOs, Governance leads and Accountable Officers.

The Group also agreed to put together a pack containing the following documents:-
Audit Handbook
Self Assessment Checklist
An Internal Audit Plan
An External Audit Plan
Terms of Reference
Board Assurance Processes
An Audit Committee Annual Workplan

In particular the Audit Committee is keen to understand from CCGs how they propose to approve membership of the CCG Board given the reduction in Non Executive/Non GP members.

External Audit

In addition to the usual progress report the Committee considered the output of the national Payment by Result audit which generally provided assurance on coding within the Clusters main providers but did highlight the potential to develop more benchmarking to assist in identifying future areas of review by CCG commissioners.

The Committee discussed the good progress on gaining External Audit assurance around the four PCT Final Accounts for 2011/12 and noted resolution on a national debate around the accounting for assets transferring to Trusts under Transforming Community Services.

The Committee also noted the arrangement for members to receive detailed briefings on the draft Final Accounts and this has occurred.

Internal Audit

The Committee received Internal Audit plans for 2012/13 and proposed changes in a number of areas progress reports for each PCT. Particular reports received were a follow up of a Continuing Healthcare in Worcestershire and the need to monitor progress on eliminating any backlogs; the Register of reports for 2011/12 and the Committee agreed that all relevant reports should be made available to CCG Chief Operating Officers. The Committee discussed a report on Information Governance in Shropshire County and that only moderate assurance had been received.

The Committee received the Internal Audit Annual Reports for each PCT and noted the generally favorable nature of the reports which would assist the Committee is signing off the Annual Governance Statements.

Counter Fraud

The Committee received an update on the Counter Fraud Issues across the Cluster.

Brian Hanford
Director of Finance

WEST MERCIA CLUSTER

AUDIT COMMITTEE

Minutes of the meeting held on 12th March 2012 at 9.30 am in the Rose Hill Room, St Richard's Hospice, Wildwood Drive, Worcester.

PRESENT:

Mr Robert Parker (Chair)	Non Executive Director - Worcestershire
Mr William Hutton	Non Executive Director - Shropshire
Mr Andrew Mason	Non Executive Director - Telford & Wrekin
Mrs Susan Mead	Non Executive Director - Hereford

IN ATTENDANCE:

Dr Philip Ashurst	Locality Associate & ex Chair HPCT Audit Committee
Mr John Snell	Locality Associate & Ex Chair T&WPCT Audit Committee
Mrs Carol Thompson	Locality Associate
Mr Brian Hanford	West Mercia Director of Finance & Ex NHSW Audit Committee member
Ms Laura Boden	Chief Finance Officer - Telford & Wrekin
Ms Donna McGrath	Chief Finance Officer - Shropshire
Ms Jill Sinclair	Deputy Director of Resources - Herefordshire
Ms Lin Jonsberg	Board Secretary – West Mercia Cluster
Miss Julia Dillon	Local Counter Fraud Specialist - Worcestershire
Mrs Liz Cave	External Audit
Mr James Elsby	External Audit
Mr James Cook	External Audit
Mr Tony Corcoran	External Audit
Mr Paul Dudfield	Internal Audit - CW Audit
Mrs Kristina Woodward	Internal Audit - CW Audit
Ms Sarah Ann Moore	Internal Audit - KPMG
Mrs Hilary Newman (Minutes)	

ACTION

01/11 Apologies

Apologies were received from Mary Walters.

Mr. Parker advised that the new West Mercia Cluster Audit Committee meetings would cover all four PCTs and would therefore need to focus on key governance issues in the last year of PCTs. A key piece of work would be to direct issues to Clinical Commissioning Groups (CCGs) as appropriate.

02/11 **Minutes of the last meeting**

NHS Worcestershire

The minutes of the meeting held on 6th December 2011 were agreed as a true record.

Shropshire County PCT

The minutes of the meeting held on 2nd November 2011 were agreed as a true record.

Mr. Hutton to sign the minutes for the meeting held on 2nd November 2011. **WH**

Telford & Wrekin PCT

Ms Boden would arrange for John Snell to confirm that the minutes of the meeting held on 15th November 2011 are a true record. *Meeting note: John Snell joined the meeting later and confirmed this was the case.* **LB**

Herefordshire PCT

The minutes of the meeting held on 19th January 2012 were agreed as a true record with the following amendment.

Item 10 Charitable Funds Update – verbal

Page six, first paragraph, final sentence to read, "The PCT has retained a small balance **(£5,000)** to cover expenditure commitments.

Dr. Ashurst explained the process used to report to the Herefordshire PCT Audit Committee and the sign off process.

Dr. Ashurst to sign off the Herefordshire PCT minutes for the meeting held on 19th January 2012. **PA**

Sarah Ann Moore joined the meeting.

ACTION

03/11 Matters arising from the minutes

03.1/11 NHS Worcestershire

Audit Committee Self Assessment

A copy of the draft Annual Report for 2011/12 would be presented to the Audit Committee in May 2012. Mr. Parker explained the process used by NHS Worcestershire. Mr. Hanford advised that separate Annual Audit reports for each PCT across the Cluster would be prepared and ideally signed off by the Audit Committee. Mr. Hanford explained the process for the sign off of the Annual Accounts for 2011/12.

Internal Audit Report – Continuing Healthcare

Mrs Woodward advised that the draft Continuing Healthcare report for the follow up review had been circulated and the report had been finalised last week. Mr. Parker advised that he was satisfied that the follow up report gave satisfactory assurance that actions would be carried out more quickly, moving forward in a positive direction.

Internal Audit Report – Income & Debtors

Action to be carried forward for Ms Walters to provide an update for the Audit Committee, following the cost benefit review of implementing a new system for prescription charges, to be carried out by Sue Johnson. **BH/MW**

Healthcare Contracting

Mr. Parker explained the issues regarding contracts not being signed off and the risks. Mr. Hanford explained the process for out of county contracts which rely on the lead commissioner processes carried out on our behalf. Mr. Hanford advised that the Strategic HA would firmly impose the 31st March 2012 deadline. There is a risk regarding the Gloucestershire Foundation Trust contract but there has been an improvement on last year. Mr. Parker requested an update on the status of outstanding contracts for the next meeting. **BH**

ACTION

03.2/11 Shropshire County PCT

Performers List

Mr Hutton referred to item 7.3 of the minutes, employment checks undertaken for dentists who were added to the Performers List prior to the introduction of application forms. Mr. Hutton advised that the review had been carried out and appropriate actions were in place.

