DUDLEY CLINICAL COMMISSIONING GROUP
PUBLIC AGENDA

Thursday 12 July 2018
1.00pm – 4.30pm
Boardroom, 3rd Floor, Brierley Hill Health & Social Care Centre,
Venture Way, DY5 1RU

QUORACY
Meetings of the governing body will be quorate when four elected GP clinical members and two other
governing body members (one from the lay members or secondary care doctor and one from the Chief
Executive Officer, Chief Operating and Finance Officer or Chief Nurse are present, (provided that if the Chair is
not present, then either the Chief Executive Officer or Chief Operating and Finance Officer must be present).

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<th>Agenda Item</th>
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<tr>
<td>1.00pm 1. Apologies</td>
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<td>1.00pm 2. Declarations of Interest</td>
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<td>meeting during questions from the public, you agree to being recorded.</td>
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| 1.05pm 3.1 Minutes from Board held on   | Enclosed   | Dr D Hegarty    |
| 10 May 2018                               |            |                |
| 1.05pm 3.2 Minutes from Extraordinary    | Enclosed   | Dr D Hegarty    |
| Board held on 7 June 2018                  |            |                |
| 1.10pm 3.3 Matters Arising                | Enclosed   | Dr D Hegarty    |

| 1.15pm 4.1 Questions from the Public      | Verbal     | Mrs J Jasper    |
|                                          |            |                |
| 1.25pm 4.2 Feet on the Street: End of    | Presentation| Mrs L Broster  |
|   Life Care                               |            |                |
| 1.40pm 4.3 Public Update                 | Enclosed   | Mrs L Broster  |

| 1.50pm 5. Chairman & Chief Executive      | Verbal     | Mr P Maubach    |
| Officer Report                            |            |                |

<p>| 2.00pm 6.1 Report from the Partnership    | Enclosed   | Dr C Handy      |
| Board                                    |            | Mr P Maubach    |
| 2.10pm 6.2 Black Country Joint           | Enclosed   |                |
| Commissioning Committee Assurance Reports|            |                |</p>
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<td>2.20pm</td>
<td>7. Quality &amp; Safety</td>
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<td>2.20pm</td>
<td>7.1 Quality and Safety Committee Report</td>
<td>Enclosed</td>
<td>Mrs C Brunt</td>
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<td>2.20pm</td>
<td>7.2 Emergency Preparedness Response and Resilience</td>
<td>Enclosed</td>
<td>Mrs C Brunt</td>
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<td>2.40pm</td>
<td>8. Governance</td>
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<td>2.40pm</td>
<td>8.1 Report from Audit &amp; Governance Committee</td>
<td>Enclosed</td>
<td>Mrs J Jasper</td>
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<td>2.50pm</td>
<td>8.2 Dudley CCG Constitution</td>
<td>Enclosed</td>
<td>Mrs J Jasper</td>
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<td>3.00pm</td>
<td>8.3 GDPR Board Assurance Update</td>
<td>Enclosed</td>
<td>Mr M Hartland</td>
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<td>3.10pm</td>
<td>8.4 Report from Remuneration &amp; HR Committee</td>
<td>Enclosed</td>
<td>Mrs S Cartwright</td>
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<td>3.20pm</td>
<td>9. Finance, Performance and Business Intelligence</td>
<td>Enclosed</td>
<td>Mr M Hartland</td>
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<td>3.20pm</td>
<td>9.1 Report from Finance, Performance &amp; Business Intelligence Committee</td>
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<td>10. Acute &amp; Community Commissioning</td>
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<td>3.30pm</td>
<td>10.1 Commissioning Development Committee Report</td>
<td>Enclosed</td>
<td>Mr N Bucktin</td>
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<td>3.40pm</td>
<td>10.2 Health &amp; Wellbeing Board Report</td>
<td>Enclosed</td>
<td>Mr N Bucktin</td>
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<td>3.50pm</td>
<td>10.3 Integrated Commissioning Executive Report</td>
<td>Enclosed</td>
<td>Mr N Bucktin</td>
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<td>4.00pm</td>
<td>10.4 MCP Procurement and Evaluation of Final Bid</td>
<td>Enclosed</td>
<td>Mr N Bucktin</td>
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<td>3.20pm</td>
<td>11. Primary Care Commissioning</td>
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<td>4.10pm</td>
<td>11.1 Report from Primary Care Commissioning Committee</td>
<td>Enclosed</td>
<td>Mrs C Brunt</td>
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<td>4.10pm</td>
<td>(including Annual Report 2017/18)</td>
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<td>4.20pm</td>
<td>11.2 Locality Feedback Report – June 2018</td>
<td>Enclosed</td>
<td>Mrs S Cartwright</td>
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<td>12. Reflection Time</td>
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<td>13. Exclusion of the Press and Public</td>
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<td>That under the Public Bodies (Admission to Meetings) Act 1960, the public</td>
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<td>and representatives of the press and broadcast media be excluded from the</td>
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<td>meeting during the consideration of the following items of business as</td>
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<td>publicity would be prejudicial to the public interest because of the</td>
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<td>confidential nature of the business to be transacted.</td>
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<td>14.</td>
<td>14. Date and Time of Next Meeting</td>
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<td>Thursday 13 September 2018</td>
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<td>3rd Floor Boardroom, Brierley Hill Health and Social Care Centre</td>
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<td>Mrs</td>
<td>Laura</td>
<td>Broster</td>
<td>Director of Communications &amp; Public Insight</td>
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<td>Mrs</td>
<td>Caroline</td>
<td>Brunt</td>
<td>Chief Nurse</td>
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<td>Mr</td>
<td>Neill</td>
<td>Bucktin</td>
<td>Director of Commissioning</td>
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<td>Mrs</td>
<td>Stephanie</td>
<td>Cartwright</td>
<td>Director of Organisational Development &amp; Human Resources</td>
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<td>Dr</td>
<td>Jonathan</td>
<td>Darby</td>
<td>Clinical Executive for Acute &amp; Community Commissioning</td>
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<td>Dr</td>
<td>Ruth</td>
<td>Edwards</td>
<td>Board Member Kingswinford, Amblecote &amp; Brierley Hill Locality / Clinical Executive for Quality &amp; Safety</td>
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<td>Ms</td>
<td>Jayne</td>
<td>Emery</td>
<td>Chief Officer of Dudley Healthwatch</td>
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<td>Dr</td>
<td>Richard</td>
<td>Gee</td>
<td>GP Engagement Lead</td>
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<td>Purshotam</td>
<td>Gupta</td>
<td>Board Member Dudley &amp; Netherton Locality</td>
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<td>Dr</td>
<td>Christopher</td>
<td>Handy</td>
<td>Lay Member for Quality &amp; Safety</td>
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<td>Deborah</td>
<td>Harkins</td>
<td>Chief Officer for Health &amp; Wellbeing (Director of Public Health)</td>
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<td>Matthew</td>
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<td>Hegarty</td>
<td>CCG Chair / Board Member Stourbridge, Wollescote &amp; Lye Locality</td>
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<td>Mrs</td>
<td>Julie</td>
<td>Jasper</td>
<td>Lay Member – Patient &amp; Public Involvement</td>
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<td>Johnson</td>
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<td>Mr</td>
<td>Daniel</td>
<td>King</td>
<td>Director of Membership Development &amp; Primary Care</td>
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<td>Rebecca</td>
<td>Lewis</td>
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<td>Steve</td>
<td>Mann</td>
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<td>Maubach</td>
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<td>Dr</td>
<td>Kiranmaya</td>
<td>Penumaka</td>
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<td>Dr</td>
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<td>Dr</td>
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| Dr    | Ruth       | Tapparo  | GP Board Member and Clinical Executive Finance, Performance & Business Intelligence | GP Partner - Three Villages Medical Practice  
Shareholder, Future Proof Health Limited  
(via practice shareholding)                                                                         |
| Mr    | Steve      | Wellings | Lay Member - Governance                                                   | Wife employed by Dudley MBC Housing Department  
One Niece employed by DGFT as a nurse  
Member of CIPFA                                                                                         |

Updated 22/06/2018
MINUTES OF THE MEETING HELD IN PUBLIC ON THURSDAY 10 MAY 2018
AT BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE

Members:
Dr D Hegarty Chair and GP Board Member – Dudley CCG
Mrs C Brunt Chief Nurse – Dudley CCG
Dr R Edwards Clinical Executive – Dudley CCG
Prof C Handy Lay Member for Quality and Safety – Dudley CCG
Mr M Hartland Chief Operating and Finance Officer – Dudley CCG
Dr T Horsburgh Clinical Executive – Dudley CCG (LMC Representative) *
Mrs J Jasper Lay Member for Patient and Public Engagement – Dudley CCG
Dr R Lewis GP Board Member – Dudley CCG
Dr M Mandiratta GP Board Member – Dudley CCG
Dr S Mann Clinical Executive – Dudley CCG
Mr P Maubach Chief Executive Officer – Dudley CCG
Dr K Penumaka GP Board Member – Dudley CCG
Dr M Read GP Board Member – Dudley CCG
Dr F Rose GP Board Member – Dudley CCG
Dr R Tapparo Clinical Executive – Dudley CCG
Mr S Wellings Lay Member for Governance/Vice Chair – Dudley CCG (Vice Chair)

Non-Voting Members:
Mrs L Broster Director of Communications and Public Insight – Dudley CCG
Mr N Bucktin Director of Commissioning – Dudley CCG
Mrs S Cartwright Director of Organisational Development and Human Resources – Dudley CCG
Ms J Emery Chief Executive – Healthwatch
Ms K Jackson Deputy Director of Public Health – Dudley MBC (for Ms D Harkins)
Mr D King Director of Membership Development and Primary Care – Dudley CCG
* Dr Horsburgh is also the LMC representative on the Board which is a non-voting role.

In Attendance:
Dr R Gee GP Engagement Lead – Dudley CCG
Ms S Johnson Deputy Chief Finance Officer – Dudley CCG

Minute Taker:
Mrs E Smith Governance Support Manager – Dudley CCG

CCG053/2018 APOLOGIES

Apologies were received from:
Dr J Darby Clinical Executive – Dudley CCG
Dr P D Gupta GP Board Member – Dudley CCG
Ms D Harkins Chief Officer, Health and Wellbeing (Director of Public Health) – Dudley MBC
Mr M Samuels Strategic Director People – Dudley MBC
DEclarations of Interest

Members were asked to disclose any interest they may have, direct or indirect, in any of the items to be considered during the course of the meeting and to note that those Members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

In addition to the declarations of interest included on the agenda, Dr Mandiratta had notified Mrs Smith that he was part of the Feldon Practice and had a practice based share hold in Future Proof.

Dr Hegarty also declared an interest in item 11.1 (Primary Care Commissioning Committee Report), which related to the deferred decision regarding a phased return to work following sickness for GPs Reimbursement Policy.

Mr Wellings reported that since the last Board meeting, an election process had been carried out to elect the Chair for Dudley CCG Board. The process had now concluded and a majority was given by the voting members of the Board for Dr Hegarty to be re-appointed. Mr Wellings congratulated Dr Hegarty and gave commiserations to Dr Tapparo, on behalf of the Board.

Mr Wellings formally handed the Chair to Dr Hegarty and resumed his role as Vice Chair.

Dr Hegarty thanked the Board for participating in the voting process and thanked Mr Wellings for stepping up into the role of Chair in Dr Hegarty’s absence. The feedback received had been exemplary.

Dr Hegarty welcomed Dr Mandiratta and Dr Penumaka to the Board as new voting members of Dudley CCG Board.

The minutes of the Board meeting held on 8 March 2018 were accepted as a true and accurate record noting the following action:

Mrs Smith to clarify Dr Darby’s declarations of interest in relation to BBC Drama, Birmingham.

The minutes of the Board meeting held on 29 March 2018 were accepted as a true and accurate record with the following exception:

Page 3 (Public Update) – the resolution stated that a detailed report on the merits and disadvantages of the engagement proposal be presented to the Extraordinary Board on 31 May 2018 however; this date was no longer required due to the deadline for the applications being 30 June 2018. It was therefore proposed to hold an Extraordinary Board meeting combined with a Board Development Session on 7 June 2018 to consider the Kinver/Moss Grove application.

Resolved:
1) The Board accepted the minutes from 8 March 2018 and 29 March 2018 as a true and accurate record noting the above exception
2) Mrs Smith to clarify Declarations of Interest with Dr Darby in relation to BBC Drama, Birmingham

It was reported that all matters arising had been completed.

Resolved:
1) The Board noted all matters arising had been completed

Questions to the Board from the public were tabled.

Question asked:
Is the Dudley CCG Board assured that DGFT governance systems are safe and robust?
Response provided by Caroline Brunt – Chief Nurse & Quality Officer

The CCG are assured that DGFT are committed to achieving robust governance processes that underpin safe day to day high quality care for patients. We recognise there is still work to do to ensure processes are in place consistently across the Trust. We recognise, as do the DGFT executive team, that governance processes within the Trust require further improvements and that some services have more developed systems than others. The recent CQC findings highlighted areas of outstanding practice alongside areas in need of significant improvements. We are working with the Trust governance team to address the issues identified and our role is to gain assurance as we test the longstanding systems alongside new and enhanced processes as they are developed. This development and assurance work has been ongoing for some time. An example of a key area of governance that we have focused on over the last two years has been learning from serious incidents including the introduction of key performance indicators to enable progress monitoring. While there is significant evidence of improvements in this area and the CCG are assured that there is greater recognition of incidents requiring investigations and the quality of these processes, for example in maternity services, we are still supporting enhancements to these to ensure there is a consist approach across the whole organisation.

The CCG Audit and Governance committee has requested a review of the CQC report at a future meeting and the progress towards the action plan will be monitored by the CCG Quality and Safety Committee.

Question asked:

1. In the light of RHH failing its CQC inspection despite the assurances given by Dianne Wake to CCG in November last year that all was well and the hospital was well placed for the winter and despite the number of high profile resignations fit for purpose, will the board call for the resignation of the Chair and board of governors. No CQC audit should come as a surprise if good governance is in place the defici encies should have been known and plans in place to address them.

Inspectors wrote: “Governance systems were not robust and did not ensure safe and effective care was being delivered.

“The culture within the department was not open and senior staff did not recognise significant areas of risk and potential harm to patients...”

“Senior staff within the service were out of touch with the reality of the quality of care and treatment provided in the department.”


2. Losing 5 board members in a year members is a concern clearly no adequate succession plan was in place. How will this be addressed in the future?

3. How will the public be reassured that the ED is now safe? clearly this judgement cannot be based on the CEO's "say so" as she staked her reputation on this prior to the inspection, will an independent re audit be commissioned?

The report said: “The emergency department was not providing safe, effective and responsive care and treatment and the care and treatment provided at times exposed patients to the risk of avoidable harm...”

“Patients presenting to the emergency department did not always receive robust and sufficient assessment of their clinical presentation and condition.”

“This posed a significant risk that life threatening conditions would not be identified and treated as quickly as they should have been.”

“We saw examples of patients who had deterioriated unnoticed due to the lack of robust assessment.”

Triage processes were inconsistent and not exercised in line with the trust policy or national guidelines.

“Patients attending the emergency department did not always receive robust and sufficient assessment of their clinical presentation and condition.

"We are fortunate that all our new Board members have benefited from comprehensive handovers, either with their predecessors or long standing deputies, who have significant organisational and local knowledge."

"Throughout this period of change, our priority has continued to be quality patient care and patient safety, and I am confident that the Board is well equipped with the expertise, skills and knowledge to effectively manage the upcoming winter pressures and achieve the trust's strategic goals." Dianne Wake


4. Will the CCG board ask DGoH to apologise to patients and the public for the avoidable failings identified in this shameful report?
Russells Hall Hospital: Patient dies waiting for treatment
Russells Hall Hospital had the best performing A&E department in the country two years ago, but it has seen its performance decline this winter.

4b. Given it is now rated inadequate who is accountable?
https://www.expressandstar.com/news/health/2018/05/02/hundreds-of-patients-waittoo-long-at-russells-hall-aes/"...300 patients were left waiting more than half an hour in ambulances outside a Black Country hospital in a month, according to new figures."

5. Will the board ask how much time and money has been spent on the uniform change and is this another example of "senior staff being out of touch with reality" when there are clearly bigger areas demanding their attention?

6. Will the board confirm that this practice has been stopped and the correct national procedure for sepsis diagnosis is now being followed?

"Professor Bryan Williams, of the Royal College of Physicians, said: "This patient safety alert is a welcome development aimed at saving lives by focusing attention on the need to use NEWS2 to better identify patients at risk of sepsis and other life threatening conditions."
The call comes after it emerged that senior doctors at one hospital removed one key indicator of serious illness from their warning score system because it "was identifying too many ill patients".

Care Quality Commission (CQC) inspectors found that the scoring system in the emergency department at Russells Hall Hospital, part of The Dudley Group NHS Foundation Trust in the West Midlands, did not include oxygen saturation levels.
The CQC report, released last week, states: "Senior clinicians amended a national early warning score system to remove one key indicator of serious illness. This was undertaken with no consultation with the medical director or evidence base and the rationale provided was that it was identifying too many ill patients and generating too many emergency calls."
http://www.watfordobserver.co.uk/news/16183707.NHS__100_patients_died_because__medics_didn_t_spot_them_deteriorating /

Response provided by Caroline Brunt – Chief Nurse & Quality Officer
There are a number of questions regarding the recent Care Quality Commission (CQC) report (April 18) into services provided by Dudley Group NHS Foundation Trust (DGFT). Many of the questions need to be responded to directly by the executive team and Board of Governors within DGFT. CCG Board requested that our representative on the Board of Governors (Dr Richard Gee) raise these questions with them at the next meeting.

While the CCG were disappointed to read the significant concerns described within the report we also acknowledge areas of good and outstanding practice have been identified and are to be commended.
Following the initial and subsequent CQC visits the CCG Quality and Safety team have been working closely with DGFT staff and colleagues from NHS Improvement, NHS England and the Dudley MBC Office of Public Health supporting the implementation of a remedial action plan and a range of assurance and monitoring visits.

The CCG recognise, as do the DGFT executive team, that governance processes within the Trust require further improvements and that some services have more developed systems than others. The CCG are assured that DGFT are committed to undertaking this work and achieving robust governance processes that underpin safe day to day high quality care for patients and to ensure processes are in place consistently across the Trust. The CCG will continue working with the Trust governance team to address the issues identified and our role is to gain assurance as we test the longstanding systems alongside new and enhanced processes as they are developed.

This development and assurance work has already been ongoing for some time. An example of a key area of governance that we have focused on over the last two years has been learning from serious incidents including the introduction of key performance indicators to enable progress monitoring. While there is significant evidence of improvements in this area and the CCG are assured that there is greater recognition of incidents requiring investigations and the quality of these processes, for example in maternity services, we are still supporting enhancements to these to ensure there is a consistent approach across the whole organisation.
Question asked:
7. Will the board publish its response to Equality and Human Rights Commission's letter sent to Dudley CCG 19/3/18?

Response provided by Neill Bucktin – Director of Commissioning
Thank you for your question. The CCG has responded to the Equality and Human Rights Commission’s letter, we will not be sharing the response publicly. However, we can confirm that we will be reviewing our policy in light of the challenge made by the commission.

Resolved:
1) The Board received questions from the public.

CCG058/2018 FEET ON THE STREET: URGENT TREATMENT CENTRE AT RUSSELLS HALL HOSPITAL

Mrs Broster reported that the Urgent Treatment Centre at Russell's Hall Hospital was open and Feet on the Street focused on views of the staff within the department.

The CCG would continue to monitor patient experience through the Urgent Treatment Centre and feedback at the Emergency Department and Malling Health. This would determine whether it was having the desired effect on patient experience, waiting times and Emergency Department targets. Healthwatch Dudley had also been involved in the development of the Urgent Treatment Centre and had met with the Chief Executive at Dudley Group NHS Foundation Trust to discuss capturing patient experience which was part of the continued journey. The Board would be kept informed of progress.

In relation to the previous agenda item which questioned the CQC report, it was noted that the information was carried out whilst building work was in progress and therefore did not reflect what had been presented by Feet on the Street.

It was clarified that the Urgent Treatment Centre is the umbrella term for the Emergency Department (ED) and the Urgent Care Centre (UCC) and the nurse who was interviewed was located at the front of the Urgent Treatment Centre (UTC) and directing them into either ED or the UCC. This information should be clarified when advising members of the public. Dr Rose confirmed that it was actually called the Emergency Treatment Centre so this would be changed in future correspondence.

Resolved:
1) The Board received the Feet on the Street presentation

CCG059/2018 PUBLIC UPDATE

Mrs Broster spoke to this item highlighting that Feet on the Street for the July Board would be in relation to End of Life and Dying Matters. A series of events, focus groups and public conversations with Dr Lucy Martin had been organised during May.

The launch of Deaf Cards was reported which was a collaboration between Dudley CCG, the Deaf Café, Dudley Council, Dudley Group NHS Foundation Trust and Healthwatch Dudley. The cards would be shown to any public service and notify that the person presenting the card was either deaf or has a hearing impairment and what their communication needs are.

Mrs Broster reminded the Board of the NHS 70th birthday on 5 July 2018. Dudley CCG AGM would be held on the morning at Brierley Hill Civic Hall and Staff Awards would take place in the Evening. There would be several organisations involved throughout the day including Healthwatch Dudley, Dudley Group NHS Foundation Trust, Dudley Council Public Health, West Midlands Ambulance Service and Dudley and Walsall Mental Health Partnership Trust. Local people would be able to attend and take part in the celebrations.

Ms Emery reported on the People’s Network. Clair Huckerby from the Pharmaceutical Medicines Management Team attended to speak about Practice Based Pharmacy and the Prescription Ordering Direct (POD) Services and what people’s knowledge were of them. This information would be collated and presented at a later date.

As part of the Young Health Champion programme, one of the Champions who suffers from Mental Health Issues and is an artist had produced a number of cards which explain the experiences and challenges she has
faced. The pack was being launched at an event which the Mayor was attending. The card was piloted to get an overall perspective and a lot of organisations would be using it as a tool to encourage discussions.

Dr Hegarty suggested inviting Dr Lucy Martin to the July Board meeting for the End of Life Feet on the Street presentation. Mrs Broster agreed to take this action forward.

Resolved:
1) The Board received the report for assurance
2) That Mrs Broster invited Dr Martin to attend July Board for Feet on the Street presentation

CHAIRMAN AND CHIEF EXECUTIVE OFFICER REPORT

CCG060/2018 REPORT

Mr Maubach spoke to the report, which was tabled.

Mr Wellings and Dr Tapparo were formally thanked for covering different aspects of the Chairs role in Dr Hegarty's absence.

Dr Lewis was congratulated on being re-elected as Locality Lead for Halesowen.

Healthwatch Dudley was looking for a new Chief Officer as Ms Emery had announced she would be leaving to take on a new role at Dudley Stroke Association. The Board thanked her for her contribution over the past years and wished her well in her new role.

Recent Events

Sustainability and Transformation Partnership (STP) Update
Dr Helen Hibbs, Accountable Officer, Wolverhampton CCG, had put herself forward as the next Senior Responsible Officer for the Black Country and West Birmingham STP as Andy Williams had stepped down from the role having led the STP work over the last two years. The Board formally thanked Andy for the work he had done in developing the STP up to this point.

As a result of Helen’s appointment, the STP was also looking to appoint an Independent Chair and Programme Director to work alongside Helen.

Joint Commissioning Committee (JCC) Executive Away Day
An event had taken place on 1 May 2018 where the four Black Country CCGs presented on the progress of their individual Placed Based Models of Care. It had been interesting to listen to the similarities and differences in the approaches being taken and to learn from each other in ways where clear opportunities could be developed for the future.

Professor Chris Ham's Visit
Professor Chris Ham, Chief Executive – Kings Fund, visited Dudley CCG on 14 March 2018 to work with Dudley CCG and system partners on how to develop integrated care systems.

360° Stakeholder Survey
The CCG had received the best results in the country for the Stakeholder Survey and the results were very positive.

Upcoming Events/Visits

Vanguard Conference
A new date had been arranged for the Vanguard Conference which was being held on 11 July 2018 at Himley Hall.

NHS 70th Birthday Celebration
The NHS would be 70 on 5th July 2018 and to celebrate, Dudley CCG would host a day of celebration at Brierley Hill Civic Hall. This would incorporate the Annual General Meeting, Public Event and Dudley CCG Staff Awards.

MCP Procurement
The bid for the MCP had been received by Dudley CCG and was being evaluated. Recommendations would be made to the CCG and Cabinet on 19 June 2018.
Mr Wellings reminded the Board Members that every member of Dudley CCG staff was required to complete Conflicts of Interest training. There was an internal deadline of 11 May 2018.

Resolved:
1) The Board noted the report for assurance

**STRATEGY**

**CCG061/2018  REPORT FROM PARTNERSHIP BOARD**

Dr Handy and Mrs Cartwright spoke to this item highlighting the key areas discussed at the Partnership Board on 28 March 2018 and 25 April 2018.

The Partnership Board in March was the final meeting to formally review the development of the vanguard programme as it officially ended on 31 March 2018. The Partnership Board heard that of the 80 components of an MCP new care model, 58 had been implemented and received assurance that the remaining 22 components would be implemented on commencement of the MCP contract.

It had been reported at the Partnership Board that the value proposition monies would be spent in full by the end of March with a very slight overspend. It also received an evaluation of the Patient Activation Measures pilot that had taken place at Lion Health.

The April Partnership Board received an update on the single point of access team that was being implemented to reduce care home admissions which would replace the service that had been decommissioned from Airedale. This would be rolled out over the next 3-6 months.

It was noted that one of the areas of development which the Partnership Board would focus on was in relation to the integrated community teams and the Partnership Board was committed to taking this forward.

It was noted that the Partnership Board would continue to look at the model which was submitted and a number of CCG staff would rejoin the Board as they had been excluded due to conflicts of interest in regard to the procurement of the MCP.

It was also noted that Sandwell and West Birmingham CCG were at the point of considering the recommissioning of West Midlands Ambulance Service, so it was suggested to triangulate the work they were doing with the Dudley Partnership Board as it was felt this would be a real opportunity to liaise more closely with the Ambulance Service.

Resolved:
1) The Board noted the report for assurance

**CCG062/2018  CORPORATE OBJECTIVES 2018/19**

Mr Maubach spoke to this item to present to the Board the headline Corporate Objectives for 2018/19 and to ask the Board for approval of the high-level corporate objectives with the expectation that they would be used to inform the objectives for all staff within the CCG.

It was noted that last year had been a significant and challenging year for the CCG ensuring the governance had been correct and conflicts of interest were managed properly.

However, the coming year would bring a new set of challenges which were significant with the transition. Assuming the MCP reached a successful conclusion, it would have a significant impact on the CCG as an organisation requiring it to restructure the way it commissions and works with its STP partners.

Board members were asked for comments on the paper being presented. Dr Tapparo felt that the lead within the objectives paper was too informal and needed to include surnames and job titles.

With regards to objective 5 which was to maintain financial sustainability and ensure delivery of the QIPP programme, Mr Hartland suggested that the Finance, Performance and BI Committee should have joint responsibility with the Commissioning Development Committee.
Professor Handy questioned objective 8 which related to communication and engagement of GPs in the delivery of QIPP and system pathway improvements and whether this was general communication and promotion of the CCG’s work; it was assumed to be the day to day business of the CCG.

Resolved:
1) The Board noted the report for assurance
2) The Board approved the high-level corporate objectives with the expectation that they would be used to form the objectives for all staff within the CCG

Mr Maubach spoke to this item providing updates from the JCC meetings held in December 2017, January 2018 and February 2018 and asked that the Board receive the update for assurance.

The Board were asked to note that as a system, a monthly joint assurance meeting is held with NHS England (NHSE) and NHS Improvement (NHSI) for the STP and following the most recent meeting, the regulators had written identifying key issues for the STP to consider. The key point which was relevant to the CCG was that there was an expectation to produce a high-level plan by the end of May to develop a strategic commissioning. The Accountable Officers had set up a small task group to work with the commissioners to produce a plan which would be presented back to the Board with recommendations on what the future of commissioning would look like within the Black Country.

Mr Wellings was satisfied that the geography of the STP and the JCC had been formally recognised as he had requested this on separate occasions.

Mr Wellings emphasised the issue in relation to the non-completion of the Midland Metropolitan Hospital and the potential that funds may be requested and diverted from Dudley to complete it. He stressed that he would not vote to support this should the matter arise.

Resolved:
1) The Board noted the report for assurance

Dr Edwards spoke to this item summarising the key issues discussed at the Quality and Safety Committee in March 2018 and asked that the Board received the report for assurance.

**CQC Inspection Visits to Dudley Group NHS Foundation Trust (DGFT)**

The area of most concern was the disappointing CQC report at DGFT as the Trust had been rated overall as ‘requiring improvement’. The Trust had been subject to a further inspection of the Emergency Department (ED) and medical escalation areas by the CQC on 15 March 2018 which identified further areas of concern. These included poor governance, high use of agency staff, failure to identify patients at risk of sepsis, and poor management of the deteriorating patient.

Immediate actions were set out in response to findings which included two additional physicians in the ED and a walkabout by senior members of the Trust to ensure effective monitoring and escalation of patients ahead of a new system planned for implementation.

The Trust’s Executive Team had expressed their disappointment and acknowledged that there was still work to do to ensure a robust safety culture.

The Trust had achieved a rating of ‘good’ for caring with the CQC identifying outstanding practice in the maternity and community services.

The CCG continued to be involved in the Dudley System Oversight and Assurance Group which is attended by NHSE, NHSI and CQC. A specific Urgent Care CQRM had also been arranged.

**Dudley and Walsall Mental Health Trust (DWMHT)**

A letter raising areas of concerns regarding quality issues had been forwarded to the Trust. A response had been received which provided details of the work being carried out by the Trust to address the concerns raised.
Black Country Partnership Foundation Trust (BCPFT)
Monthly escalation calls had been held with the Director of Nursing, BCPFT and the Chief Nurse, Dudley CCG, to discuss quality issues at BCPFT.

Primary Care
The following CQC Primary Care inspections had been carried out:

- AW Surgeries were inspected as part of the CQCs 10% re-inspection of good or outstanding practices
- Castle Meadows Surgery – rated as ‘requires improvement’ for the safe and well-led domains following a focused inspection. A full inspection would be carried out within the next 12 months as a result of the registration change
- Pedmore Medical Practice – rated on re-inspection as ‘good overall’ and for all domains following a previous ‘requires improvement’ rating overall and for the safe, effective and well-led domains

Safeguarding
Dudley and Sandwell CCGs were working with the Chairs of the respective Safeguarding Boards and Child Death Overview Panel (CDOP) to merge the two panels. The plan is to bring the four panels together that cover the Black Country STP on a bi-annual basis to discuss emerging themes and to share learning.

Black Country Local Maternity Services (LMS)
The LMS was awaiting the outcome for the Wave 2 Perinatal Mental Health bid, to support and implement perinatal mental health services to women in the Black Country STP.

Transforming Care Programme (TCP)
An outline of plans being introduced by NHSE to support the Black Country to achieve the defined trajectory had been shared and additional resource from NHSE had been identified to support local activity.

Board members were asked for comments and Dr Lewis asked for clarification on how the two additional physicians had been included within the ED following the CQC inspection. It was confirmed that the Trust had followed a recruitment process to appoint two additional physicians who were in post. It was also confirmed that a walkabout by ‘Senior Members of the Trust’ was a combination of both management and clinicians.

Dr Gee requested updates from the Dudley System Oversight and Assurance Group meetings to ensure the action plan agreed between the CQC and DGFT was being progressed. Dr Edwards confirmed that updates would be reported to the Quality and Safety Committee and then presented as part of the Board report.

Mr Maubach reported that NHSE would be providing some resource to the Black Country to check service reviews. This was because as a system, it was not achieving the target on the number of patients being discharged out of inpatient facilities. The review would identify whether assessments were accurate or it would identify a further piece of work that would need to be carried out.

Guidance had also been produced from NHSE on how finances would be managed with the transfer of patients from specialised services to CCGs as the funds do not follow the patient so there was an urgent need to understand the current state of play for quality and financial risks to both the CCG and to the Local Authority. In addition, there also needed to be clarity on what is being asked by the Regulators and whether it presents risk to the patients and to the system. Mr Hartland and Mrs Brunt agreed to take this action and provide an update to the July Board.

As a final point, it was reported that there had been a change of leadership within the TCP, in that Helen Hibbs was the Chair of the TCP Board and Claire Parker would be stepping down as the Senior Responsible Officer.

Resolved:
1) The Board received the report for assurance
2) Updates from the Dudley System Oversight and Assurance Group to be included in the Quality and Safety Committee Board report
3) Mr Hartland and Mrs Brunt to provide an update to Governing Body on quality and finance issues associated with TCP Programme.
GOVERNANCE

REPORT FROM AUDIT AND GOVERNANCE COMMITTEE (INCLUDING COMMITTEE ANNUAL REPORT)

Mrs Jasper spoke to this item, highlighting the key areas that were considered at the Audit and Governance Committee on 22 March 2018 and 3 May 2018 and the decisions made under delegated powers.

Information Governance (IG)
The Committee received the IG End of Year Report on the IG Toolkit submission which gave an overview of the performance in relation to version 14.1 of the toolkit and summarised the information that had been presented to previous meetings. It was noted that 66% was required for a level 2 submission and any score above that meant the CCG had achieved level 3 in the majority of areas. The score of 92% was an increase of 3% on last year. The Committee approved its submission with a score of 92%.

Board Assurance Framework and Risk Register
The Committee received the Board Assurance Framework and Risk Register and approved the closure of risks 132 and 145 which would be discussed in further detail under the next agenda item.

Internal Audit
The Committee received and approved the three-year Internal Audit Strategy for 2018-21. It also received and approved the Internal Audit Plan 2018/19.

Anti-Fraud
The Committee received and approved the Counter Fraud Workplan for 2018/19.

Local Security Management
The Committee received and approved a revised Security Management Policy and Security Management Strategy. It also received and approved a Security Management Workplan for 2018/19.

Conflicts of Interest
The revised Conflicts of Interest Policy was received and approved subject to some minor changes that were agreed.

Committee Terms of Reference
The Committee received and approved the revised Terms of Reference that had been updated in line with NHS England’s recommendations.

Operational Scheme of Delegation
The Committee received and approved an updated Operational Scheme of Delegation.

Annual Report 2017/18
A new category had been included within the Annual Report which related to the MCP and STP and in conclusion, the Committee were of the opinion that the annual report was consistent with the draft governance statement, Head of Internal Audit opinion, and that there were no matters that the Committee was aware of at the time of reporting that had not been disclosed appropriately.

Mrs Jasper advised that this would be her last Audit and Governance Committee Annual Report that she would be presenting as she would be stepping down from her role, in accordance with Dudley CCG’s Constitution, prior to next year’s annual report.

Resolved:
1) The Board received the report for assurance
2) The Board noted the decisions made under delegated powers

RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

Mrs Jasper spoke to this item providing the Board with an update on the combined Board Assurance Framework (BAF) and Risk Register as at 10 April 2018.

The Board was asked to review risks 13, 112 and 150, 151 and 152 for which it is directly responsible and update accordingly.
Risk 13 – Failure of the governing body to demonstrate appropriate leadership/clinical leadership may result in poor strategy and implementation, and thereby fail to meet statutory and regulatory responsibilities

It was recommended to reduce the residual risk from 12 to 8, recognising the skills and capabilities within the system, and the way in which the governing body manages the CCG and the system. The risk also needed to include the 360° assurance under the internal assurance heading.

Risk 112 – Potential lack of alignment between STP and MCP Strategies

It was recommended to increase the residual risk to 12, the mitigating action being the strategic commissioning which was referred to earlier in the meeting.

Risk 150 – There is a risk that change of leadership in local system organisations will impact on system deliver, particularly in relation to loss of local knowledge

No further amendments were to be made to this risk at the time of reporting.

Risk 151 – There is a risk that the CCG fails to meet its statutory duties in respect of the delivery of high quality care to the population of Dudley

No further amendments were to be made to this risk at the time of reporting.

Risk 152 – There is a risk that significant transformation of the system does not take into account the views of Dudley people. This may result in services which do not meet the needs of local people, the possibility of Judicial Reviews, and ultimately a loss of trust in health service commissioning through inadequate involvement, openness and transparency.

This was a new risk that had been added for which the governing body was accountable. However it was noted that Dudley CCG does more engagement than any other CCG in the country and has visitors from all over the world to see what communication and engagement Dudley have been undertaking.

Mrs Broster provided some context to the risk being added in that it had been noted by audit that there was an absence of any risk on the register in respect of engagement and whilst internal audit had given assurance, there were external factors that could influence the pace with which the CCG were expected to make decisions. It was noted that the residual risk was low because of the control factors that the CCG has and the gaps in control were the ones that the CCG could not influence as an organisation directly. It was therefore felt that the risk needed to be reworded to reflect this which Mrs Broster agreed to take forward.