Board Assurance Framework

Mr. Hutton would check with the LCFS for Shropshire that the changes regarding the new Bribery Act were being implemented. **WH**

03.3/11 Workplan

Mr. Parker commented that this would be key for the six CCGs. Ms Dillon advised that the Shropshire LCFS Counter Fraud workplan for the CCGs would cover the inclusion of the Bribery Act within the workplan.

Telford & Wrekin PCT

Ms Boden advised that the Audit Committee meeting due to be held on 17th January 2012 had been cancelled.

External Audit – Annual Audit Letter

Ms Boden referred to the transfer of some of the Finance staff, involved in the Final Accounts process, to the Shropshire Community Trust and confirmed appropriate assurances had been obtained from the service provider.

Recommendation Tracking

Ms Boden advised that the IMT Disaster Recovery Plan is due to be presented at the next Audit Committee meeting. **LB**

Update on Serious Incident Root Cause Analysis

Ms Boden advised that a Serious Incident Root Cause Analysis assurance report should be available to be presented to the Audit Committee in May 2012. Mr. Hanford would discuss the report with Sue Doheny and decide if it should be presented to the Audit Committee. **BH**

ACTION

03.4/11 **Herefordshire PCT**

Item 6.2 Internal Audit Report – Financial Reporting

Ms Jonsberg advised that the West Mercia Cluster Standing Financial Instructions and Standing Orders had been revised and presented to the Cluster Board on 17th January 2012. Ms Jonsberg would circulate feedback and amendments to the Audit Committee this week. **LJ**

Item 11 Update on Procurement of Soft Facilities Management for Mental Health

Ms Jonsberg confirmed that negotiations for the award of the contract were being finalised and the contract would be presented to the Cluster Board for sign off. **LJ**

04/11 **Board Assurance Framework and Assurance Pro-forma – Herefordshire PCT, Shropshire County PCT, Telford & Wrekin PCT and NHS Worcestershire**

Ms Jonsberg advised that the Board Assurance Framework for the four PCTs had been presented to the Cluster Board on 28th February 2012. The top ten risks identified for the four PCTs were presented to the Audit Committee to be reviewed and for an update from the chairs of the former Audit Committees.

Ms Jonsberg explained the proposed Board Assurance process and pro-forma. The Cluster Board had approved the use of the pro-forma to be completed at the end of each Audit Committee meeting. Ms Jonsberg advised that a risk owner and RAG rating would need to be identified. Dr. Ashurst suggested that a nil return be completed when there are no issues to record.

Mr. Parker advised that the Committee needed to identify the current major risks for the Cluster and other locality ongoing issues.

Dr. Ashurst explained the Herefordshire PCT Board Assurance Framework process for identifying through the directorates the key risks. Red rated risks were updated through the Board and also risk assessments for all Board strategic objectives. Mr. Parker advised that the Cluster Board had agreed that the Executive Team should prepare a draft set of Corporate Objectives for the Cluster Board. The Cluster Audit Committee would identify any risks and gaps in these objectives.

		ACTION
04/11	**Board Assurance Framework and Assurance Pro-forma – continued**	
	Dr. Ashurst asked how the risks at locality level would be monitored. Mr. Hanford identified that Dr. Jonathan Leach will oversee risks across the Cluster that relate to independent contractors. Mr. Hanford also proposed that ownership for all identified risks be reviewed and wherever practicable risks be managed at local level through CCGs. Dr. Leach had signalled that there would be local independent contractor panels and this would retain local focus.	
	Mr. Parker commented that the new committees would need to be aware that they need to complete the assurance pro-forma. Mr. Parker asked for the detail of the new committees to be presented to the Audit Committee.	**BH**
	Mr. Hanford advised that Ms Jonsberg and the Chief Finance Officers would go through the Board Assurance Framework charts to note the scores and identify the lead for each risk.	**LJ/LB/ DMcG/ MP/MW**
	Dr. Ashurst explained the process used by Herefordshire PCT to score the risks and advised that Herefordshire PCT had produced scoring guidelines. Mr. Parker agreed that the Cluster Audit Committee would adopt the Herefordshire PCT process. Ms Jonsberg would circulate the Herefordshire PCT Board Assurance Framework scoring process guidelines to the Committee. Mr. Hanford advised that Lucy Noon, Head of Corporate Governance assisted by Alison Smith, Governance Lead and Lin Jonsberg, Board Secretary would oversee the process.	**LJ**

		ACTION
04/11	**Board Assurance Framework and Assurance Pro-forma – continued**	
	Ms Jonsberg advised that the National Commissioning Board sub committee and Audit Committee meeting dates had not yet been finalised. Ms Jonsberg commented that the CCGs would need to take responsibility for reporting risks. Ms Jonsberg suggested that the chair for each committee identify someone to take a note of the risks at each meeting. Ms Jonsberg would contact the Chief Operating Officers and Chief Finance Officers to take this forward. Mr. Hanford and Ms Jonsberg to produce a standard briefing for the first committee meetings. Ms Jonsberg would be asked to collate the completed assurance pro-formas. Mrs. Mead commented that a robust structure around this process is important. Mr. Parker advised that the two Non Executive Directors for each CCG Board should be responsible for reinforcing at CCG Board meetings the need to take forward and adopt the Board Assurance Framework process. Ms Jonsberg would distribute the Board Assurance Framework guidance to the Locality Non Executive Directors and the Cluster Non Executive Directors as soon as possible.	**LJ** **LJ/BH** **LJ** **LJ**
	Mr. Mason and Mr. Snell joined the meeting.	
	Mr. Hanford summarised the move to the new operating model lead by the Chief Operating Officers for the CCGs. Mr. Hanford explained the structure and reporting process for CCG committees. High level items would be reported to the Cluster Audit Committee.	
	Mr. Parker asked Mr. Hanford to provide a summary of the process for the reporting of risks including any key items for the next Audit Committee meeting. Mr. Parker commented that NHS Worcestershire Audit Committee Non Executive Directors had attended a Board Assurance briefing session led by Internal Audit. Mrs. Thompson asked how frequently the updates on risk assurance from Directors would be presented. Mr. Hanford suggested quarterly updates from the CCGs and the Chief Finance Officers around the key risks. Mr. Parker commented that assurance risks would be presented to the Quality & Performance Review Committee. Ms Jonsberg advised that the CCGs had requested that the Board Assurance Framework be included on the agenda for the Board to Board development day.	**BH**

		ACTION
04/11	**Board Assurance Framework and Assurance Pro-forma - continued**	
	Mrs. Thompson referred to the NHS Worcestershire Board Assurance Framework. Mrs. Thompson asked if the schedule had been updated since the Audit Committee meeting on 6th December 2011. Mrs. Thompson commented on the need to be careful regarding the use of abbreviations on the schedule. Mrs. Thompson confirmed that the top 10 risks had been reported to the NHS Worcestershire Quality & Patient Safety Assurance Committee and there were no concerns to report.	
	Mr. Parker asked Mr. Hanford to provide a draft proposal of what to include in the Corporate Objectives and the key objectives to be monitored at Cluster level. Mr. Hanford to ask Audit Committee Non Executive Directors for a view and present a draft proposal to the next Audit Committee.	**BH**
	Mr. Hutton referred the Shropshire County PCT and Telford & Wrekin PCT Board Assurance Framework.	
	Mr. Hutton commented that there was concern regarding the combined Risk Register across the Cluster being over generalised. Mr. Mason suggested categorising common issues and Shropshire/Telford & Wrekin specific issues. Mr. Parker agreed and asked Mr. Mason and Mr. Hutton to action.	**AM/WH**
	Mr. Parker requested a brief report be presented to the Cluster Board to outline how to take forward the Board Assurance Framework reporting.	**LJ**
	Ms Jonsberg completed the assurance pro-forma for this meeting.	
	The Committee noted the current Board Assurance Frameworks from each PCT and the provisional top ten risks identified for each.	
	The Committee reviewed the Board Assurance Framework process to taken forward.	
	The Committee endorsed the use of the Assurance Pro-forma at the Committee and to submit the completed form to the Board Secretary after each meeting for review and where necessary, incorporation into the relevant Board Assurance Framework (in agreement with the relevant Executive Director(s).	

ACTION

05/11 External Audit Reports

05.1/11 Audit Opinion Plan 2011/12

Mrs. Cave presented the Audit Opinion Plans for 2011/12 for Herefordshire PCT, Shropshire County PCT, Telford & Wrekin PCT and NHS Worcestershire. The Herefordshire PCT and NHS Worcestershire PCT Audit Opinion Plans had previously been presented to their Audit Committees. Mrs. Cave advised that the Shropshire County PCT and Telford & Wrekin PCT Plans had not been presented to their Audit Committees but any issues could be raised at this meeting.

Mrs. Cave advised that all the plans are based on a national framework tailored to the local risks in each PCT. Mrs. Cave referred to the Herefordshire PCT Audit Plan as an example and went through the significant and specific risks listed on page five of the report. Mr. Cook explained the risk regarding the Hoople organisation which provides support services to Herefordshire PCT. Ms Sinclair explained that the year end position between Herefordshire PCT and Hoople had been agreed. Ms Sinclair advised that Hoople had provided assurance for the Herefordshire PCT Audit Committee regarding the year end. PCT staff had undertaken the preparation of the final accounts to ensure continuity of staff preparing the accounts.

Mr. Hanford advised that clarity would be required regarding the new National Commissioning Board system for accounting arrangements. It is anticipated that the CCGs will need to use this system. In 2012/13 working towards the new national system all CCGs would use the same set of financial systems from 2013/14. Mr. Hanford advised that he is confident that the systems for the 2011/12 accounts are robust but future arrangements would need to be monitored. Dr. Ashurst confirmed that Mr. Hanford's comments had been noted.

ACTION

05/11 External Audit Reports

05.1/11 Audit Opinion Plan 2011/12 - continued

Mr. Corcoran referred to Telford & Wrekin PCT. Mr. Corcoran referred to the Continuing Healthcare issue that led to a qualification but noted that from 2011/12 the materiality of the transaction had dropped from £300,000 to £60,000. Mrs. Cave advised that there is a national risk issue regarding the transfer of assets. Mrs. Cave explained the lease arrangements in Herefordshire. Mr. Cook advised that the Department of Health had struggled to provide guidance on lease arrangements. Mr. Cook explained the 21st March 2012 deadline for further guidance. External Audit would examine individual arrangements for each PCT regarding the assets on balance sheets to interpret the guidelines. Ms Sinclair explained the arrangements with Wye Valley signed by the Chief Executive

Mrs. Cave referred to Value for Money on page nine of the Herefordshire PCT Plan. Mrs. Cave explained that all the plans have risk around securing financial targets and QIPP. The contract performance of Wye Valley Trust is an additional risk for Herefordshire PCT.

Mr. Corcoran mentioned that the 10% fee reduction is common to all the PCTs.

Mr. Hanford confirmed that in statutory terms all the PCTs remained separate organisations and would be audited separately.

Mr. Parker requested that all reports presented to the Audit Committee are clearly headed with the name of the relevant PCT. **All**

There were no issues to raise regarding the Shropshire County PCT Audit Plan.

Mrs. Cave confirmed that there would be separate Annual Governance reports issued for each PCT and separate audits of the accounts.

ACTION

05/11 External Audit Reports

05.2/11 Annual Audit Letters 2010/11

Mr. Hanford advised that the Annual Audit Letters for 2010/11 for Herefordshire PCT, Shropshire County PCT, Telford & Wrekin PCT and NHS Worcestershire were presented to the Cluster Audit Committee as a legacy handover.

Mrs. Cave confirmed that there were no significant concerns in any of the letters.

05.3/11 Progress Report March 2012 – West Mercia PCT Cluster

Mr. Elsby went through the Progress Report for the West Mercia Cluster for 2001/12.

Mr. Elsby referred to page three of the report and explained how External Audit will report to the Cluster Audit Committee. Separate Annual Governance reports and Annual Audit Letters will be produced with a separate summary of the main issues.

Mr. Elsby referred to the detailed work programme for the four PCTs at appendices 1 to 4 and advised that work is on target.

Mr. Elsby referred to the assurance programme for Payment by Results and the phase two findings on page five of the report. Mr. Elsby advised that the reports would be issued shortly to the PCTs. The reports would be presented to the next Audit Committee meeting. **JE**

Mr. Elsby advised that the Audit Commission is outsourcing the in-house Audit Practice and confirmed that the contract had been awarded to Grant Thornton. The work would transfer to Grant Thornton on 1st November 2012. Mrs. Cave advised that the staff currently responsible for the audit of the PCTs within the West Mercia Cluster would transfer to Grant Thornton on 1st November 2012. The contract with the PCTs would remain the same.