Proposed Risk for Closure

Risk 6 – Failure of a main provider (for example Dudley Group NHS FT, BCPT and other Providers) due to financial pressures will result in inadequate care for the local population

The Board agreed to the closure of this risk as the financial elements were captured in Risk 148 and the Quality and Safety Committee capture the quality elements in the risks for which they are responsible.

Resolved:
1) The Board received the report for assurance
2) The Board agreed to the closure of risk 6
3) The Board accepted new risk 152 as its responsibility with Mrs Broster rewording the risk to reflect the Board’s comments
4) The Board agreed to reduce the residual score of risk 13 to 8 and to increase the residual score of risk 112 to 12
5) The Board agreed that there were no updates to be made to risks 150 and 151

Mr Hartland spoke to this item to seek assurances from the Board to support the approval of the Annual Report and Accounts 2017/18.

Board members were advised that the approved Annual Report and Accounts would be submitted to NHS England by the national deadline of 29 May 2018 and will be formally presented at the CCG’s Annual General Meeting on 5 July 2018.

As part of the audit process and responsibility of Governing Body members, there were two statements which required ratification by all Board Members to confirm they were accurate and applied to them. The two statements were:

- So far as they were aware, there was no relevant audit information of which the CCG’s auditor was unaware that would be relevant for the purposes of their audit report; and
They had taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the CCG’s auditor was aware of that information.

It was noted that the Audit and Governance Committee had been given delegated authority to approve the Annual Report and Accounts.

Recognising the apologies that had been received and that there were deputies in attendance on behalf of Board Members, Dr Hegarty asked if there was anyone that could not comply with the above statements. All those present agreed with both statements.

Mr Hartland would liaise with those members who were absent to obtain their agreement on the aforementioned statements.

Resolved:
1) The Board recognised that authority to approve the Annual Report and Accounts had been delegated to the Audit and Governance Committee
2) The Board members present confirmed that so far as they were aware, there was no relevant audit information of which the Clinical Commissioning Group’s auditor was unaware that would be relevant for the purposes of their audit report
3) The Board members present confirmed that the members had taken all the steps they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the Clinical Commissioning Group’s auditor was aware of that information
4) That Mr Hartland would liaise with those Board members who were absent to obtain their agreement on the aforementioned statements

**CCG068/2018 REPORT FROM REMUNERATION AND HR COMMITTEE**

Mrs Cartwright spoke to this item to provide assurance to the Board regarding key issues discussed and approved by the Remuneration and HR Committee held on 4 April 2018.

**Sickness Absence**
It was noted that there had been a slight decrease in the sickness absence rate which was reported at 1.37% and had returned to below the CCG target rate of 3%.

**Quarterly Workforce Dashboard**
Mandatory training compliance had increased to 93% and noted that the only outstanding mandatory training was for staff who were on sick leave or maternity leave.

PDR compliance had reduced to 77.48% however the Committee were advised that the CCG was about to enter its PDR cycle (April – June) and therefore this figure would increase to almost 100%.

**Risk Register**
The Committee made a slight amendment to one of their risks to include the establishment of the Task and Finish Group on the future shape of Dudley CCG.

**Update on MCP Primary Care Development, STP and Black Country Joint Commissioning**
It was noted that the timeline for submission of the MCP bid was incorrect on the Board report and that it should read 8 May 2018 and not 25 April 2018.

**GP Contracts**
Work was ongoing with regards to the variation of contracting approaches for CCG Clinical Leads and elected members. It was anticipated that the desktop audit would be concluded by the next Remuneration and HR Committee in June 2018.

**Sickness Policy**
The CCG sickness policy was under review following questions raised by staff side. This would be concluded by the next Committee in June 2018.

Mrs Cartwright reassured the Board that as part of the staff survey, it had been reported that there was a lack of consistency on how sickness was reported. Work had been completed to ensure Senior Managers and Line Managers were aware of the correct sickness reporting procedure which had seen an improvement.
National Pay Deal Update
An announcement on the national pay deal was expected at the end of June however, the next Committee was arranged for the beginning of June. An extraordinary Committee would be arranged to discuss and consider the pay arrangements following the announcement.

Director Pay Review
The Committee had received a report summarising the actions taken since December 2016 to consider Director Terms and Conditions and it was noted that this had been concluded.

Resolved:
1) The Board received the report for assurance

CCG069/2018 STAKEHOLDER SURVEY FEEDBACK

Mrs Cartwright spoke to this item to provide a summary to the Board on the results of the CCG Stakeholder Survey 2017/18.

It was noted that Dudley CCG had received excellent feedback from the survey and it was rated above the national, cluster and DCO average on every measure. It had also received a better response rate than previous years.

An action plan had been produced which related to Membership Engagement. Some of the feedback received was that practices did not feel as engaged as they had done in previous years. Mr King had attended locality meetings to obtain feedback and one of the points raised was in relation to how localities feed into the Board and how the Board can return feedback to localities and to look at how this could be improved.

A development session for elected members had been arranged which Mrs Cartwright and Mr King would be leading and feedback from that would be circulated to practices.

Board members were asked for comments and Mr Wellings expressed his disappointment that no response had been received from the Health and Wellbeing Board and only half of the NHS Providers had taken part. Mrs Cartwright advised that there had been an error in the system with Health and Wellbeing Board but to also note that the survey was only sent to one individual. This would be reviewed for the next survey.

It was acknowledged how speedily an action plan had been put in place following the results of the survey and that the member practices had appreciated that. Each locality had developed their own action plan and feedback from these would be discussed with the elected members development session. As a result it was hoped to have a refreshed agenda and purpose for locality meetings which would develop throughout the year.

Resolved:
1) The Board received the report for assurance and noted the action plan to address issues identified

FINANCE, PERFORMANCE & BUSINESS INTELLIGENCE

CCG070/2018 REPORT FROM FINANCE, PERFORMANCE & BUSINESS INTELLIGENCE COMMITTEE

Dr Tapparo spoke to this item summarising the key issues discussed by the Finance, Performance and Business Intelligence Committees on 1 March 2018 and 29 March 2018.

It was noted that a year to date underspend of £10,373,690 was reported and the CCG expected to achieve its revised year end control total of £10,964,000 as agreed with NHS England.

The Commissioning Development Committee (CDC) was forecast to overspend its delegated budget by £6.1m which had been discussed at the CDC and Finance, Performance and Business Intelligence Committees. Rectification plans were being monitored and reviewed for each of the overspent items (this excluded Free Nursing Care, where the rate was nationally agreed).

It was reported that A&E 4 hour waits had failed to achieve the 95% national standard in February 2018, with 80.6% of patients admitted, transferred or discharged within 4 hours. This had been reported at 81.8% in January 2018. A remedial action plan had not been agreed with the Trust at the time of Board but it was noted that the CCG proposed recovery trajectory aimed to recover the 95% by March 2019 which was in line with national guidance.
IAPT access continued to underperform against the national standard. A contractual performance notice had been issued and the CCG would work with the Trust to agree a remedial action plan.

It was noted that both 45 and 60 minute ambulance handover breaches had improved in February to 93 and 56 respectively.

QIPP continued to be scrutinised. The latest forecast reported against the plans being £14.4m which were on track to achieve its target for 2017/18. Next year’s gross target was reported at £16.99m. At the time of Board it was reported that recurrent savings of £19.1m had been identified in the latest QIPP programme with a rolling balance of £2.11m contributing to the 2019/20 programme.

The Committee agreed the Financial Plan for 2018/19 which had been subsequently approved by the Extraordinary Board on 29 March 2018.

Revised Terms of Reference were presented and approved by the Committee, which reflected NHS England’s comments following the proposed Constitution submitted in November.

The Committee also approved the write off of aged payables debit balances with a financial implication of £3,716.22.

Mr Wellings commented on how well the Local Authority in Dudley had worked to reduce delayed transfers of care and the noticeable impact it had made. However, it was noted that patients from Staffordshire and Worcestershire were still experiencing issues in terms of their delayed transfers of care. This had been raised with several organisations and Trusts but despite efforts to resolve this, there were still issues outside of Dudley’s boundary which needed to be addressed.

With regards to performance indicators which related to cancelled operations, it was noted that these figures recorded cancellations on or after the day of admission. Members highlighted that there were higher figures for operations being cancelled 1-2 weeks prior to the operation date and that consideration should be given as to how the reporting can be enhanced to reflect this. Similar concerns were raised in respect of cancer waits and whether by working to the target drives a behaviour that may not always be the best for the patient. It was agreed that this issue would be picked up by the Quality and Safety Committee to identify if there might be a cohort of patients that are not being tracked and to build in a different pattern of behaviour. It was also agreed that consideration should be given to the wider context i.e. how Dudley CCG commissions for outcomes in all acute services.

Resolved:
1) The Board received the report for assurance
2) The Board received and approved the revised Terms of Reference noting the comments raised.
3) The Quality and Safety Committee to identify if there was a cohort of patients that are not identified by the national targets and this may impact on when they receive care.

**ACUTE AND COMMUNITY COMMISSIONING**

**CCG071/2018 REPORT FROM COMMISSIONING DEVELOPMENT COMMITTEE**

Mr Bucktin spoke to this item asking Board members to note the matters considered by the Commissioning Development Committee held on 21 March 2018 and 18 April 2018 and to approve the business case for enhanced support to care homes.

QIPP
The QIPP Plan for 2018/19 had been approved by the Committee and arrangements were being put in place to focus on those schemes where there were risks in relation to delivery.

Prescription Ordering Direct (POD)
The Committee approved a plan to support the roll out of the POD development which forms a key element of the QIPP plan. Members of the Committee would visit the POD in May to get a better understanding on the function of the service.

Support to Care Homes
The Committee approved a proposal to provide enhanced support to care homes, with the intention to reduce the number of emergency admissions from care homes to secondary care.

An implementation plan was being developed to manage the delivery of the proposal.
Children and Young People’s Continuing Care Policy
A minor revision had been made to the policy which related to the eligibility of children with breathing needs.

Ophthalmology – Any Qualified Provider (AQP)
Following the receipt of bids which had not met the evaluation criteria, the Committee agreed to begin a further AQP procurement process for ophthalmology.

In relation to the Local Government Association Peer Review for Special Educational Needs and Disabilities, Dr Horsburgh indicated that it should read as the role of the ‘Designated’ Medical Officer and not ‘District’ Medical Officer.

Under the same heading, Dr Horsburgh raised concerns around the high level of staff turnover within the Children’s Directorate at the Council which may have been a contributing factor to our ability to effectively network. It was suggested that Mr Maubach and Mr Samuels should consider how best our 2 organisations could make progress on developing a Strategy for Children’s Services across the Borough.

As a point of clarity, it was noted that the second bullet under 6.2 should read ‘a local bespoke telemedicine solution using ipads’

It was also noted that the numbering within the report was incorrect.

Resolved:
1) The Board received the report for assurance
2) The Board ratified the business case for enhanced support to care homes
3) The Board noted the amendments to be made within the report
4) Mr Maubach and Mr Samuels to discuss how to make progress on developing a strategy for Children’s Service across the Borough.

CCG072/2018 REPORT FROM HEALTH AND WELLBEING BOARD (HWBB)

Mr Bucktin spoke to this item summarising the matters considered by the Health and Wellbeing Board (HWBB) at its meeting on 22 March 2018.

The HWBB received a set of reports from its main partnership bodies on progress with strategic priorities which included the Safe and Sound Board; Adults Alliance and Children & Young People’s Alliance. The general theme which arose and where work needed to take place was in relation to prevention.

In addition, the HWBB also held a separate development session with representatives of the Combined Authority and the STP which identified areas of commonality between the work programmes of the Board itself, the STP and the Combined Authority.

The HWBB received and noted the proposed engagement plan for the proposed community based care model for people with disabilities and received updates on the MCP Development and the Better Care Fund.

Resolved:
1) The Board received the report for assurance

CCG073/2018 REPORT FROM INTEGRATED COMMISSIONING EXECUTIVE (ICE)

Mr Bucktin spoke to this item summarising the matters considered by the Integrated Commissioning Executive (ICE) at its meeting held on 7 March 2018 and 11 April 2018.

The ICE approved a methodology for reviewing schemes which were funded on a non-recurrent basis from the iBCF. Reviews were to commence so that decisions could be made on potential recurrent funding of the schemes based on their impact within the wider health and care system. This would then feed into the planning processes of the CCG and the Local Authority.

A similar process would then be carried out on the entirety of the BCF Plan.

As mentioned earlier in the agenda, the success in the reduction of delayed transfers of care and problems with neighbouring authorities was noted. The improved performance in non-emergency admissions was also noted.
Greater connectivity between the BCF and QIPP schemes was being developed as there was a degree of crossover. The relevant QIPP schemes had been shared with council colleagues and the impact on BCF considered and the Local Authority had shared their plans too.

Care Homes are a key link between BCF and QIPP so a proposal was being presented to the Executive.

Resolved:
1) The Board received the report for assurance

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<th>CCG074/2018</th>
<th>MCP PROCUREMENT PROCESS – PROGRESS REPORT</th>
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Mr Bucktin spoke to this item to advise the Board on progress with the MCP procurement process.

It was reported that the final bid had been received and was in the process of being evaluated. The evaluation and moderation should be completed by mid June 2018. An evaluation report would then be produced and presented to the CCG Board and to the Council Cabinet on 19 June 2018.

The first of two judicial reviews had taken place whereby the judge indicated that the judgement should be available prior to the next hearing. Informal feedback from NHS England suggested they would be disappointed should the review not be in their favour. The next hearing was due to take place on 23 and 24 May 2018.

In relation to the regulatory processes, it was anticipated that an initial submission for ISAP Checkpoint 2 would be made in early July 2018, with the final submission being made in September 2018. Prior to the initial submission, it was proposed that a Board Development Session is held to consider in depth the documentation and evidence being submitted prior to considering it fully at the July Board. The final submission would follow a similar process, prior to the Board considering this at its meeting on 13 September 2018.

It was noted that the issue of ensuring the Board is sighted on all documentation arose from the failure of the Uniting Care contract and the CCGs position in relation to these. It was reported that the Procurement Project Board had reviewed and updated this in light of the current stage of the procurement and had been attached as part of the Board paper. Also attached to the paper was the latest register of interest which had been reviewed.

Resolved:
1) The Board received the report for assurance and noted the progress with the MCP procurement
2) The Board noted the CCG’s position in relation to the recommendations arising from the Uniting Care reports
3) The Board noted the MCP Procurement Project Board’s register of interest

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<th>PRIMARY CARE COMMISSIONING</th>
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<tr>
<th>CCG075/2018</th>
<th>REPORT FROM PRIMARY CARE COMMISSIONING COMMITTEE (PCCC)</th>
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Mrs Brunt spoke to this item summarising the key issues discussed at the meetings of the PCCC held on 16 March 2018 and 20 April 2018.

Stourside Medical Practice – branch closures at Tenlands Road and Coombswood Road
Closure dates had been scheduled for Tenlands Road Surgery which was 7 September 2018 and Coombswood Road would close on 14 September 2018.

Moss Grove Surgery
The Committee received an update on an application by Moss Grove Surgery in Kinver to join Dudley CCG and then merge with Moss Grove, Kingswinford. At the time of Board, it was noted that there was a public consultation underway which was due to end on 11 May 2018. The Committee would then consider the merger request in principle at its May meeting and make a recommendation to the Governing Body in respect of the change in CCG boundary and list of members.

Mrs Broster updated the Board on the public consultation that was underway and advised that her team were going through the feedback that had been received to date. She assured the Board that she was satisfied with the level of engagement that had taken place by the practice, how well attended the public meetings had been and the substantial feedback that had been received. Letters had also been received by Dudley CCG with regard to stakeholder views on the Constitutional change and responses were being made to the questions raised.
Mr Maubach advised that he was part of a conference call with South East Staffordshire and Peninsula CCG and NHS England and there was concern that SESSP CCG may not submit their side of the application therefore NHSE would not consider it. Dudley CCG felt it was appropriate and that NHSE should consider it as it had a duty of responsibility to the member practice. Further concerns were raised which related to this setting a precedent to other practices who may want to transfer to Dudley CCG in future.

The main concern was that SESSP CCG would not support the application unless it included the transfer of the historic deficit, which was quite significant, across to Dudley. However Mr Maubach had made it clear that Dudley’s position would be the opposite and it would be inappropriate for the deficit to transfer. It was agreed that a further joint conference call should take place with the Chief Executive Officer closer to the submission to determine whether the applications were aligned.

Terms of Reference
The Board received the revised Terms of Reference that had been approved by the Primary Care Commissioning Committee.

Resolved:
1) The Board received the report for assurance and noted the decisions taken by the Primary Care Commissioning Committee
2) The Board received the revised Terms of Reference for assurance

CCG076/2018 REFLECTION TIME

Dr Mann made a recommendation to consider going paperless for Board meetings. Mr Hartland agreed to liaise with Dudley IT Services to see what options would be available.

Resolved:
1) Mr Hartland to liaise with Dudley IT Services regarding paperless options for Board

EXCLUSION OF THE PRESS AND PUBLIC

That under the Public Bodies (Admission to Meetings) Act 1960, the public and representatives of the press and broadcast media be excluded from the meeting during the consideration of the following items of business as publicity would be prejudicial to the public interest because of the confidential nature of the business to be transacted.

DATE AND TIME OF NEXT MEETING

Thursday 12 July 2018
1pm – 5pm
Boardroom, Brierley Hill Health and Social Care Centre

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

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MINUTES OF THE MEETING HELD IN PUBLIC ON THURSDAY 7 JUNE 2018
AT THE VILLAGE HOTEL, CASTLEGATE DRIVE, DUDLEY

Dr D Hegarty Chair and GP Board Member – Dudley CCG
Mrs C Brunt Chief Nurse – Dudley CCG
Dr R Edwards Clinical Executive – Dudley CCG
Dr P D Gupta GP Board Member – Dudley CCG
Mr M Hartland Chief Operating and Finance Officer – Dudley CCG
Dr T Horsburgh Clinical Executive – Dudley CCG (LMC Representative) *
Mrs J Jasper Lay Member for Patient and Public Engagement – Dudley CCG
Dr S Mann Clinical Executive – Dudley CCG
Mr P Maubach Chief Executive Officer – Dudley CCG
Dr M Read GP Board Member – Dudley CCG
Dr F Rose GP Board Member – Dudley CCG
Mr M Samuels Strategic Director People – Dudley MBC
Dr R Tapparo Clinical Executive – Dudley CCG
Mr S Wellings Lay Member for Governance/Vice Chair – Dudley CCG (Vice Chair)

Non-Voting Members:

Mrs L Broster Director of Communications and Public Insight – Dudley CCG
Mr N Bucktin Director of Commissioning – Dudley CCG
Mrs S Cartwright Director of Organisational Development and Human Resources – Dudley CCG
Mrs B Kaur Consultant in Public Health – Dudley MBC (representing Ms D Harkin)
* Dr Horsburgh is also the LMC representative on the Board which is a non-voting role.

In Attendance:

Mrs E Smith Governance Support Manager – Dudley CCG

Minute Taker:

Mrs S Sirrell PA to Director of Organisational Development & Human Resources/Deputy Business
Support Manager – Dudley CCG

CCG077/2018 APOLOGIES

Apologies were received from:

Dr J Darby Clinical Executive – Dudley CCG
Dr R Gee GP Engagement Lead – Dudley CCG
Ms D Harkins Chief Officer, Health and Wellbeing (Director of Public Health) – Dudley MBC
Prof C Handy Lay Member for Quality and Safety – Dudley CCG
Ms S Johnson Deputy Chief Finance Officer – Dudley CCG
Mr D King Director of Membership Development and Primary Care – Dudley CCG
Dr R Lewis GP Board Member – Dudley CCG
Dr M Mandiratta GP Board Member – Dudley CCG
Dr K Penumaka GP Board Member – Dudley CCG
DECLARATIONS OF INTEREST

Members were asked to disclose any interest they may have, direct or indirect, in any of the items to be considered during the course of the meeting and to note that those Members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

This meeting was held in public and was recorded purely as an aide memoir for the minute taker to ensure an accurate transcript of the meeting, decisions and actions. Once the minutes were approved, the recording would be destroyed. All care is taken to maintain privacy; however, as visitors in the public gallery, their presence may be recorded. Should they contribute to the meeting, they agreed to being recorded.

Dr Hegarty advised the Board that Dr Simon Hughes was in attendance in the public gallery to listen to the discussion being had with regards to the application for Moss Grove Surgery. It was noted that the Board may address Dr Hughes to contribute should there be points of clarification required.

APPLICATION FOR MOSS GROVE SURGERY, KINVER

Mr Hartland spoke to this item requesting Governing Body members to consider recommendations from the Committees and make a decision on the application to NHS England for Moss Grove Surgery, Kinver, to join Dudley CCG.

The paper was presented from a governance perspective as the decision in which the Board would make could have an impact on the Constitution of the CCG that would require further approval from NHS England.

It was noted that an application had been received from Moss Grove, Kinver, to join Dudley CCG on 14 March 2018 and to also merge Moss Grove, Kinver with Moss Grove, Kingswinford. The paper described the reasons why the practice believed the case was acceptable and it was on that basis that Dudley CCG had followed the governance processes to build on the proposal that had been made. It was reported that the practice had made a strong case in relation to patient flows as the majority of patients registered at Kinver attended Dudley Group NHS Foundation Trust (DGFT) and they also felt that the MCP would benefit the population of Kinver.

Mr Hartland explained the process to enable practices to merge, the first stage being that Kinver must join Dudley CCG, the CCG must accept the practice and the Constitution amended to reflect the change. As part of that, the CCG was required to make an application to NHS England by 30 June 2018 for the Constitution change to enable the processes at the Department of Health to ultimately amend the CCG recurrent allocations from 1 April 2019.

In addition, the process also defined that any application made to NHSE would require a matched application from South East Staffordshire and Seisdon Peninsula (SESSP) CCG that NHSE would need to ratify and constitutional changes made to both CCGs. The application should include the outcome of consultation, due diligence, impact of NHSE and quality assessments.

Dudley CCG had completed a due diligence exercise and the relevant Committees had considered the consequences of the practice joining the CCG. The Commissioning Development Committee supported the practice with no immediate issues or concerns. Primary Care Commissioning Committee supported the transfer to the CCG and in principle would support the merger of the two practices, subject to the practice confirming the Kinver branch would remain open for two years. Finance, Performance and Business Intelligence Committee supported with conditions; the first being that there would be no additional financial burden on Dudley CCG as a consequence of the transfer.

Several issues had been discussed by the Finance, Performance and Business Intelligence Committee which Mr Hartland advised the Board of. It was acknowledged that the practice had a recurrent underspend of £144,000 and the view of the Committee was that it was an acceptable risk to take and would support it on that basis. However, there was a legacy issue with regards to historical debt in SESSP CCG in that they had a legacy debt of approximately £42m and SESSP CCG had stated that in principle they would support the transfer but as part of that, the historic debt should also transfer. The Board were assured that this element of the request had not been agreed by the Committee and NHSE had confirmed that there was no precedent and they would state the historic debt would not transfer however, that was the position that SESSP CCG were taking in their application to NHSE so at the time of Board that issue had not been concluded and advised Board that there may be a discrepancy on the overall assurance when NHSE make their decision.

Mr Hartland reiterated to the Board that Finance, Performance and Business Intelligence Committee supported the recurrent position of £144,000 but it did not support the transfer of the historic debt from SESSP CCG.
With regards to performance, the practice perform well but they do appear in the lower quartile of performance standards within the CCG however an improvement plan had been agreed therefore the Committee accepted this.

In relation to Estates, the Committee asked how that would fit into Dudley’s Estate Strategy and it was advised that where the Kinver practice is located it would not be expected to be consumed into a hub so the continuation of an independent site in Kinver would be expected and supported. In addition, any extra activity due to patients moving to the Kingswinford practice for services that Kinver would normally provide, had been built into the development of the Kingswinford hub.

The Audit and Governance Committee supported the information governance view that had been taken by Finance, Performance and Business Intelligence Committee and there were no considerations taken by the Remuneration and HR Committee at the time of Board.

In summary, the application was supported by the Board Committees, with the one condition applied by Finance, Performance and Business Intelligence Committee.

The Board were assured that consultations had taken place with the public, stakeholders and the membership which had all concluded. Financial, due diligence and Committee engagement had all been completed to a satisfactory level so assurance was also given for this.

Other points which the Board were asked to note was in relation to the Constitution and the only change that would be made would be the list of practices.

Dudley CCG would therefore submit the application as presented, the quality impact assessment would be tested and submitted with the application recognising that the likelihood was that there would not be a mirror application made by SESSP CCG which would need consideration by the Board.

The risks that the Board were asked to note were that NHSE could refuse the application due to a mismatch; that Dudley CCG could be made to take a proportion of the historic debt; that Moss Grove, Kinver close their practice thereby patients would naturally flow into Dudley practices.

Mrs Broster asked that it be recorded on the significant length that the practice had gone to for involving patients and stakeholders within the consultation. The Board were also asked to be mindful of the strong degree of positivity and support for the proposals from the residents and patients registered across both sites. Whilst there were concerns on the impact of appointment times, this was mirrored across both sites and the practice were aware of this and had plans in place to monitor the situation should the proposals be put in place. Mrs Broster provided assurance to the Board that adequate involvement had been had, Dudley had met its statutory duty in the process and that stakeholders had been given the opportunity to comment throughout the consultation.

Dr Edwards joined the meeting

Dr Hegarty echoed Mrs Broster’s point and the feedback he had received personally on how helpful members of the public had found Dr Mark Hopkin in addressing some of the issues.

Mr Wellings informed the Board that the Primary Care Commissioning Committee had considered the report at its last meeting and the decision made in this paper did not accurately reflect the discussion that was being presented to the Board. The Committee raised their concern on the Kinver practice closing and making it a minimum of 2 years before this could happen, but there had been a clear message from the Committee that it would not want the practice to close at all because of the impact on the patients and the impact on the costs for Dudley CCG that it would have to pick up to commission another practice. There had also been assurance from Dr Mark Hopkin, who attended the Committee, that this had also been the practice’s approach.

With regards to the quality impact assessment, Mrs Broster reported that there was no proposed change to service delivery from the practice so when the practice produced the proposal to make a merger application, they conducted a quality impact assessment, so essentially the partnership had conducted the exercise in arriving at the decision to make the application. What would be required from them is the relevant paperwork that proves the quality impact assessment had been covered.

Dr Horsburgh felt it was important to note for members of the public that the historic debt was not within the practice, it was the debt within the system and that the practice was actually underspent.

Mrs Jasper asked what assurance had been given that SESSP CCG had given to persuade a mirror application. Mr Hartland advised that they were using Dudley’s template and would mirror what Dudley had suggested with.
the exception of the financial deficit. Mr Maubach reported that he had held conference calls with SESSP CCG Accountable Officer and the two NHSE teams to try and reach an agreement on a mirror application, however an agreement had still not been reached at the time of board. An email from NHSE had stated that even if Dudley were to propose to buy out the historic debt for a smoother transfer, this would not be possible under current NHSE rules.

Mr Samuels pointed out that as a Local Authority in Dudley, they would be unable to provide services for people who were resident outside of the Dudley borough and would mean that any resource that was being put into the MCP by the Local Authority should not be spent on Staffordshire residents.

It was questioned whether there would be an impact in service provision and it was noted that on day one, all the existing services would be provided by the existing providers and the CCG would pay for those services on behalf of that practice.

It was noted that Dr Mann and Dr Tapparo had a conflict in interest as both of their respective practices had patients residing in Kinver who were accessing community services. Dr Mann also pointed out that although a public consultation would have to take place to close the surgery, if the application was not approved, there could be a risk that Moss Grove Kinver would leave nonetheless and patients in Kinver would potentially join the neighbouring practices.

Mrs Broster clarified for members that within the Constitution, it only listed practices rather than boundaries, which is why the actual change to the Constitution did not include reference to a boundary change even though there would be one as Dudley CCG would take on five local authority boundary codes.

Mrs Brunt advised the Board that SESSP CCG had proposed to create a caretaking arrangement in relation to resilience. Dudley had asked for that to be discussed with the practice and it was one of the proposals that was being put forward in order to manage and protect the provision of services for that particular population but she was uncertain as to whether this had been explored.

It was clarified that this application was different to that of other practices who sat on the Dudley borders in that there is a different ownership model within the two surgeries. Should other practices apply to join Dudley, it was noted that the CCG would consider those in a very different way.

Dr Tapparo asked for some assurance that the resource that would follow the patients would be spent on primary care and to increase the resources currently in place rather than diluting the services. Mr Hartland advised that there would be an element of the budget that would be ringfenced for primary care that would be added to Dudley’s delegated ringfenced amount from NHSE. The remainder would be commissioning spend and consideration would need to be given as to how it would be mapped against Dudley’s current investment profile and would be judged as any other practice within Dudley.

The recommendation to the Board was for members to consider the proposal and to make a decision on the application. For clarification, sub-committees had recommended to the Board not to accept the transfer of the historical debt which all Board members approved of.

With regards to Kinver remaining open for a minimum of 2 years, it was confirmed that the minutes from the Primary Care Commissioning Committee, where the 2 years had been suggested, had not been approved. The Board therefore agreed that the minimum of 2 years was purely a suggestion and a process for consideration would have to be followed for any closure which the practice were clearly aware of. The Board supported this.

Resolved:
1) The Board agreed that Dudley CCG would not accept the transfer of the historical debt
2) The Board supported the removal of Kinver remaining open for a minimum of 2 years, noting a process for consideration would have to be followed for any closure
3) The Board approved the proposed application to NHSE for Moss Grove Surgery, Kinver to join Dudley CCG
It was recognised that progress needed to be made but it had to be within the financial constraints of the budget and if it was not delivered within the financial plan, an extraordinary measure would have to be put in place to deal with that as the Committee does not have delegated authority to vary against a budget.

The Board approved delegated authority to be given to the Commissioning Development Committee noting it had to be in line with the CCG’s financial budget, the MCP service model and with the CCG’s governance structure.

Resolved:
1) The Board gave their approval for delegated authority to be given to the Commissioning Development Committee within the confines of Dudley CCG’s existing financial budget, MCP service model and governance structure

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<tr>
<th>CCG081/2018</th>
<th>OPHTHALMOLOGY ANY QUALIFIED PROVIDER (AQP) – TENDER AWARD</th>
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Mr Bucktin spoke to this item and reported that the Commissioning Development Committee had received a report regarding an Any Qualified Provider (AQP) award for Ophthalmology services and the bids received did not fit the criteria. The procurement notice was therefore reissued and further bids had been received. The bids had been evaluated and were in a position to award the relevant contracts. It was advised that the budget for this was less than £500,000.

The Board were asked for delegated authority to be given to the Commissioning Development Committee to oversee the award report which they approved.

Resolved:
1) The Board gave their approval for delegated authority to be given to the Commissioning Development Committee to approve the Ophthalmology Any Qualified Provider Tender Award

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With regards to the paper on Moss Grove, the CCG team and the practice were commended on the extremely well-prepared paper which gave a good example of good practice to prepare the Board to make their decision.

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That under the Public Bodies (Admission to Meetings) Act 1960, the public and representatives of the press and broadcast media be excluded from the meeting during the consideration of the following items of business as publicity would be prejudicial to the public interest because of the confidential nature of the business to be transacted.

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<th>DATE AND TIME OF NEXT MEETING</th>
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Thursday 6 September 2018  
1pm – 5pm  
Boardroom, Brierley Hill Health and Social Care Centre

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<th>MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD</th>
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# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

## MATTERS OUTSTANDING

FROM MAY 2018 – PUBLIC BOARD MEETING

<table>
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<tr>
<th>ITEM NO</th>
<th>AGENDA ITEM</th>
<th>ACTION TO BE TAKEN</th>
<th>ACTION FOR</th>
<th>UPDATE</th>
<th>COMPLETED</th>
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<tr>
<td>CCG059/2018</td>
<td>Public Update</td>
<td>1) That Mrs Broster invite Dr Martin to attend July Board for Feet on the Street presentation</td>
<td>Mrs Broster</td>
<td>Dr Martin has been invited for the presentation on End of Life</td>
<td>COMPLETE</td>
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<tr>
<td>CCG064/2018</td>
<td>Report from Quality &amp; Safety Committee</td>
<td>1) Updates from the Dudley System Oversight and Assurance Group to be included in the Quality and Safety Committee Board report</td>
<td>Mrs C Brunt</td>
<td>This is picked up in the Quality &amp; Safety Report – Agenda Item 7.1</td>
<td>COMPLETE</td>
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<td>2) Mr Hartland and Mrs Brunt to provide an update to Governing Body on quality and finance issues associated with TCP Programme.</td>
<td>Mr Hartland/ Mrs Brunt</td>
<td>This item is reflected in the relevant Committee reports and a verbal update will be provided</td>
<td>COMPLETE</td>
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<tr>
<td>CCG067/2018</td>
<td>Statement of Disclosure to Auditors</td>
<td>1) That Mr Hartland would liaise with those Board members who were absent to obtain their agreement on the aforementioned statements.</td>
<td>Mr Hartland</td>
<td>All members have confirmed their statements</td>
<td>COMPLETE</td>
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<td>CCG070/2018</td>
<td>Report from Finance, Performance and Business Intelligence</td>
<td>1) The Quality and Safety Committee to identify if there was a cohort of patients that are not identified by the national targets and this may impact on when they receive care.</td>
<td>Mrs C Brunt</td>
<td>Work progressing</td>
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<td>CCG071/2018</td>
<td>Report from the Commissioning Development Committee</td>
<td>1) Mr Maubach and Mr Samuels to discuss how to make progress on developing a strategy for Children’s Service across the Borough.</td>
<td>Mr Maubach</td>
<td>Telephone call between Mr Samuels and Mr Maubach is being arranged.</td>
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<td>ITEM NO</td>
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<td>CCG076/2018</td>
<td>Reflection Time</td>
<td>1) Mr Hartland to liaise with Dudley IT Services regarding paperless options for Board</td>
<td>Mr Hartland</td>
<td>Review ongoing. Proposal being taken to the next IT Strategy Meeting</td>
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Introduction
This report is presented with the aim of keeping Board Members up to date with important Communications and Engagement issues and ‘hot topics’.

It is also produced with the specific aim of further strengthening the patient voice at our board meetings by including sections dedicated to feedback from our Patient Participation Groups, Patient Opportunity Panel (POPs) and Healthwatch.

This month, Feet on the Street ventured into the borough, to explore views and perceptions around death and the terminology we use. This will feed into the work that Dr Lucy Martin is developing with colleagues across the wider partnership.

Patient Opportunity Panel (POP) Meeting - The group met and shared some really fascinating stories of achievements within their local communities from healthy walking groups to building allotments. Members offered advice on community funding through the community forums and opportunities to connect into wider activities. Helen spoke with the group about the work that was being undertaken as part of the personalised care programme through NHS England and advised she would keep the group updated as it fitted so well with the direction of travel.

POP Tour - Following on from Diane Wake’s visit to the POP group in April and the offer of a hospital tour, 9 POP members took advantage of the opportunity and visited on the 8th June. The group spent 3 hours on their visit and gave really positive feedback about their experience which has been shared with Diane.

Dudley Borough Healthcare Forum (HCF) - The HCF looked at self-care with participants. We wanted to understand what people thought ‘self-care’ was, and what some of the barriers and enablers to self-care are. This work will feed into the strategy that we are developing with public health and as part of the wider personalised care programme.

Moss Grove Kinver and Kingswinford - The full report on public views around the proposal for Moss Grove Kinver to join Dudley CCG was considered by the Governing Body on the 7th June 2018. The report stated that overall, there was a strong degree of positivity and agreement towards the proposals with: 63% of the online survey sample stating they felt positive towards the proposals and 24% ‘neither positive or negative’; high levels of positivity towards the proposals at the CCG organised public events and stakeholder meetings; and the majority of organisations
either expressing support for the proposals or outlining the potential benefits of the transfer in their correspondence.

The benefits outlined include;

- The merger will make both practices more sustainable now and in the future
- Patients will have the ability to access a greater range of services
- Potential greater availability of appointments as patients will be able to access appointments at both practices
- Potential decrease in the burden placed on the CCG due to a more streamlined administration process

The main concerns outlined by participants are the prospect of ‘longer waiting times, difficulties getting appointments’, ‘increased pressure of extra patients’, travel issues and fear of a decline in service availability.

The vast majority of concerns raised were addressed by the practice at the public meetings in terms of a commitment to monitor the usage of both sites to ensure resources were allocated dependant on patient flow. The practice did confirm that there was no intention however to reduce services on either site and that appointment slots would remain the same.