Mrs. Cave referred to the Wyre Forest CCG Governance Workshop held on 6th March 2012, which had dealt with the role of the Audit Committee. Mrs. Cave had received very positive feedback from Wyre Forest CCG. The Wyre Forest CCG Board were very engaged.

		ACTION
05.3/11	**Progress Report March 2012 – West Mercia PCT Cluster - continued**	
	Mr. Parker asked when the remaining five CCGs would host these workshops. Mrs. Cave had been advised by Simon Hairsnape that Redditch & Bromsgrove CCG would be ready in approximately three months	
	Mr. Hanford advised that for the reassurance process the evidence from the workshops would be helpful.	
	Mrs. Cave to contact Simon Trickett to discuss arrangements for a South Worcestershire CCG Workshop.	**LC**
	There was discussion on the CCG Board sub committees. Mr. Mason advised that Telford & Wrekin CCG have sub committees but an Audit Committee had not yet been held. Mr. Hutton advised that the Shropshire CCG Cluster representative is Dr Helen Herrity. Ms Mead sits on the Herefordshire CCG Board with another Non Executive Director. The Shropshire CCG Quality & Performance Committee is being set up.	
	Mr. Hanford advised that for 2012/13 the West Mercia Cluster Audit Committee is the statutory Audit Committee for the Cluster.	
	Mr. Parker advised that a framework for the CCGs needs to be agreed to look at key audit reports. South Worcestershire CCG had discussed the possibility of assistance from Locality Associates drawn from ex Non Executive Directors regarding the establishment of CCG sub committees. Mr. Parker asked Mr. Hanford with Mr. Hutton and Dr. Ashurst to consider what to include on the CCG Audit agendas to start the process. Mrs. Cave advised that External Audit could arrange further workshops based on the structure of the Wyre Forest CCG workshop.	**BH/WH/ PA**
	Ms Mead commented that it is important to consider potential conflicts of interests where GPs are in federations of providers. Mrs. Cave advised that national guidance does not deal with all issues. Miss Dillon commented that the Bribery Act legislation regarding declaring conflicts of interest is helpful. Ms Jonsberg suggested incorporating information on the Bribery Act into the Board to Board meetings. Ms Jonsberg to forward the dates for the Board to Board meetings to Mrs. Cave when available.	**LJ**

ACTION

05.3/11 Progress Report March 2012 – West Mercia PCT Cluster - continued

Mr. Parker asked if all the GPs had completed the declaration of conflict of interests forms. Ms Jonsberg would confirm this with the Chief Operating Officers. **LJ**

Mr. Hanford advised that organisational development is lead by Paul Maubach, Director of Commissioning Development. Mr. Hanford would discuss with Paul Maubach how the Audit Committee would action some of these recommendations. **BH**

06/11 Internal Audit Reports

06.1/11 Progress Reports – CW Audit Shropshire County PCT, Telford &Wrekin PCT & NHS Worcestershire

Mr. Dudfield presented the individual progress reports for Shropshire County PCT, Telford & Wrekin PCT and NHS Worcestershire for Quarter 4.

Mr. Dudfield advised that the reviews had progressed as planned. The Head of Internal Audit Opinion would be completed by the end of March 2012.

Mr. Dudfield referred to the recommendation tracking on page four of the NHS Worcestershire report and advised that there were no level three recommendations to report. Mr. Dudfield advised that for Shropshire County PCT and Telford & Wrekin PCT there were no outstanding recommendations. Mr. Dudfield advised that in future recommendations would be consolidated. Mrs. Woodward confirmed that there were no high level recommendations outstanding for NHS Worcestershire. It was agreed that the scoring levels used for recommendations would be consistent for all reports to the PCTs. The key to the reporting scores would be included in the reports. **KW**

Mr. Dudfield confirmed that GP Governance arrangements would be included in the Internal Audit Plan for 2012/13. The GPs had not been ready for this to be included in the 2011/12 Plan and Mrs. Woodward advised that the days had been used to carry out the staff overpayment review instead.

ACTION

06/11 Internal Audit Reports - continued

06.2/11 Progress Report – KPMG Herefordshire PCT

Ms Moore presented the Progress Report for Herefordshire PCT and provided an update.

Ms Moore advised that there was an outstanding report for Corporate Governance. Ms Moore advised that there were 17 outstanding recommendations 10 of which were past the due date timescale. Ms Sinclair provided an update and explained the timing issue. Ms Sinclair advised that nine of the outstanding recommendations had been implemented and the remaining recommendations were mandatory training which would be addressed fully.

Ms Moore confirmed that there were no high priority recommendations. Ms Moore advised that the Corporate Governance report would be available at the end of March 2012. Ms Sinclair and Dr. Ashurst would review the Corporate Governance report. Mr. Parker asked for the report to be sent to Dr. Ashurst as soon as possible and asked Dr. Ashurst to make him aware of any significant issues. **SAM/ PA**

Adult Safeguarding – CW Audit

06.3/11 Ms Woodward presented the Adult Safeguarding report for joint work delivered to Shropshire County PCT and Telford & Wrekin PCT.

Ms Woodward reported moderate assurance for the design and operation of the system's internal controls. Ms Woodward advised that there was no Non Executive Lead. Ms Woodward advised that there was insufficient monitoring of contracts and an absence of a policy. Mr. Mason advised that a structure needed to be in place for Non Executive Director involvement. Mr. Parker asked what operates below the Quality & Performance Review Committee and who is the Lead Executive. Mr. Hanford advised that Sue Doheny is the Executive Lead. Mr. Hanford to ask Sue Doheny to provide an update for the Audit Committee. **BH** Mr. Parker asked for this to be recorded on an assurance risk pro-forma, if it remains a risk to be reported to the Quality & Performance Committee. **LJ**

ACTION

06.3/11 Adult Safeguarding – CW Audit

Mr. Parker asked for all Internal Audit reports to include a circulation list. **KW/SAM**

Following the Audit Committee meeting Mrs. Woodward confirmed that the Adult Safeguarding report had been circulated to Linda Collins – Izquierdo, Joy Henry, Donna McGrath, Laura Boden, Mike Innes, Caron Morton and Audit Committee members. The report has also been sent to Sue Doheny.

07/11 Report from Local Counter Fraud Specialist

Miss Dillon provided a verbal update and outlined the requirements around Counter Fraud.

Herefordshire PCT Counter Fraud Service is provided by KPMG. Shropshire County PCT, Telford & Wrekin PCT and NHS Worcestershire Local Counter Fraud Speclialists (LCFS) were previously employed by the PCTs. The LCFS are now employed by the provider organisations and provide a Counter Fraud service to the PCTs via a service level agreement. Miss Dillon explained the future expectation of future LCFS provision for both commissioners and providers and explained the potential for a conflict of interests.

Mr. Hanford advised that the way in which these services are arranged would be considered. The Commissioning Support Organisation (CSO) may in future offer these services.

Mr. Parker highlighted dental fraud issues as an area of concern.

Miss Dillon advised that LCFS colleagues agreed that there is the potential for a major conflict of interest within CCGs which the CCG Boards need to be aware of. Mr. Parker commented that this links to earlier discussions and asked Ms Jonsberg to follow this up. **LJ**

Miss Dillon explained the National Fraud Initiative. Miss Dillon asked how the Audit Committee would like future reports to be presented to the Audit Committee. Mr. Parker requested that the LCFS via the providers and the Counter Fraud Service provided by KPMG provide a consistent report to summarise the key issues for the Cluster. Mr. Parker advised that the reporting process for urgent items would be via Mr. Parker, Mr. Hanford for NHS Worcestershire and the leads for the other PCTs.

		ACTION
07/11	**Report from Local Counter Fraud Specialist - continued** Ms Moore advised that KPMG was the outsourced LCFS provision. Karen Sharrocks had prepared the Counter Fraud Progress Report presented to the Audit Committee. Ms Moore advised that there was nothing of concern to report. Ms Moore presented the KMPG Counter Fraud Protocol – Internal Audit Report.	
08/11	**Losses & Special Payments Return** Mr. Hanford asked the Committee's view to consider how to standardise the process for reporting salary overpayments and losses and special payments to the Audit Committee.	**All**
09/11	**Waivers** Mr. Hanford presented the schedule of waivers for NHS Worcestershire. Mr. Hanford advised that the NHS Worcestershire schedule included waivers for Cluster arrangements. The facilities waivers referred to services delegated operationally to the Provider Arm and every waiver issued is listed. Mr. Hanford referred to the first item on the schedule for the provision of security at the old Malvern Hospital site and advised that it was anticipated that a sale would be agreed in April/May 2012. Mr. Parker asked if the costs are aggregated as part of the sale value. Mr. Hanford to check and confirm if the costs are aggregated. Mr. Hanford commented that the priority is to sell the site.	**BH**
	Mr. Hanford referred to the waiver for Philip Siegert consultancy services and advised that the service is for how the space is used within the new Malvern Community Hospital on a day to day basis. Mr. Parker asked if the Worcestershire Health & Care Trust Audit Committee is challenging the cost of this service. Mr. Hanford would ask for an update from the Worcestershire Health & Care Trust Audit Committee.	**BH**
	Mr. Hanford referred to the waivers raised for the Cluster and explained that a trading account had been established with NHS Worcestershire Cluster accounts on a weighted capitation basis.	

		ACTION
09/11	**Waivers – continued**	
	Mr. Hanford referred to the waiver for the extension of existing consultancy services for the Project Management Organisation (PMO) consultancy support and System Plan/QIPP support provided by Deloittes. Mr. Hanford advised that existing arrangements to operate as a Cluster feeding out to PCTs would eventually be passed to the National Commissioning Board. Mr. Hanford explained the management process for CCGs and the proposed way forward regarding Cluster and CCG roles. Mr. Parker and Mr. Hanford would discuss Estates and running costs.	**RP/BH**
	Ms Sinclair referred to the schedule of waivers for Hereford. Ms Sinclair reported that waiver number 151 was the only outstanding waiver.	
	The Audit Committee noted the waivers.	
10/11	**Audit Committee Terms of Reference**	
	Mr. Parker advised that the Audit Committee Terms of Reference had been presented to the Cluster Board and were presented to the Audit Committee for comments. Mr. Hanford confirmed that the Cluster Board signs off the Audit Committee Terms of Reference.	
	It was agreed that the following amendments would be made to the Terms of Reference. • "Statement on Internal Control" to be replaced with "Annual Governance Statement on Internal Control". • "World Class Commissioning Standards" to be removed.	
	Ms. Jonsberg would arrange for an amended copy of the Terms of Reference to be presented to the Cluster Board on 27th March 2012.	**LJ**

ACTION

11/11 Any Other Business

11.1/11 Annual Accounts Process

Mr. Hanford confirmed that the preparation of Annual Accounts is on schedule and there is a timetable in place.

Mr. Parker explained that NHS Worcestershire had previously held a Final Accounts briefing session for the Non Executive Directors, prior to the approval of the Final Accounts by the Audit Committee. It was agreed that Mr. Hanford and Mr. Parker would meet with Non Executive Directors for separate Final Accounts briefing sessions with each of the individual PCTs. Mrs. Newman would confirm details of the briefing sessions. **HN**

11.2/11 Debtors

The Committee agreed that write-offs for all the PCTs would be presented to the Cluster Audit Committee.

The Committee agreed that aged debtors would be presented to the Quality Performance & Review Committee.

11.3/11 Assurance Matters

Mr. Hanford advised that updates on legacy documentation are usually presented to the Board. Mr. Hanford would consider compliance issues at locality level.

Mr. Parker advised that specific legal issues relating to Herefordshire PCT should be discussed with Lin Jonsberg on a case by case basis. Mr. Parker confirmed that NHSLA legal claims regarding employee/employer liability should be presented to the Audit Committee on a needs basis, case by case or if there are any significant issues.

Ms Jonsberg identified the following items for recording on an assurance pro-forma.

- Out of area contracts for Gloucestershire Foundation Trust. Mr. Hanford requested that these should be presented to the Audit Committee to keep members appraised.
- National Commissioning Board system across England. Mr. Hanford advised that this is regarding the new financial system in 2012/13 and for 2013/14 to be considered.

ACTION

11.3/11 Any Other Business

11.3/11 Assurance Matters – continued

- Conflicts of interest regarding CCGs.
- CCGs risk planning arrangements.
- Adult Safeguarding.
- Herefordshire PCT's partnership and Hoople arrangement.

12/11 Date and time of next meeting

It was agreed that the next Cluster Audit Committee meeting would be held 9.30 am - 12.30 pm on Wednesday, 2nd May 2012. Mr. Parker and Mr. Hanford would hold separate Final Accounts briefing sessions with individual PCTs in the afternoon of 2nd May 2012.

The Audit Committee meeting agreed that the Audit Committee meeting to approve the Final Accounts would be held 9.30 am - 12.30 pm on Thursday, 31st May 2012.