Both practice PPGs support the proposals and Heathwatch Staffordshire endorsed the process of involvement and suggested that they support the proposals as they are in the best interests of patients.

The Governing Body resolved to put in an application to NHS England for the practice to join Dudley CCG.

Wheelchair conversations - The team supported the Planned Care Commissioner in a meeting with ‘We Love Carers’ to discuss recent experiences of changes in wheelchair services. There will be a public involvement exercise to seek views on some proposed changes to the eligibility criteria and the feedback from this group and others will be key to informing to future commissioning of this service.

Personalised Care Programme - Funding for this programme has been confirmed and conversations are continuing across the STP site about how we start to spread and sustain personalised care and support across the Black Country. Early conversations involve linking in with other demonstrator sites to understand their challenges and progress in delivering personal health budgets, health coaching, personalised care and support plans and self-management.

NHS70 - Celebrations are taking place on 5th July at Brierley Hill Civic Hall between 10.30am and 2.30pm. Local primary schools have been invited to take part in a competition which looks at how the NHS might look in the future. Vamos will be performing on the day, Healthwatch Dudley and the Young Health Champions, Dudley Group NHS Foundation Trust, Dudley Council Public Health colleagues, West Midlands Ambulance Service and Dudley and Walsall Mental Health Partnership NHS Trust will all be helping out on the day with different activities. Local people and communities will be able to drop in and have a drink and light refreshments and take part in the celebrations. We will showcase some of the outputs from the day at the Board meeting in September.
We continue to work with our providers to monitor the experience of patients using services. These are reported regularly to the CCG Quality and Safety Committee.

The infographic below illustrates a summary of the key indicators of experience at The Dudley Group FT.
I am proud to have taken over the leadership of Healthwatch Dudley and to share our 2017/18 annual report.

We have got lots of important work coming up to help meet our priorities which will include:

- Listening to peoples experiences of the Russells Hall Hospital Paediatric Assessment Unit,
- Setting up a new Community Reporters project,
- Listening to adults at risk through our homelessness survey,
- Supporting the work of Dudley Safeguarding Adults Board by hearing and sharing more genuine experiences of care,
- Helping our Young Health Champions to make a difference for other young people,
- Helping partners to better understand the causes of child neglect through our Thrive project,
- Supporting our growing Network of Information Champions,

I'm looking forward to meeting and working with Dudley CCG Board members and sharing the outcomes from these and other projects where we have listened to the views of local people to strengthen local services.

Andrea Crew, Healthwatch Dudley Chief Officer.

The Healthwatch Dudley 2017/18 annual report will be available to download on 30th June 2018.

http://www.healthwatchdudley.co.uk/reports

A range of Healthwatch Dudley evidence based reports are available to download at www.healthwatchdudley.co.uk/reports
Winter
We have now received the Black Country Winter 2017/18 evaluation from the CSU. This has been shared with the A&E Board for information and will support a decision on the Winter campaign for 2018/19.

Proactive and Reactive Media Activity- The table in appendix 1 gives a breakdown and hyperlinks to recent media activity for the CCG.

The Advertising total has been calculated as £147,225 with £125,219 of this relating to negative coverage around Wheelchair Services and Cataract Surgery.

The CCG have received and responded to media enquiries regarding local wheelchair services, however we have not had an opportunity to respond to anything related to Cataract Surgery.

Communications and Engagement – Media Monitoring – May & June 2018

<table>
<thead>
<tr>
<th>Title/weblink</th>
<th>Summary</th>
<th>Release Date</th>
<th>Coverage (with links where available)</th>
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<tbody>
<tr>
<td>GP &amp; Pharmacy Opening Times for May Bank Holiday in Dudley</td>
<td>Press Release</td>
<td>01.05.2018</td>
<td>Release</td>
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<td>Health chiefs urge parents to get children immunised against measles</td>
<td>Press Release</td>
<td>01.05.2018</td>
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<td>Dudley Health Profiles (Health Inequalities)</td>
<td>Media Enquiry</td>
<td>02.05.2018</td>
<td>Express &amp; Star – Alex Ross</td>
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<td>Programme aims to help prevent type 2 diabetes</td>
<td>Coverage of Press Release</td>
<td>02.05.2018</td>
<td>Stourbridge News Article</td>
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<td>Dudley CCG Invites Public to attend Board Meeting</td>
<td>Press Release</td>
<td>04.05.2018</td>
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<td>Dudley CCG to hold board meeting</td>
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<td>06.05.2018</td>
<td>Stourbridge News, Dudley News, Halesowen News</td>
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<td>Calls to have being active as the norm</td>
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<td>07.05.2018</td>
<td>Express &amp; Star (Wton)</td>
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<td>Inactive Adults high in borough</td>
<td>Coverage of Media Enquiry</td>
<td>07.05.2018</td>
<td>Express &amp; Star (Dudley) Article</td>
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<tr>
<td>The jaw-dropping number of West Midlands patients with no GP access outside working hours</td>
<td>Media Story</td>
<td>08.05.2018</td>
<td>Birmingham Mail Article</td>
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<tr>
<td>People can quiz health officials</td>
<td>Coverage of Press Release</td>
<td>08.05.2018</td>
<td>Express &amp; Star (Wton) Article</td>
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<td>MCP Bid</td>
<td>Media Enquiry</td>
<td>09.05.2018</td>
<td>Health Service Journal (HSJ) – Rebecca Thomas</td>
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<td>OBESITY BLAMED ON CAR CULTURE</td>
<td>Media Story</td>
<td>10.05.2018</td>
<td>Dudley, Halesowen &amp; Stourbridge Chronicles Article</td>
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<td>GPs failing on out-of-hours appointments</td>
<td>Media Story</td>
<td>14.05.2018</td>
<td>Birmingham Mail Article</td>
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<td>End of Life Meeting ‘Dying Matters’</td>
<td>Media Enquiry</td>
<td>14.05.2018</td>
<td>Local Democracy Group</td>
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<td>Dying Matters awareness meeting in Dudley</td>
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<td>15.05.2018</td>
<td>Dudley News, Halesowen News Stourbridge News Article</td>
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<td>New card launched to give deaf people a helping hand</td>
<td>Press Release</td>
<td>15.05.2018</td>
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<td>Dr David Hegarty re-elected as Chair of NHS Dudley CCG</td>
<td>Press Release</td>
<td>16.05.2018</td>
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<td>New card launched to give deaf people in Dudley a helping hand</td>
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<td>17.05.2018</td>
<td>Dudley News, Stourbridge News Halesowen News Article Web Article</td>
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<td>People in the Midlands denied access to life-changing technology</td>
<td>Media Story</td>
<td>17.05.2018</td>
<td>Diabetes UK</td>
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<td>Three more years for top CCG boss</td>
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<td>Express &amp; Star (Dudley, Walsall, Wton)</td>
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<td>GPs failing on out-of-hours appointments</td>
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<td>18.05.2018</td>
<td>Solihull News</td>
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<td>QIPP</td>
<td>Media Enquiry</td>
<td>18.05.2018</td>
<td>Local Democracy Group – George Makin</td>
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<td>Public Invited to Dudley CCG’s Primary Care Commissioning Committee Meeting</td>
<td>Press Release</td>
<td>18.05.2018</td>
<td>Release</td>
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<td>Invitation to Health Meeting</td>
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<td>Express &amp; Star Article</td>
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<td>Dudley CCG chairman Dr David Hegarty re-appointed for another three years</td>
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<td>21.05.2018</td>
<td>Halesowen News, Dudley News, Stourbridge News</td>
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<td>Deaf support services creates new card</td>
<td>Coverage of Press Release</td>
<td>21.05.2018</td>
<td>Express &amp; Star Article</td>
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<td>Find out more about Dudley's healthcare at CCG meeting</td>
<td>Coverage of Press Release</td>
<td>22.05.2018</td>
<td>Dudley News Article</td>
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<td>New card will help deaf people to communicate</td>
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<td>23.05.2018</td>
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<td>Deaf support service creates helpful card</td>
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<td>Halesowen Chronicle, Stourbridge Chronicle, Dudley Chronicle</td>
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<td>BLIND INJUSTICE Fury as thousands of patients denied life-changing cataracts surgery despite official guidelines</td>
<td>Media Story</td>
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<td>what a blind injustice!</td>
<td>Media Story</td>
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<td>Daily Mail</td>
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<td>Fury as thousands of patients denied life-changing cataracts surgery despite official guidelines</td>
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<td>Irish Sun</td>
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<td>Wheelchair Services</td>
<td>Media Enquiry</td>
<td>01.06.2018</td>
<td>Dudley News – Kelly Harris</td>
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<td>Statement in response to the article: CCGs U-turn on ‘de-humanising’ funding policies after legal threat</td>
<td>Rebuttal</td>
<td>01.06.2018</td>
<td>HSJ Rebuttal Statement</td>
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<td>WeLoveCarers fights changes to borough’s wheelchair services</td>
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<td>Dudley News, Halesowen News, Stourbridge News</td>
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<td>Wheelchair rule prompts anger</td>
<td>Coverage of Media Enquiry</td>
<td>06.06.2018</td>
<td>Dudley News</td>
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<td>Dudley CCG appoints first Consultant Pharmacist for Primary Care, working at a population level</td>
<td>Press Release</td>
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<td>Consultant Pharmacist Interview</td>
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<td>Pharmaceutical Journal – Emma Dent</td>
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<td>EHRC Media Enquiry</td>
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<td>Dudley News – Kelly Harris</td>
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<td>Dudley CCG to review Continuing Healthcare policy after being accused of forcing patients into care homes Coverage of Media Enquiry</td>
<td>12.06.2018</td>
<td>Halesowen News, Stourbridge News, Dudley News Article</td>
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<td>Medical role is first in UK Press Release Coverage of Press Release</td>
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<td>Express &amp; Star (Dudley) Article</td>
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<td>First pharmacist for primary care appointed Coverage of Press Release</td>
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<td>First primary care pharmacy consultant working at population level appointed Coverage of Press Release</td>
<td>14.06.2018</td>
<td>BioPortfolio (Web) Article</td>
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<td>Pharmaceutical Journal Article</td>
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<td>Join Your Local Maternity Voice Partnership Press Release</td>
<td>14.06.2018</td>
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<td>Tea party for NHS birthday Coverage of Press Release</td>
<td>14.06.2018</td>
<td>Express &amp; Star Article</td>
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<td>Discretionary funding - general practice RFI0988) Media Enquiry</td>
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<td>Nicola Merrifield – Pulse Article</td>
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<td>Midlands Express &amp; Star Article Article</td>
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<td>Express &amp; Star (Wton) Article</td>
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<td>Coverage of Press Release</td>
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<td>Express &amp; Star Article</td>
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<td>DISABLED 'DENIED WHEELCHAIRS'</td>
<td>Coverage of Media Enquiry</td>
<td>21.06.2018</td>
<td>Stourbridge &amp; Dudley Chronicles Article</td>
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<td>Charity says disabled are denied wheelchairs</td>
<td>Coverage of Media Enquiry</td>
<td>21.06.208</td>
<td>Halesowen Chronicle Article</td>
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</table>
**TITLE OF REPORT:** Update from Partnership Board

**PURPOSE OF REPORT:** To update the Board on the developments of the Partnership Board

**AUTHOR OF REPORT:** Mrs Stephanie Cartwright, Director of Organisational Development and Human Resources

**MANAGEMENT LEAD:** Mrs Stephanie Cartwright, Director of Organisational Development and Human Resources

**CLINICAL LEAD:** Dr David Hegarty, Chair

**KEY POINTS:**
- Since the last report the Partnership Board has met once (30 May 2018) where it:
  - Received a presentation on a summary of the bid submission for the MCP
  - Considered the future Ambulance Services requirements
  - Discussed the implications of poor housing on health.
- Governance arrangements continue to reflect the separation of procurement of the MCP from development of the MCP

**RECOMMENDATION:** That the CCG Board notes the progress of the Partnership Board to date

**FINANCIAL IMPLICATIONS:** None

**WHAT ENGAGEMENT HAS TAKEN PLACE:** There is a specific workstream dedicated solely to communications and engagement on MCP development that includes representation from all organisations involved.

**ACTION REQUIRED:**
- Decision
- Approval
- Assurance
1. INTRODUCTION

The Dudley Partnership Board includes invitees from all organisations included in developing the Dudley Multi-specialty Community Provider. These organisations are as follows:

- Dudley Clinical Commissioning Group (lead organisation)
- Dudley Metropolitan Borough Council
- Dudley Group Foundation NHS Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- Dudley Council for the Voluntary Sector
- Black Country Partnership NHS Foundation Trust
- Dudley Primary Care Providers
- West Midlands Ambulance Service (WMAS) NHS Foundation Trust

2. REPORT

The Partnership Board has agreed that it will continue to meet on a monthly basis to oversee the implementation of the core components of the MCP and to review the progress in the implementation of the new model of care and to provide the opportunity to raise robust challenge and to air issues that require partnership debate and discussion. The Partnership Board has met once since the last report to the Board meeting, on 30 May 2018.

The Partnership Board in May focussed on three areas: a presentation on a summary of the bid submission for the MCP, a discussion around the ambulance service contract, and a short discussion on the implications of poor housing on health.

The presentation on the summary of the MCP bid submission focussed on the clinical model for the MCP, the organisational form proposals and a summary of the planned transitional arrangements including the establishment of the MCP Transition Board. The Board discussed the proposals and asked for an update on transition once the announcement on preferred bidder had been made by the CCG.

The discussion with regard to the WMAS contract led to suggested areas for improvement including considering potential incentivising non-conveyance and simplifying access to local services for ease of redirection by the ambulance crews. The Board re-iterated it’s wish for further involvement in local planning by the service. The Urgent Care Commissioner agreed to include the Partnership Board comments when discussing the contract and will update the Board on developments over the next couple of months.

Partnership Board agreed that a detailed debate on the impact of housing on health would be beneficial but agreed that it would be of more value once council and CCG colleagues could return to the table following the announcement of whether there is a preferred bidder for the MCP. This item was therefore deferred to the next meeting.

3. RECOMMENDATION

The Board is asked to note the contents of this report for assurance.

Stephanie Cartwright
Director of Organisational Development and Human Resources
June 2018
DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Board: 12 July 2018
Report: Black Country Joint Commissioning Committee (BCJCC) Assurance Report
Agenda item No: 6.2

<table>
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<tr>
<th>TITLE OF REPORT:</th>
<th>Black Country Joint Commissioning Committee (BCJCC) Assurance Report</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>This report provides a summary of business considered at the BCJCC meeting on 22 June 2018 and the minutes from the March and May meetings.</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Angela Poulton, JCC Programme Director</td>
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<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr Paul Maubach, Accountable Officer</td>
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<tr>
<td>CLINICAL LEAD:</td>
<td>Dr Anand Rischie, Chair – Walsall CCG/Chair Black Country JCC</td>
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| KEY POINTS: | • Place-Based Commissioning Update – Dudley  
• Clinical Leadership Group (CLG) Update  
• Programme Performance  
• Specialised Services  
• Project Support Office Update  
• Cancer Alliance  
• Personalised Care Demonstrator Site Bid  
• Future Support for the JCC  
• STP Individual Placement Support Service  
• Minutes from the 22 March 2018 meeting (Appendix 1)  
• Minutes from the 10 May 2018 meeting (Appendix 2) |
| RECOMMENDATION: | 1) To note the contents of the report for update on activity and assurance  
2) To note the minutes from the meetings held in March and May 2018 |
| FINANCIAL IMPLICATIONS: | |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | |
| ACTION REQUIRED: | Decision  
Approval  
✓ Assurance |
1.0 Action Log and Matters Arising

1.1 There had been satisfactory progress on all items. A revised JCC Risk Register template was agreed which will now be populated to include risks relating to areas formally delegated and risks of common interest that individual CCGs are best able to manage. The importance of ensuring an effective feedback loop from CCGs to the JCC for the purpose of managing the Risk Register was agreed.

2.0 Place-Based Commissioning Update – Dudley

2.1 Paul Maubach provided an update regarding the MCP procurement, explaining that the bid evaluation phase was underway as a joint process involving Dudley Council and the CCG. There are two National judicial reviews, which relate to the ACO contract, one of which has failed and the outcome of the other is awaited. Once the outcome of the bid evaluation is confirmed, the contract will be subject to a 9-month assurance process. A National public consultation on the contract will take be undertaken by NHS England later this year. Members were referred to the Health Select Committee report.

3.0 Clinical Leadership Group (CLG) Update

3.1 Angela Poulton confirmed that the first draft Black Country Clinical Strategy has been issued to CLG members, CCG clinical Chairs and leads, Medical Directors, Chief Nurses and Chief Executives/Accountable Officers. Feedback is starting to be received which will be considered by CLG when the document is reviewed on 29th June and will inform a further version. Dr Helen Hibbs confirmed that the Clinical Strategy will be the focus of the ICS Development Workshop scheduled for 2nd July.

4.0 Programme Performance

4.1 Angela Poulton referred members to the latest Black Country STP performance reports. A&E 4-hour performance continues to be challenging but it was noted that that Royal Wolverhampton are now meeting the standard with improvement being seen at Walsall. 62-day cancer target performance continues to not be met, partly due to tertiary referral delays but also capacity issues and reductions in the 104-day waits. The Cancer Alliance is involved and is going to put a manager into Royal Wolverhampton for support.

4.2 Dr Helen Hibbs reported that TCP trajectories continue to not be met owing to the number of admission and there is close monitoring by NHS England. There is a deep dive scheduled for the end of next week. The Pathway Group workshop held last week focussed on how to work differently and achieve a standardised approach. The providers are working better with CCGs. The new community model commissioning specifications have been sent to governing bodies. Discussions about the need for a longer term financial plan and the associated financial risks were discussed, and it was agreed that the Chief Financial Officers would undertake an options appraisal on the best way to approach their management to be reported at a future JCC meeting. There are challenges with regards Local Authority engagement arising out of the financial risk and risk posed by forensic patients being in the community, and a meeting with the four Directors of Adult Social Services has been scheduled.

5.0 Specialised Services

5.1 Angela Poulton presented information on Specialised Services that had been sourced from Midlands & Lancashire CSU, based upon provider SUS data that Arden & Gem CSU had shared. Access to the National Commissioning Database Repository has not been possible. Owing to the significant data quality issues in the information presented, Angela Poulton recommended that the only way to obtain reliable and validated information is to request this directly from the Specialised Service team. The Committee shared their dissatisfaction at the lack of engagement by Specialised Services. Dr Helen Hibbs confirmed that a meeting is being scheduled with Rachel O’Connor.
6.0 Project Support Office Update

6.1 Dr Helen Hibbs confirmed that the advert has gone out for the STP Portfolio Director. A shared drive is being created to support the STP and JCC work using Wolverhampton staff on a temporary basis. Programme briefs with hi-level milestone plans are being developed with support from NHSE staff.

7.0 Cancer Alliance

7.1 The Committee received a report from Paul Tulley confirming Cancer Alliance governance arrangements and staff resources aligned to the cancer improvement work. The transformation funding was being used to appoint interim staff which was flagged as a concern as there is the need to find sustainable resourcing solutions.

8.0 Personalised Care Demonstrator Site Bid

8.1 Laura Broster confirmed that the bid had been approved and that adverts would be going out for the posts to support delivery.

9.0 Future Support for the JCC

9.1 Angela Poulton’s secondment ends at the end of June. The Accountable Officers to agree future support.

10.0 STP Individual Placement Support Service

10.1 Steven Marshall gave an overview of the Individual Placement Support Service (IPS). The Five Year Forward View specifications outline key provisions for IPS across the STP. There are a number of waves for funding. The funding application was developed by Dudley and Walsall Mental Health Trust who are current providers of this. There will be funding for two years, and Finance Directors have been advised of the need to find funding for years 3 and 4.

10.2 The service specification has been agreed by Wolverhampton CCG Commissioning Committee as the lead commissioner, and will be shared with other CCG Governing Bodies.

11.0 Consent Agenda Reports

10.1 The consent reports were noted.

Appendix 1 – BJCC - March 2018 minutes
Appendix 2 – BJCC - May 2018 minutes
Minutes of Meeting dated 22nd March 2018

**Members:**
Dr Anand Rischie – Chairman, Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Helen Hibbs – Accountable Officer, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Prof. Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG’s
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Angela Poulton - Programme Director – Joint Commissioning Committee
Peter Price – Lay Member, Wolverhampton CCG
Jim Oatridge – Lay Member, Wolverhampton CCG

**In Attendance:**
Charlotte Harris – Note Taker, NHS England
Laura Broster – Director of Communications and Public Insight
Dr Ruth Tapparo – GP/Board Member, Dudley CCG

**Apologies:**
Dr David Hegarty – Chairman, Dudley CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Simon Collings – agenda item deferred to May meeting
Paula Furnival, Director of Adult Social Care, Walsall MBC

1. **INTRODUCTION**

1.1 Dr Anand Rischie welcomed members.

1.2 Apologies as noted above.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. None were given.

1.4 The minutes of the meeting held on the 15th February were agreed as an accurate record of the meeting.

1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 There was a discussion regarding the number of apologies for the scheduled April meeting. Owing to only one Accountable Officer being able to attend, despite quoracy requirements being fulfilled, it was agreed to cancel the April meeting.

1.7 Regarding action 070, Angela Poulton questioned whether there involvement of Accountable Officers is required rather than just an Executive Director from each CCG or whether the
Executive Director would be party to decision making. Paul Maubach noted it depended on the scheme of delegation within the CCG as to whether the director had delegated authority. It is director level with support from their own scheme of delegation from their own organisation. Matt Hartland suggested that both an Executive with the appropriate authority and their respective CFO be included. James Green confirmed that this was envisioned for rapid decision making on smaller issues.

1.8 Regarding action 072, there has been a joint meeting with all the audit chairs across the Black Country and low appetite to establishing a shared risk register resulting in agreement that the Governance Subgroup should review risk registers and identify commonalities. Jim Oatridge will report back at a future meeting.

1.9 Regarding action 073, Nick Harding confirmed that a West Birmingham Joint Commissioning Committee has been established and that the CCG will feed into both Joint Committees.

1.10 Regarding action 074, it was agreed not to continue with the meeting as this duplicated the ICS development meetings taking place.

1.11 Regarding action 075, the plan had been discussed in the February JCC. They are waiting for this year’s contracts to be agreed and next year’s plans to be assured. Matthew Hartland stated there is an aim for completion by the end of June, an update on which will be provided at the July JCC meeting.

1.12 Regarding action 076, this has been deferred until the next JCC meeting. Matthew Hartland informed that Specialised Services has not yet made an offer to providers raising risks and issues. Paul Maubach shared his frustration at the lack of engagement and provision of performance information over many months in relation to Specialised Services, despite repeated requests from Angela Poulton, and suggested the JCC Chair formally writing raising the matter. James Green questioned whether the committee had specified clearly what information was required and for what purpose. Paul Maubach stated that it had been previously agreed that Specialised Services activity and expenditure for the Black Country population would be provided, and that there are elements of specialised services that interface with other services such as renal services. Nick Harding referred members to the National Commissioning Data Repository tool that commissioners can use to get spend and activity profiles, currently hosted by Arden and Gem CSU.

**Action:** Angela Poulton to seek access the NCDR information with a view to presenting the Black Country Specialised Services activity and spend profile at the next JCC meeting.

2. **CORE BUSINESS**

2.1 **STP Update**

2.1.1 Andy Williams confirmed that the Black Country and West Birmingham Transformation Partnership Governance and Interim Arrangements paper has been approved. There had been discussions with council leaders and NHS lead colleagues. The resources for financially appointing will be transferred from NHS England (NHSE). The recruitment process has begun. There will be a panel for the Independent Chair position, and recruitment process will be undertaken by an external consultancy for 15,000. There will be regulatory involvement in all of the appointments but in particular for the SRO and Independent Chair. Letters for expression of interests of the SRO role are being sent on 22nd March. An indication has been requested by 6th April. The Programme Director position will
be advertised as an external open process on NHS Jobs. Andy Williams confirmed that the job will be advertised as a Very Senior Manager level post and will not be ring-fenced.

2.1.2 Paul Maubach questioned the finance for the new positions and whether the £278,000 from the STP would cover all of it. Andy Williams informed that the STP money will be used to begin with and beyond that level of funding partners will need to agree how to share costs. There was question as to what would occur should the local councils not contribute financially, and will this render the STP as an NHS construct. Peter Price made the point that if the local authorities see benefits for them they may choose to contribute in the future. Dr Anand Rischie stated that there is an expectation that the Independent Chair will be recruited from a non-health background. Andy Williams reiterated that once resources have been exhausted the partners would need to decide funding arrangements going forward.

2.1.3 Paul Maubach shared concerns about appointing the SRO position externally and asked whether other STPs had appointed external candidates. Andy Williams discussed the three typologies that are being used in other STPs. Birmingham and Solihull has an existing partner as the lead. Stafford has a combination of Independent Chair and Programme Director with the absence of a SRO. Other areas have seen the post holder resign from their contracted role to lead the STP on a full or part time basis. The challenge will be if a SRO cannot be identified that carries everyone’s confidence. Paul Maubach suggested that if an existing Accountable Officer or Chief Executive was to become the SRO, they would have the competence to do the role and that ensuring the confidence of partners needs to feature in the appointment process. There was discussion about whose appointment the SRO role was and the expectation that the regulator will not appoint an individual who will not secure the confidence of partners.

2.1.4 There was discussion about whether anyone is prepared to take on the role and if not this would trigger a discussion with the regulator regarding reasons. Helen Hibbs stated the SRO was a difficult role and without consensus between the Accountable Officers and Chief Executives the individual concerned will be being set up to fail. Andy Williams anticipated that there will be a break between the current and new infrastructure and contingency arrangements are needed to allow for the process for him standing down and someone else taking up the appointment. Nick Harding stated that there is the need to find someone to front up the STP for its safety, that the JCC has a role in driving this forward and that there is the need to find ways to protect the SRO as not doable in current circumstances.

2.1.5 Discussion followed regarding the hosting of the new roles, Andy Williams informing members that this would be determined with involvement of the post holder appointed and may be dependent upon their current role and place of work. There was a discussion regarding the hosting of the Programme Director and the composition and hosting of the Programme Management Office (PMO). Helen Hibbs stated that this discussion needs to continue outside the meeting. Andy Williams noted the issues in relation to the STP and the JCC position, and suggested that care needs to be taken regarding positioning the JCC to mitigate the risk that regulators start to hold the JCC to account for STP performance. Angela Poulton informed members that she had draft paper setting out what the PMO could look like and options for establishing but as an agenda item this had been deferred to the next meeting.

2.1.6 Paul Maubach stated that whilst there was increasing clarity regarding place based commissioning and the mental health ambition, the acute narrative was still to be developed. The suggestion was made to review other nationally designated ICSs such as Sheffield given its similar geography and five geographical areas linked to five local authorities and CCGs. It has presented a clear strategy on acute services and developed a clear narrative around the acute services place based work. Paul Maubach suggested that achieving clarity
regarding acute services would allow consideration of the support required to achieve the
desired future state.

2.1.7 Peter Price noted that in Appendix 1 of the Black Country and West Birmingham
Transformation Partnership Governance and Interim Arrangements paper the CCGs were
not identified on there.

2.1.8 Andy Williams confirmed that the appointment process will start shortly for the Programme
Director position. Paul Maubach suggested that there was a need to have an agreement as
to where the Programme Director will be hosted.

**Action:** Accountable Officers to agree appointment and hosting arrangements in
relation to the Programme Director appointment before the successful candidate
starts.

2.1.9 Nick Harding noted that there needs to be an agenda item for the next meeting on how to
decide what work needs collective responsibility and ensuring that this work lands correctly.

**Action:** Charlotte Harris to ensure an agenda item is included for to add collective
responsibility work as an item on the next agenda for the JCC meeting.

2.2 Clinical Leadership Group (CLG) Update

2.2.1 Nick Harding shared that the CLG meeting earlier that day had been positive. Hypertension
had been identified as a priority area of action, with Dudley CCG having had considerable
success in transformation across its local system and the multiplicity of solutions available to
resolve some of the issues. An update on the Local Maternity Services programme was
given. The cardiovascular work will come formally to the committee to move it forward and
in agreeing for this it had been identified that managerial support for the work is not
identified.

2.2.2 There was a request for the CLG to produce a refreshed Clinical Strategy based upon
workstreams and tensions exist regarding whether this is a job for CLG or whether the CLG
was set up to direct work. Nick Harding raised three issues in relation to the CLG: lack of
managerial support to support clinical leaders and do the work; whether there needs to be
financial input to the CLG; and deliverability of the Chair role in less than two days a week,
and the need for a discussion between all CCG Chairs regarding timescales to make the
CLG happen given current CLG Chair’s time availability.

2.2.2 Helen Hibbs shared that on the back of the recent STP stocktake it had been suggested that
the CLG should be the backbone of strategy for developing a clear joint vision and for all to
be tied into it. Dr Anand Rischie suggested that the CLG should develop the strategy and
refer it to the JCC for the financial and contractual support. It was suggested that clinical
chairs could have a discussion about linking the CLG into the workstreams and PMO to
ensure that there is no duplication of work.

**Action:** Clinical chairs to discuss CLG links into workstreams and the PMO to ensure
there is no duplication of work.

2.2.3 Nick Harding confirmed that Jonathon Odum was the only representative for providers at the
CLG meeting. Laura Broster stated that there is the need to triangulate the clinical strategy
with finance and CCG performance across the Black Country. Matthew Hartland asked if
there is a financial representative on the CLG to avoid there being a disconnect between
strategic ambition and available funding. Helen Hibbs noted that the CLG needs to be
clinically led and managerially supported. Nick Harding suggested that the new leadership
could review the CLG and how to drive work forward but the lack of managerial support to the CLG was notable. Angela Poulton stated that her understanding was that Joanne Alner had been provided by NHSE 2-3 days per week to support the CLG which was confirmed but the view expressed that this was not materialising. Angela Poulton offered support to produce the necessary papers to progress CLG delivery which was agreed.

2.3 Local Place Based Commissioning – Update & Implications for 2018/19 Commissioning Intentions

2.3.1 Paul Maubach provided an update regarding Walsall CCG where there is the Walsall Together Provider Alliance which involves practices, the acute trusts, the mental health trust and the council has been established. Arrangements are being put in place from April 2018 as a mechanism for the collaboration of integrated care. It has been problematic finding the right GP representative. There is a question over whether a lead provider is needed, who that would be and how it would work. There is a clear programme of work focused upon prioritising some key service areas and related outcome measures such as making the Multi-Disciplinary Team work better in the community. The plan is to use 2018/19 as an organisational development period to enable services to be commissioned properly. Every GP practice is involved. All community services provided by health and social care have been distributed into community teams working alongside primary care that have been organised into 4 localities, practices having been consulted regarding alignment based upon geography resulting in a population based alignment and approach.

2.3.2 Paul Maubach gave an update on Dudley CCG. Paul Maubach presented the Dudley model to the Health Select Committee (HSC) and the plan to use the new Accountable Care Organisation contract which is subject to judicial review. The HSC will be gathering the evidence from the different parties about the benefits of integrated care and single contractual arrangements. The procurement for the MCP closes on 22nd March. A bid will be put together by the 2 Trusts and GPs within a month, with MCP contract sign off in June. There was an Assurance Review meeting with NHS England and NHS Improvement where the assurance process has been mapped out and they are working on a timeframe. They will be creating a new NHS provider, The Dudley MCP Foundation Trust that will be running services in an integrated way from April 2019, the first in this country.

2.3.3 James Green asked about the impact of residual services on Dudley Group of Hospitals NHS Trust and whether there is a viability issue. Through the discussion it was confirmed that the new MCP will take a share of the Trust control total and that there is no viability issue which is an integral part of the NHSE assurance process, the latter requiring a full transaction review and assurance process for both Dudley Group and the new MCP.

2.3.4 There was a discussion regarding the outcomes evidence relating to the MCP in the context of the mixed evidence from Accountable Care Organisations internationally. Paul Maubach reported that there are notably better outcomes in mortality rates and improvement in life expectancy through pursuing the MCP model rather than an alliance model but pointed to there being a three year process. Consideration is now turning to what the CCG will look like once the MCP is established. Paul Maubach confirmed that the details will be shared once the case is finalised around July and suggested that it would be beneficial for each local system to take it in turns to present each month.

Actions:
- Paul Maubach to share details of the new Dudley MCP Foundation Trust once the case is finalised circa July
- Charlotte Harris to include a standing agenda item for CCGs to provide place based commissioning updates by rotation
2.3.5 Helen Hibbs gave an update on Wolverhampton CCG. The GPs have grouped into hubs, including the Medical Chambers model and the vertical integration practices, and the outcomes from each model should be comparable. There has been good engagement from GP leaders, Mental Health and Social Care about an alliance. There has been a meeting with clinical engagement to define a strategy for frail elderly, long term conditions, cancer, children and mental health. Governance is still being worked through including the contract as the plan is to review the Community and Acute contract and to start moving money out of the acute into the community and primary care without destabilising the provider. The Local Authority is fully signed up founded on the good work undertaken via the Better Care Fund (BCF) in relation to integrated teams and IT developments such as shared care records, with the focus now being on expanding the BCF given its aim to integrate care and getting the Trust more aligned.

2.3.6 Andy Williams gave an update on Sandwell and West Birmingham CCG. Work has been undertaken to build up the primary care base and developing networks of 30-50K population and with reasonable geographical coherence. A small number of practices have yet to align. There is a development framework called Primary Care Commissioning Framework which creates a set of financial and practical resource allocations to support the primary care plan, routed via networks to incentivise those practices yet to align. There has been decent local government engagement, and a good Better Care Fund process within Sandwell but primarily focused on integration at intermediate care level to date and now shifting to primary care, with David Stevens actively involved in the Primary Care Network discussions.

2.3.7 Birmingham Better Care Fund is organised on the city wide footprint, and discussions have taken place regarding how to develop the locality structure, one being Western Birmingham. Work has been started on Birmingham & Solihull CCG (BSOL) primary care networks, and the CCG has met with BSOL regarding how to create West Birmingham as a place and subset for which a work programme has been agreed. There is complexity over governance due to having two local authorities, and two mental health providers. Jonathon Pearson has been identified as the independent chair to facilitate the process and act as ‘honest broker’. The plan is to have the governance up and running and the work programme more formalised within the next month or so. The focus is on agreeing outcome areas that all partners to work, a possibility being the first 1000 days and last 1000 days system strategy to deliver a great start and end of life for local people.

2.3.8 Paul Maubach noted a commonality around alliance arrangements and the opportunity to review later on in the year how best to commission from an alliance to gain the learning through sharing information. Andy Williams noted that with BSOL they are evolving the organisation with members as both providers and commissioners.

2.3.9 Dr Anand Rischie suggested a further update in September. Paul Maubach suggested a workshop on what does commissioning an alliance look like as something beneficial to with Executive teams on. Nick Harding stated it would be useful to learn what to do when organisations will not come to the table. Helen Hibbs advised they are likely to get involved when enhanced services are starting to be commissioned at scale. Dr Salma Reehana suggested it would be the extended hours that will drive people. Angela Poulton noted that this could be delivered a future JCC Executive Development session.

Action: Angela Poulton to use a future JCC Joint Executive Development session to consider what commissioning an alliance looks like

2.4 Mental Health and Learning Disabilities (Including TCP)

2.4.1 Helen Hibbs informed that new funding had been received to invest in the CAMHS project. The Perinatal Mental Health bid had been submitted. They should have feedback by 29th
March. Pilot clinics are already set up in each locality. The second Individual Placement Support (IPS) bid has been submitted. There has been discussion as the IPS bid requires that at some stage, CCGs may need to pick up the funding so if it is successful this will need to go through governance structures. There is work on a joint mental health strategy across the Black Country. Transforming Care Together is not proceeding. Helen Hibbs and Steve Marshall have met with the two Mental Health Trust Chief Executives who have agreed to continue working in an aligned way. There is a Mental Health summit on 16th May and there will be encouragement for as many clinicians to attend as possible. The workforce plan has been submitted. There needs to be a Mental Health Delivery Plan on a Page, which has had an extension on the submission date until 26th March. The commissioners are meeting on 23rd March to input.

2.4.2 Paul Maubach referred members to Appendix 2, the Commissioner as One Services Summary and stated that there is still the need to identify which services should be delivered once and those four times to a common standard. Helen Hibbs confirmed that services highlighted in green have been agreed to be commissioned as one service, those in orange have not had a decision reached until more information is available, and those in red are to be commissioned separately but to a common standard. As there will be two providers, Steve Marshall is leading the work to review whether there can be a single Black Country contract. Tony Gallagher is doing the financial work around Learning Disabilities and Mental Health joint commissioning.