Ms Jonsberg to discuss with Lucy Noon and Alison Smith the timing of the draft Annual Reports to be presented to locality meetings. **LJ**

RP/HJN – March 2012

Signed: …… Date: ……

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT:	National Commissioning (Transition & Performance) Committee Meeting – Chair's Report, 11th May 2012
REPORT AUTHOR :	Dr Helen Herritty, Non Exec Director
PRESENTED BY:	Dr Helen Herritty, Non Exec Director
PURPOSE OF REPORT:	To inform the Board about matters considered and decisions made at the meeting of the NC (T&P) Committee held on 11th May 2012
KEY POINTS:	This report summarises the output of the second meeting of the National Commissioning Board Sub Committee. The meeting reviewed the progress of the primary care workstreams, a range of governance processes, progress with some legacy performance issues and the situation, and some proposals, with regard to future operating models. There is uncertainty around the footprint which the NCB will operate at locally, with suggestion that this may not be on a West Mercia footprint. This presents a risk to workstreams in primary care and also in some aspects of public health which are due to transition to the NCB (incl immunisation and screening). Uncertainty means we are unable to progress plans for the future shape of local primary care and public health commissioning functions; this, at a time when recruitment into some of the other new NHS structures is taking place, presents a risk that gaps in capacity and capability could occur. In mitigation, there are active work groups in

	place across all key areas – gathering information, making linkages and assessing resilience – ensuring work can move quickly ahead upon the resolution of the footprint issue and ensuring current delivery is maintained.

RECOMMENDATION TO THE BOARD:	The Board is asked to note the report.

CONTEXT & IMPLICATIONS	
Strategic Objectives	Delivering for today & planning for tomorrow.
Financial	N/A
Legal	N/A
Risk & Assurance	Uncertainty around the local footprint of the National Commissioning board presents potential risk to delivery of current primary care and some public health commissioning functions. There are active work groups in all key areas assessing resilience and providing assurance to committee
HR, Equality & Diversity	N/A
National Policy	The paper includes discussion of transition of functions to new NHS structures
Carbon/Sustainability	N/A
Partnership	Primary care commissioning workstreams are in close liaison with emerging CCGs

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	N/A

Chairman's Report National Commissioning (Transition & Performance) Committee (11/05/12)

Items discussed:
Primary care operational group workstreams:
Progress
Governance:
Mapping of subgroups:
Process for accreditation of practitioners with special interests
Local Dispute resolution process for dental contracts (Shrops)
Procedures for Managing Contractors whose performance gives cause for concern
Performers list management committee terms of ref (Shrops)
Primary care premises group tems of ref. (Shrops)
Legacy performance issues:
Shropshire Dental Access
Worcester Diabetes Survey
Telford Orthodontic and oral surgery referrals
Public health
Screening and immunisation programmes future models
Military Health
Position statement
Offender health
Position statement

Summary of key issues for the Board:
Primary care operational group workstreams: each area has an identified lead and work is progressing in each strand. Groups are tasked with both looking at current delivery (now including regular risk assessments of resilience) and options for future configuration. The lack of decision around the footprint for the local offices of the National Commissioning Board is hampering work on future configuration and the potential benefits of harmonising and rationalising the work across the four PCTs. In the meantime, a pragmatic approach is being adopted, PCTs are agreeing common approaches and adopting common policies where it makes sense to do so to improve delivery in year, but not dismantling processes which remain effective for the individual PCTs. A common approach to QOF has been agreed for this year and in line with the ambition to improve quality in primary care it has been agreed that, as a minimum, all PCTs will visit the lower quartile of practices based on the overall total QOF points achieved. CCG colleagues have been kept informed of the plans and are invited to join with the visits if they wish. The committee was assured that liaison with CCGs was a key feature of all the workstreams.

Governance.

Each PCT has a slightly different approach to primary care governance. A list of the various decision making and advisory sub groups has been collated for each PCT and terms of reference for each are in the process of / have been reviewed to ensure they are consistent with current cluster arrangements. It is

anticipated this will be completed by the next meeting. The committee approved amendments to the T.O.Rs of several such sub groups.

JL has visited the key decision making groups in each PCT and gave assurance to the Committee that the processes in place for managing contractual disputes, and the performance of practitioners giving cause for concern, are fit for purpose; this is critical since such decisions can be subject to legal challenge. Shropshire has recently updated its procedures for Managing Contractors whose performance gives cause for concern to include dentists and optometrists as well as GPs. These procedures were approved by the Committee, and it was recommended that the other PCTs use them too, an exception report will be presented to the committee's next meeting giving a rationale to explain if any variations in these procedures are recommended across the cluster.

The committee reviewed and supported the approach to accreditation of practitioners with special interest across Shropshire Telford and Wrekin and recommended a piece of work to look at the practicalities of rolling this out across the cluster. Worcester has a similar but less sophisticated accreditation process and Hereford, which has previously not had a need for such a process, is now looking to put one in place.

Legacy performance Issues.

Shropshire Dental Access: this is a vital sign, the PCT is making good progress and is on track to meet the access target.
Worcester Diabetes Survey: last year's National Diabetes Survey highlighted Worcester as an outlier. Significant work has been undertaken which revealed that the primary problem was a coding issue and activity which was happening in primary was not being picked up. The issue has been flagged to the survey organisers and the problem is being addressed. The next national survey is due to take place shortly and the results for all 4 PCTs will be reported to the committee.
Telford Orthodontic and Oral surgery referrals: a large number of referrals are being made from primary care into secondary care, many of which could be dealt with in primary care a significant number being for 'treatment planning'. This is contributing to 18 week waits. A number of recommendations were made including commissioning a dedicated 'assessment and treatment planning service for primary care'. The committee felt it needed to understand the way the same issue was being dealt with across the cluster and have a more detailed understanding of the resource implications before supporting the recommendations

Public Health: Immunisation and screening.

A paper was presented detailing the future workforce and governance requirements for these work streams as set out in national guidance. The committee noted the model as best practice in line with guidance, but was unable to support because of the uncertainty around the NCB footprint, furthermore the committee would need to see more detail about the HR and

resource implications, ideally in the wider context of the NCB requirements. RH believed the current management and governance to be satisfactory but expressed concerns about ongoing sustainability given the moves to recruit into CCGs and the whole uncertainty around the NCB footprint. A screening and immunisation group is to be convened (recognising this may only be temporary) to provide assurance on risk, temporary governance structures and the continuing quality and safety of local programmes.

Military Health and Offender Health Position Statements

A basic summary of current governance arrangements was presented, the committee is seeking further detail in the next meeting.