2.4.3 Helen Hibbs advised that the Transforming Care Programme (TCP) trajectory is going the wrong way as they have had admissions from those sectioned into Mental Health beds. The trajectory at the moment is 16 beds by April 2019 which is unlikely to be achievable as there are currently 14 patients where it seems it is unsafe to discharge. NHSE is unhappy with delivery of the programme. There was a recovery event on 16th March reviewing a model where the TCP model would move into an accountable care arrangement and the funding would come from each of the CCGs to the provider for the provider to do the commissioning. Providers had little notice and have little capacity and capability to the commissioning. The local authorities were not brought into this. There was a meeting with the Regional Board on 19th March. A refreshed plan for delivery is needed. Wolverhampton has had a marketing engagement event for providers who can provide in the community and have the expertise to see forensic patients. They were unhappy with the uptake reviews of patients with learning disabilities in the annual health check. This needs to have a recovery action plan. The community model needs to be put in place and the provider incentivised appropriately. There is a meeting occurring about finance and the contract, both issues requiring resolution.

2.4.4 Discussion followed regarding there being patients beyond the end date that cannot be discharged in a lawful way and the national lead for TCP is meeting Simon Stevens on the 22nd April. A letter will be written requesting changing the trajectory. Paul Maubach confirmed that the clinical model has been presented to Dudley as well as Wolverhampton and Sandwell and West Birmingham, and is going to Walsall in the next week or two. The clinical model cannot be signed off until the finances have been sorted via the TCP Finance Group. James Green confirmed there is no change in the finance commitments in the plans so far. Whilst the Funding Transfer Agreement process has been restarted this is not the case for new cases and other issues remain around proposed future funding arrangements.

2.4.5 Nick Harding emphasised the need to protect clinical safety versus managing the numbers as these are patients we are talking about, some of which are seriously ill with forensic problems, and suggested the potential of a letter of support from the JCC Chair and perhaps Ray James. TCP is challenging for commissioners and considering the legal framework it is not an easy task to predict how many patients will remain as inpatients at the end. Helen Hibbs informed that currently they are doing some internal clinical challenge. They are reviewing all patients that are unlikely to be discharged during the programme and delayed
discharges and they are looking at the legal framework. At the end of the next quarter, this may come back with a request for additional support.

2.5 Acute Contracts – 2018/19 Update, Risks & Opportunities

2.5.1 Matthew Hartland confirmed that the deadline for contracts being signed is 23rd March. Dudley Group will sign despite income at risk. Manor Hospital has been agreed. New Cross has had the heads of term agreed but not signed owing to a gap in Staffordshire which until reconciled the contract cannot be signed. There is a meeting on 23rd March but it is not sure if agreement will be reached. James Green stated that West Midlands Ambulance Service and the Black Country Partnership contracts have been agreed. Sandwell and West Birmingham will not be agreed.

2.5.2 Paul Maubach raised the issue of there being no Black Country acute narrative, setting out the vision for the future configuration of services that for example might address areas where there is overcapacity in the system or where there is inconsistent standard of provision. Nick Harding suggested the Independent Chair for the STP will need to consider this with the acute providers. Discussion followed regarding whether there were any services known to require change and whether this was for CLG to determine. Nick Harding stated that CLG would need data to evidence services requiring change, leading to wider discussion regarding data review of acute services to identify whether there are any issues that need addressing collectively. The CLG could review this and devise some solutions. There was discussion regarding TCT no longer proceeding and the sustainability of MH providers, data needed in relation to the priority areas already highlighted by CLG and former Black Country reviews to be taken into account. Helen Hibbs felt consideration was needed regarding whether some services cannot be done as four across the Black Country. In some of the clinical specialities there are not enough consultants to provide it for them. Paul Maubach suggested that by the end of quarter one, there needs to be a decision from the JCC as to what the acute agenda is. Matthew Hartland suggested a stocktake of the providers to review the performance and quality issues to see if there are consistencies to work on. Helen Hibbs suggested work around Urology.

2.5.3 Nick Harding raised the need for a refreshed clinical strategy and the concerns in relation to it being seen as another Black Country review. The suggestion was made that the former Black Country Review reports be revisited and a shared view of CCG commissioning issues that need to be addressed be confirmed. Angela Poulton stated that the this had been done as part of the work to enable the CLG to recommend to the JCC the priority areas for joint commissioning in September last year, the outcome of which had been the decision by AOs that this was the work of the STP. Prior work could be taken with additional data for consideration at a future JCC Executive Development session. Dr Ruth Tapparo noted that the work has been done and the CLG need an acute priority and a primary care priority with a subject to review. Helen Hibbs suggested one CCG leading on different areas. It was agreed that Angela Poulton would summarise previous work on identifying priorities, supporting performance data and include the CLG additional priorities.

**Action:** Angela Poulton to summarise previous work on identifying priorities including CLG priorities, providing supporting performance data.

2.6 Priority Programme Status

2.6.1 Angela Poulton referred members to the February Joint Executive Development session, at which there was consensus for the joint commissioning priority areas to be confirmed and a Programme Management Office (PMO) to support and drive delivery. Angela Poulton has worked with Mike Hastings and has taken adapted one of their PMO templates to create 6 joint commissioning Programme Briefs, and has provided a status summary that identifies
where there are Exec commissioning and also clinical leads, and the extent of organisation in relation to delivery teams and performance/governance frameworks. TCP and the Local Maternity Strategy organisation well developed, and Paul Tulley and Steven Marshall are driving the work to progress arrangements and delivery in relation to Cancer and Mental Health.

2.6.2 Angela Poulton asked whether members could confirm the areas where a Brief has been produced could be considered the joint commissioning priorities so that how performance is monitored going forwards can be developed. There are a number of options for creating the PMO which needs to be considered in the context of STP organisation currently being established. Members were reminded that the Exec teams wanted joint commissioning priorities to be clarified, and where there are gaps in clinical or managerial leadership these need to be filled. Commissioning for the Black Country is still considered an ‘add-on’ resulting to current conversations raising capacity to deliver joint commissioning work programmes in terms of Exec time and people resources. Helen Hibbs agreed the list of priorities and suggested there were some that would come under Elective Care. Angela Poulton noted that the priorities for which Briefs had been prepared do not currently include the CLG priorities, Respiratory and Hypertension. Nick Harding suggested that work by CLG to produce the refreshed clinical strategy should inform which workstreams needed to be in place, and that works needs to be done first. In turn, this would identify people that need to be appointed to do the work. The JCC can then identify if someone is already in place. Paul Maubach raised the issue that the CCGs have still not agreed how to share resources to enable joint commissioning and that this is needed.

**Action: Nick Harding to present the refreshed Clinical Strategy at a future meeting to inform joint commissioning priorities and related workstream organisation decision making.**

3. **DECISIONS REQUIRED**

3.1 **Personalised Care Demonstrator site Memorandum of Understanding**

3.1.1 Laura Broster informed members that the bid opportunity had been discussed at the Clinical Leadership Group meeting. Dudley CCG and NHSE have been actively working on social prescribing, patient activation measures and health coaching, and on the back of this NHSE had approached Dudley with a view to the Black Country submitting a bid to be a demonstrator site for personalised care. The ‘ask’ are outlined in the paper including 2% of the population of Dudley benefitting from personalised care and 1% of the rest of the Black Country. There were key targets broken down that should be achievable. The main areas of risk are the ways the money will flow, such as 70% will be upfront and 30% to follow mid-year on achievement of trajectory against these targets. This can result in a risk of non-achievement of around £90,000. The main risk is around Personal Health Budgets (PHBs). Currently the planning guidance states that the Black Country needs to achieve between 1-2% of the population benefiting by March 2021. Currently, this is significantly lower and is well behind trajectory. NHSE has agreed a target of the number of PHBs in the Black Country to 900 by end of March 2019 as part of the bid. There was a teleconference with PHB leads who continue to highlight a risk regarding attainment of the 900 by this time.

3.1.2 Recommendations include that the action plan needs more work but excepting the PHB target issue, the others should be achievable. Feedback regarding the action plan was welcomed, and it needs to be signed off by the STP lead and a local authority lead. There needs to be a co-ordinated Commissioner lead across the Black Country and that person needs to be identified. NHSE has agreed to an extension to sign up to this until the end of April 2018 whilst discussions continue in relation agreeing an achievable PHB target. There is currently no STP lead for personalised care. Paul Maubach suggested that the definition
of PHB would need to be changed to have public acceptance. Laura Broster has organised a meeting with Joe Fraser and PHB leads on 11th April. Matthew Hartland suggested if there is a coding issue that this should be sorted first.

3.1.3 Health coaching is part of the action plan. There will be £100,000 to invest into Primary Care to allow resource to train and develop health coaches. Lion Health has agreed to release their health coach for two days per week to spread the learning. A decision was given that this would be used across the Black Country and there would be a signature towards the MOU. Paul Maubach suggested getting the local authority signature from Dudley as the governance will be hosted in Dudley.

3.2 Black Country Joint Policies of Limited Clinical Value (POLCV)

3.2.1 Angela Poulton reminded members that it had been agreed at the February meeting that there should be a joint approach to developing a POLCV for subacromial decompression. It had been identified that this opportunity had been identified by BSOL, leading to a teleconference with Paul Tulley and Neil Walker to discuss the Black Country joining BSOL in their work to develop POLCVs for this procedure in addition to two other image guided arthroscopic joint procedures. The evidence review work costs could be shared, and enhance the process given its independent and thorough basis. All four CCGs have agreed to participate in the joint process and contribute their share of costs which is in the region of £7K each.

3.2.3 Dr Ruth Tapparo questioned whether there were many differences between the CCGs in regards to policies. Angela Poulton confirmed the need to know this had been identified, and how to undertake this comparison was being actively explored with potential CSU support via the Joint Policy Group led by Sharon Sidhu.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 Update reports were provided.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 None.

6. DATE OF NEXT MEETING –

Thursday 10th May, 10:00-13:00, CCG Main Meeting Room, Wolverhampton CCG, Wolverhampton Science Park, Glaisher Drive, WV10 9RU.
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<tr>
<th>No.</th>
<th>Date</th>
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<tbody>
<tr>
<td>070</td>
<td>10th Jan 2018</td>
<td>Angela Poulton to circulate the revised wording in relation to 1.2.6c to Governance leads and Chief Financial Officers to ensure consistency of agreement by all CCG Governing Bodies</td>
<td>Angela Poulton</td>
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<td>071</td>
<td>10th Jan 2018</td>
<td>Paul Maubach, Andy Williams and Helen Hibbs to meet to explore the appointment process to STP Clinical Lead roles before the February JCC.</td>
<td>Paul Maubach</td>
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<td>072</td>
<td>10th Jan 2018</td>
<td>Risk registers be reviewed by the joint governance forum with a view to identifying the commonalities between the four CCG registers for report back to a future JCC meeting.</td>
<td>Jim Oatridge</td>
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<td>075</td>
<td>10th Jan 2018</td>
<td>James Green and Matthew Hartland to develop a plan on how to undertake the necessary diligence to support the Black Country STP becoming an ICS in the future, for report back at the July JCC meeting.</td>
<td>James Green and Matthew Hartland</td>
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<td>076</td>
<td>10th Jan 2018</td>
<td>Simon Collings to provide the finance and activity data for Specialised Services provided for Black Country registered patients at future JCC meetings.</td>
<td>Simon Collings</td>
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<td>084</td>
<td>15th Feb 2018</td>
<td>Paul Maubach to lead the work to assess current work undertaken by CCG primary care staff and identify how to create capacity for primary care workforce planning.</td>
<td>Paul Maubach</td>
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<td>088</td>
<td>22nd Mar 2018</td>
<td>Angela Poulton to seek access the NCDR information with a view to presenting the Black Country Specialised Services activity and spend profile at the next JCC meeting.</td>
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<td>Andy Williams/ Helen Hibbs/ Paul Maubach</td>
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<td>Angela Poulton</td>
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<tr>
<td>097</td>
<td>22\textsuperscript{nd} Mar 2018</td>
<td>Nick Harding to present the refreshed Clinical Strategy at a future meeting to inform joint commissioning priorities and related workstream organisation decision making.</td>
<td>Nick Harding</td>
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</tbody>
</table>
Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 10th May 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Dr David Hegarty – Chairman, Dudley CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG’s
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Angela Poulton - Programme Director – Joint Commissioning Committee
Peter Price – Lay Member, Wolverhampton CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG

In Attendance:
Charlotte Harris – Note Taker, NHS England
Helen Cook – Communications and Engagement, Wolverhampton CCG
John Deffenbaugh – Director of Frontline (coach to Chair)

Apologies:
Prof. Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Ruth Tapparo – GP/Board Member, Dudley CCG
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. None were given.

1.4 The minutes of the meeting held on the 28th March were agreed as an accurate record of the meeting.

1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 Action 072, Jim Oatridge confirmed that this is still in progress.

1.7 Actions 076/88, Angela Poulton stated that data was included in the papers but not sourced from NCDR. Simon Collings was unable to attend the meeting.
1.8 Action 084, Paul Maubach confirmed that it had been agreed that capacity was needed to progress GPVF workforce plan, and that a revised proposal requiring £26,000 investment per CCG was being consider. This item to be discussed further under agenda item 3.1.

1.9 Action 091, for discussion at the next Clinical Leadership Group Meeting scheduled for the 24th May.

1.10 Action 093, all CCGs shared their place-based journeys and aspirations at the JCC Executive Visioning Session on 1st May so this standing agenda item will commence from June.

1.11 It was agreed to merge actions 095, 096 and 097 into one action as it involves the work around Clinical Strategy.

2. CORE BUSINESS

2.1 The Place Based Commissioning update was deferred to the June JCC meeting.

2.2 Clinical Leadership Group Update

2.2.1 Dr Anand Rischie referred members to the paper Addressing Clinical Priorities across the Black Country System, setting out the approach to developing the Black Country Clinical Strategy that was approved by CLG when it met on 26th April 2018. The CLG also received a comprehensive presentation on Frailty that highlighted good practice across the system and generated discussion about the opportunities to transfer learning to improve care and reduce variation across organisations. It was agreed to establish a Frailty Working Group for this purpose, supported by the Right Care team. There are other working groups for Hypertension and Respiratory already established. The need for finance representatives to be involved in the working groups at the right time was agreed.

Action: Angela Poulton to connect the CLG working group leads with Matt Hartland/James Green.

2.2.2 Paula Furnival discussed the gaps to be addressed, including the three main interfaces Learning Disabilities, Mental Health and Frailty, and identified the opportunity to bring local authorities into discussions about commissioning intentions and delivery this is currently only the case for the Transforming Care Programme.

Action: Local Authority representatives to be invited to the Clinical Leadership Group meetings.

2.2.3 Paul Maubach asked how the acute sustainability review work will feed into the development of the clinical strategy and how the collaborative Mental Health commissioning will be reflected. Provider processes to review the sustainability of their services may identify a few areas which need more dialogue across the system. There is a need for a review of what the Trusts are doing and the timetables they are working towards. For Mental Health, there is a workshop for the two Trusts on 16th May 2018 and it was questioned how this would work into the priorities and Clinical Strategy. Angela Poulton noted that the work will confirm what is already in the system and identify gaps. Dr Helen Hibbs stated that Richard Beeken is leading the Acute Sustainability Review across the four trusts which must be completed by 31st August 2018. The clinical strategy needs to be agreed by 30th September 2018. The clinical strategy and sustainability review are equally important and will work together.

Action: Angela Poulton to ensure the findings of the acute sustainability review are fed into the final clinical strategy.
2.2.4 Dr Anand Rischie noted the attendance at the CLG is good but acute Trust representation remains low. Dr David Hegarty suggested this was the link through to sustainability reviews, and raised the importance of gaining better clarity regarding NHSE expectations of the Clinical Strategy. It was suggested that this might be discussed at the next CLG. There needs to be networking across all clinical strategy development across the West Midlands to ensure they are all aligned regarding their approach and structure, and involving NHS England on route. There is recognition for a need to include a children and young person strategy with Mental Health and interaction with Social Care and the Third Sector.

Action: Dr David Hegarty to review whether there is a forum where the Chairs of the Clinical Leadership Groups meet.

2.2.6 Matthew Hartland noted that the list was long and suggested this needed to be a smaller to ensure focus and delivery. Regarding the working groups There is a need to understand the Terms of Reference for the groups and making sure they are aligned to other items of work. The Estate Strategy and Capitals Bid are both being worked on and these need to be aligned with the Clinical Strategy.

2.2.7 It was confirmed the wider determinants of health, such as housing, will be on the place based agenda. Dr David Hegarty confirmed there was a paper on the wider determinants of health which reviewed the health and financial opportunities. This has already been to some health and well-being boards. There was a real recognition at the CLG that this was important.

Actions:
- Prof. Nick Harding as Chair of the Clinical Leadership Group to write to all Trusts requesting representation at meetings.
- Dr Anand Rischie to discuss with Prof Nick Harding how to engage Local Authority colleagues in the work of the Clinical Leadership Group, including the working groups, before the next JCC meeting.

2.3 Collective Responsibilities

2.3.1 Dr Anand Rischie discussed the importance of the Committee needing to identify services and activities for which the 4 CCGs have collective responsibility. The work being undertaken via the CLG will help to inform this. Dr Helen Hibbs referred members to the work that is just starting to provide NHSE with the Black Country roadmap to strategic commissioning which is required by 21st May. An Executive lead from each CCG will be identified to work on developing the roadmap.

2.3.2 It was noted that Prof. Nick Harding had mentioned at the CLG and JCC that by having representation of the four systems they will need to sign up to have collective responsibility. Each system will work on place based care and with their local authority. There needs to be collective responsibility on the system and system plus levels. There are similarities in how the systems are working but they are commissioning differently, and opportunities to commission together need to be identified. It was suggested there needs to be a statement of commitment to have collective responsibility. Mike Abel noted that it is an important aspect but can be difficult to put into practice. There are examples of collective working not being done or not working well. There is a need to come together to accept collective responsibility and working.

2.3.3 Andy Williams referred members to the need for relationships between NHSE and the STP leadership to establish, the place-based work that is progressing and suggested the need for the nature of strategic commissioning to be more clearly defined. There are some cases
where provider and commissioner intentions are slightly out of phase. There needs to be a review of what the nature of strategic commissioning is and there is uncertainty on how to embrace it. If strategic commissioning is about working the traditional way but at a larger footprint this may not work, and there may be the need to start commissioning in a different way. The outcomes and resource for each programme need to be defined. Dr Helen Hibbs agreed this will not make things better the health economy or change the health for patients if a change is not made. The ICS Development has Strategic Commissioning as an important element. This should be agreed in a multitude of forums until it is sorted. The suggestion was made to ask whether the roadmap to strategic commissioning should be a CLG agenda item.

**Actions:**

Angela Poulton to speak to Prof. Nick Harding regarding adding Strategic Commissioning as a CLG agenda item.  
The AO’s to discuss and agree a clearer definition of strategic commissioning

### 2.4 Programme Performance

#### 2.4.1 Angela Poulton presented the STP reports on performance of the priority areas produced by the NHSE STP programme office. There are areas where all STPs within the West Midlands that are not performing, namely A&E. The Black Country is doing better for many of the performance standards than other STPs. It was confirmed the Accountable Officers regularly see this information. It was agreed it was a pragmatic way of having performance information at the JCC at this time. Dr Helen Hibbs noted that the Performance Leads across the STP were currently meeting and discussing ways to get information to the JCC and across the patch. They are aware of the information but there needs to be a discussion on what is being done to address it. An automated way of getting the information would be beneficial. The performance of Cancer is an issue for Royal Wolverhampton Trust. They recently met with NHS England and NHS Improvement and are working to be on a recovery trajectory by 2019.

#### 2.4.2 Andy Williams noted that the STP is being judged in two ways; performance, which we are doing well overall, and how the system works collectively. There are opportunities to work together to improve this perception and make an impact on some areas that are not performing well. It was questioned whether the performance reports can reflect on style and way the STP is working collectively.

#### 2.4.3 Dr Helen Hibbs gave an update on the Transforming Care Programme. They have failed their trajectory as previously reported. There has been a revision of the governance structure as NHS England requested. Dr Helen Hibbs will chair the TCP Board and NHS England has put a temporary Programme Manager and small team in to support the Programme. The Black Country has a lot of long stay in-patients which will not be discharged in time which means they are likely to fail next year. Discussions with Ray James and upwards communications did no lead to Simon Stevens agreeing to revise the trajectories or life of the Programme. The recovery plan has been submitted, included in the papers. There has been internal scrutiny of the cases outstanding and external scrutiny reviews are being undertaken by national professionals from NHS England next week. The Clinical Pathway Group is meeting more often. There is ongoing work with Black Country Provider Foundation Trust.

#### 2.4.4 Matthew Hartland gave an update on the financial implications. The budget for CCGs is £21.7 million. This is for the cost of the beds and the community model. There has been risk identified following the implementation of the revised FTA process. There will also be a risk around the new model for the NHS and the local councils. The risk that has been identified in
total is £4.4 million. This is half for the NHS and half for the councils, the NHS element currently not budgeted for. The costing for the beds model is nearly complete with the pricing being agreed. Budgets have been identified for the community model. The Black Country delivery model has not concluded. The FTA process states the funding does not follow the patient but the net increase or reduction will go down to the Black Country so there is a net position. The Finance Group are working to see the best way to proportion the risk down for each CCG.

2.4.5 Paul Maubach suggested an external group doing a risk assessment with confirmation of the potential of moving patients and the time it will take can be reflected to NHS England, and may be helpful. Dr Helen Hibbs agreed, and shared that there is potentially more that can be done, for example with forensic patients being in the community. It needs to be crystal clear that everything that can be done has been attempted.

2.4.6 Paula Furnival informed members that there has been no change in situation for local authorities; TCP nationally and regionally has been based on the funding following the patient. The National Funding Agreement has not been published yet but it is expected that this will affirm this. Ray James is seeking to have the funding follow the patients appropriately. Angela Poulton raised that she had been contacted by Rita Symons to discuss the governance arrangements around TCP. The only thing that has been delegated to the JCC is the transitional funding and the oversight, with every other aspect including the community model requiring approval by each of the four CCG Governing Bodies. Dr Helen Hibbs noted that to be fully delegated to the JCC, TCP requires sign off from governing bodies. NHS England is requesting one commissioner for this programme, and the Accountable Officers will discuss this further outside the meeting. TCP will remain a standing agenda item.

Action: The Accountable Officers to discuss governance arrangements for TCP.

2.5 Specialised Services

2.5.1 Angela Poulton informed she was unable to get the information from the National Commissioning Data Repository and that work is ongoing with Midlands and Lancashire CSU and Arden and GEM CSU to access the database. The information included in the papers has been sourced from Secondary Uses Data, and is unlikely to be accurate as it has not been subject to the level of validation Specialised Services commissioners undertake for their reporting. Paul Maubach remarked that the information will be understated and noted that the information as presented does give spend to budget details, comparison of activity/spend to other STPs or highlight any contract performance issues. It is important to make progress on the specialised commissioning element due to the flows of patients and the development of services within the Black Country. This should sit alongside the future of strategic commissioning.

2.5.2 Matthew Hartland noted that there is uncertainty on the budget, what the contract spending is and if there is overspending or under. Paul Maubach informed Toby Lewis has raised concerns over lack of progress over specialised commissioning. NHS England has replied with a request for what the Black Country would like. This will need to be a formal request back to NHS England. James Green noted in proportion terms it is showing a lot less than half.

Action: Dr Helen Hibbs to arrange a meeting with Rachel O’Connor to discuss Specialised Services.

2.6 STP and ICS Update
2.6.1 Thanks were given to Andy Williams for all his work leading the Black Country STP, recognised to have been a challenging task. Dr Helen Hibbs has agreed to take over as the STP Lead. There are interviews for the Independent Chair occurring next week. There has been discussion regarding an interim Portfolio Director that may not be full time. The letter from the STP Stocktake meeting noted there are key areas for focus including a plan to develop a Strategic Commissioning Structure and Roadmap by the 31st May 2018, a draft Clinical Strategy by the 28th June 2018 with full completion by 30th September 2018, completion of the Acute Sustainability Reviews finalised by the 31st August 2018, engagement with regards to Specialised Commissioning, the JCC Commissioning Intentions for 2019/20 by the 30th September 2018, non-executive collaborative engagement and NHS leaders continuing their joint working. There is a Mental Health Summit occurring next week which will help with the commissioning intentions. Julie Jasper enquired about the penal regime for non-delivery to which Dr Helen Hibbs confirmed her confidence that the requirements would be met.

2.6.2 Dr David Hegarty noted that there are systems being held up as examples but are also described as not functioning well. Dr Helen Hibbs informed there have been a lot of changes happening in NHS England and NHS Improvement leading to a lot of reorganisation. Dr David Hegarty noted how the STP works together is something that needs work on. Jim Oatridge noted there has been a focus on failure. There needs to be a focus on achievements. Dr Anand Rischie referred to previous conversations around sorting the acute agenda to help the image of collaboration. Dr Helen Hibbs suggested that hard commissioning works for a while but there needs to be work done on relationships too.

2.6.3 Dr Helen Hibbs referred to the ICS Development presentation and how strategic commissioning is important. This had been discussed at the Visioning Session on 1st May 2018. The presentation was adapted from the Coventry and Warwickshire STP. It is an overview of the current thoughts around strategic commissioning. It was suggested that the Black Country STP would need to review the areas shown regarding aligning commissioning functions and what would fall under tactical and strategic commissioning for the Black Country. There was a discussion on place based commissioning and if was agreed that it will sit within the ICS system but this is for each local system to decide. Dr Helen Hibbs informed that Wolverhampton has not agreed whether CCG functions will sit with the acute trusts or within the local authority. There is a clear direction of travel that some tactical functions will need to sit in the place based.

2.7 The Risk Register was deferred to the June JCC meeting.

3. DECISIONS REQUIRED

3.1 Strategic Commissioning Roadmap and Proposal Project Support Arrangements for Joint Commissioning

3.1.1 This is an NHSE requirement, identified in the stocktake letter. The three Accountable Officers will nominate an Executive from within the 4 teams to be part of the Task and Finish Group to do the work, reviewing both strategic and tactical functions. There was a discussion about the need for more resources to support the STP and JCC. This includes the proposed Project Support Office (PSO) and extends to staff to deliver the GPFV workforce plan. Matthew Hartland advised that CCGs are all at running cost thresholds and there will need to be some internal review to identify funding for any additional posts. Paul Maubach noted this is a necessary requirement to keep on top of things as areas of work with stall. Funding for the Portfolio Director will come from the STP but this is non-recurrent. There will need to be work on future strategic commissioning and how this will be resources.
3.1.2 The combined cost to each CCG for the PSO and GPFV will be £57,000. Wolverhampton will be the host for the PMO. The Task and Finish Group will be reporting back at the end of June. Andy Williams noted there are fundamental questions that need addressing by the Accountable Officers regarding Strategic Commissioning. He questioned how far the remit of Strategic Commissioning goes and what the correct scale is. There needs to be a look at what the open conversation with partners is to look like. There needs to be wider conversations with local government and NHS partners. Dr Helen Hibbs suggested there was no blueprint on how to do this and so they are doing this in stages. They will need to hold the provider alliance to account in regards to quality. There is a new Regional structure which includes the West and East Midlands. It was agreed that this would be a way forward and it was approved.

**Action:** The AO’s to discuss and agree a clearer definition of strategic commissioning.

3.1.3 Paula Furnival informed that local authorities would welcome being part of the discussion. The Mental Health commission involves a prevention and community model, the focus being to minimise clinical intervention requirements through building community assets and resilience to enable quick recovery.

3.1.4 It was confirmed that Mike Hastings, Stephanie Cartwright and Paul Tulley have been nominated for the Task and Finish Group. Andy Williams will appoint the representative from Sandwell and West Birmingham.

3.2 **Personalised Care Demonstrator Site Bid**

3.2.1 Angela Poulton reported that since the last JCC she had been involved in discussion between Joe Fraser and Personal Health Budget (PHB) leads to agree the revised targets, and it has become apparent that there are more PHBs than are currently reported. Owing to the later start date, the funding has been reduced by £50,000 to £250,000 and the spending plan revised accordingly.

3.2.2 There was a discussion about the need for a Black Country Personalised Care lead to be identified as Laura Broster is Director of Communications and will not have capacity moving forward to deliver this remit. Angela Poulton reported that despite requests to all four CCGs, a lead has not been found. Matt Hartland added that backfill was available for the Personalised Care lead. The assumption is that the work will be handed to the STP Portfolio Director should a lead not be identified who can interface with NHS England, which was not supported.

**Action:** The Accountable Officers to identify a Black Country commissioning lead for Personalised Care.

3.2.3 The JCC were asked whether there should be a continuation of the bid in light of the revised PHB targets and spending plan. Signatures are required from Dr Helen Hibbs (STP), Paul Maubach (CCG) and Paula Furnival (Local Authority). Paula Furnival stated that she requires the support of the other Local Authority Directors of Adult Social Care to enable her to act as signatory. Paula Furnival shared that there are existing cohorts of individuals who have combined health and social care funding that meet the requirements for PHBs, and there needs to be a conversation on who is to leads from the local authorities. Angela Poulton to follow up outside the meeting.

**Action:** Angela Poulton to discuss Local Authority lead sign off for the Personalised Care Demonstrator Site with Paula Furnival.
3.2.3 Paul Maubach noted there is a risk of not receiving all the funding should targets not be met but the spending profiled holding it back which reduces the risk. Angela Poulton noted that there is a better understanding of PHBs and the Committee agreed to continue with the bid submission. James Green noted there needs to be a joint approach for PHBs and it was agreed there needs to be PHB lead to oversee. It was suggested there needs to be review of the financial risk of the change in activity. Paula Furnival informed there could be shared learning gained from local authorities regarding managing risks and budgets.

4. **SUBGROUPS UPDATE (CONSENT AGENDA)**

4.1 CCG Collaboration – BC Decommissioning Policy

4.1.1 Angela Poulton presented the *Decommissioning and Disinvestment Policy*. There is a later version. It is a work in progress. Mike Abel requested that when the final policy is presented to this Committee it needs to be accompanied by a document that sets out the differences between the joint policy and the existing approved CCG policies and confirmation that each CCG has agreed the content proposed. Angela Poulton confirmed the process being followed and the CCG representatives working with her on the policy development, and agreed to these requirements. The joint policy will be overarching and allow for each CCG’s local processes to be applied. The ambition is to achieve sign off by end of July, ensuring due approval process.

4.1.2 There were no other sub-group reports. Angela Poulton noted that some groups were suspended, such as the Systems Design and Contractual Frameworks group that will be recommence in July. The joint Finance work largely occurs via the STP and operational joint forums and it was agreed that updates will be provided as needed.

5. **SUMMARY OF ACTIONS AND ANY OTHER BUSINESS**

5.1 ICS Development Programme – 12/07/2018

5.1.1 There was request from Helen Black for the JCC meeting in July to be used for the ICS Development Programme. Dr Helen Hibbs noted that the JCC meeting should not be used but there may be the option to allow the ICS Development Programme session to take place immediately before/after the meeting. This will be worked out at the meeting with PWC taking place tomorrow.

5.2 It was agreed that due to many members not being available for the 14th June scheduled meeting, the JCC meeting for June would be moved to the same date as the JCC Executive Away Day on 21st June.

6. **DATE OF NEXT MEETING**

Thursday 21st June, 09:30-11:00, Venue to be confirmed.
## JCC Action Log

<table>
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<tbody>
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<td>Risk registers be reviewed by the joint governance forum with a view to identifying the commonalities between the four CCG registers for report back to a future JCC meeting.</td>
<td>Jim Oatridge</td>
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<td>075</td>
<td>10th Jan 2018</td>
<td>James Green and Matthew Hartland to develop a plan on how to undertake the necessary diligence to support the Black Country STP becoming an ICS in the future, for report back at the July JCC meeting.</td>
<td>James Green and Matthew Hartland</td>
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<td>Simon Collings to provide the finance and activity data for Specialised Services provided for Black Country registered patients at future JCC meetings.</td>
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<td>084</td>
<td>15th Feb 2018</td>
<td>Paul Maubach to lead the work to assess current work undertaken by CCG primary care staff and identify how to create capacity for primary care workforce planning.</td>
<td>Paul Maubach</td>
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<td>Angela Poulton to seek access the NCDR information with a view to presenting the Black Country Specialised Services activity and spend profile at the next JCC meeting.</td>
<td>Angela Poulton</td>
<td>05/06 Still no access – will chase</td>
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<tr>
<td>102</td>
<td>10th Apr 2018</td>
<td>Angela Poulton to speak to Prof. Nick Harding regarding adding Strategic Commissioning as a CLG agenda item.</td>
<td>Angela Poulton</td>
<td>05/06 To be completed</td>
</tr>
<tr>
<td>103</td>
<td>10th Apr 2018</td>
<td>The AO's to discuss and agree a clearer definition of strategic commissioning.</td>
<td>Andy Williams/Helen Hibbs/Paul Maubach</td>
<td>04/06 This work is being done through the ICS development programme.</td>
</tr>
<tr>
<td>104</td>
<td>10th Apr 2018</td>
<td>The Accountable Officers to discuss governance arrangements for TCP.</td>
<td>Andy Williams/Helen Hibbs/Paul Maubach</td>
<td>04/06 Ongoing discussions through TCP Programme</td>
</tr>
<tr>
<td>105</td>
<td>10th Apr 2018</td>
<td>Dr Helen Hibbs to arrange a meeting with Rachel O’Connor to discuss Specialised Services.</td>
<td>Helen Hibbs</td>
<td>04/06 Contact made being made with Rachel O’Connor. Meeting being arranged with Simon Collings ASAP.</td>
</tr>
<tr>
<td>106</td>
<td>10th Apr 2018</td>
<td>The Accountable Officers to have a discussion regarding the Strategic Commissioner.</td>
<td>Andy Williams/Helen Hibbs/Paul Maubach</td>
<td>04/06 This work is being done through the ICS development programme. Amalgamate with 104.</td>
</tr>
<tr>
<td>107</td>
<td>10th Apr 2018</td>
<td>The Accountable Officers to identify a Black Country commissioning lead for Personalised Care.</td>
<td>Andy Williams/Helen Hibbs/Paul Maubach</td>
<td>08/06 Paul Maubach has advised that Dudley will lead on this.</td>
</tr>
<tr>
<td>108</td>
<td>10th Apr 2018</td>
<td>Angela Poulton to discuss Local Authority lead sign off for the Personalised Care Demonstrator Site with Paula Furnival.</td>
<td>Angela Poulton</td>
<td>05/06 In process of being signed off – need to be signed separately</td>
</tr>
</tbody>
</table>
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 12 July 2018  
**Report:** Quality & Safety Committee Report  
**Agenda item No:** 7.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Quality &amp; Safety Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To provide on-going assurance to the Governing Body regarding Quality and Safety in accordance with the CCG’s statutory duties.</td>
</tr>
</tbody>
</table>
| AUTHOR(s) OF REPORT: | Mrs Caroline Brunt, Chief Nurse  
Ms Marcia Minott, Head of Quality & Safety |
| MANAGEMENT LEAD: | Mrs Caroline Brunt, Chief Nurse |
| CLINICAL LEAD: | Dr Ruth Edwards, Clinical Executive Lead for Quality |

## KEY POINTS:

**Dudley Group NHS Foundation Trust (DGFT)**
- Oversight & Assurance process post Care Quality Commissioning (CQC) inspections
- Cancer Waiting times
- Maternity Performance Assurance Group (MPAG)
- Serious Incident Management and KPI’s update

**Dudley Walsall Mental Health Trust (D&WMT)**
- NHSI Closing the Gap Collaborative (Physical Health)
- Joint Dudley and Walsall CCG CQRM

**Black Country Partnership Foundation Trust (BCPFT)**

Malling Health

Primary Care
- Care Quality Commission (CQC) update (Appendix 1)

Infection Prevention & Control (IPC)

Black Country Local Maternity Systems (LMS)

Transforming Care programme (TCP)

End of year Assurance NHSE

Risk Register Review

CQUINS
<table>
<thead>
<tr>
<th>RECOMMENDATION:</th>
<th>1) Accept this report as a source of ongoing assurance that the CCG Quality &amp; Safety Committee continues to maintain rigorous oversight of all clinical quality standards in line with the CCG’s statutory duties.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINANCIAL IMPLICATIONS:</td>
<td>None to report</td>
</tr>
<tr>
<td>WHAT ENGAGEMENT HAS TAKEN PLACE:</td>
<td>User experience is an essential component of quality assurance and surveillance and as such public views and feedback form part of the triangulation of hard and soft intelligence.</td>
</tr>
</tbody>
</table>
| ACTION REQUIRED: | Decision  
Approval  
✔ Assurance |
1. INTRODUCTION

1.1 The CCG Quality & Safety Committee meets bi-monthly and was chaired on 19 June 2018 by Dr Ruth Edwards, Clinical Executive for Quality & Safety. This report is a material summation of the Committee’s meeting and contains relevant details of activity being carried out by the Quality and Safety team. The report also contains information on key activities and issues identified since the last meeting was held.

1.2 The Governing Body will be briefed on any contemporaneous matters of consequence arising after submission of this report at its meeting.

2. KEY ISSUES DISCUSSED

2.1 Dudley Group NHS Foundation Trust (DGFT)

2.1.1 Care Quality Commission Inspection - Oversight and Assurance process

The CQC Requires Improvement rating with an Inadequate Rating in the Emergency Department (ED) DGFT was applied following the unannounced core service inspection of Urgent Care Services on 5 & 6 December 2017.

Another unannounced core service inspection of Urgent Care Services took place on 11 January 2018 and a further review of Emergency Department records was undertaken during the announced well led inspection on 16, 17 and 18 January 2018. Following this inspection the CQC was not assured that patients were receiving safe care and therefore imposed further conditions relating to initial and clinical assessment on DGFT registration on 5 February 2018. A further unannounced core service inspection of Urgent Care Services took place on 15 March 2018 and most recently, on 28 June 2018, a team undertook an unannounced focused inspection of the Emergency Department at Russells Hall Hospital.

During these inspections themes have been evident within the Emergency Department: failures in management of sepsis and the deteriorating patient alongside concerns relating to triage and initial clinical assessment.

Over the months since the initial inspection an Oversight and Scrutiny Group has been meeting monthly with representatives from the CQC, NHSI, NHSE and Dudley CCG. Scrutiny has been applied to the achievement of planned actions. In addition there has been additional scrutiny applied through the regional Quality and Surveillance Group (QSG).

Alongside the local Oversight and Scrutiny Group, joint local assurance visits have been agreed with the most recent on 4 June 2018. Following this visit an additional QSG escalation call was held to discuss the findings. This visit offered regulators and commissioners evidence that there had been improvements in care. However further immediate assurances were requested from the Trust in relation to the deteriorating patient which was deemed to be satisfactory by NHSI and following the call, issues associated with patient identification and access to clinical records and documentation given the recent IT upgrade were highlighted as requiring further assurance. During this call the CCG was asked to provide information regarding DGFT reported Serious Incidents (Sis) and relevant information was shared with the CQC.

In addition to joint assurance processes, the CCG has ensured ED has been an agenda item on the DGFT CQRM and the areas of concern have been discussed in governance forums including a series of local quality visits focused on clinical pathways aligned with the areas of CQC findings. Further assurance has been requested from the Trust via CQRM discussion including workforce information – this is currently awaited.
The CCG has also provided support to the DGFT staff e.g. immediate paediatric safeguarding audits and revised governance arrangements in relation to ED have been implemented through the newly restructured Urgent Care Operational Group Chaired by the CCG.

2.1.2 Cancer Waiting times

The Quality and Safety team are seeking additional assurance from the Trust regarding cancer waiting times which have been performing below national targets. At the June CQRM the Trust gave a commitment to focusing on improving their position.

The cancer 2 week wait (urgent cancer referrals) performance had been below target previously but has recently shown improvement with May at 96% against a target of 93%. The Trust continue to be non-compliant with the 62 day overall target although there has been an improvement in May to 84% (previously 80.9%) against a target of 85%.

Onward referrals to tertiary cancer centres within 38 days remains a challenge; reports have been received from Cancer Alliance reviews at both UHB & Royal Wolverhampton which have recommended some areas for improvement and progress on these actions will be monitored via CQRM.

A Contract Performance Notice is to be issued against local quality indicators with regards to 62 day and onward referrals which will require a Remedial Action Plan to be agreed with the CCG to identify how performance will be brought back on track.

2.1.3 Maternity Performance Assurance Group (MPAG)

The MPAG now demonstrates improved engagement. Representation is more consistent and at a senior level. Discussions within the meetings are positive and focused on improving services for mothers, babies and their families.

A maternity audit lead is confirmed as now in place and audit reports have shown significant improvement in their quality with clear recommendations and these are being monitoring through MPAG.

The quality dashboard has evolved and now includes narrative to support the data.

External reviews are underway on five maternity Serious Incidents (SIs) and a sixth is planned. The external reviewer, who was involved in the review of cases during the Maternity Quality Improvement Board, reflected on the improved standard and depth of analysis of the RCA reports which demonstrated the significant efforts they had made in this area with genuine multi-disciplinary involvement evidenced within the reports.

2.1.4 Serious Incident (SI) Key Performance Indicators (KPIs)

The Quality & Safety Committee monitors the quality of SI Root Cause Analysis (RCA) investigations through a number of KPIs agreed with the Trust. Achievement against the agreed KPIs remains a challenge with on average less than 50% of RCAs currently being closed on first CCG review. This raises concern regarding the quality of the investigation as well as creating a significant resource challenge to the Q&S team who have to repeatedly review RCAs.

The Trust are taking steps to address this, not least with the recent recruitment to several new posts which will provide a governance team resource dedicated to each of the three divisions (Medicine, Surgery & Support Services). Monitoring of the KPIs continues both via CQRM and through monthly meetings between the CCG Q&S team and the DGFT Director of Governance.
2.2 **Dudley & Walsall Mental Health Trust (D&WMHT)**

The Trust have joined the NHSI Closing the Gap Collaborative (Physical Health) which was launched in June 2018. This is a collaborative agreement (CA) between NHSI and the Trust to work in partnership to improve patient care & staff experience through a structured programme utilizing quality improvement theory and methodology.

2.2.1 **Dudley and Walsall CCG’s planned Joint CQRM**

Dudley CCG continues to work collaboratively with Walsall CCG. Discussions have taken place with Walsall CCG to join up the assurance processes from September 2018 within CQRMs. This will streamline assurance regarding clinical and quality issues and build on the work already progressed to jointly monitor SI management systems.

2.3 **Black Country Partnership NHS Foundation Trust (BCPFT)**

The Director of Nursing BCPFT and the Dudley CCG Chief Nurse continue to have monthly calls to discuss any relevant issues with a particular focus on the Transforming Care Programme related issues.

2.4 **Malling Health**

The CCG is aware of a number of senior staff having left or are in the process of leaving the organisation, albeit not necessarily from the local management team. Discussions are underway to gain assurance that this will have no adverse impact on the service provided by Malling with regards to the Urgent Treatment Centre.

2.5 **Primary Care**

An updated summary of CQC Primary Care inspections is provided in Appendix 1.

One CQC report has been published since the last meeting.

The Primary Care Assurance Tool (PCAT) data analysis is undertaken monthly to identify where practices may benefit from additional support; one practice was identified during this reporting period.

Following a limited roll-out to seven practices, over the next few months all practices will be given access to Datix to support robust incident and patient safety concern reporting.

Following concerns being raised previously regarding flu vaccination ordering, all Dudley practices have now correctly ordered flu vaccines for their over 65s in line with national guidance.

2.6 **Infection Prevention & Control**

Dudley CCG ended the year 2017/18 with 65 cases significantly under the threshold of 76 and offers an encouraging result demonstrating a continued improvement on 2016/17.

For 2018/19 the linear trajectory suggests that Dudley CCG will end with 76 breaching the target of 75 and DGFT will end the year with 27 meeting the target of 28. However, every effort will be made to ensure achievement of the target.

2.7 **Black Country Local Maternity Systems (LMS)**

The LMS work streams are continuing to hold regular meetings with CCG representatives attending where appropriate.
The Black Country Mental Health STP has been successful in the bid for Wave 2 NHSE funding to implement perinatal mental health services for women in the Black Country STP.

2.8 **Wheelchair Services**

Work is continuing with the provider to address some concerns regarding wheelchair assessments and eligibility criteria.

2.9 **Transforming Care Programme (TCP)**

Dudley and the wider Black Country remain on regional and national escalation as a result of the ongoing delays in meeting the defined trajectory for the discharge of learning disability patients into the community.

A series of actions have been undertaken to offer assurance of the Black Country engagement to progress the TCP aims. The following offer a summary of key actions:

- Progress towards meeting expected discharges and towards increased admission avoidance.
- Participation in Clinical Review Panels with national experts offering recommendations to support discharge planning for adults, children and young people.
- Undertaken and shared Root Cause Analysis investigations associated with admissions to establish and learn relevant lessons.
- Embedding Care and Treatment Reviews in contracts to avoid admissions with these not taking place unless in an emergency.
- Greater involvement of current providers, particularly senior staff within BCPFT to support the assurance process, alongside actions to develop market engagement to provide additional community based services. Market engagement has been identified as critical to the sustainability of community services and to thinking differently about future service models.
- Finalisation of a Black Country clinical service specification to be varied into contracts and localised across the four CCGs.
- Improved coordination and increased involvement of senior CCG and provider leaders in the escalation associated with clinical delays.
- Improved coordination and collaboration between CCG and Specialist Commissioning case managers.
- Refining and streamlining of tracking documentation and risk registers to improve oversight and reduce the workload on case managers.

A TCP Black Country Deep Dive Assurance meeting was held on 29 June at which quarter 1 performance was assessed and quarter 2 milestones were agreed. Proposed plans to extend the trajectory beyond March 2019 have not been accepted. National and current performance enhanced scrutiny will be ongoing.

Financial modelling has been progressed and is reported in the Black Country TCP Board report.

A presentation regarding the clinical model will be presented to Health & Adult Social Care Scrutiny Committee on 11 July 2018.

2.10 **CCG End of Year Assurance**

The end of year assurance assessment from NHSE outlined areas in which they required greater assurance regarding the quality and safety agenda and associated governance.

Follow up discussions have been undertaken to clarify the specific nature of the assurance.
required.

2.11 **Risk Register**

The risk register has been reviewed and, a number of risks have been closed however two new risks were discussed; the Emergency Department at DGFT and capacity issues within the Quality and Safety team and these will be added during the next updating process.

2.12 **CQUINS**

All Dudley CCG Providers have forwarded supporting evidence of CQUIN achievements during 2017/18. Reviews of the evidence have taken place with feedback and queries having been returned where required.

D&WMHT have worked collaboratively with DGFT to achieve an improved response to frequent attenders at the ED.

BCPFT have worked successfully towards improving the health and wellbeing of their staff. All providers have made improvements in the uptake of staff flu vaccinations during 2017/18.

3.0 **RECOMMENDATIONS**

1) The Board is asked to accept this report as a source of ongoing assurance that the CCG Quality & Safety Committee continues to maintain rigorous oversight of all clinical quality standards in line with the CCG’s statutory duties.

Marcia Minott  
Head of Quality & Safety  
June 2018

Enc: Appendix 1 – Primary Care – Care Quality Commission (CQC) Ratings Summary
Care Quality Commission (CQC) Ratings

This section shows the results for the latest CQC inspections, the scores are calculated as follows; 1. Inadequate, 2. Requires Improvement, 3. Good, 4. Outstanding.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Visit Date</th>
<th>Sum of CQC</th>
<th>Overall Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well Led</th>
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</thead>
<tbody>
<tr>
<td>THORNES ROAD</td>
<td>Jun 2018</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>AW SURGERIES</td>
<td>Mar 2018</td>
<td>13</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
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<td>2</td>
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<tr>
<td>CASTLE MEADOWS SURGERY</td>
<td>Feb 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<tr>
<td>PENDMORE MEDICAL PRACTICE</td>
<td>Jan 2018</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<tr>
<td>BATH STREET MEDICAL CENTRE</td>
<td>Dec 2017</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>THE WATERFRONT SURGERY</td>
<td>Nov 2017</td>
<td>11</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>STOURSIDE MEDICAL PRACTICE</td>
<td>Nov 2017</td>
<td>13</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
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<tr>
<td>KEELINGE HOUSE</td>
<td>Nov 2017</td>
<td>14</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
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<tr>
<td>BEAN MEDICAL PRACTICE</td>
<td>Oct 2017</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>COSELEY MEDICAL CENTRE</td>
<td>Aug 2017</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
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<tr>
<td>DUDLEY VOODO SURGERY</td>
<td>Jul 2017</td>
<td>14</td>
<td>3</td>
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## Emergency Preparedness Response and Resilience (EPRR) Update

**Agenda item No:** 7.2

<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>Emergency Preparedness Response and Resilience (EPRR) Update</th>
</tr>
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<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To provide the Committee with assurance that the CCG is adhering to its EPRR requirements</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Mr G Griffiths-Dale, Deputy Director of Commissioning</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr R Tapparo – Clinical Executive for Finance, Performance &amp; Business Intelligence</td>
</tr>
<tr>
<td><strong>KEY POINTS:</strong></td>
<td>All NHS organisations are required to meet the minimum standards for Emergency Preparedness, Resilience and Response:</td>
</tr>
<tr>
<td></td>
<td>- Board received training at April meeting</td>
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<tr>
<td></td>
<td>- Annual assurance process will take place over the summer</td>
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<td></td>
<td>- System desktop exercise will take place in July</td>
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<td></td>
<td>- Further work is required on business continuity in primary care</td>
</tr>
<tr>
<td><strong>RECOMMENDATION:</strong></td>
<td>The Dudley CCG Board are asked to:</td>
</tr>
<tr>
<td></td>
<td>- Note the upcoming EPRR self-assessment process, based on the responsibilities from the Board training event</td>
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<tr>
<td></td>
<td>- Note the upcoming system desktop exercise to be held in July</td>
</tr>
<tr>
<td></td>
<td>- Support the development of business continuity planning in primary care</td>
</tr>
<tr>
<td><strong>FINANCIAL IMPLICATIONS:</strong></td>
<td>Cost of CSU Regional Capacity Management Team undertaking a review of EPRR compliance with national standards</td>
</tr>
<tr>
<td><strong>WHAT ENGAGEMENT HAS TAKEN PLACE:</strong></td>
<td>Significant engagement and support provided by The CSU Regional Capacity Management Team and the NHS England regional EPRR team.</td>
</tr>
<tr>
<td><strong>ACTION REQUIRED:</strong></td>
<td>Decision Approval ✓ Assurance</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1. All NHS organisations are required to meet the minimum standards for Emergency Preparedness, Resilience and Response.

1.2. The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients.

1.3. The CCG is classified as a Category 2 responder under the Civil Contingencies Act, a supporting agency to the primary Category 1 responders. However, for EPRR arrangements to work effectively all organisations are required to participate in system planning. The CCG responsibilities should be seen as part of the full EPRR framework, which has been mapped by NHS England in December 2017. The CCG Board received a training event on the key standards and requirements at its meeting on the 12 April.
2. ANNUAL ASSESSMENT

2.1. Over the next few months the CCG will assess its preparedness against the EPRR core standards. These are the minimum standards which NHS organisations must meet. The CCG was last assessed against the standards published in July 2017, and the revised standards are expected to build on the lessons learnt from last year’s assessment.

2.2. The 2018 standards are due to be published in June and July and are likely to strengthen the requirement for responding to major incidents, in the aftermath of a number of mass casualty events across the UK, and business continuity following winter disruption due to snow and flooding and IT disruption following the ransomware attack in May 2017.

2.3. In preparation for winter 2018, the Dudley system will also review surge plans to identify services likely to be affected by any significant rises in demand. The urgent care system has been under pressure for long periods with rising acuity and demand. The Urgent Care system is currently reviewing funded capacity both from System Resilience Funds and the Improved Better Care Fund (iBCF) to ensure that maximum service resilience is maintained.

2.4. The review against the 2018 standards will be carried out by the CSU to give an independent assessment, with the results fed into the Urgent Care Operational Group and the A&E Delivery Board as well as the internal CCG reporting streams.
2.5. A full external assessment by NHS England will be carried out in the Autumn and reported back for assurance to the Board.

3. **SYSTEM EXERCISING**

3.1. A key element of the EPRR system is regular exercising of key plans to ensure that they work in practice. Exercises are usually carried out in 2 forms

3.1.1. Live exercises
3.1.2. Desktop review

3.2. As part of the system testing, Dudley Group NHS Foundation Trust will be holding a desktop exercise, Exercise Minerva, on 19 July. This exercise will test command and control structures at both strategic and tactical level. The CCG will be an observer at this exercise to learn lessons for changes required for the wider system

3.3. It is expected that a live exercise will be undertaken in 2019

4. **BUSINESS CONTINUITY IN PRIMARY CARE**

4.1. All NHS organisations have a duty to put in place continuity arrangements, under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012. The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) set out these requirements for all organisations. This means that services should be maintained to set standards during any disruption, or recovered to these standards as soon as possible

4.2. Business Continuity Management (BCM) gives organisations a framework for identifying and managing risks that could disrupt normal service.

4.3. A key risk that emerged over the winter was business continuity planning in primary care. A number of practices had issues during major snow events. This is not unusual nationally, but significant disruption to primary care during major weather events places a significant strain on the urgent care system. It is

![Business Continuity Management Diagram](source: adapted from Deming)
therefore proposed to work with practice managers to look at business continuity arrangements going forward, both at a practice and locality level to look at ways to strengthen resilience.

5. RECOMMENDATION

5.1. The Dudley CCG Governing Body are asked to:

- Note the upcoming EPRR self-assessment process, based on the responsibilities from the Board training event
- Note the upcoming system desktop exercise to be held in July
- Support the development of Business Continuity planning in Primary Care

Geraint Griffiths-Dale
Deputy Director of Commissioning
# Dudley Clinical Commissioning Group Board

**Date of Board:** 12 July 2018  
**Report:** Audit & Governance Committee Report  
**Agenda item No:** 8.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Audit &amp; Governance Committee Report</th>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of the key issues discussed and agreed at the Audit &amp; Governance Committee meeting on 24 May 2018</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
</tbody>
</table>
| MANAGEMENT LEAD: | Mr M Hartland, Chief Operating and Finance Officer  
Mrs J Jasper, Chair – Audit & Governance Committee. |
| CLINICAL LEAD: | Dr R Tapparo, Clinical Executive Finance, Performance & Business Intelligence |
| KEY POINTS: | Items received for assurance or **approved** under delegated authority at meeting held on 24 May 2018:  
- **Constitutional Change - GP Practice Application to Join Dudley CCG** - the Committee received an update on the process taking place and was assured that all aspects were covered.  
- **Policies** – update received in relation to the General Data Protection Regulations (GDPR) impact on all CCG policies received for assurance. **Revised Freedom of Information, Sanctions and Redress and Conflicts of Interest Policies** approved under delegated authority.  
- **Annual Report & Accounts 2017/18** – The Committee received the External Audit Findings Report; Letter of Representation; Statement of Accountable Officer’s Responsibilities; Governance Statement; External Audit Opinion; and Board Members Assurance Statement for assurance. The Committee **approved the CCG’s Annual Report & Accounts 2017/18** under delegated authority |
| RECOMMENDATION: | The Board is asked to:  
1) Receive this report for assurance  
2) Note the decisions made under delegated authority |
| FINANCIAL IMPLICATIONS: | None |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | Extensive engagement around the Annual Report & Accounts |
| ACTION REQUIRED: | Decision  
- **Approval**  
- **Assurance** |
## 1.0 INTRODUCTION
The report summarises the key issues discussed at the Audit & Governance Committee meeting on 24 May 2018.

## 2.0 KEY INDICATOR SUMMARY
The following items are indicators of the current position in relation to the main responsibilities and obligations of the Committee as defined in the CCG’s Constitution and the Committee’s Terms of Reference.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Position</th>
<th>RAG</th>
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<tbody>
<tr>
<td>1. Regulation and Control</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>CCG Governance Arrangements – Constitution</td>
<td>Updated Constitution submitted to and approved by NHSE 22 June 2018. Currently under review for proposed boundary changes.</td>
<td></td>
</tr>
<tr>
<td>Scheme of Delegation</td>
<td>Revised Operational Scheme of Delegation approved 22 March 2018.</td>
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</tr>
<tr>
<td>Compliance with Prime Financial Policies</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Board &amp; Committee Effectiveness</td>
<td>Continued progress against Governance Improvement Plan.</td>
<td></td>
</tr>
<tr>
<td>2. Annual Report and Accounts (ARA) 2017/18</td>
<td>NHSE &amp; External Audit training events attended. ARA submitted in line with timetable &amp; NHSE requirements.</td>
<td></td>
</tr>
<tr>
<td>3. Operational &amp; Risk Management</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Anti-Fraud and Security</td>
<td>Anti- Fraud and Local Security Management Specialist Work-plans 2018/19 approved. Progress reports being received.</td>
<td></td>
</tr>
<tr>
<td>Risk Management Arrangements – Combined BAF &amp; Risk Register in place; Chairs/Management Leads of committees attending &amp; updating Audit &amp; Governance Committee;</td>
<td>BAF &amp; Risk Register updated monthly and actively managed. BAF &amp; Risk Register critically reviewed and updated at Committee level.</td>
<td></td>
</tr>
<tr>
<td>Report newly commissioned services</td>
<td>Procurement Strategy &amp; reporting updated to reflect new managing conflicts of interest guidance.</td>
<td></td>
</tr>
<tr>
<td>External Audit</td>
<td>Audit findings report and External Audit Opinion issued for year ended 31 March 2018</td>
<td></td>
</tr>
<tr>
<td>Internal Audit</td>
<td>Audit Plan 2018/19 approved March 2018. All audits complete-overall assurance rating currently significant.</td>
<td></td>
</tr>
<tr>
<td>Other Policies</td>
<td>Policies being reviewed and updated routinely.</td>
<td></td>
</tr>
<tr>
<td>4. Information Governance</td>
<td>CSU IG staff on-site regularly progressing IG Work-plan and supporting CCG officers. Toolkit rated Green by Internal Audit.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Group established</td>
<td>IG Steering Group meetings scheduled throughout 2018/19</td>
<td></td>
</tr>
<tr>
<td>Compliance with Information Governance toolkit</td>
<td>Toolkit 2017/18 IG Toolkit submitted with 92%</td>
<td></td>
</tr>
<tr>
<td>Information Asset Management structure to be established with IAOs and IAAs identified from CCG staff</td>
<td>IG working with IAOs &amp; IAAs to take forward information asset register update.</td>
<td></td>
</tr>
<tr>
<td>Freedom of Information requests (FOIs)</td>
<td>All responded to within required timescale</td>
<td></td>
</tr>
</tbody>
</table>
3.0 ITEMS DISCUSSED

3.1 Constitutional Change - GP Practice Application to Join Dudley CCG
The Committee received a paper on the application process for Moss Grove Surgery, Kinver, to join the CCG. Although the governance team was managing the process, the Constitutional change required would be minimal if the application was approved. The Committee was assured that the CCG had considered all the IG implications.

The Committee noted that the Commissioning Development Committee had already considered the application and that the Primary Care Commissioning (PCCC) and Finance, Performance and Business Intelligence (FP&BI) Committees would be considering the implications of the practice joining the CCG before a recommendation was made to the Governing Body. The PCCC would consider the merger application in principle as it could not be formally agreed until the constitutional change had been agreed by NHS England. The Governing Body approved the application to change its constitutional boundaries at the extraordinary Board meeting on 7 June 2018.

The Committee noted that an application to NHS England (NHSE) required a matched application from South East Staffs and Seisdon Peninsula (SESSP) CCG.

The potential risks were that NHSE may refuse the application and that if the merger were to be agreed, the practice may consider closure at a future date.

From a financial perspective, the issue was the treatment of the historical deficit. The FP&BI Committee had previously considered the issue and agreed that it would not accept the transfer of the historical debt. NHSE had indicated that the debt was at CCG level and not practice level and would not therefore transfer.

The Committee noted the process taking place and was assured that the governance aspects were covered.

3.2 Committee Policies Update
The Committee received an update on the position of the Committees’ policies in relation to the General Data Protection Regulations (GDPR) for assurance.

The Committee also approved the revised Freedom of Information Policy; Sanctions and Redress Policy and Conflicts of Interest Policy under its delegated authority.

3.3 Annual Report & Accounts 2017/18
The Committee received the draft audited Annual Report & Accounts 2017/18 for approval noting that the amendments made since the first draft included input from the public and patient reading panel and CCG senior managers in addition to changes arising from the audit and NHSE reviews. In support of their decision the Committee approved or received for assurance the following:

- **The External Audit Findings Report** – the CCG’s Auditors provided an unqualified regulatory opinion on both the financial statements and the value for money conclusion. In terms of the value for money conclusion, it was concluded that adequate governance arrangements were in place for the procurement of the MCP and it was not identified as a significant risk for 2017/18.
- **The External Audit Findings Report – MCP** - The report made reference to the fact that the provider vehicle for the MCP did not yet exist and the particular challenges this presented for the CCG to carry out due diligence processes to assess the organisational strength of the provider. It added that while the ISAP process could help with this, the Board needs to be satisfied that it had sufficient assurance from all available sources before formally entering into the contract. The Committee welcomed this important statement and it was agreed Mr Hartland would use this in the report to the Board from this Committee.
- **The Letter of Representation** - approved by the Committee and signed by the Audit & Governance Committee Chair and the Chief Operating & Finance Officer
- **The Statement of Accountable Officer’s Responsibilities** - this was agreed by the Accountable Officer
- **The Governance Statement** – the Accountable Officer confirmed that, to the best of his knowledge, this was a true statement
- **External Audit Opinion** - External audit had provided an unqualified opinion on both the financial statements and the value for money conclusion
- **Board Members Assurance Statement** – Board members had confirmed that they were not aware of any relevant audit information that needed to be brought to the auditors’ attention.

The Committee approved the CCG’s Annual Report & Accounts 2017/18 under delegated authority

### 4.0 DECISIONS TAKEN UNDER DELEGATED POWERS

- Approved the revised Freedom of Information Policy
- Approved the revised Sanctions and Redress Policy
- Approved the revised Conflicts of Interest Policy
- Approved the CCG’s Annual Report & Accounts 2017/18

### 5.0 DECISIONS REFERRED TO THE BOARD

- None

### 6.0 RECOMMENDATIONS

The Board is asked to:

1) Receive this report for assurance
2) Note the decisions taken under delegated authority

Mr M Hartland  
Chief Operating and Finance Officer  
July 2018
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 July 2018  
**Report:** Dudley CCG Constitution – Updated version approved 22 June 2018  
**Agenda item No:** 8.2

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Dudley CCG’s Constitution – Updated version approved 22 June 2018</th>
</tr>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To present to the Board the latest version of the CCGs Constitution that was approved by NHS England on the 22 June 2018 for assurance.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr D Hegarty, Chair</td>
</tr>
</tbody>
</table>
| KEY POINTS:               | • On 22 June 2018 NHS England issued approval of the CCG’s amended Constitution. This reflected the changes approved by the Board at its meeting on March 2018.  
                            | • This version of the Constitution will now be circulated to all GP Practices for information and published on the CCGs website |
| RECOMMENDATION:           | 1) The Board is asked to receive the latest version of the Constitution approved by NHS England on the 22 June 2018 for assurance |
| FINANCIAL IMPLICATIONS:   | None                                                             |
| ACTION REQUIRED:          | Decision Approval  
                            | ✓ Assurance                                                       |
Dear David and Paul

Re: NHS Dudley Clinical Commissioning Group application to amend the constitution

Thank you for your application to amend the constitution of NHS Dudley CCG, which we received in final form on 23 May 2018.

Your proposed changes to the constitution have been reviewed by the NHS England (Midlands and East) regional team. We note in particular:

- updates to the composition of the Governing Body
- inclusion of the joint appointments
- updates to the governance structure including the establishment of:
  - the Black Country Joint Commissioning Committee as a joint committee with NHS Walsall CCG, NHS Sandwell and West Birmingham CCG and NHS Wolverhampton CCG
  - the Multi-Specialty Community Provider Procurement Project Board
- updates to the list of member practices
- updates to the joint working arrangements
- updates to the description of roles and responsibilities
- updates to reflect the current statutory guidance for managing conflicts of interest
- updates to the Scheme of Reservation and Delegation and Standing Orders
- updates to committees’ Terms of Reference.

NHS England is happy to approve your proposed changes to your constitution in line with Section 14E of the NHS Act 2006 (as inserted by the Health and Social Care Act 2012).

In line with the above legislation, the CCG must publish its revised constitution, as agreed, as soon as practicable.

If you have any queries relating to this process, please email england.me-ops@nhs.net, and your query will be dealt with by a member of the team.
Yours sincerely

GRAEME JONES
Regional Director of Operations and Delivery (Midlands and East)

cc: Alastair McIntyre, Operations Director, NHS England
    Emma Smith, Governance Support Manager, NHS Dudley CCG
Our Constitution

Version: 5.2
### Amendment History

<table>
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<tr>
<th>Version</th>
<th>Date</th>
<th>Amendment History</th>
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<tr>
<td>4b</td>
<td>02/04/13</td>
<td>Constitution &amp; associated committee terms of reference formally adopted at by the CCG Board under its delegated authority prior to making an application to the NHS Commissioning Board (NHSCB).</td>
</tr>
<tr>
<td>4c</td>
<td>31/07/13</td>
<td>Changes discussed and agreed at the CCG Board 2nd April 2013, approved by NHSCB 31st July 2013.</td>
</tr>
<tr>
<td>4d</td>
<td>16/12/13</td>
<td>Changes discussed and agreed at the CCG Board 7th November 2013, approved by NHSCB 16th December 2013.</td>
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<tr>
<td>4e</td>
<td>29/05/14</td>
<td>Changes discussed and agreed at CCG Board 3rd April 2014, approved NHSE Local Area Team 29th May 2014.</td>
</tr>
<tr>
<td>4f</td>
<td>18/12/14</td>
<td>Changes discussed and agreed at CCG Boards 11th September and 13th November 2014. Changes discussed at Primary Care Co-commissioning Task &amp; Finish Group and approved by Governing Body meeting of 8th January 2015.</td>
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<td>4g</td>
<td>31/07/15</td>
<td>Changes discussed and agreed at CCG Board 14th May 2015, approved NHS Commissioning Board 31 July 2015.</td>
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<tr>
<td>4h</td>
<td>21/01/16</td>
<td>Changes discussed and agreed at CCG Boards 10th September 2015 and 12th November 2015. Approved by NHS Commissioning Board 21 January 2016.</td>
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<tr>
<td>4i</td>
<td>12/07/2016</td>
<td>Changes discussed and agreed at CCG Board 12th May 2016. <strong>Approved by NHS England 11 August 2016</strong>.</td>
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</table>
| 4j      | 28/06/2017 | Changes to Appendix B
Changes made to Clinical Executive Titles
Changes made to Chief Nurse reference
Changes to Conflicts of Interest Policy
Formatting throughout.                                                                                                                 |
| 5       | 01/02/2018 | Incorporation of NHS England’s comments as presented to Board on the 8th March.                                                                                                                                   |
| 5.1     | 13/03/2018 | Incorporation of Paul Capener’s comments as presented to Board on the 29th March.                                                                                                                                |
| 5.2     | 11/05/2018 | Further comments from NHS England.                                                                                                                                                                               |

### Reviewers

This document has been reviewed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
<th>Version</th>
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</thead>
<tbody>
<tr>
<td>Emma Smith</td>
<td>Governance Support Manager</td>
<td>07/12/2017</td>
<td>5.0</td>
</tr>
<tr>
<td>Erika Polgar</td>
<td>Operations and Delivery Manager - NHSE</td>
<td>24/01/2018</td>
<td>5.0</td>
</tr>
<tr>
<td>Paul Capener</td>
<td>Governance Support</td>
<td>14/03/2018</td>
<td>5.1</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>Governance Support Manager</td>
<td>03/04/2018</td>
<td>5.1</td>
</tr>
<tr>
<td>Erika Polgar</td>
<td>Operations and Delivery Manager - NHSE</td>
<td>27/04/2018</td>
<td>5.1</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>Governance Support Manager</td>
<td>23/05/2018</td>
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### Approvals

This document has been approved by:

<table>
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<tr>
<th>Committee/Board</th>
<th>Date</th>
<th>Version</th>
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<tr>
<td>Dudley CCG Governing Body</td>
<td>09/11/2017</td>
<td>5.0</td>
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<tr>
<td>NHS England</td>
<td>22/06/2018</td>
<td>5.2</td>
</tr>
<tr>
<td>Dudley CCG Governing Body</td>
<td>TBC</td>
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</tbody>
</table>
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FOREWORD

The NHS Dudley Clinical Commissioning Group (the ‘CCG’) Constitution sets out in one document the principles and values that guide how the CCG operates and make decisions on behalf of the public it serves. It describes the arrangements made by the CCG to meet its responsibilities for commissioning care for the people of the Metropolitan Borough of Dudley. This includes details of the governing principles, rules and procedures that we have established to ensure probity and accountability in the day to day running of the clinical commissioning group; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

Our CCG vision is; “to promote good health and ensure high quality health services for the people of Dudley.” We will achieve this through:

• the engagement of our primary medical services member practices
• partnership with Dudley Metropolitan Borough Council
• effective working relationships with health & social care service providers & the voluntary sector
• involvement of patients and the public
• Having high calibre staff working in partnership with clinical leads.

Our desire to improve the quality and safety of services is the foundation of everything we do. We will work together as a clinically led team within the organisation and with our partners to share good practice, improve integration, take shared pride in our work, and work collaboratively every step of the way.

This collaborative approach is in evidence throughout our governance structures, by the fact that our GP members of the CCG’s Governing Body are democratically elected by member practices and by our commitment to patient and public engagement in the work of the CCG.

This Constitution has been written in partnership with our member practices and the Local Medical Committee to ensure that it is understood at every level of the CCG. The contents of this document apply to the following, all of whom are required to adhere to it as a condition of their appointment:

• Dudley CCG member practices
• Dudley CCG employees
• individuals working on behalf of Dudley CCG
• anyone who is a member of Dudley CCG’s Governing Body and/or its Committees or Sub-Committee

This Constitution includes the following:

• details of the CCG member practices
• the area which the CCG covers
• arrangements for the discharge of the CCG’s functions and those of its Governing Body, the procedure to be followed by the CCG and its Governing Body in making decisions and securing transparency in its decision making
• arrangements for discharging the CCG’s duties in relation to registers of interests and managing conflicts of interests
• arrangements for securing the involvement of persons who are, or may be, provided with services commissioned by the CCG in certain aspects of those commissioning decisions
• the principles that underpin these arrangements.
I do hope that you find it covers all of these areas and meets your expectations.

Best wishes

David Hegarty
Chair
NHS Dudley Clinical Commissioning Group

NB A copy of this constitution can be found in our publication scheme under “Who we are and what we do” at our web-site:  [http://www.dudleyccg.nhs.uk/publication-scheme/](http://www.dudleyccg.nhs.uk/publication-scheme/)
1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Dudley Clinical Commissioning Group.

1.2. Statutory Framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”).¹ They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 (“the 2006 Act”).² The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.³

1.2.2. The NHS Commissioning Board (known as NHS England and referred to as such throughout this document) is responsible for determining applications from prospective groups to be established as clinical commissioning groups⁴ and undertakes an annual assessment of each established group.⁵ It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.⁶

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.⁷ Definitions of key terms used in this constitution are provided in Appendix A.

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Dudley Clinical Commissioning Group and has effect from 5 day of December 2012, when NHS England established the Group.⁸ This constitution was revised under delegated authority from the Governing Body on 23 May 2018 with NHS England approval of the application on 22 June 2018.

¹ See section 11 of the 2006 Act, inserted by section 10 of the 2012 Act
² See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
³ Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
⁴ See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
⁵ See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
⁶ See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
⁷ See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
⁸ See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in two circumstances:

   a) where the Group applies to NHS England and that application is granted;

   b) where in the circumstances set out in legislation NHS England varies the Group’s constitution other than on application by the Group.

9 See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
2. **AREA COVERED**

The geographical area covered by NHS Dudley Clinical Commissioning Group is the area covered by the Dudley Metropolitan Borough Council.
3. **MEMBERSHIP**

3.1 **Membership of the Clinical Commissioning Group**

3.1.1 Appendix B of this constitution contains the list of member practices of NHS Dudley Clinical Commissioning Group. The signature sheets of the practice representatives confirming their agreement to this constitution are held in electronic format within the CCG Constitution folders and are available to view on request by contacting the Governance Team on 01384 322040.

3.2 **Eligibility**

3.2.1 Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this group.