Summary of Risks

The uncertainty around the NCB footprint presents a risk to workstreams in primary care, and in immunisation and screening in public health. Uncertainty means we are unable to plan for the future shape of local primary care and public health commissioning functions and at a time when recruitment into some of the new structures is taking place, there is a risk that gaps will occur. In mitigation there are active work groups in place across all key areas, gathering information, making linkages and assessing resilience ensuring work can move quickly ahead upon the resolution of the footprint issue.

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

REPORT TO BOARD

Subject:	**Register of Interests 2012**
Presented By:	Lin Jonsberg, Board Secretary

PURPOSE OF THE REPORT:

To present the Register of Declared Interests of Members of the Boards of the West Mercia PCT cluster in line with governance requirements.

KEY POINTS:

- Individuals' declared interests.
- Individual declaration forms are available to be viewed at any time in the Register held by the Board Secretary.
- This report presents the declarations for cluster board voting and non-voting members and deputies where nominated.
- A further report providing details of the interests of CCG non-board members will be brought to the next Board meeting.

RECOMMENDATIONS:

The Board is asked to **note** the register of interests.

CONTEXT & IMPLICATIONS:

Financial	Not applicable
Legal	Statutory requirement for PCT Boards as part of the Code of Conduct.
Risk and Assurance *(Risk Register/BAF)*	Not included on risk register
HR/Personnel	N/A
Equality & Diversity	N/A
Strategic Objectives	N/A

Healthcare/National Policy *(e.g. CQC/Annual Health Check)*	Board Standing Orders and NHS Code of Conduct
Partners/Other Directorates	N/A
Carbon Impact/Sustainability	N/A
Other Significant Issues	N/A

GOVERNANCE

Process/Committee approval with date(s)

	N/A

REGISTER OF INTERESTS 2012

For members of the West Mercia PCT Cluster Board and Clinical Commissioning Group sub-committees

Name and Title	Interest Declared	Current @ 03/12 (if not, date of expiry)	Member of (PCT) Board/CCG committee
Joanna Newton Chair	1. Chair of Governors, Weobley Primary School 2. Shareholder, Glaxo Smith Kline (GSK)	Yes Yes	West Mercia Cluster Board
Eamonn Kelly Chief Executive	None declared	N/A	West Mercia Cluster Board
Brian Hanford Director of Finance	1. Trustee and Treasurer of HALO (non pecuniary) 2. Spouse employed by Hoople (contractor to Herefordshire PCT)	Yes Yes	West Mercia Cluster Board
Helen Herritty Non-Executive Director	Husband employed by company supplying pumps to public sector building refurbishments	Yes	West Mercia Cluster Board
Louise Lomax Non-Executive Director	1. Director, Severn Gorge countryside trust 2. Consultant trainer, Citizens' Advice	Yes Yes	West Mercia Cluster Board
Andrew Mason Vice Chair and Non Executive Director	Trustee, Wyldwoods Charity	Yes	West Mercia Cluster Board
Susan Mead Non-Executive Director	Husband NED, NHS Midlands & East SHA	Yes Yes	West Mercia Cluster Board
William Hutton Non-Executive Director	1. Fiancee employed by Shropshire Community Health Trust as Ward Sister 2. Employed by Oracle Corporation supplying IT products and services to NHS	Yes Yes	West Mercia Cluster Board
Rob Parker Non-Executive Director	Rob Parker coaching & development (owner)	Yes	West Mercia Cluster Board

Name and Title	Interest Declared	Current @ 03/12 (if not, date of expiry)	Member of (PCT) Board/CCG committee
Dr Bryan Smith Non-Executive Director	None declared	N/A	West Mercia Cluster Board
Sue Doheny Director of Nursing	None declared	N/A	West Mercia Cluster Board (from 1/2/12)
Jill Houghton Director of Nursing	None declared	N/A	West Mercia Cluster Board (to 31/1/12)
Dr Richard Harling Director of Public Health	None declared	N/A	West Mercia Cluster Board (NHS Worcestershire)
Dr Sarah Aitken Interim Director of Public Health	Observer, Halo Board	Yes	West Mercia Cluster Board (NHS Herefordshire)
Dr Catherine Woodward	Executive Member, West Midlands Regional Council, BMA	Yes	West Mercia Cluster Board (NHS Telford & Wrekin)
Dr Kiran Patel Medical Director	Consultant Cardiologist and Honorary Senior Lecturer, Sandwell and West Birmingham NHS Trust	N/A	West Mercia Cluster Board

Dr Michael Innes Chair, Telford & Wrekin CCG and PEC Chair, Telford & Wrekin	1. GP Partner, Stirchley Medical Practice 2. Member, BMA 3. Fellow, Royal College of General Pracitioners	Yes Yes Yes	West Mercia Cluster Board (NHS Telford & Wrekin)
Dr Bill Gowans Chair, Shropshire CAP	Member of Shropdoc, April 2011 – 23 April 2012	Yes *to 23/4/12*	West Mercia Cluster Board (Shropshire County PCT)
Dr Ian Tait Chair, Herefordshire CRG	1. Dr Ian Tait: Partnership with Dr Ilsley and Partners, Nunwell Surgery, Pump Street, Bromyard PMS contract with Herefordshire PCT. 2. Gillian Diane Tait (wife): associate dentist working with a) Mr Paul Felton, High Street, Bromyard: holds dental contract with Herefordshire PCT. b) with Bradley Shorthouse dentists, Kidderminster 3. Gillian Diane Tait (wife) Trustee of Hope Family Centre, Bromyard.	Yes Yes Yes	West Mercia Cluster Board (NHS Herefordshire)