3.2.2 A Member shall cease to be a Member of the Group if they cease to meet the eligibility criteria in 3.2.1 above.

---

10 See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made
4. **VISION, VALUES AND PRINCIPLES**

4.1 **Vision**

4.1.1. The vision of NHS Dudley Clinical Commissioning Group is ‘To promote good health and ensure high quality health services for the people of Dudley’

4.1.2. The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2 **Values**

4.2.1. Good corporate governance arrangements are critical to achieving the Group’s objectives.

4.2.2. The values that lie at the heart of the Group’s work are to:

   a) be a caring organisation  
   b) be a patient centred organisation  
   c) work together as teams within the organisation and with partners  
   d) have quality and safety as the foundation of everything we do  
   e) be an organisation which leads by example  
   f) be a learning organisation  
   g) be an inclusive organisation  
   h) have a focus on prevention and health promotion  
   i) be an innovative organisation  
   j) promote excellent financial management

4.3 **Aims**

4.3.1. The Group’s aims are to:

   a) be a clinically-led organisation (ensuring close working partnerships between clinicians and managers)  
   b) have primary care at the heart of the organisation (ensuring the full engagement of constituent practices)  
   c) focus on quality and continuous improvement  
   d) have the meaningful involvement of patients and public  
   e) work with partners to improve health outcomes and services and reduce health inequalities  
   f) live within available resources.
4.4 **Principles of Good Governance**

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act, the Group will at all times observe “such generally accepted principles of good governance” in the way it conducts its business. These include:

a) The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business

b) *The Good Governance Standard for Public Services*\(^\text{12}\)

c) The standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the ‘Nolan Principles’\(^\text{13}\)

d) The seven key principles of the *NHS Constitution*\(^\text{14}\)

e) The Equality Act 2010.\(^\text{15}\)


4.5 **Accountability**

4.5.1. The Group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

a) publishing its constitution

b) appointing independent lay members and non GP clinicians to its Governing Body

c) holding meetings of its Governing Body in public (except where the Group considers that it would not be in the public interest in relation to all or part of a meeting)

d) publishing annually a commissioning plan

e) complying with local authority health overview and scrutiny requirements

---

\(^{11}\) Inserted by section 25 of the 2012 Act

\(^{12}\) *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

\(^{13}\) See Appendix G

\(^{14}\) See Appendix H

f) meeting annually in public to publish and present its annual report (which must be published)

g) producing annual financial accounts in respect of each financial year which must be externally audited

h) having a published and clear complaints process

i) complying with the Freedom of Information Act 2000

j) providing information to NHS England as required.

4.5.2. In addition to these statutory requirements, the Group will demonstrate its accountability by publishing its key policies and procedures on the Group’s website: www.dudleyccg.nhs.uk.

4.5.3 The Governing Body of the Group will throughout each year have an ongoing role in reviewing the Group’s governance arrangements to ensure that the Group continues to reflect the principles of good governance.
5. FUNCTIONS AND GENERAL DUTIES

5.1 Functions

5.1.1. The functions that the Group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health’s Functions of clinical commissioning groups: a working document. They relate to:

a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   i) all people registered with our member GP practices, and
   ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning group
b) commissioning emergency care for anyone present in the Group’s area
c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group’s employees
d) determining the remuneration and travelling or other allowances of members of its Governing Body.

5.1.2. In discharging its functions the Group will:

a) **act**, when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to promote a comprehensive health service and with the objectives and requirements placed on NHS England through the mandate published by the Secretary of State before the start of each financial year by:
   i) delegating delivery of this responsibility to the Governing Body
   ii) establishing the Commissioning Development Committee to support the Governing Body in meeting that responsibility
   iii) agreeing a commissioning policy, strategy and plans consistent with this duty
   iv) requiring our performance in delivery of this duty to be monitored by the Commissioning Development Committee

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16 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
17 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
18 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
b) **meet the public sector equality duty**\(^{19}\) by:

i) delegating responsibility for delivering this duty to the Group’s Governing Body

ii) ensuring the publication of an Equality and Diversity Strategy with supporting policies and clear objectives

iii) ensuring regular reporting of performance against the Equality and Diversity Strategic aims and annual objectives to the Group’s Governing Body

iv) ensuring the annual publication of a report to demonstrate compliance with this duty

v) requiring our performance in delivery of this duty to be monitored by the Commissioning Development Committee

c) work in partnership with its local authority to develop *joint strategic needs assessments*\(^{20}\) and *joint health and wellbeing strategies*\(^{21}\) by:

i) ensuring appropriate membership of, and participation in, the Dudley Health and Wellbeing Board: the Group members of the Health and Wellbeing Board being; the Group Chairman, the Clinical Executive for the Multispecialty Community Provider (MCP) and the Chief Accountable Officer

ii) delegating lead responsibility for overseeing the discharge of this duty to the Clinical Executive for the Multispecialty Community Provider (MCP)

iii) ensuring regular reports to the Group’s Governing Body

iv) Ensuring compliance with the requirements of paragraphs 5.2.13 and 6.5.2 of this constitution

v) Requiring the Commissioning Development Committee to consider the Director of Public Health’s Annual Report and the Joint Strategic Needs Assessment and formulate the Group’s contribution to the Joint Health and Wellbeing Strategy.

**5.2. General Duties**

- in discharging its functions the Group will:

5.2.1. Make arrangements to *secure public involvement* in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements\(^{22}\) by:

a) delegating responsibility for overseeing the discharge of this general duty to the Clinical Executive for the Multispecialty Community Provider (MCP)

b) ensuring public and lay representation on the Group’s Governing Body

c) publishing and implementing a communication and engagement strategy

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\(^{19}\) See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

\(^{20}\) See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

\(^{21}\) See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

\(^{22}\) See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
d) ensuring that the Group complies with the following principles when engaging with the public:

i) that public involvement occurs at all stages of decision making: planning of the commissioning arrangements; development and consideration of proposals for changes in commissioning arrangements; and decisions affecting the operation of the commissioning arrangements.

ii) working collaboratively with our partners to ensure we engage the widest possible audience, using a variety of methods tailored to specific needs of different patient groups and communities, and actively seeking out the views of those groups most vulnerable to widening health inequalities.

iii) ensuring clarity about the purpose of engagement and focusing on engagement as a means of service improvement.

iv) valuing the feedback that the public give us and allowing adequate time and resource for this.

v) listening and taking account of all views - even those which may conflict with an organisationally favoured decision.

vi) ensuring that we truly understand our public feedback; accurately represent all views and act appropriately on the basis of feedback received.

vii) demonstrating responsible leadership by being transparent about our rationale.

viii) publishing information about health services.

ix) at all times seeking to build trust and reciprocity and to offer respect and empathy towards all stakeholders

e) requiring annual reports to the Governing Body of compliance against these principles

f) engaging with the local Health Overview and Scrutiny Committee

g) maintaining a public web-site with on-line engagement tools and a database of engagement activity

h) ensuring compliance with the Cabinet Office’s Code of Practice on Consultation where formal consultation is required.

i) requiring our performance in the delivery of this duty to be monitored by the Commissioning Development Committee

5.2.2. Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution by:

a) delegating responsibility for the discharge of this general duty to the

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23 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
Accountable Officer

b) requiring our performance in the delivery of this duty to be monitored by the Clinical Commissioning and Quality & Safety Committees.

5.2.3 Act **effectively, efficiently and economically**\(^{24}\) by:

a) delegating responsibility for delivering this duty to the Governing Body

b) establishing the Finance, Performance & Business Intelligence Committee to support the Governing Body in meeting that responsibility

c) using our Standing Orders, Prime Financial Policies, and Scheme of Reservation and Delegation as the policy framework through which this duty will be delivered

d) Requiring our performance in delivery of this duty to be monitored by the Audit Committee

5.2.4 Act with a view **to securing continuous improvement to the quality of services**\(^{25}\) by:

a) delegating responsibility for delivering this duty to the Governing Body and lead responsibility for overseeing the delivery of this duty to the Clinical Executive for Quality and Safety.

b) establishing the Commissioning Development Committee to support the Governing Body in meeting this responsibility, by ensuring the Group is commissioning improved quality

c) requiring our performance in delivery of this duty to be monitored by the Quality & Safety Committee

5.2.5 Assist and support NHS England in relation to the Board’s duty to **improve the quality of primary medical services**\(^{26}\) by:

a) delegating responsibility for delivering this duty to the Governing Body

b) establishing the Primary Care Commissioning Committee to support the Governing Body in meeting this responsibility

c) developing a Primary Care Strategy that ensures the delivery of this duty

5.2.6 Commission primary care medical services under delegated authority from NHS England by:

a) delegating responsibility for delivering this duty to the Primary Care

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\(^{24}\) See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{25}\) See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{26}\) See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
Commissioning Committee

5.2.7 Have regard to the need to reduce inequalities by delegating responsibility for delivering this duty to the Governing Body, which will discharge it in a manner consistent with our public sector equality duty at 5.1.2(b) above.

5.2.8 Promote the involvement of patients, their carers and representatives in decisions about their healthcare by delegating responsibility for delivering this duty to the Governing Body with regard to applicable guidance issued from time to time by the Department of Health or NHS England.

5.2.9 Act with a view to enabling patients to make choices by:

a) delegating responsibility for delivering this duty to the Chief Accountable Officer

b) ensuring patients have choice in terms of their care through:

i) provision of information to enable patients to make informed choices

ii) wherever possible, commissioning services from a pluralistic range of providers

iii) Provision, where appropriate, of personal budgets and care plans.

5.2.10 Obtain appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) Ensuring that the Governing Body comprises a membership which includes a mix of clinical and non-clinical expertise, including but not limited to GPs or other health care professionals, secondary care clinicians, nurses, public health consultants, experienced and capable officers and independent lay members with a range of skills and expertise ensuring that local healthcare professionals and others with experience and expertise as appropriate are consulted on the development of the Group’s commissioning plan and in the development and implementation of any other commissioning or decommissioning plans;

b) establishing appropriate links with professional bodies, including the local professional representative committees which are not directly represented on the Group’s Governing Body

c) establishing a Memorandum of Agreement with the Director of Public Health for the provision of public health advice

d) ensuring that the Director of Public Health is represented at meetings of the Governing Body and relevant Committees.

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27 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.11 **Promote innovation** \(^{31}\) by:

a) delegating responsibility for delivering this duty to the Commissioning Development Committee and lead responsibility for the discharge of this duty to a named, elected GP member of the Governing Body.

5.2.12 **Promote research and the use of research** \(^{32}\) by delegating responsibility for delivering this duty to the Governing Body which shall have regard to applicable guidance issued from time to time by the Department of Health or NHS England.

5.2.13 Have regard to the need to **promote education and training** \(^{33}\) for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty \(^{34}\) by:

a) delegating responsibility for delivering this duty to a named GP member of the Governing Body with lead responsibility for education and training

b) ensuring the Group’s participation in the nationally agreed arrangements for education and training

c) ensuring that all employees participate in mandatory training as specified by the Governing Body.

5.2.14 Act with a view to **promoting integration** of both health services with other health services and health services with health-related and social care services where the Group considers that this would improve the quality of services or reduce inequalities \(^{35}\) by:

a) delegating responsibility for delivering this duty to the Commissioning Development Committee

b) promoting and entering into appropriate agreements under Section 75 of the NHS Act 2006 which promote this duty

c) ensuring that, through participation in the Health and Wellbeing Board, opportunities for integration are considered and promoted whilst considering the joint Health and Wellbeing Strategy

5.3 **General Financial Duties** – the Group will perform its functions so as to:

5.3.1 **Ensure its expenditure does not exceed the aggregate of its allotments for the**

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\(^{31}\) See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{32}\) See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{33}\) See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{34}\) See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

\(^{35}\) See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
financial year by:

a) delegating responsibility for delivering this duty to the Chief Finance Officer

b) establishing the Finance, Performance & Business Intelligence Committee to support the Chief Finance Officer in meeting that responsibility, and to monitor our performance in delivering this duty.

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered

d) documenting accounting and budgetary control procedures that enable all officers and employees of the Group to comply with this policy framework

5.3.2 Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year by:

a) delegating responsibility for delivering this duty to the Chief Finance Officer

b) establishing the Finance, Performance & Business Intelligence Committee to support the Chief Finance Officer in meeting that responsibility, and to monitor our performance in delivering this duty.

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered

d) documenting accounting and budgetary control procedures that enable all officers and employees of the Group to comply with this policy framework

5.3.3 Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by NHS England by:

a) delegating responsibility for delivering this duty to the Chief Finance Officer

b) establishing the Finance, Performance & Business Intelligence Committee to support the Chief Finance Officer in meeting that responsibility, and to monitor our performance in delivering this duty.

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered

d) documenting accounting and budgetary control procedures that enable all

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36 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
37 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
38 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
officers and employees of the Group to comply with this policy framework

5.3.4 **Publish an explanation of how the Group spent any payment in respect of quality** made to it by NHS England by

a) delegating responsibility for delivering this duty to the Chief Finance Officer, who will be required to ensure that it is achievable by virtue of meeting the duties at 5.3.1 to 5.3.3 above

b) requiring the Chief Finance Officer to prepare an annual report to the Governing Body on how the Group has spent any funds received from NHS England in respect of quality.

5.4 **Other Relevant Regulations, Directions and Documents**

5.4.1 The Group will

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or NHS England; and

c) take account, as appropriate, of documents issued by NHS England.

5.4.2 The Group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its Scheme of Reservation and Delegation and other relevant group policies and procedures.

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39 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
6. **DECISION MAKING: THE GOVERNING STRUCTURE**

6.1 **Authority to act**

6.1.1 The Clinical Commissioning Group is accountable for exercising the statutory functions of the Group. It may grant authority to act on its behalf to:

a) any of its members;

b) its Governing Body;

c) employees;

d) a Committee or Sub-Committee of the Group.

6.1.2 The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the Group as expressed through:

a) the Group’s Scheme of Reservation and Delegation; and

b) for Committees, their Terms of Reference.

6.2 **Scheme of Reservation and Delegation**

6.2.1 The Group’s Scheme of Reservation and Delegation sets out:

a) those decisions that are reserved for the membership as a whole;

b) those decisions that are the responsibility of its Governing Body (and its committees), the Group’s committees and Sub-Committees, individual members and employees.

6.2.2 The Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated.

6.3 **General**

6.3.1 In discharging functions of the Group that have been delegated to its Governing Body (and its Committees), the Group’s joint Committees and Committees and individuals must:

a) comply with the Group’s principles of good governance,

b) operate in accordance with the Group’s Scheme of Reservation and Delegation.

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40 See Appendix D
41 See section 4.4 on Principles of Good Governance above
Delegation,

c) comply with the Group’s Standing Orders,\(^{43}\)
d) comply with the Group’s arrangements for discharging its statutory duties\(^ {44}\)
e) where appropriate, ensure that member practices have had the opportunity to contribute to the Group’s decision making process.

6.3.2 When discharging their delegated functions, Committees and Sub-Committees and joint Committees must also operate in accordance with their approved terms of reference.

6.3.3 The Group has established the Black Country and West Birmingham Joint Commissioning Committee with NHS Sandwell & West Birmingham, NHS Wolverhampton and NHS Walsall CCGs.

6.4 Joint commissioning arrangements with other Clinical Commissioning Groups

6.4.1 The Clinical Commissioning Group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

6.4.2 The CCG may make arrangements with one or more CCG in respect of:

a) delegating any of the CCG’s commissioning functions to another CCG;

b) exercising any of the commissioning functions of another CCG; or

c) exercising jointly the commissioning functions of the CCG and another CCG

6.4.3 For the purposes of the arrangements described at paragraph 6.4.2, the CCG may:

a) make payments to another CCG;

b) receive payments from another CCG;

c) make the services of its employees or any other resources available to another CCG; or

d) receive the services of the employees or the resources available to another CCG.

\(^{42}\) See appendix D
\(^{43}\) See appendix C
\(^{44}\) See chapter 5 above
6.4.4 Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

6.4.5 For the purposes of the arrangements described at paragraph 6.4.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.4.2c above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.4.6 Where the CCG makes arrangements with another CCG as described at paragraph 6.4.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.4.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.4.2. above.

6.4.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.4.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

6.4.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements, the lead clinician and lead manager of the lead CCG to make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.4.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year.

6.4.12 The CCG has established a Joint Commissioning Committee with NHS Sandwell and West Birmingham, NHS Wolverhampton and NHS Walsall CCGs to exercise the functions set out in the Committee’s Terms of Reference and in line with the CCG’s Scheme of Reservation and Delegation. No commissioning functions have yet been
delegated to the Joint Commissioning Committee. The Terms of Reference are available on our website.

6.5 Joint commissioning arrangements with NHS England for the exercise of CCG functions

6.5.1 The CCG may wish to work together with NHS England in the exercise of its commissioning functions.

6.5.2 The CCG and NHS England may make arrangements to exercise any of the CCG’s commissioning functions jointly.

6.5.3 The arrangements referred to in paragraph 6.5.2 above may include other CCGs.

6.5.4 Where joint commissioning arrangements pursuant to 6.5.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.5.5 Arrangements made pursuant to 6.5.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.5.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.5.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund; and
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.5.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.2 above.

6.5.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.5.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

6.5.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Chief Accountable Officer of the CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to
review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.5.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

6.6 Joint commissioning arrangements with NHS England for the exercise of NHS England’s functions

6.6.1 The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

6.6.2 The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:

- Exercise such functions as specified by NHS England under delegated arrangements;
- Jointly exercise such functions as specified with NHS England.

6.6.3 Where arrangements are made for the CCG and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

6.6.4 Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

6.6.5 For the purposes of the arrangements described at paragraph 6.6.2 above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.6.6 Where the CCG enters into arrangements with NHS England as described at paragraph 6.6.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
6.6.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 6.6.2 above.

6.6.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.6.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

6.6.10 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the Chief Accountable Officer of the CCG make a quarterly written report to the Governing Body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.6.11 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

6.7 Committees of the Group

6.7.1 The following committees have been established by the Group and are each accountable to the Governing Body:

a) Audit & Governance Committee
b) Remuneration & Human Resources Committee
c) Finance, Performance & Business Intelligence Committee
d) Quality and Safety Committee
e) Commissioning Development Committee
f) Primary Care Commissioning Committee
g) Multi-speciality Community Provider (MCP) Procurement Project Board
h) Black Country & West Birmingham Joint Commissioning Committee

6.7.2 Committees will only be able to establish their own Sub-Committees, to assist them in discharging their respective responsibilities, if this has been agreed with the Governing Body.

6.8 Joint Arrangements

6.8.1 The Group will, as made appropriate by the development and delivery of its commissioning plans, enter into joint or collaborative arrangements with other clinical commissioning groups and document these arrangements in accordance with either paragraph 6.4, 6.5 or 6.6 above, dependent upon the nature of the arrangement.

6.8.2 The Group has collaborative arrangements in place with Dudley Metropolitan Borough Council established for specific activities under Section 75 of the NHS Act 2006.
6.9 The Governing Body

6.9.1 Functions - the Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution. The Group has also delegated to the Governing Body additional functions of the Group connected with the Group’s main functions as set out from paragraph 6.9.1(d)45. The Governing Body has responsibility for:

a) ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically (see 5.2.3 above) and in accordance with the Groups principles of good governance 46 (its main function);

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

c) approving any functions of the Group that are specified in regulations; 47

d) leading the setting of vision and strategy

e) approving budgets and commissioning plans (Prime Financial Policy 7)

f) providing assurance with regard to strategic risk management (Prime Financial Policy 15.3).

g) approving the Group’s detailed Scheme of Delegation, Standing Orders, Prime Financial Policies and annual report and financial statements

h) agreeing changes to the terms of reference of committees

i) deciding to ratify any reported non-compliance with Standing Orders or upon the course of action required as a result of it (Standing Order 5).

6.9.2 Composition of the Governing Body - the Governing Body shall not have less than 12 members (and all shall have voting rights unless otherwise stated) and comprises of:

a) the chair; (appointed by the voting members of the Governing Body from the 10 elected GP representatives)

b) the lay member vice chair (elected by the voting members of the Governing Body from the nominated lay members)

45 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
46 See section 4.4 on Principles of Good Governance above
47 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
c) up to 10 (including the Chair) elected GP representatives of member practices;

d) Clinical Executives of which there are currently five (to the extent that these roles have not been filled from within the elected GP representatives);

e) The CCG has three lay members on the Governing Body:
   i. Lay member for Governance who is the Chair of the Primary Care Commissioning Committee; Chair of Remuneration & HR Committee (Lay member Committee)
   ii. Lay member for Patient & Public Engagement who is Chair of the Audit & Governance Committee (Lay Member Committee)
   iii. Lay member for Quality & Safety who is the Vice Chair of the Quality & Safety Committee

f) one registered nurse who will be employed as the Group’s Chief Nurse;

g) one secondary care specialist doctor;

h) the accountable officer who will be employed as the Group’s Chief Accountable Officer;

i) the Chief Finance Officer, an individual with a recognised accountancy qualification who will be employed by the Group;

j) Chief Executive for the Dudley Metropolitan Council or their formally nominated Deputy

The Governing Body may invite such other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Any such person may speak and participate in debate, but may not vote.

k) The Governing Body will invite the following individuals to attend any or all of its meetings

   ii) Chief Officer of Health & Wellbeing (Director of Public Health)
   iii) Healthwatch (or statutory equivalent) representative
   iv) representative of the Local Medical Committee (LMC)
   v) up to five CCG executive directors

The Group’s Standing Orders (Appendix C) define how the Group will, in accordance with any relevant regulations, appoint the various categories of members of the Governing Body, their tenure in office, how a person would resign from their post and the grounds for their removal from office. They also specify those persons who will be invited to attend meetings of the Governing Body as well as the arrangements for admission of the public and press.

6.9.3 Committees of the Governing Body - the Governing Body has appointed the following committees (their terms of reference as approved and updated by the
Group from time to time are available from the accountable officer on written request):

a) **Audit & Governance Committee** – the Audit & Governance Committee, which is accountable to the Group’s Governing Body, provides the Governing Body with an independent and objective view of the Group’s systems or risk management, governance and internal control. The Governing Body has approved and keeps under review the terms of reference for the Audit & Governance Committee, which includes information on the membership of the Audit & Governance Committee. As this Committee is a Lay Committee, the Lay Member for Patient & Public Engagement Chairs the meeting and the Vice Chair is the Lay Member for Governance.

b) **Remuneration & Human Resource Committee** – the Remuneration & Human Resource Committee, which is accountable to the Group’s Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the Remuneration & Human Resource Committee, which includes information on the membership of the Remuneration & Human Resource Committee. As this Committee is a Lay Committee, the Lay Member for Governance Chairs the meeting and the Vice Chair is the Lay Member for Patient and Public Engagement.

c) **Finance, Performance and Business Intelligence Committee** – the Finance, Performance and Business Intelligence Committee which is accountable to the Group’s Governing Body, ensures full consideration of financial performance and associated planning issues for the Group and monitors performance against service delivery indicators and targets. The Governing Body has approved and keeps under review the terms of reference for the Finance, Performance and Business Intelligence Committee, which includes information on the membership of the Finance, Performance and Business Intelligence Committee.

In addition the Group or the Governing Body has conferred or delegated functions, connected with the Group’s main function, to its Finance, Performance and Business Intelligence Committee in accordance with the Finance, Performance and Business Intelligence Committee’s terms of reference. The Chair for this Committee is the Clinical Executive for Finance, Performance & Business Intelligence and the Vice Chair is the Lay Member for Governance.

d) **Quality and Safety Committee** – the Quality and Safety Committee which is accountable to the Group’s Governing Body, is authorised to review and recommend all issues pertinent to quality and safety for the Group and to provide assurance to the Governing Body that the commissioned services are of high quality. The Governing Body has approved and keeps under review the terms of reference for the Quality and Safety Committee, which includes information on the membership of the Quality and Safety Committee.

In addition the Governing Body has conferred or delegated functions, connected
with the Governing Body’s main function, to its Quality and Safety Committee in accordance with the Quality and Safety Committee’s terms of reference. The Chair for this Committee is the Clinical Executive for Quality & Safety and the Vice Chair is the Lay Member for Quality & Safety.

e) **Commissioning Development Committee** – the Commissioning Development Committee, which is accountable to the Group’s Governing Body, is authorised to consider proposed commissioning plans; the communication and engagement strategy of the Group, and the delivery of this, and make appropriate recommendations to the Governing Body. The Governing Body has approved and keeps under review the terms of reference for the Commissioning Development Committee, which includes information on the membership of the Commissioning Development Committee.

In addition the Governing Body has conferred or delegated functions, connected with the Governing Body’s main function, to its Commissioning Development Committee in accordance with the Commissioning Development Committee’s terms of reference. The Chair for this Committee is the Clinical Executive for Acute & Community Commissioning and the Vice Chair is the Lay Member for Governance.

f) **Primary Care Commissioning Committee** – the Primary Care Commissioning Committee is accountable to the Group’s Governing Body. The Committee is authorised to approve decisions on the review, planning and procurement of primary care medical services in Dudley, under delegated authority from NHS England.

The Governing Body has conferred or delegated functions to its Primary Care Commissioning Committee in accordance with the Primary Care Commissioning Committee’s terms of reference. The Chair for this Committee is the Lay Member for Governance and the Vice Chair is the Lay Member for Quality & Safety.

g) **Multi-Speciality Community Provider (MCP) Procurement Project Board** – the MCP Project Board is accountable to the Group’s Governing Body. The Project Board is to take all decisions regarding the Multi-Specialty Community Provider (MCP) procurement except the decision to commence procurement and to award the contract. The Chair for this Committee is the Chief Accountable Officer and the Vice Chair is the Chief Finance Officer.

h) **Black Country and West Birmingham Joint Commissioning Committee** – the Joint Committee with NHS Sandwell and West Birmingham, NHS Wolverhampton and NHS Walsall CCGs is accountable to the governing body for establishing a single commissioning view in line with the Sustainable Transformation Plan (STP) arrangements for key services across the Black Country and West Birmingham. No Commissioning functions have yet been delegated to the Joint Commissioning Committee. The Chair & Vice Chair for this Committee is appointed from among the Clinical Chairs of the four CCGs on a rolling basis.
7. ROLES AND RESPONSIBILITIES

7.1 Practice Representatives

7.1.1 Practice representatives represent their practice’s views and act on behalf of the practice in matters relating to the Group. The role of each practice representative is to ensure effective participation of the practice as a member of the Group by:

a) participating in group locality and borough meetings including educational events and workshops

b) acting as the first point of contact for the Group within the practice and facilitating two-way communication between the Group and the practice as required. This includes, but is not limited to, disseminating commissioning updates and information within the practice and seeking comment and feedback from the practice on proposed group policies and commissioning plans.

7.2 Elected GP Representatives of Member Practices

7.2.1 The elected GP representatives are voting members of the Governing Body. In addition to the general responsibilities of all Governing Body members, elected GP representatives will provide clinical leadership for the Group and bring a clinical perspective to the workings of the Group in the discharge of its general duties and functions. They will provide a direct link between the locality from which they are elected and the Governing Body.

7.3 Other GP and Primary Care Health Professionals

7.3.1 In addition to the elected GP representatives identified in section 7.2 above, the Group has identified a number of clinical lead roles who will be voting members of the Governing Body, to support the work of the Group and represent the Group rather than represent their own individual practices. These currently are:

a) the Clinical Executive for Finance, Performance & Business Intelligence

b) the Clinical Executive for Acute & Community Commissioning

c) the Clinical Executive for the Multispecialty Community Provider (MCP)

d) the Clinical Executive for Quality and Safety

e) the Clinical Executive for Primary Care Commissioning

but the span of responsibility attached to the five Clinical Executive posts may vary from time to time.

Other clinical lead roles may also be appointed by the Governing Body from time to time.
7.4 All Members of the Group's Governing Body

7.4.1 Guidance on the roles of members of the Group’s Governing Body is set out in a separate document. In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.5 The Chair of the Governing Body

7.5.1 The Chair of the Governing Body is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) building and developing the Group’s Governing Body and its individual members;

c) ensuring that the Group has proper constitutional and governance arrangements in place;

d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;

e) supporting the Chief Accountable Officer in discharging the responsibilities of the organisation;

f) contributing to building a shared vision of the aims, values and culture of the organisation;

g) leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;

h) overseeing governance and particularly ensuring that the Governing Body and the wider group behaves with the utmost transparency and responsiveness at all times;

i) ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;

j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies).

48 Clinical commissioning group Governing Body Members – Roles Attributes and Skills, NHS Commissioning Board Authority, April 2012
7.6 **The Vice Chair of the Governing Body**

7.6.1 The Vice Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.6.2 Details of how they will be appointed, their tenure of office and resignation or removal from office are included in the Group’s Standing Orders.

7.7 **Role of the Accountable Officer**

7.7.1 The Accountable Officer of the Group is a member of the Governing Body, and will be known as the Chief Accountable Officer.

7.7.2 This role of Accountable Officer has been summarised in a national document⁴⁹ as:

a) being responsible for ensuring that the Clinical Commissioning Group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money

b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through relevant agencies) is embodied and that safeguarding of funds is ensured through effective financial and management systems

c) working closely with the Chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation’s on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going developments of its members and staff.

7.7.3 In addition to the Accountable Officer’s general duties, where the accountable officer is also the senior clinical voice of the Group they will take the lead in interactions with stakeholders, including NHS England

7.8 **Role of the Chief Finance Officer**

7.8.1 The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the Clinical Commissioning Group and for supervising financial control and accounting systems

7.8.2 This role of Chief Finance Officer has been summarised in a national document⁵⁰ as:

a) being the Governing Body’s professional expert on finance and ensuring,

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⁴⁹ See the latest version of the NHS Commissioning Board Authority’s Clinical commissioning group Governing Body members: Role outlines, attributes and skills

⁵⁰ See the latest version of the NHS Commissioning Board’s Clinical commissioning group Governing Body members: Role outlines, attributes and skills
through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

b) making appropriate arrangements to support, monitor on the Group’s finances;

c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group’s resources;

d) being able to advise the Governing Body on the effective, efficient and economic use of the Group’s allocation to remain within that allocation and deliver required financial targets and duties;

e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;

f) responsible for the governance function within the Group;

g) responsible for managing corporate functions provided externally, including the Commissioning Support Service provider(s);

h) lead on management and negotiation of contracts with providers

7.9 Role of the Registered Nurse

7.9.1 The Registered Nurse is a member of the Governing Body and is responsible for ensuring commissioned services provide high quality services to patients.

7.9.2 The role is responsible for collective corporate responsibility for strategic and operational performance as a member of the CCG Board.

7.9.3 The role will be responsible for providing leadership and line management to nurses working within the CCG, and professional guidance to those working in the wider primary care system where relevant.

7.10 Role of the Lay Members

7.10.1 The Lay Members are members of the Governing Body and are responsible for bringing specific expertise and experience to the work of the Governing Body.

7.10.2 Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day to day running of the organisation.

7.10.3 The CCG has three lay members on the Governing Body:

a) Lay member for Governance who is the Chair of the Primary Care Commissioning Committee; Chair of Remuneration & HR Committee (Lay member Committee)

b) Lay member for Patient & Public Engagement who is Chair of the Audit & Governance Committee (Lay Member Committee)
c) Lay member for Quality & Safety who is the Vice Chair of the Quality & Safety Committee

7.11 Role of the Secondary Care Clinician

7.11.1 The Secondary Care Clinician is a member of the Governing Body and is responsible for bringing a broader view on health care issues to support the work of the CCG.

7.11.2 This role of Secondary Care Clinician has been summarised in a national document as:

- must be a consultant – either currently employed, or in employment at some time in the period of 10 years ending with the date of the individual's appointment to the governing body;
- has a high level of understanding of how care is delivered in a secondary care setting;
- be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;
- be highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working;
- be able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value;
- be able to contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation’s circumstances; and
- be able to provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service re-design, clinical pathways and system reform.

7.12 Joint Arrangements with other Organisations

7.12.1 The Group has the following joint arrangements with other organisations:

a) The Chief Accountable Officer is employed by Dudley Clinical Commissioning Group and shall also work for Walsall Clinical Commissioning Group.

b) The Chief Finance Officer is employed by Dudley Clinical Commissioning group and shall also work for Walsall Clinical Commissioning Group and Wolverhampton Clinical Commissioning Group.

7.13 Responsibilities of member practices to the Group and of the Group, (acting by its Governing Body), to member practices

7.13.1 The Group is a membership organisation and the effective participation of each member practice will be essential in developing and sustaining high quality...
compliance arrangements.

7.13.2 The bilateral accountabilities of the Group (acting by its Governing Body) and its member practices to one another are described in paragraphs 7.10.3 – 7.10.4 of this constitution.

7.13.3 Member practice responsibilities to the Group.

Each member practice shall:

a) appoint a practice representative to undertake the role as described in paragraph 7.1 of this constitution, in line with the practice’s agreed procedure for nomination and appointment,

b) nominate and release an appropriate representative to attend the Practice Manager Alliance Meetings

c) undertake regular practice meetings to monitor performance against the commissioning indicators as set out in the Group’s monthly commissioning performance reports.

d) meet with the Group’s GP Engagement Lead and agree plans to support the delivery of the commissioning strategies of the Group.

e) support the Group’s commissioning intentions and commissioning strategies and use, where appropriate and in accordance with patient choice, local services and pathways as commissioned by the Group

f) access relevant information via agreed group systems as appropriate regarding pathways, referral guidelines and other relevant commissioning information

g) make reasonable efforts to ensure the member practice remains within its commissioning budget

h) work with the Group to meet its quality and productivity targets set out within the Group’s commissioning strategies.

i) take account of all duties, rights, pledges and values as set out in the NHS Constitution; and

j) respond in a timely manner to reasonable information requests from the Group

7.13.4 Responsibilities of the Group (acting by its Governing Body) to member practices. The Group shall:

a) ensure that all member practices will receive at least one visit per year from representatives of the Group to discuss practice level commissioning issues and priorities.
b) ensure that, in addition to the AGM, there will be at least two other group general meetings each year that do not have the public in attendance.

c) ensure that an annual survey of member practices (designed and administered in conjunction with the LMC) is undertaken to obtain feedback on levels of satisfaction and perceived engagement with the commissioning process and report the survey results will be reported to a public meeting of the Governing Body.

d) ensure that GP representatives appointed to the Governing Body will be appointed in accordance with the process set out in Standing Orders paragraph 2.2 (Appendix C of this constitution)

e) ensure that member practices are kept informed of Group business through locality meetings, newsletters and education events, and other appropriate means

f) ensure that, in addition to the elected GP representatives, each locality has a Group named management point of contact for any concerns or issues.

g) ensure that the Governing Body provides information management tools, training and support to enable member practices to review information at patient level and support the member practice to meet its financial and quality targets.

7.14 Dispute Resolution Process

7.14.1 This process is to be used in the event of disputes and concerns being raised by either:

i) practice members who have concerns regarding the Governing Body or general workings of the Group or;

ii) the Governing Body in relation to the behaviour of any practice member.

7.14.2 Issues and concerns raised using this process will be dealt with promptly and in a supportive and constructive manner.

7.14.3 The process for member practices who wish to raise a grievance or concern is set out below.

Member practices should, in the normal course of events, be able to raise any concerns with their named group management contact, their elected GP representative for their locality, or the Group’s GP engagement lead. In circumstances where this routine contact does not resolve the issue satisfactorily, then member practices should follow the procedure set out below:

i) member practices should set out their grievance or issue in writing and submit this to the Accountable Officer

ii) the Accountable Officer will acknowledge receipt of the correspondence within 3 working days.
iii) in most instances the Chair and/or the Accountable Officer will make direct contact with the member practice to discuss the matter and agree any appropriate actions to resolve the issue. (Dependent upon the nature of the issue, the Chair will involve other colleagues from the Group with relevant lead responsibilities.) Any agreed actions will be confirmed in writing.

iv) if the above actions fail to resolve the issue to the satisfaction of the member practice, then the matter will be referred to a lay member of the Governing Body, who will be responsible for leading the consideration of the matter at a meeting of the full Governing Body. The member practice will be able to attend to make direct representation to this meeting.

v) member practices may involve the LMC (or other external support) at any stage of this process.

7.14.4 The process for the Governing Body raising concerns with a member practice is set out below:

In the normal course of events any concerns regarding a member practice’s compliance with its responsibilities as a member of the Group, would be raised informally via routine reporting and contact with the Group management contact or GP engagement lead. Where concerns and issues cannot be resolved via normal day to day contact, then the process set out below should be followed:

i) the Governing Body will set out the nature of the concerns in writing and send these to the member practice;

ii) the member practice will then be asked to meet with the elected GP locality representative, and/or the Chair and/or the Accountable Officer to discuss the issue of concern and agree a way forward within an agreed timescale;

iii) where appropriate, a recovery/action plan may be identified and agreed between the member practice and a nominated Clinical Executive, (and the LMC if requested by the member practice). The Clinical Executive will ensure that the member practice is provided with the appropriate information and assistance to support the member practice in the delivery of this plan;

iv) the recovery/action plan will be reviewed by the appropriate CCG Committee which will monitor the member practice’s achievements against the recovery plans objectives;

v) if the member practice does not respond to support and demonstrate improvement in line with the plan, this will be considered by the Governing Body and discussed within the confidential section;

vi) Member practices may and the Group will support the member practice to involve the LMC (or other external support), at any stage of this process.
8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1 Standards of Business Conduct

8.1.1 Employees, Members, Committee and Sub-Committee members of the Group and members of the Governing Body (and its Committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the Group and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix G.

8.1.2 They must comply with the Group’s policy on business conduct, including the requirements set out in the policy for meeting the Group’s duties with regard to registering and managing conflicts of interest. This policy is available on the Group’s website at http://www.dudleyccg.nhs.uk/publication-scheme-v2/.

8.1.3 Individuals contracted to work on behalf of the Group or otherwise providing services or facilities to the Group will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.1.4 Due consideration will be given to the available guidelines and protocols from statutory bodies and recognised national institutions such as the General Medical Council, General Pharmaceutical Council, and Royal College of General Practitioners in managing conflicts of interest.

8.2 Conflicts of Interest

8.2.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the Clinical Commissioning Group will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the Group will be taken and seen to be taken without any possibility of the influence of external or private interest.

8.2.2 Where an individual, i.e. an employee, group member, member of the Governing Body, or a member of a Committee or a Sub-Committee of the Group or its Governing Body has an interest, or becomes aware of an interest, which could lead to a conflict of interest in the event of the Group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

An interest will include:

a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);
b) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit from the consequences of a commissioning decision;

c) a non-pecuniary interest: where an individual holds a non-remunerative or not-for-profit interest in an organisation, that will benefit from the consequences of a commissioning decision(for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

d) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual’s house).

e) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

f) A potential conflict of interest arises where any of the above interests may be affected by a decision or proposed decision of the Group, or where as a result of the interest there may be a conflict between the interest and the interest of the Group, or between the individual’s interest and their duty to the Group as employee, member or otherwise.

8.2.3 If in doubt, the individual concerned should assume that a potential conflict of interest exists.

8.3 Declaring and Registering Interests

8.3.1 The Group will maintain one or more registers of the interests of:

a) the members of the Group;

b) the members of its Governing Body;

c) the members of its Committees or Sub-Committees and the Committees or Sub-Committees of its Governing Body; and
d) its employees.

8.3.2 The registers will be published on the Group’s website at http://www.dudleyccg.nhs.uk/publication-scheme-v2/

8.3.3 Individuals will declare any interest that they have in writing to the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral
declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.5 The Audit & Governance Committee will ensure that the register(s) of interest is reviewed regularly, and updated as necessary.

8.4 Managing Conflicts of Interest: general

8.4.1 Individual members of the Group, the Governing Body, Committees or Sub-Committees, the Committees or Sub-Committees of its Governing Body and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest, as described in the Group’s Conflicts of Interest (including Gifts & Hospitality) Policy and is available on the CCG Website http://www.dudleyccg.nhs.uk/publication-scheme-v2/

8.5 Managing Conflicts of Interest: contractors and people who provide services to the Group

8.5.1 Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the Clinical Commissioning Group in relation to the potential provision of services or facilities to the Group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2 Anyone contracted to provide services or facilities directly to the Clinical Commissioning Group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.5.3 Contractors and people who provide services to the Group are required to comply with the Group’s Conflicts of Interest (including Gifts & Hospitality) Policy referred to at 8.4.1.

8.6 Transparency in Procuring Services

8.6.1 The Group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The Group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2 The Group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

a) all relevant clinicians (not just members of the Group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

b) service redesign and procurement processes are conducted in an open,
transparent, non-discriminatory and fair way

8.6.3 Copies of this Procurement Strategy will be available on the Group’s website at http://www.dudleyccg.nhs.uk/publication-scheme-v2/ under ‘What we spend and how we spend it’.

9. **THE GROUP AS EMPLOYER**

9.1 The Group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the Group.

9.2 The Group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.

9.3 The Group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the Group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4 The Group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The Group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.

9.5 The Group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6 The Group will ensure that employees’ behaviour reflects the values, aims and principles set out above.

9.7 The Group will ensure that it complies with all aspects of employment law.

9.8 The Group will ensure that its employees have access to such expert advice and training opportunities as they may require to deliver their responsibilities effectively.

9.9 The Group will adopt a Code of Conduct for staff and will maintain and promote effective ‘whistleblowing’ procedures to ensure that concerned staff have means through which their concerns can be voiced. The Group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the Group, any member of its Governing Body, any member of any of its committees or Sub-Committees or the committees or Sub-Committees of its Governing Body, or any
employee of the Group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

9.10 Copies of this Code of Conduct, together with the other policies and procedures outlined in this section, will be available at the Group’s website http://www.dudleyccg.nhs.uk/publication-scheme-v2/

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1 General

a) The Group will publish annually a commissioning plan and an annual report, presenting the Group’s annual report to a public meeting.

b) Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the Group’s website at http://www.dudleyccg.nhs.uk/our-board/

c) The Group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2 Standing Orders

a) This constitution is also informed by a number of documents which provide further details on how the Group will operate. They are the Group’s:

1. Standing orders (Appendix C) – which sets out the arrangements for meetings and the appointment processes to elect the Group’s representatives and appoint to the Group’s Committees, including the Governing Body;

2. Scheme of reservation and delegation (Appendix D) – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the Group’s Governing Body, the Governing Body’s committees and Sub-Committees, the Group’s Committees and Sub-Committees, individual members and employees;

3. Prime financial policies (Appendix E) – which sets out the arrangements for managing the Group’s financial affairs.
## APPENDIX A
### DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

<table>
<thead>
<tr>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
</tbody>
</table>
| **Accountable officer, usually referred to as Chief Executive** | an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the Group:  
  - complies with its obligations under:  
    - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
    - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
    - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
    - any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
  - exercises its functions in a way which provides good value for money. |
| **Chair of the Governing Body** | the geographical area that the Group has responsibility for, as defined in Chapter 2 of this constitution |
| **Chief finance officer, usually referred to as Chief Operating & Finance Officer** | the qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance |
| **Clinical commissioning group** | a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 |
| **Committee** | a committee or Sub-Committee created and appointed by:  
  - the membership of the Group  
  - a committee / Sub-Committee created by a committee created / appointed by the membership of the Group  
  - a committee / Sub-Committee created / appointed by the Governing Body |
| **Financial year** | this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March |
| **Governing Body, usually referred to as Board** | NHS Dudley Clinical Commissioning Group, whose constitution this is |
| | the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with:  
  - its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and  
  - such generally accepted principles of good governance as are relevant to it. |
<table>
<thead>
<tr>
<th><strong>Governing Body Member, usually referred to as Board Member</strong></th>
<th>any member appointed to the Governing Body of the Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lay member, usually referred to as Non-Executive Director</strong></td>
<td>a lay member of the Governing Body, appointed by the Group. A lay member is an individual who is not a member of the Group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)</td>
</tr>
<tr>
<td><strong>Practice representatives</strong></td>
<td>an individual appointed by a practice (who is a member of the Group) to act on its behalf in the dealings between it and the Group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the</td>
</tr>
</tbody>
</table>
| **Registers of interests** | registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of:  
  - the members of the Group;  
  - the members of its Governing Body;  
  - the members of its committees or Sub-Committees and committees or sub-committees of its Governing Body; and  
  - its employees. |
| **Registered Nurse usually referred to as Chief Nurse** | the individual employed by the Group with responsibility for Quality & Safety |
| **Regulations** | Any regulations issued by the Secretary of State under the 2006 Act, 2012 Act or any other relevant legislation that determines the duties, powers or conduct of a clinical commissioning group |
### APPENDIX B
#### LIST OF MEMBER PRACTICES BY LOCALITY

<table>
<thead>
<tr>
<th>Sedgley, Coseley and Gornal</th>
<th>Stourbridge, Wollescote and Lye</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Northway Surgery</td>
<td>30 Lion Health</td>
</tr>
<tr>
<td>2 Bath Street Surgery</td>
<td>31 Pedmore Medical Practice</td>
</tr>
<tr>
<td>3 Coseley Medical Centre</td>
<td>32 Chapel Street Surgery</td>
</tr>
<tr>
<td>4 Woodsetton Medical Centre</td>
<td>33 The Limes Surgery</td>
</tr>
<tr>
<td>5 The Ridgeway Surgery</td>
<td></td>
</tr>
<tr>
<td>6 The Greens Health Centre</td>
<td></td>
</tr>
<tr>
<td>7 Lower Gornal Health Centre</td>
<td></td>
</tr>
<tr>
<td>8 Castle Meadows Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dudley and Netherton</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9 St James Medical Practice (Dr White)</td>
<td>35 Wychbury Medical Group</td>
</tr>
<tr>
<td>10 St James Medical Practice (Dr Porter)</td>
<td></td>
</tr>
<tr>
<td>11 Eve Hill Medical Practice</td>
<td></td>
</tr>
<tr>
<td>12 Stepping Stones Medical Practice</td>
<td></td>
</tr>
<tr>
<td>13 Cross Street Health Centre</td>
<td></td>
</tr>
<tr>
<td>14 Central Clinic</td>
<td></td>
</tr>
<tr>
<td>15 Bean Road Surgery</td>
<td></td>
</tr>
<tr>
<td>16 Keeling House Surgery</td>
<td></td>
</tr>
<tr>
<td>17 Links Medical Practice</td>
<td></td>
</tr>
<tr>
<td>17a Hazel Road Surgery (Netherton Surgery Branch)</td>
<td></td>
</tr>
<tr>
<td>18 Netherton Health Centre</td>
<td></td>
</tr>
<tr>
<td>19 Dudley Wood Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kingswinford, Amblecote and Brierley Hill</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20 High Oak Surgery</td>
<td></td>
</tr>
<tr>
<td>21 Kingswinford Health Centre</td>
<td></td>
</tr>
<tr>
<td>22 Moss Grove Surgery</td>
<td></td>
</tr>
<tr>
<td>23 Summerhill Surgery</td>
<td></td>
</tr>
<tr>
<td>24 Rangeways Road Surgery</td>
<td></td>
</tr>
<tr>
<td>25 Wordsley Green Health Centre</td>
<td></td>
</tr>
<tr>
<td>26 AW Surgeries</td>
<td></td>
</tr>
<tr>
<td>26a Withymoor Surgery (AW Branch)</td>
<td></td>
</tr>
<tr>
<td>27 Waterfront Surgery</td>
<td></td>
</tr>
<tr>
<td>28 Quincy Rise Surgery</td>
<td></td>
</tr>
<tr>
<td>29 Three Villages Medical Practice</td>
<td></td>
</tr>
<tr>
<td>29a Wollaston Surgery (Three Villages Branch)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Halesowen and Quarry Bank</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30a Chapel House Lane (Wychbury Branch)</td>
<td></td>
</tr>
<tr>
<td>36 Thorns Road Surgery</td>
<td></td>
</tr>
<tr>
<td>37 Quarry Bank Medical Centre</td>
<td></td>
</tr>
<tr>
<td>38 Clement Road Medical Centre</td>
<td></td>
</tr>
<tr>
<td>39 Feldon Lane Surgery</td>
<td></td>
</tr>
<tr>
<td>39a Hawne Lane Surgery (Feldon Lane Branch)</td>
<td></td>
</tr>
<tr>
<td>40 Crestfield Surgery</td>
<td></td>
</tr>
<tr>
<td>41 Alexandra Medical Centre</td>
<td></td>
</tr>
<tr>
<td>42 Lapal Medical Practice</td>
<td></td>
</tr>
<tr>
<td>43 Meadowbrook Surgery</td>
<td></td>
</tr>
<tr>
<td>44 Stourside Medical Practice</td>
<td></td>
</tr>
<tr>
<td>44a Tenlands Avenue Surgery (Stourside Branch)</td>
<td></td>
</tr>
<tr>
<td>44b Coombs Road Surgery (Stourside Branch)</td>
<td></td>
</tr>
<tr>
<td>45 St Margaret’s Wells Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Area</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>35b Cradley Road Surgery (Wychbury Branch)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C
STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These standing orders have been drawn up to regulate the proceedings of the NHS Dudley Clinical Commissioning Group so that Group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the Group is established.

1.1.2. The standing orders, together with the Group’s scheme of reservation and delegation and the Group’s prime financial policies, provide a procedural framework within which the Group discharges its business. They set out:

a) the arrangements for conducting the business of the Group;

b) the appointment of member practice representatives;

c) the procedure to be followed at meetings of the Group, the Governing Body and any committees or Sub-Committees of the Group or the Governing Body;

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

1.1.3 These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate of any relevant guidance.

1.1.4. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the Group’s constitution. Group members, employees, members of the Governing Body, members of the Governing Body’s Committees and Sub-Committees, members of the Group’s Committees and Sub-Committees and persons working on behalf of the Group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.
1.2. Schedule of matters reserved to the clinical commissioning group and the scheme of reservation and delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the Group with powers to delegate the Group’s functions and those of the Governing Body to certain bodies (such as Committees) and certain persons. The Group has decided that certain decisions may only be exercised by the Group in formal session. These decisions and also those delegated are contained in the Group’s scheme of reservation and delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1 Composition of membership

2.1.1 Chapter 3 of the Group’s constitution provides details of the membership of the Group (also see Appendix B).

2.1.2 Chapter 6 of the Group’s constitution provides details of the governing structure used in the Group’s decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the Group and its Governing Body, including the role of practice representatives (section 7.1 of the constitution).

2.2. Key Roles

2.2.1 Paragraph 6.9.2 of the Group’s constitution sets out the composition of the Group’s Governing Body whilst Chapter 7 of the Group’s constitution identifies certain key roles and responsibilities within the Group and its Governing Body. These standing orders set out how the Group appoints individuals to these key roles.

2.2.2 The Chair of the Governing Body, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – the Chair of the Governing Body may be nominated by any voting member of the Governing Body from amongst the elected GP members of the Governing Body;

b) **Eligibility** – nominees for Chair of the Governing Body must be an elected GP member of the Governing Body and meet the person specification of the agreed role description of chair of the Governing Body.

c) **Appointment process** – should there be more than one eligible nominee for the role then this role will be appointed via election from within the voting members of the Board. Should there be only one eligible nominee then the individual will be confirmed in post.

d) **Term of office** - 3 years
e) **Eligibility for reappointment** - there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria and are subject to a nomination and election process every 3 years.

f) **Grounds for removal from office** - where the individual is no longer a member of the Group, where the individual is no longer an elected GP member of the Governing Body, where the individual is no longer on the Dudley Performers list; where the individual does not comply with the code of conduct.

g) **Notice period** - A minimum of 2 months’ notice is required, which notice must be provided in writing to the Accountable Officer and Vice Chair of the Governing Body.

2.2.3 The Vice Chair of the Governing Body, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – the Vice Chair of the Governing Body may be nominated from amongst the appointed lay members of the Board by any voting member of the Governing Body.

b) **Eligibility** – the Vice Chair of the Governing Body must be one of the appointed lay members of the Governing Body. They must meet the criteria set out in the agreed role description.

c) **Appointment process** – should there be more than 1 eligible nominee, then this appointment shall be via election by the voting members of the Governing Body. If only 1 eligible nominee then they would be confirmed in post.

d) **Term of office** - 3 years

e) **Eligibility for reappointment** – there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria.

f) **Grounds for removal from office** - no longer being eligible as defined at (b) above, failure to comply with the Code of Conduct or any proven misconduct that would in the case of an employee of the Group result in their dismissal.

g) **Notice period** - one month to be served in writing to the Chair.

2.2.4 The lay members of the Governing Body, as listed in paragraph 6.9.2 of the Group’s constitution, are subject to the following appointment process:

a) **Nominations** – persons who meet the requirements of and are not disqualified by regulations, will be invited to apply for these positions;

b) **Eligibility** – further qualifying criteria for each of the positions will be clearly set out and only applicants who meet those criteria will be considered;
c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to each position;

d) **Term of office** – 3 years

e) **Eligibility for reappointment** – there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to comply with the Code of Conduct or any proven misconduct that would in the case of an employee of the Group result in their dismissal;

g) **Notice period** – one month to be served in writing to the Chair.

2.2.5 The elected GP representatives of member practices, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – any GP from the Dudley Performers list may self-nominate to stand for election in one of the 5 CCG localities, in line with the electoral process agreed and overseen by the LMC. (Up to 2 GP elected representative Governing Body members will be appointed from each locality). Nominees will only be eligible to stand for election if they have met the eligibility criteria (see below)

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description. This assessment will be carried out by an independent committee, accountable to the Remuneration & HR Committee.

c) **Appointment process** – appointed via election from an electorate comprising all GPs on the Dudley Performers list.

d) **Term of office** - 3 years

e) **Eligibility for reappointment** - there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria and are subject to a nomination and election process every 3 years.

f) **Grounds for removal from office** - where the individual is no longer a member of the Group; where the individual is no longer on the Dudley Performers list; where the individual does not comply with the code of conduct.

g) **Notice period** – 2 months’ notice provided in writing to the Chair of the Governing Body

2.2.6 The Practice Representative, as listed in paragraph 7.1 of the Group’s constitution is subject to the following appointment process:

a) **Nominations** – the Practice Representative shall be nominated by the member practice
b) **Eligibility** – nominees for Practice Representative will normally be a general practitioner partner or other healthcare professional partner of the member practice or a general practitioner or other healthcare professional employee of the member practice, but practices may nominate a non clinician partner or employee.

c) **Term of Office** – this is determined by each member practice

d) **Eligibility for Re-appointment** – practice representatives shall be eligible for re-appointment in line with the member practice’s agreed process for nomination

e) **Grounds for Removal from office** – the member practice may ask its representative to stand down in line with its agreed internal processes. The Group can request the removal from office of any practice representative who does not fulfil the requirements of the role i.e. ensuring meaningful engagement of the member practice with the Group.

f) **Notice Period** – the normal notice period shall be 1 month, unless an alternative period is mutually agreed between the practice representative and the member practice - member practices shall inform the Group’s Accountable Officer of the name of the practice representative.

2.2.7. The **Clinical Executive roles**, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – any Governing Body GP member on the Dudley Performer’s list would be eligible to self-nominate, following advertisement of the vacancy.

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description. This assessment will be carried out by an independent committee, accountable to the CCG Remuneration & HR Committee.

c) **Appointment process** – Applications in the first instance will be accepted from all Dudley clinicians who meet the job description & person specification requirements. Should an appointment not be made, applications will be accepted from clinicians outside Dudley and a national advert will be placed.

d) **Term of office** – 3 years

e) **Eligibility for reappointment** – there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria. The Chair and Accountable Officer can jointly agree for a reappointment to be renewed automatically; otherwise the post will be subject to a competitive appointment process (as outlined above) after each term.

f) **Grounds for removal from office** - where the individual is no longer a member of the Group; where the individual is no longer on the Dudley Performers list; where the individual does not comply with the code of conduct.
g) **Notice period** – A minimum of 2 months’ notice is required, which notice must be provided in writing to the Accountable Officer and Chair of the Governing Body.

2.2.8 The **Registered Nurse** role, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – membership of the Governing Body will rest with the individual appointed as the Group’s Chief Nurse and applications will be sought by advertising that position

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description.

c) **Appointment process** – a competitive recruitment process will be held, eligible applicants will be shortlisted and selected by interview using criteria designed to identify the candidate best suited to the position

d) **Term of office** – this is a substantive role

e) **Eligibility for reappointment** – substantive post subject to terms and conditions of NHS employment

f) **Grounds for removal from office** – as per NHS terms and conditions and subject to the Group’s HR policies and procedures.

g) **Notice period** – In accordance with NHS terms and conditions.

2.2.9 The **Secondary Care Doctor role**, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – any individual may self-nominate following advertisement of the vacancy.

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description. This assessment will be carried out by an independent committee, accountable to the Remuneration Committee.

c) **Appointment process** – a competitive recruitment process will be held, overseen by an independent committee, accountable to the Remuneration Committee

d) **Term of office** – 3 years

e) **Eligibility for reappointment** - there is no limit to the number of terms of office served by an individual providing that they continue to meet the eligibility criteria and are subject to a competitive appointment process (as outlined above) after each term.
2.2.10 The **Accountable Officer role**, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – membership of the Governing Body will rest with the individual appointed as the Group’s Chief Accountable Officer and applications will be sought by advertising that position. The recruitment process is carried out by the CCG and the appointment of the Chief Accountable Officer is approved by NHS England.

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description.

c) **Appointment process** – a competitive recruitment process will be held, eligible applicants will be shortlisted and selected by interview using criteria designed to identify the candidate best suited to the position.

d) **Term of office** – this is a substantive role.

h) **Eligibility for reappointment** – substantive post subject to terms and conditions of NHS employment.

i) **Grounds for removal from office** – as per NHS terms and conditions and subject to the Group’s HR policies and procedures.

j) **Notice period** – In accordance with NHS terms and conditions.

2.2.11 The **Chief Finance Officer role**, as listed in paragraph 6.9.2 of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – membership of the Governing Body will rest with the individual appointed as the Group’s Chief Finance Officer and applications will be sought by advertising that position.

b) **Eligibility** – must be assessed as meeting the eligibility criteria set out in the agreed role description.

c) **Appointment process** – a competitive recruitment process will be held, eligible applicants will be shortlisted and selected by interview using criteria designed to identify the candidate best suited to the position.
d) **Term of office** – this is a substantive role

k) **Eligibility for reappointment** – substantive post subject to terms and conditions of NHS employment

l) **Grounds for removal from office** – as per NHS terms and conditions and subject to the Group’s HR policies and procedures.

m) **Notice period** – In accordance with NHS terms and conditions.

2.2.12 The roles and responsibilities of each of these key roles are set out either in paragraph 6.9.2 or Chapter 7 of the Group’s constitution. Role descriptions are approved by the Governing Body and amended from time to time in accordance with the requirements set out in the Group’s constitution.

2.3 **Suspension or Removal of a Member of the Governing Body**

The suspension and / or removal of a member of the Governing Body will follow the CCG’s Suspension and Removal Policy for Office Holders, with the exception of those Governing Body members who are directly employed by the CCG under NHS employment contracts in which case their terms and conditions of employment will apply.
3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

3.1.1. Ordinary meetings of the Group shall be held at regular intervals at such times and places as the Group may determine.

3.1.2. An extraordinary meeting of the Group will be held if deemed necessary by the Governing Body or if requested in writing to the Chair of the Governing Body by at least ten practice representatives. At least 5 working days’ notice will be given to all members via an e-mail to their practice representative. Unless otherwise determined by the Governing Body or the Chair thereof, because of the nature of the business of the meeting, the details of the date, time and venue of such meetings will be publicised on the Group’s website at www.dudleyccg.nhs.uk.

3.1.3. The Governing Body will schedule its meetings in advance and hold at least six such meetings in each financial year. Details of meeting dates, times and venues will be published on the Group’s website (www.dudleyccg.nhs.uk) and no meeting will be rescheduled without at least 5 working days’ notice of the re-arranged date.

3.1.4. Committees of the Group or the Governing Body and any Sub-Committees thereof will hold meetings as specified in their terms of reference.

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chief Finance Officer at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 8 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 5 working days before the date the meeting will take place.

3.2.2. Agendas and certain papers for the Group’s Governing Body – including details about meeting dates, times and venues - will be published on the Group’s website at www.dudleyccg.nhs.uk

3.3. Petitions and Direct Representations from Member Practices

3.3.1. Where a petition or a request for direct representation from a member practice has been received by the Group, the Chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body. Member practices who wish to make direct representation to the Governing Body shall use this method to make their request. A representative of the member practice may be present with speaking rights when their representation is being considered by the Governing Body.

3.4. Chair of a meeting

3.4.1. At any meeting of the Group or its Governing Body or of a Committee or Sub-
Committee, the Chair of the Group, Governing Body, Committee or Sub-Committee, if any and if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if any and if present, shall preside.

3.4.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a Chair or Deputy a member of the Group, Governing Body, Committee or Sub-Committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.5. Chair’s ruling

3.5.1. The decision of the Chair of the Governing Body on questions of order, relevancy and regularity and their interpretation of the constitution, standing orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.6. Quorum

3.6.1 Meetings of the Governing Body will be quorate when four elected GP clinical members and two other Governing Body member (one from the lay members or secondary care doctor and one from the Chief Accountable Officer, Chief Finance Officer or Registered Nurse are present, (provided that if the Chair is not present, then either the Accountable Officer or Chief Finance Officer must be present).

3.6.2 An officer in attendance for a Governing Body member but without formal acting up status for the purposes of decision making may not count towards the quorum.

3.6.3 If the reason for a meeting (or part thereof) not being quorate is that all or some of the elected members are disqualified from taking part in a vote due to a declared interest, those members can take part in a discussion of the relevant item of business but will not be allowed to vote upon it. The Chair of the meeting for that item of business will ensure that the requirements of the constitution at 8.4.1 have been met.

3.6.2 For all other of the Group’s Committees and Sub-Committees, including the Governing Body’s Committees and Sub-Committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference. Arrangements can be made for representatives to attend in the place of Chief Officers, with agreement by the Governing Body.

3.7 Decision making

3.7.1 Chapter 6 of the Group’s constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the Group’s statutory functions. In the event that the Governing Body’s decisions cannot be reached by consensus, a vote of members will be required, the process for which is set out below:
a) **Eligibility** – the following members of the Governing Body are eligible to vote (subject to conflicts of interest rules); each of the 10 elected GP representative members, three lay members, Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Registered Nurse, Dudley Metropolitan Borough Council Chief Executive. The five Clinical Executives will also be eligible to vote (where these are not already elected GP representative members and as such will already have a vote).

b) **Majority necessary to confirm a decision** - before taking a vote, the Board shall ensure that the majority of those present are elected GP members. In the event that they are in the minority then sufficient non-GP members will be required to withdraw from the vote until such time as the GP elected members are in the majority. When the vote is taken, a majority of one is required to confirm a decision.

c) **Casting vote** – in the event of a tie the casting vote will be held by the Chair of the Governing Body unless he/she has declared an interest in which case the Vice Chair will hold the casting vote.

d) **Dissenting views** – will be recorded in the minutes of the meeting

3.7.2 Should a vote be taken the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.7.3 For all other of the Group’s Committees and Sub-Committees, including the Governing Body’s committees and Sub-Committee, the details of the process for holding a vote are set out in the appropriate terms of reference.

3.8. **Emergency powers and urgent decisions**

3.8.1 The powers which the Governing Body has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Accountable Officer and the Chair after having consulted at least two elected GP representative members. The exercise of such powers by the Accountable Officer and Chair shall be reported to the next formal meeting of the Governing Body for formal ratification.

3.9 **Suspension of Standing Orders**

3.9.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, provided at least two thirds (rounded up to a whole number) of voting Governing Body members are present (including at least one of the Accountable Officer, Chair or Chief Finance Officer), and that at least two thirds of those present signify their agreement.

3.9.2 A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
3.9.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body’s Audit Committee for review of the reasonableness of the decision to suspend standing orders.

3.10. Record of Attendance

3.10.1 The names of all members of the meeting present at the meeting shall be recorded in the minutes of the Group’s meetings. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body’s committees / Sub-Committees present shall be recorded in the minutes of the respective Governing Body committee / Sub-Committee meetings.

3.11 Minutes

3.11.1 The names of individuals attending each Governing Body meeting shall be recorded in the minutes of each meeting.

3.11.2 The secretary to the Governing Body shall be responsible for taking and drafting minutes of the meeting.

3.11.3 Minutes shall be signed off as a true record of the meeting by the Chair of the Governing Body at the following meeting of the Governing Body.

3.11.4 Minutes shall be circulated to members of the Governing Body with agenda papers.

3.11.5 Minutes shall be made available to the public via the Group’s web-site once these have been signed off. Member practices shall receive copies of the minutes directly via e-mail.

3.12 Admission of public and the press

3.12.1 Admission and exclusion on grounds of confidentiality of business to be transacted

3.12.2 The public and representatives of the press may attend all meetings of the Governing Body, but shall be required to withdraw upon the Governing Body resolving as follows:

i) ‘that representatives of the press, and other members of the public, be excluded from the remainder of this 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

ii) the Group shall seek guidance from the Chief Finance Officer or Lay Member for Governance to ensure correct procedure is followed on matters involving the exclusion of the public and the representatives of the press from meetings of the Governing Body.
3.13 **General disturbances**

3.13.1 The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Governing Body's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Governing Body resolving as follows:

i) ‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Governing Body to complete its business without the presence of the public’. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

3.14 **Business proposed to be transacted when the press and public have been excluded from a meeting**

3.14.1 Matters to be dealt with by the Governing Body following the exclusion of representatives of the press, and other members of the public, as provided in 3.12.1 and 3.12.2 above; shall be confidential to the members of the Governing Body.

3.14.2 Members and officers or any employee of the Group in attendance shall not reveal or disclose the contents of any papers or minutes headed 'Items Taken in Private' outside of the Group, without the express permission of the Group. This prohibition shall apply equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

3.15 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

3.15.1 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Governing Body. Such permission shall be granted only upon resolution of the Governing Body.

4. **APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

4.1. **Appointment of Committees and Sub-Committees**

4.1.1. The Group may appoint Committees and Sub-Committees of the Group, subject to any regulations made by the Secretary of State, and make provision for the appointment of Committees and Sub-Committees of its Governing Body. Where such Committees and Sub-Committees of the Group, or Committees and Sub-Committees of its Governing Body, are appointed they are included in Chapter 6 of the Group’s constitution.
4.1.2. Other than where there are statutory requirements, such as in relation to the Governing Body’s Audit & Governance Committee or Remuneration & HR Committee, the Group shall determine the membership and terms of reference of Committees and Sub-Committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Group.

4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body’s Committees and Sub-Committee and all Committees and Sub-Committees unless stated otherwise in the committee or Sub-Committee’s terms of reference.

4.2. Terms of Reference

4.2.1 Terms of reference as approved and updated by the Group from time to time and are available from the Accountable Officer on written request.

4.3. Delegation of Powers by Committees to Sub-Committees

4.3.1. Where Committees are authorised to establish Sub-Committees they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Group.

4.4. Approval of Appointments to Committees and Sub-Committees

4.4.1. The Group shall approve the appointments to each of the committees and Sub-Committees which it has formally constituted including those the Governing Body. The Group shall agree such travelling or other allowances as it considers appropriate.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

5.1. If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall first be reported to the next formal meeting of the Audit Committee and then to the next formal meeting of the Governing Body for action or ratification. All members of the Group and staff have a duty to disclose any non-compliance with these standing orders to the Accountable Officer as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group’s seal

6.1.1. The Group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

NHS Dudley Clinical Commissioning Group’s Constitution
Version: 5.2 NHS Commissioning Board: Effective Date: 22/06/2018
a) the Accountable Officer;

b) the Chair of the Governing Body;

c) the Chief Finance Officer;

6.1.2 The use of the seal shall be reported to the CCG Governing Body annually.

6.2. Execution of a document by signature

6.2.1. The following individuals are authorised to execute a document on behalf of the Group by their signature.

a) the Accountable Officer

b) the Chair of the Governing Body

c) the Chief Finance Officer

7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1. Policy statements: general principles

7.1.1. The Group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Dudley Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the Group’s standing orders.
APPENDIX D
SCHEME OF RESERVATION & DELEGATION

1. SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

1.1. The arrangements made by the Group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated in the Group’s constitution.

1.2. The Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated.

1.3. The table below indicates which decisions have been reserved to the membership and these decisions can only be taken at a quorate meeting of the Group itself, as described in the constitution and Standing Orders or under 3.8.1 of Standing Orders in an emergency or in unforeseen circumstances.

1.4. Other decisions have been delegated to the Governing Body and these must be taken at a quorate meeting of that body, as described in the constitution and Standing Orders, or under 3.8.1 of Standing Orders in an emergency or in unforeseen circumstances.

1.5. Decisions delegated to the Accountable Officer or the Chief Finance Officer must be taken by the relevant individual or someone with express, written authority to do so on their behalf.

1.6. Decisions delegated to Committees or Sub-Committees must be taken at a quorate meeting of that body, as described in the constitution, Standing Orders and the relevant terms of reference.
### SCHEME OF RESERVATION & DELEGATION FOR THE GROUP

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
<th>Reserved to the Membership</th>
<th>Reserved/Delegated to Governing Body</th>
<th>Delegated to Committee</th>
<th>Officer</th>
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</thead>
<tbody>
<tr>
<td>REGULATION AND CONTROL</td>
<td>1. Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.</td>
<td>✓</td>
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<td></td>
<td>2. Consider and approve applications to NHS England on any matter concerning changes to the Group’s constitution, including terms of reference for the Group’s Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
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<td>✓</td>
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<td></td>
<td>3. Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the Group, delegated to the Governing Body, delegated to a committee or Sub-Committee of the Group or to one of its members or employees.</td>
<td></td>
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<td>✓</td>
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<td></td>
<td>4. Prepare the Group’s overarching scheme of reservation and delegation, which sets out those decisions of the Group reserved to the membership and those delegated to the group’s Governing Body, committees and Sub-Committees of the Group, or its members or employees and which sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the Governing Body’s committees and Sub-Committees, members of the Governing Body, an individual who is member of the Group but not the Governing Body or a specified person and for inclusion in the Group’s constitution.</td>
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<td></td>
<td>Chief Finance Officer</td>
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<td></td>
<td>5. Approve the Group’s overarching scheme of reservation and delegation.</td>
<td>✓</td>
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<td></td>
<td>6. Prepare the Group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of</td>
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<td></td>
<td>Chief Finance</td>
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</tbody>
</table>

NHS Dudley Clinical Commissioning Group’s Constitution
Version: 4.i NHS Commissioning Board: Effective Date: 11 August 2016
<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
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<th>Officer</th>
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<tbody>
<tr>
<td>PRACTICE MEMBER</td>
<td>Approve arrangements for</td>
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</tbody>
</table>

1. Approve arrangements for

2. Approve the Group’s operational scheme of delegation that underpins the Group’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.