Name and Title	Interest Declared	Current @ 03/12 (if not, date of expiry)	Member of (PCT) Board/CCG committee
Professor Rod Thomson Director of Public Health Shropshire County PCT	1. Council Member RCN 2. Foundation Governor, Alder Hay Children's Hospital 3. Shareholder (not for profit) Ford Hall Community Farm, Market Drayton.	Yes Yes Yes	West Mercia Cluster Board (Shropshire County PCT)
Leigh Griffin Deputy Chief Executive	Director, Sefton for Africa	Yes	West Mercia Cluster Board (non-voting member)
Valerie Beint Corporate Director, Shropshire Council	None declared	n/a	West Mercia Cluster Board (Shropshire County PCT non voting deputy)
Paul Clifford Corporate Director, Telford & Wrekin Council	Director, Telford & Wrekin Council	Yes	West Mercia Cluster Board (NHS Telford & Wrekin non voting member)
Chris Bull Chief Executive, HPS	Chief Executive, Herefordshire Council.	Yes	West Mercia Cluster Board (NHS Herefordshire, non voting member)
Lin Jonsberg Board Secretary	1. Tribunal judge, mental health tribunals service 2. Trustee, Deaf Direct, Worcester (non-pecuniary)	Yes Yes	West Mercia Cluster Board (officer)
Paul Maubach Director of Commissioning Development	None declared	N/A	West Mercia Cluster Board (non voting member)
Suzanne Penny Interim Head of HR	Director, Dinedor Associates Ltd	Yes	West Mercia Cluster Board (officer)
Dr Caron Morton GP, Chair, Shropshire CCG	1. CCG Chair 2. GP partner, Ludlow (to March 12)	Yes No to 03/12)	West Mercia Cluster Board (Shropshire County PCT, non-voting member)
Dr Andrew Watts GP, Chair, Herefordshire CCG	1. Partner, Sarum House GP Surgery, Hereford. 2. Fee received from Lilly pharmaceuticals for contribution to pathway design rec'd	Yes No	West Mercia Cluster Board (NHS Herefordshire non-voting member)

	Dec 11		
Simon Trickett Chief Operating Officer, S Worcs CCG	Director of Worcestershire Health & Care NHS Trust July 11-March 12	Yes	West Mercia Cluster Board (NHS Worcestershire, non-voting deputy)
Dr Felix Blaine PEC Member and S Worcs CCG	1 Share in Elgar Health Care	Yes	Worcestershire PEC/Clinical Senate

NHS Herefordshire | NHS Shropshire County Primary Care Trust | NHS Telford and Wrekin | NHS Worcestershire

West Mercia Cluster

BOARD MEETING

TITLE OF REPORT	**REPORT OF SEALING OF DOCUMENTS**
REPORT AUTHOR	**LIN JONSBERG, BOARD SECRETARY**
PRESENTED BY	**LIN JONSBERG, BOARD SECRETARY**
PURPOSE OF REPORT	In accordance with Standing Orders, to advise the Board on the use of the official seal for the period since last reported for NHS Herefordshire, Shropshire County PCT, NHS Telford & Wrekin, and NHS Worcestershire. The Board is asked to note the use of the PCT Seal on the occasions since last reported.

REGISTER OF SEALING NHS HEREFORDSHIRE
Entry No 137 Renewal of existing lease from 1997 for the pharmacy, Ross Community Hospital. The document has been affixed with the official seal of Herefordshire PCT since the last board report. Lease is for Adam Myers Limited, 84 Raddlebarn Road, Selly Oak, Birmingham, B29 6HH. Company number 03840734. Review date 25th April 2015. Signatures are Eamonn Kelly, Chief Executive West Mercia Cluster, and Brian Hanford, Director of Finance, West Mercia Cluster. On 8 May 2012 the Chief Executive and the Director of Finance signed and sealed the agreement (under seal number 137)
REGISTER OF SEALING SHROPSHIRE COUNTY PCT
There were no documents requiring the seal for this period.
REGISTER OF SEALING NHS TELFORD & WREKIN
22.05.12 Telford and Wrekin PCT and the Borough of Telford and Wrekin Agreement in respect of a grant pursuant to Section 256 of the National Health Service Act 2006 – Dementia Memory Services £30,517

22.05.12
Telford and Wrekin PCT and the Borough of Telford and Wrekin
Deed of surrender relating to: Part of the ground floor, The Glebe Centre 13,15 and 17, Glebe Street, Wellington Telford

REGISTER OF SEALING NHS WORCESTERSHIRE

Register entry number 46

The PCT seal was used on 1st March 2012 and was affixed to the lease for a tenancy for office space provided by the Landlord Droitwich H C Limited at Droitwich Medical Centre, Droitwich, Worcestershire. This was signed by the Chief Executive and Director of Finance under delegated authority.

This lease is to provide temporary office accommodation for South Worcestershire Clinical Commissioning Group for an amount of £35,000.00 for a 12 month period. A Notice of Offer of Lease without security of tenure has been received and the Statutory Declaration Prior to Agreement, Excluding Security of Tenure was signed by Brian Hanford and witnessed by a solicitor on 9th March 2012.

Register entry numbers 47, 48 & 49

The seal was affixed to two documents relating to NHS Worcestershire's tenancy at Unit 3, The Triangle, Wildwood Way, Worcester, one being a licence to Wild Wood Rooms Ltd to sublet the Ground Floor of Unit 3 to NHS Worcestershire, and the second being the Sub Lease between Sanlam Life & Pensions, Wild Wood Rooms Ltd and NHS Worcestershire.

The seal was affixed to a document relating new amendments to the Planning Obligation by Agreement for Church Hill District Centre.

These documents were signed by the West Mercia Chief Executive and West Mercia Director of Finance.

Register entry number 50

The seal was affixed to a Deed of Variation relating to an Agreement for the Provision of Community Health Services between NHS Worcestershire and Assura Wyre Forest LLP. The reason for the contract variation was to formally acknowledge year two prices for the MSK ICAT service provided by Assura Vertis.

This document was signed by the Chief Operating Officer, Wyre Forest CCG and West Mercian Director of Finance.

Register entry numbers 51, 52, 53 & 54

The seal was affixed to a 2012/13 Deed of Variation relating to Community Services between NHS Worcestershire and Worcestershire Health & Care NHS Trust.

The seal was affixed to a 2012/13 Deed of Variation relating to Learning Disability Services between Worcestershire PCT and Worcestershire Health & Care Trust.

The seal was affixed to a 2012/13 Deed of Variation relating to the NHS Standard Acute Hospital Services Contract between Worcestershire PCT and Worcestershire Acute Hospitals NHS Trust.

The seal was affixed to a 2012/13 Deed of Variation relating to the NHS Standard Acute Hospital

Services Contract between BMI Healthcare and Worcestershire PCT.

These documents were signed by the West Mercia Chief Executive.

RECOMMENDATION TO THE BOARD	The Board is asked to note the use of the PCT Seals on the occasions since last reported.

CONTEXT & IMPLICATIONS	
Strategic Objectives	N/A
Financial	None expected
Legal	Statutory requirement.
Risk & Assurance	None

HR, Equality & Diversity	N/A
National Policy	Statutory requirement
Carbon/Sustainability	N/A
Partnership	N/A

GOVERNANCE	
Committee/Approval Process (with dates) *as appropriate*	N/A for this report