3. Prepare detailed financial policies that underpin the clinical commissioning group’s prime financial policies.

4. Approve detailed financial policies.

5. Approve arrangements for managing exceptional funding requests.

6. Determine of process for making grants and loans to voluntary organisations.

7. Ensure the Group's expenditure does not exceed the aggregate of the CCG’s allotments for the financial year.

8. Ensure the Group's use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year.


10. Publish an explanation of how the Group spent any payment in respect of quality made to it by NHS England.
<table>
<thead>
<tr>
<th>Policy Area</th>
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</thead>
<tbody>
<tr>
<td>REPRESENTATIVES AND MEMBERS OF GOVERNING BODY</td>
<td>• identifying practice members to represent practices in matters concerning the work of the Group; and • appointing clinical leaders to represent the Group’s membership on the Group’s Governing Body, for example through election (if desired).</td>
<td>✓</td>
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<td></td>
<td>2. Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.</td>
<td>✓</td>
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<td></td>
<td>3. Approve arrangements for identifying the Group’s proposed accountable officer.</td>
<td>✓</td>
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<tr>
<td>STRATEGY AND PLANNING</td>
<td>1. Approve the Group’s operating structure.</td>
<td>✓</td>
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<tr>
<td></td>
<td>2. Approve the Group’s commissioning plan.</td>
<td>✓</td>
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<tr>
<td></td>
<td>3. Approve the Group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution.</td>
<td>✓</td>
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<td></td>
<td>4. Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the Group’s ability to achieve its agreed strategic aims.</td>
<td></td>
<td>Finance, Performance &amp; Business Intelligence</td>
<td></td>
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</tr>
<tr>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
<td>1. Approve the Group’s annual report and annual accounts.</td>
<td></td>
<td>Audit &amp; Governance</td>
<td></td>
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<tr>
<td></td>
<td>2. Approve arrangements for discharging the Group’s statutory financial duties.</td>
<td></td>
<td>Finance, Performance &amp; Business Intelligence</td>
<td></td>
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</tr>
<tr>
<td>HUMAN RESOURCES</td>
<td>1. Approve terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.</td>
<td></td>
<td></td>
<td>Remuneration &amp; HR</td>
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<td></td>
<td>2. Approve terms and conditions of employment for all employees of the</td>
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<td>Policy Area</td>
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<td>Group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.</td>
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<td>Remuneration &amp; HR</td>
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<td>3. Approve any other terms and conditions of services for the Group’s employees.</td>
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<td>Remuneration &amp; HR</td>
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<tr>
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<td>4. Determine the terms and conditions of employment for all employees of the Group.</td>
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<td>Remuneration &amp; HR</td>
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<tr>
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<td>5. Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.</td>
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<td>Remuneration &amp; HR</td>
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<td>6. Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.</td>
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<td>Remuneration &amp; HR</td>
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<td>7. Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the Clinical Commissioning Group) and for other persons working on behalf of the Group.</td>
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<td></td>
<td>Remuneration &amp; HR</td>
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<td>8. Review disciplinary arrangements where the Accountable Officer is an employee or member of another Clinical Commissioning Group.</td>
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<td>Remuneration &amp; HR</td>
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<tr>
<td></td>
<td>9. Approve arrangements for discharging the Group’s statutory duties as an employer.</td>
<td>✓</td>
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<td>Remuneration &amp; HR</td>
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<td></td>
<td>10. Approve human resources policies for employees and for other persons working on behalf of the Group.</td>
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<td>Remuneration &amp; HR</td>
</tr>
<tr>
<td>QUALITY AND SAFETY</td>
<td>1. Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.</td>
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<td>Quality and Safety</td>
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<td></td>
<td>2. Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.</td>
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<td>Quality and Safety</td>
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<tr>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
<td>1. Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the Group.</td>
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<td>Chief Finance Officer</td>
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<td></td>
<td>2. Approve the Group’s counter fraud and security management arrangements.</td>
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<td>Audit &amp; Governance</td>
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<tr>
<td></td>
<td>3. Approve the Group’s risk management arrangements.</td>
<td></td>
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<td></td>
<td>Audit &amp; Governance</td>
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<td>4. Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
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<td>Finance, Performance &amp; Business Intelligence</td>
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<tr>
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<td>5. Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the Group.</td>
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<td>Audit &amp; Governance</td>
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<td>6. Approve proposals for action on litigation against or on behalf of the clinical commissioning group.</td>
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<td>✓</td>
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<tr>
<td></td>
<td>7. Approve the Group’s arrangements for business continuity</td>
<td></td>
<td></td>
<td></td>
<td>Audit &amp; Governance</td>
</tr>
<tr>
<td>INFORMATION GOVERNANCE</td>
<td>1. Approve the Group’s arrangements for handling complaints.</td>
<td></td>
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<td>Quality and Safety</td>
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<tr>
<td></td>
<td>2. Approve arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data.</td>
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<td>Audit &amp; Governance</td>
</tr>
<tr>
<td>TENDERING AND CONTRACTING</td>
<td>1. Approve the Group’s contracts for any commissioning support.</td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
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<tr>
<td><strong>PARTNERSHIP WORKING</strong></td>
<td>2. Approve the Group’s contracts for corporate support (for example finance provision).</td>
<td></td>
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<td></td>
<td>Finance, Performance &amp; Business Intelligence</td>
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<tr>
<td></td>
<td>1. Approve decisions that individual members or employees of the Group participating in joint arrangements on behalf of the Group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.</td>
<td></td>
<td></td>
<td></td>
<td>Chief Accountable Officer</td>
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<tr>
<td></td>
<td>2. Approve decisions delegated to joint committees established under section 75 of the 2006 Act.</td>
<td></td>
<td></td>
<td></td>
<td>Chief Accountable Officer</td>
</tr>
<tr>
<td><strong>COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</strong></td>
<td>1. Determination of arrangements for discharging the Group’s statutory duties associated with its commissioning functions, including but not limited to securing public involvement, ensuring patient choice, securing continuous improvement in the quality of services, innovation, research, education and training and obtaining appropriate advice.</td>
<td></td>
<td>Commissioning Development</td>
<td></td>
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<td></td>
<td>2. Determination of arrangements put in place to promote a comprehensive health service</td>
<td>✓</td>
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<td></td>
<td>3. Determination of arrangements to meet the public sector equality duty</td>
<td>✓</td>
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<td></td>
<td>4. Promote the involvement of patients, carers and representatives in decision about their healthcare</td>
<td>✓</td>
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<td></td>
<td>5. Determination of the arrangements to secure engagement with the public, patient and their representatives in decisions about their healthcare – Engagement</td>
<td></td>
<td>Commissioning Development</td>
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<tr>
<td></td>
<td>6. Determination of the arrangements to secure engagement with the public, patient and their representatives in decisions about their healthcare - Patient Experience</td>
<td></td>
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<td>Quality and Safety</td>
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<tr>
<td>Policy Area</td>
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<td>Reserved to the Membership</td>
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<tr>
<td>7.</td>
<td>Determination of arrangements for supporting NHS England as regards improving the quality of primary medical services</td>
<td></td>
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<td>Quality and Safety</td>
</tr>
<tr>
<td>8.</td>
<td>Determination of arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate.</td>
<td></td>
<td></td>
<td></td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>9.</td>
<td>Determination of arrangements for securing health services that are provided in a way that promotes awareness of, and has regard to the NHS Constitution</td>
<td></td>
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<tr>
<td>10.</td>
<td>Determination of arrangements for the review, planning and procurement of primary care medical services (under delegated authority from NHS England). To include</td>
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<td></td>
<td>• GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);</td>
<td></td>
<td></td>
<td></td>
<td>Primary Care Commissioning</td>
</tr>
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<td></td>
<td>• Newly designed enhanced services (“Local Enhanced Services (LES)” and “Directed Enhanced Services (DES)”);</td>
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<td></td>
<td>• Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);</td>
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<td></td>
<td>• The ability to establish new GP practices in an area;</td>
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<td></td>
<td>• Approving practice mergers; and</td>
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<tr>
<td></td>
<td>• Making decisions on ‘discretionary’ payments (e.g., returner/retainer schemes).</td>
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<tr>
<td>11.</td>
<td>Overseeing the arrangements for co-ordinating the commissioning of services, other than primary medical services as delegated to the Primary Care Committee in 8 above, with other groups and or with the local authority(ies)</td>
<td></td>
<td></td>
<td></td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>12.</td>
<td>Promoting integration of both health services with other health services and health services with health-related and social care services where the Group considers that this would improve the quality of services or reduce inequalities</td>
<td></td>
<td></td>
<td></td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
<td>Reserved/Delegated to Governing Body</td>
<td>Delegated to Committee</td>
<td>Officer</td>
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<tr>
<td></td>
<td>13. Decisions regarding the Multi-Specialty Community Provider (MCP)</td>
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<td></td>
<td>MCP Project Board</td>
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<td></td>
<td>procurement except the decision to commence procurement and to award the contract.</td>
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<tr>
<td></td>
<td>14. Decision to commence MCP procurement and to award the contract</td>
<td></td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>COMMUNICATIONS</td>
<td>1. Approve arrangements for handling Freedom of Information requests.</td>
<td></td>
<td></td>
<td>Audit &amp; Governance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Determine arrangements for handling Freedom of Information requests.</td>
<td></td>
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<td></td>
<td>Chief Accountable Officer</td>
</tr>
</tbody>
</table>
APPENDIX E
PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the Group’s constitution.

1.1.2. The prime financial policies are part of the Group’s control environment for managing the organisation’s financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Appendix D.

1.1.3. In support of these prime financial policies, the Group has prepared more detailed policies, recommended by the Chief Finance Officer and approved by the Finance, Performance and Business Intelligence Committee known as detailed financial policies. The Group refers to these prime and detailed financial policies together as the Clinical Commissioning Group’s financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies.

1.1.5. A list of the Group’s detailed financial policies will be published and maintained on the Group’s website at www.dudleyccg.nhs.uk

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the Group’s constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.
1.2. **Overriding Prime Financial Policies**

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body’s Audit & Governance Committee for referring action or ratification. All of the Group’s members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.

1.3. **Responsibilities and delegation**

1.3.1. The roles and responsibilities of group’s members, employees, members of the Governing Body, members of the Governing Body’s Committees and Sub-Committees, members of the Group’s committee and Sub-Committee (if any) and persons working on behalf of the Group are set out in chapters 6 and 7 of this constitution.

1.3.2. The financial decisions delegated by members of the Group are set out in the Group’s scheme of reservation and delegation or the detailed operational scheme of delegation as appropriate.

1.4. **Contractors and their employees**

1.4.1. Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Financial Officer to ensure that such persons are made aware of this and that contractual terms ensure that the contractor and their employees comply with the same standards of governance and financial probity as would apply to any employee of the Group.

1.5. **Amendment of Prime Financial Policies**

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body’s Audit & Governance Committee, the Chief Finance Officer will recommend amendments, as fitting, to the Finance, Performance and Business Intelligence Committee for approval. As these prime financial policies are an integral part of the Group’s constitution, any amendment will not come into force until the Group applies to NHS England and that application is granted.
2. INTERNAL CONTROL

POLICY the Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

2.1. The Governing Body is required to establish an Audit & Governance Committee with terms of reference agreed by the Governing Body (see paragraph 6.9.3(a) of the Group’s constitution for further information).

2.2. The Chief Finance Officer has overall responsibility for the Group’s systems of internal control.

2.3. The Chief Finance Officer will ensure that:
   a) financial policies are considered for review and update annually;
   b) a system is in place for proper checking and reporting of all breaches of financial policies; and
   c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY the Group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews.

3.1. In line with the terms of reference for the Governing Body’s Audit & Governance Committee, the Head of Internal Audit and the appointed external auditor will have direct and unrestricted access to Audit & Governance Committee members and the Chair of the Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The Head of Internal Audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit & Governance Committee members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the Head of Internal Audit and external auditors.

3.3. The Chief Finance Officer will ensure that:
   a) the Group has a professional and technically competent internal audit function; and
b) the Governing Body’s Audit & Governance Committee approves any changes to the provision or delivery of assurance services to the Group.

4. COUNTERING FRAUD AND CORRUPTION

POLICY the Group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The Group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered.

4.1. The Governing Body’s Audit & Governance Committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The Governing Body’s Audit & Governance Committee will ensure that the Group has arrangements in place to work effectively with NHS Counter Fraud Authority.

5. EXPENDITURE CONTROL

5.1. The Group is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Finance Officer will:

   a) provide reports in the form required by NHS England;

   b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice;

   c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

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52 See section 223(H) of the 2012 Act
6. **ALLOTMENTS**\(^{53}\)

6.1. The Group’s Chief Finance Officer will:

a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the Group’s entitlement to funds;

b) prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

c) regularly update the Group’s Finance, Performance and Business Intelligence Committee and Governing Body on significant changes to the initial allocation and the uses of such funds.

7. **COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING**

**POLICY** the Group will produce and publish an annual commissioning plan\(^{54}\) that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets

7.1. The Accountable Officer will annually compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for review by the Finance, Performance and Business Intelligence Committee and their recommendation to the Group’s Governing Body for approval.

7.3. The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Finance, Performance and Business Intelligence Committee This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Accountable Officer has overall responsibility for ensuring that information relating to the Group’s accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.5. The Commissioning Development Committee will approve consultation arrangements for the Group’s commissioning plan\(^{55}\).

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\(^{53}\) See section 223(G) of the 2012 Act

\(^{54}\) See section 14Z11 of the 2012 Act
8. **ANNUAL ACCOUNTS AND REPORTS**

**POLICY** the Group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The Chief Finance Officer will ensure the Group:

   a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Audit & Governance Committee;

   b) prepares the accounts according to the timetable approved by the Audit & Governance Committee;

   c) complies with statutory requirements and relevant directions for the publication of annual report;

   d) considers the external auditor’s management letter and fully address all issues within agreed timescales; and

   e) publishes the external auditor’s management letter on the Group’s website at [www.dudleyccg.nhs.uk](http://www.dudleyccg.nhs.uk)

9. **INFORMATION TECHNOLOGY**

**POLICY** the Group will ensure the accuracy and security of the Group’s computerised financial data.

9.1. The Chief Finance Officer is responsible for the accuracy and security of the Group’s computerised financial data and shall:

   a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Group’s data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

   b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

   c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

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55 See section 14Z13 of the 2012 Act
56 See Schedule 2 section 17 of the 2012 Act
d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the chief finance officer may consider necessary are being carried out.

9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

**POLICY** the Group will run an accounting system that creates management and financial accounts

10.1. The Chief Finance Officer will ensure:

a) the Group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall at least annually seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

**POLICY** the Group will keep enough liquidity to meet its current commitments

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the Group at regular intervals to ensure they are in accordance with Secretary of State directions, best practice and represent best value for money;

b) manage the Group’s banking arrangements and advise the Group on the provision of banking services and operation of accounts;

c) prepare detailed instructions on the operation of bank accounts.
11.2. The Finance, Performance and Business Intelligence Committee shall approve the overall banking arrangements.

12. **INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.**

**POLICY** the Group will operate a sound system for prompt recording, invoicing and collection of all monies due seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the Group or its functions ensure its power to make grants and loans is used to discharge its functions effectively.

12.1 The Chief Finance Officer is responsible for:

- a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;
- b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;
- c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary;
- d) developing effective arrangements for making grants or loans.

13. **TENDERING AND CONTRACTING PROCEDURE**

**POLICY** the Group:

- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.
13.1. The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the Group’s Audit & Governance Committee.

13.2. The approval of the award of any contract will be given in accordance with the Group’s detailed operational scheme of delegation.

13.3. The Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

   a) the Group’s standing orders;
   b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
   c) take into account as appropriate any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.4. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. COMMISSIONING

POLICY working in partnership with relevant national and local stakeholders, the Group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The Group will coordinate its work with NHS England, other clinical commissioning groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Group’s Finance, Performance and Business Intelligence Committee detailing actual and forecast expenditure and activity for each contract.

14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.
15. RISK MANAGEMENT AND INSURANCE

POLICY the Group will put arrangements in place for evaluation and management of its risks

15.1 The Chief Finance Officer will ensure that adequate insurance arrangements are in put in place.

15.2 The Accountable Officer will ensure that the Group has effective arrangements in place to manage risk. This will be achieved through the maintenance of a Risk Management Strategy, Board Assurance Framework and Corporate Risk Register

15.3 The Risk Management Strategy identifies the Group’s risk management process for systematically identifying risks, analysing the likelihood and impact of their occurrence and then deciding what action to take to mitigate risk.

15.4 A Board Assurance Framework and Corporate Risk Register will be maintained, to provide evidence that the Group is doing its reasonable best to manage, direct and control itself so as to meet its corporate objectives. The Board Assurance Framework will provide a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the Group and provide a structure for the evidence to support the Group’s Annual Governance Statement.

16. PAYROLL

POLICY the Group will put arrangements in place for an effective payroll service

16.1. The Chief Finance Officer will ensure that the payroll service selected:

   a) is supported by appropriate (i.e. contracted) terms and conditions;

   b) has adequate internal controls and audit review processes;

   c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

16.3 Where another health organisation or any other agency provides a payroll service, the Chief Finance Officer shall at least annually seek assurances that adequate controls are in operation
17. NON-PAY EXPENDITURE

POLICY the Group will seek to obtain the best value for money goods and services received.

17.1. The Group’s Finance, Performance and Business Intelligence Committee will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers through the detailed operational scheme of delegation.

17.2. The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

   a) advise the Audit & Governance Committee on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;

   b) be responsible for the prompt payment of all properly authorised accounts and claims;

   c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY the Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place policies to secure the safe storage of the Group’s fixed assets.

18.1. The Accountable Officer will

   a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

   b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

   c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;
d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. INFORMATION GOVERNANCE

POLICY The Group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance.

19.1. The Accountable Officer shall nominate an individual to act as the Group’s Caldicott Guardian who will:

   a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;

   b) publish and maintain a Freedom of Information Publication Scheme and ensure that arrangements are in place for effective responses to Freedom of Information requests as required by the relevant legislation;

   c) be responsible for ensuring that the Group maintains compliance with all other relevant legislation including the Data Protection Act 1998.

19.2. The Chief Finance Officer will act as the Group’s Senior Information Risk Owner.

19.3. Information governance policies to facilitate the above will be approved by the Governing Body and the Group will use the NHS Information Governance Toolkit to assess its performance in this area.

20. TRUST FUNDS AND TRUSTEES

POLICY The Group will put arrangements in place to provide for the appointment of trustees if the Group holds property on trust.

20.1. The Chief Finance Officer shall ensure that each trust fund which the Group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F
CONFLICT OF INTEREST POLICY

The latest CCG’s Conflicts of Interest Policy (including Gifts and Hospitality) is available on the CCG website. http://www.dudleyccg.nhs.uk/publication-scheme-v2/ under ‘Policies and Procedures relating to the conduct of business and the provision of services’.
APPENDIX G
NOLAN PRINCIPLES

1. The ‘Nolan Principles’ set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

   a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

   b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

   c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

   d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

   e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

   f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

   g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life (1995)*

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59 Available at http://www.public-standards.gov.uk/
APPENDIX H

NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **the NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. **access to NHS services is based on clinical need, not an individual’s ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. **the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.

6. **the NHS is committed to providing best value for taxpayers’ money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. **the NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.
**APPENDIX I**

**CHECKLIST FOR A CLINICAL COMMISSIONING GROUP’S CONSTITUTION**

<table>
<thead>
<tr>
<th>Essential/ Optional</th>
<th>Content</th>
<th>Included</th>
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<tbody>
<tr>
<td>Essential</td>
<td>The constitution must specify:</td>
<td>√</td>
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<tr>
<td></td>
<td>• the name of the clinical commissioning group;</td>
<td>√</td>
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<td></td>
<td>• the members of the group; and</td>
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<td></td>
<td>• the area of the group</td>
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<td></td>
<td>The name of the group must comply with such requirements as may be prescribed</td>
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<tr>
<td></td>
<td>The constitution must specify the <strong>arrangements made by the clinical commissioning group for the discharge of its functions</strong> (including its functions in determining the terms and conditions of its employees)</td>
<td>√</td>
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<tr>
<td>Optional</td>
<td>The arrangements may include provision:</td>
<td>√</td>
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<td></td>
<td>• for the appointment of committees or sub-committees of the clinical commissioning group; and</td>
<td>√</td>
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<td></td>
<td>• for any such committees to consist of or include persons other than members or employees of the clinical commissioning group</td>
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<td>(Contained in separate terms of reference see App C Para 4.2.1)</td>
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<tr>
<td>Optional</td>
<td>The arrangements may include provision for any functions of the clinical commissioning group to be exercised on its behalf by:</td>
<td>√</td>
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<tr>
<td></td>
<td>• any of its members or employees;</td>
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<td></td>
<td>• its governing body; or</td>
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<td></td>
<td>• a committee or sub-committee of the group</td>
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<tr>
<td>Essential</td>
<td>The constitution must specify the <strong>procedure to be followed by the clinical commissioning group in making decisions</strong></td>
<td>√</td>
</tr>
<tr>
<td>Essential</td>
<td>The constitution must specify the <strong>arrangements made by the clinical commissioning group for discharging its duties in respect of registers of interest and management of conflicts of interest</strong> as specified under section 14O(1) to (4) of the 2006 Act, as inserted by section 25 of the 2012 Act</td>
<td>√</td>
</tr>
<tr>
<td>Essential</td>
<td>The constitution must also specify the <strong>arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the group and the manner in which they are made</strong></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>The provisions made above must secure that there is effective participation by each member of the clinical commissioning group in the exercise of the group’s functions</td>
<td>√</td>
</tr>
<tr>
<td>Essential</td>
<td>The constitution must specify the <strong>arrangements made by the clinical commissioning group for the discharge of the functions of its governing body</strong></td>
<td>√</td>
</tr>
<tr>
<td>Essential</td>
<td>The arrangements must include: provision for the appointment of the audit committee and remuneration committee of the governing body</td>
<td>√</td>
</tr>
<tr>
<td>Essential/ Optional</td>
<td>Content</td>
<td>Included</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Optional</td>
<td>The arrangements may include:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>• provision for the audit committee (but not the remuneration committee) to include individuals who are not members of the governing body</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• provision for the appointment of other committees or sub-committees of the governing body. These may include provision for a committee or sub-committee to include individuals who are not members of the governing body but are:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* members of the clinical commissioning group, or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* individuals of a description specified in the constitution (Contained in separate terms of reference see App C Para 4.2.1)</td>
<td></td>
</tr>
<tr>
<td>Optional</td>
<td>The arrangements may include provision for any functions of the governing body to be exercised on its behalf by:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>• any committee or sub-committee of the governing body,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• a member of the governing body;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• a member of the clinical commissioning group who is an individual (but is not a member of the governing body); or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• an individual of a description specified in the constitution</td>
<td></td>
</tr>
<tr>
<td>Essential</td>
<td>The constitution must specify the <strong>procedure to be followed by the governing body in making decisions</strong></td>
<td>✓</td>
</tr>
<tr>
<td>Essential</td>
<td>The constitution must also specify the <strong>arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the governing body and the manner in which they are made</strong></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>This provision must include provision for meetings of governing bodies to be open to the public, except where the clinical commissioning group considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting</td>
<td>✓</td>
</tr>
<tr>
<td>Essential</td>
<td>In its constitution, the clinical commissioning group must describe the <strong>arrangements</strong> which it has made and include a statement of the principles which it will follow in implementing those arrangements, <strong>to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved</strong> (whether by being consulted or provided with information or in other ways):</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>• in the planning of the commissioning arrangements by the group;</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>• in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>• in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact</td>
<td>✓</td>
</tr>
</tbody>
</table>
APPENDIX J
SIGNATURE SHEETS

The signature sheets of the practice representatives confirming their agreement to this constitution are held in electronic format within the CCG Constitution folders and are available to view on request by contacting the Governance Team at contact@dudleyccg.nhs.uk
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 July 2018  
**Report:** General Data Protection Regulations (GDPR) Board Assurance Report  
**Agenda item No:** 8.3

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>General Data Protection Regulations (GDPR) Assurance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To provide the Board with the assurance that the CCG is meeting its requirements in relation to GDPR.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr D Hegarty, Chair</td>
</tr>
</tbody>
</table>
| KEY POINTS: | 1. GDPR forms part of the data protection law in the UK, together with the new Data Protection Act (DPA) 2018. The main provisions of these apply from 25 May 2018  
2. There are seven key principles of GDPR, broadly similar to the principles in the DPA 1998, with an added ‘accountability’ principle which specifically requires organisations to take responsibility for complying with the principles and have appropriate processes and records in place to demonstrate that you comply |
| RECOMMENDATION: | The Board is asked to note the report for assurance |
| FINANCIAL IMPLICATIONS: | None |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | None |
| ACTION REQUIRED: | Decision  
✓ Approval  
✓ Assurance |
1.0 INTRODUCTION

General Data Protection Regulations (GDPR)

1.1 The EU General Data Protection Regulations (GDPR), which was approved in 2016 came into force on 25 May 2018 and is directly applicable as law in the UK. The Data Protection Act 2018 defines how GDPR applies to UK Data Protection Law and the two pieces of legislation should be read side by side.

1.2 GDPR include a set of principles that are largely similar to those of the Data Protection Act 1998. A significant addition is the principle of ‘accountability’. Whilst organisations must comply with the requirements of the GDPR, they must also be able to demonstrate compliance. This is reinforced by specific responsibilities of ‘the controller’, to implement appropriate technical and organisational measures, including policies where proportionate in relation to processing activities.

1.3 The focus is on evidence-based compliance with specified requirements for transparency, more extensive rights for data subjects and considerably harsher penalties for non-compliance. The key obligations supporting accountability are (in no particular order of importance):

- the recording of all data processing activities with their lawful justification and data retention periods
- routinely conducting and reviewing data protection impact assessments where processing is likely to pose a high risk to individuals’ rights and freedoms
- assessing the need for data protection impact assessment at an early stage, and incorporating data protection measures by default in the design and operation of information systems and processes
- ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights
- ensuring that data subjects’ rights are respected (the provision of copies of records free of charge, rights to rectification, erasure, to restrict processing, data portability, to object, and in relation to automated decision making)
- notification of personal data security breaches to the Information Commissioner
- the appointment of a suitably qualified and experienced Data Protection Officer.

1.4 Some of these requirements should be established good practice and organisations that have performed well in their Information Governance Toolkit scores should have a good baseline to work from.

1.5 By establishing or adjusting governance arrangements to comply with the GDPR, organisations will be confident not only that they are respecting the law and data subjects’ rights but also that they are mitigating risk appropriately and have a defence in the event of a breach.

1.6 Under GDPR, fines are significantly increased and may be imposed for any infringement of the Regulation, not just data security breaches. The maximum fine for breaches under the DPA 1998 was £500,000. Under GDPR there will be two levels of fines. The lower level fine for breaches of GDPR infringements in relation to processes is €10 million or 2% of the company’s global annual turnover of the previous financial year, whichever is higher. The higher level fine for breaches of GDPR principles is €20 million or 4% of the company’s global annual turnover of the previous financial year.

2.0 CURRENT ASSURANCE STATUS

2.1 The IG Team at Arden & GEM CSU is currently working as part of NHS England’s GDPR Working Group, which includes membership from all CSU’s, NHSE and NHS Digital to develop guidance and
plans which can then be used in partnership with customers to progress towards implementing the requirements of the GDPR.

**GDPR Implementation plans**

2.2 The CSU IG Team have taken a proactive approach to the GDPR and have undertaken a full analysis of the requirements. This analysis has now been converted into an implementation plan which has incorporated national guidance, where appropriate, from the government, NHS Digital and internet research for best practice.

2.3 Arden & GEM CSU Team are subject to monthly compliance meetings with NHSE. A template table has been provided to NHSE to provide assurance of GDPR compliance within the CSU. NHSE have confirmed that they are satisfied that the CSU are taking satisfactory actions to be compliant with the requirements of GDPR.

2.4 The table below has been adapted for Dudley CCG and provides a summary of CCG’s position in relation to GDPR compliance, as of 13th June 2018.

<table>
<thead>
<tr>
<th>Project</th>
<th>Task(s)</th>
<th>CSU Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Status</strong></td>
</tr>
<tr>
<td><strong>Staff communications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop comms plan</td>
<td>Complete All staff communications started 12 articles in line with '12 steps'</td>
</tr>
<tr>
<td></td>
<td>Deliver comms plan (ongoing)</td>
<td>In progress Plan has been developed focusing on the ICO’s Guidance - 12 steps to GDPR Compliance. 12 weekly communications will be sent via all staff email, focusing on a different topic each week, detailing what the requirement is, how it will affect staff and any action they made need to take.</td>
</tr>
<tr>
<td></td>
<td>Assess impact of comms plan</td>
<td>Ongoing Individual teams / IAOs are contacting CSU IG Compliance officer for items relevant for the Personal processing within their area</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>Update MaST for GDPR compliance</td>
<td>Complete 95% compliance achieved as of March 2018. Data Security Awareness Level 1 training mandatory for all Health &amp; Social Care staff.</td>
</tr>
<tr>
<td></td>
<td>IAO / IAA Training and Awareness</td>
<td>Complete IG Compliance officer in regular contact with IAOs in relation to specific tasks for GDPR Compliance. Part of DSPT programme of work.</td>
</tr>
<tr>
<td></td>
<td>SIRO Training and Awareness</td>
<td>Ongoing To be picked up as part of DSPT requirement also</td>
</tr>
<tr>
<td><strong>IG procedures</strong></td>
<td>Subjects' rights procedure (post-bill)</td>
<td>In progress Review currently being undertaken of documents currently in place. NHSE template to be reviewed</td>
</tr>
<tr>
<td></td>
<td>Incident reporting procedure (post-bill)</td>
<td>Ongoing There will be no change of documents until DSPT function is delivered. Review of documents currently in place (no change until DSPT function delivered)</td>
</tr>
<tr>
<td></td>
<td>DPIA procedure (post-bill)</td>
<td>Complete Review of documents currently in place (no change other than renaming to DPIA as template robust and covers GDPR compliance</td>
</tr>
<tr>
<td><strong>Record of processing</strong></td>
<td>Ensure record of processing meets GDPR requirements</td>
<td>Complete Part of GDPR work plan. IAOs have been asked to identify the legal basis for processing PCD and document on the IAR.</td>
</tr>
<tr>
<td></td>
<td>Review and update existing assets</td>
<td>Complete IAR updated March 2018. Part of IG Improvement Plan work. Review with IAOs will be carried out throughout the year.</td>
</tr>
<tr>
<td>Project</td>
<td>Task(s)</td>
<td>Status</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Privacy Notice</td>
<td>Design structure</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Develop content</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Publication</td>
<td>In progress</td>
</tr>
<tr>
<td></td>
<td>Develop draft wording for PoC info.</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Identify PoC across business</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Review point of contact privacy information (ongoing)</td>
<td>In progress</td>
</tr>
<tr>
<td>Establish processes and functions of DPO</td>
<td>Point of contact for ICO</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Point of contact for data subjects</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Point of contact for CSU staff</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Other identified responsibilities in DPO framework</td>
<td>Complete</td>
</tr>
<tr>
<td>Undertake data processor assurance</td>
<td>Establish process for data processor assurance</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Undertake assurance of highest risk data processors (ongoing)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Oversee updates to contracts</td>
<td>Establish process for contract updates</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Update contracts and agreements (ongoing)</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

3.0 RECOMMENDATION

3.1 That the Board is assured that the work being carried out by Arden and GEM CSU on behalf of the CGG is meeting the requirements of the new GDPR regulations.

Mr Matt Hartland  
Chief Operating and Finance Officer  
July 2018
<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Remuneration and HR Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To provide assurance to the Board regarding key issues discussed and approved by the Remuneration and HR Committee held on 6 June 2018</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs S Cartwright, Director of Organisational Development, Transformation and Human Resources</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs S Cartwright, Director of Organisational Development, Transformation and Human Resources</td>
</tr>
<tr>
<td>CLINICAL LEAD/LAY MEMBER:</td>
<td>Dr David Hegarty, Chair and Mr S Wellings, Lay Member for Governance</td>
</tr>
</tbody>
</table>
| KEY POINTS: | • Workforce dashboard reviewed noting the same sickness absence at a rate of 1.37% which is below the CCG target of 3%. Mandatory training is showing compliance of 75% but it was noted by the Committee that there was a discrepancy with the data. The PDR rate was reported at 65.45% and the headcount is currently at 110 employees  
• A paper on the arrangements around the development of the CCG was considered  
• Black Country and West Birmingham joint commissioning and STP work was discussed and the Committee updated  
• An agreement on the contractual approach for GP clinical leads who transferred to Dudley CCG when it commenced  
• A verbal update on the national pay deal for agenda for change staff  
• Agreement on the performance review for the CCG Chief Officers  
• Review of the Committee Risk Register  
• Ratification of the revised Mobile Devices Policy under delegated authority |
| RECOMMENDATION: | The Board to receive the report for assurance and note the decisions taken under delegated powers |
| FINANCIAL IMPLICATIONS: | Within financial plan |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | n/a |
| ACTION REQUIRED: | Decision  
✓ Assurance |
1.0 INTRODUCTION

1.1 This report provides assurance to the Board with regard to key issues discussed and approved by the Remuneration and HR Committee on 6 June 2018. The following items are a description of the current position in relation to the main responsibilities and obligations of the Committee as defined by the CCG Constitution and Terms of Reference.

1.2 Due to the nature of the Committee, there is no set of key indicators to report to Board.

2.0 ITEMS DISCUSSED

2.1 Quarterly Workforce Dashboard

The Committee receives regular updates on HR and workforce metrics applicable to the CCG. This includes analysis of vacancies, banding/skill-mix ratios, sickness, Personal Development Review completion and mandatory training compliance.

In June, the Committee noted that the sickness absence rate had remained the same as the previous report at 1.37% and continues to be below the CCG target rate of 3%. The Committee were assured that there is currently no long term sickness absence and were also assured that sickness is being managed appropriately.

The Committee reviewed mandatory training and PDR compliance. Mandatory training compliance was reported at 75%, although the Committee has since learnt there was a discrepancy with the data reported and therefore the figure would have been significantly higher. The Committee have been re-assured that this discrepancy has now been resolved. PDR compliance had reduced slightly to 65.45% and the Committee were informed that the CCG PDR process should be concluded by the end of June 2018 and therefore at the point of the next Committee the compliance should be almost 100%. The Committee were also informed that headcount is currently 110.

2.2 Risk Register

The Committee reviewed the current Risk Register and noted their satisfaction with the current risks.

2.3 Update on MCP Primary Care Development

The Committee reviewed a paper on the arrangements with regard to the development of the MCP. The Committee noted that the conflict of interest arrangements that had been put in place with regard to the CCG team working separately on the procurement and the MCP development had come to an end following the submission of the bid on 8 May 2018. The Committee also noted the introduction of an MCP Transition Board which has been established between Dudley Group NHS Foundation Trust and the GP Steering Group. CCG representatives will join this Transition Board if there is an announced preferred bidder from the procurement process. The Committee discussed the recruitment to the MCP Interim Leadership Team process that is being developed. This process will be implemented if there is an announcement of preferred bidder and the Committee noted that any positions would only be recruited to on an interim basis and therefore if this involved CCG staff, then the staff would need to be released on a secondment arrangement. The Committee acknowledged that some CCG posts would be working across both MCP development and CCG business and that the CCG would have the choice on whether to agree to secondments.
2.4 STP and Black Country Joint Commissioning

The Committee received a verbal update which informed them that Helen Hibbs (Wolverhampton CCG Accountable Officer) has been appointed as the Senior Responsible Officer for the health organisations in the STP. The Chair has also been appointed to and is currently awaiting approval by NHS England before the appointment can be announced. The Programme Director will also be appointed to. The Black Country CCG Chairs and Accountable Officers are working on developing the Black Country collaborative strategic commissioning arrangements. Mrs Cartwright reported that the CCG HR leads are engaging regularly with the Black Country staff side representatives.

2.5 GP Contractual Arrangements

The Committee received an update on the desktop exercise that has taken place with regard to the GP contractual arrangements and went through in detail the arrangements regarding the clinical leads who transferred to the CCG when it was established. A proposal was agreed with regard to these posts and these clinical leads will now be consulted with.

2.6 Update on National Pay Deal

The Committee received an update on the national pay deal. The CCG HR and finance teams will work on implementation of the deal and the Committee will receive a report on the impact on the CCG at the next Committee meeting.

2.7 Mobile Devices Policy

The Committee approved the revised Mobile Devices Policy, which had been updated following the migration to NHS mail, under delegated authority.

2.8 VSM Performance Related Pay Value

As per the CCG policy and the Very Senior Manager contract the Committee received the annual performance assessment for each of the staff on Very Senior Manager contracts: Paul Maubach, Matthew Hartland and Caroline Brunt. The Remuneration and HR Committee supported the recommendations from the Accountable Officer and Chair for the respective reports to categorise each officer as A – Exceeding Expectations, therefore each officer was awarded a performance related pay bonus. The Remuneration and HR Committee deferred the decision for cost of living award for each of the officers until the national pay deal was approved, although agreed that any future decision will be backdated to April 2018.

3. RECOMMENDATION

1. The Board is asked to receive the update from the Remuneration and HR Committee for assurance noting the decisions taken under delegated authority.

Mrs S Cartwright
Director of Organisational Development and Human Resources
July 2018
### DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 12 July 2018  
**Report:** Finance, Performance and Business Intelligence Committee Report  
**Agenda item No:** 9.1

<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>Finance, Performance and Business Intelligence Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To advise the Board of key issues discussed at the Finance, Performance and Business Intelligence Committees on 26 April 2018 and 31 May 2018</td>
</tr>
</tbody>
</table>
| **AUTHOR OF REPORT:** | Mr M Hartland, Chief Finance and Operating Officer  
Mr J Smith, Head of Financial Management - Corporate |
| **MANAGEMENT LEAD:** | Mr M Hartland, Chief Finance and Operating Officer |
| **CLINICAL LEAD:** | Dr R Tapparo, Clinical Executive for Finance, Performance and BI |

**KEY POINTS:**
- Based on the post-audit year end accounts the CCG met all financial duties in 2017/18 and reported a year end surplus of £13,611,204, meeting its revised control total as agreed with NHS England following their instruction in March to release the CCG’s 0.5% Non-Recurrent Reserve and Category M Drug price concessions into the CCG’s position at year end.
- All NHS England financial assurance indicators in 2017/18 were met and the CCG expects to meet all financial duties in 2018/19.
- The CCG is reporting a year to date underspend of £834,000 for April 2018 and expects to achieve its year end control total of £10,004,000 as agreed with NHS England. This is set to increase to £12,651,000 next month to reflect the 2017/18 in-year surplus increase of £2,647,000.
- NHS Constitution standards are being achieved at headline level with the exception of A&E. There are also performance exceptions to note in relation to Ambulance Handovers; Mixed Sex Accommodation; IAPT Access; Dementia and BCF.
- The Commissioning Development Committee (CDC) is forecast to break even against its delegated budget.
- The Committee received updates on the Board Assurance Framework (BAF) and Risk Register.
- Reports from the IT Strategy Group and Estates Strategy Group were received.
- The Committee supported the progression of the application to NHSE for Moss Grove Surgery, Kinver to join Dudley CCG on the basis no historical debt transferred.

**RECOMMENDATION:** The Board is asked to:
- receive the report for assurance

**FINANCIAL IMPLICATIONS:** As outlined in report and key points above

**WHAT ENGAGEMENT HAS TAKEN PLACE:** None

**ACTION REQUIRED:** ✓ Assurance
1.0 INTRODUCTION

The report summarises the key issues discussed by the Finance, Performance and Business Intelligence Committees at its meetings on 26 April and 31 May 2018.

2.0 KEY INDICATOR SUMMARY

The CCG met all financial duties in 2017/18 and reported a year end surplus of £13,611,204, meeting its revised control total as agreed with NHS England following their instruction to CCGs in March to release the 0.5% Non-Recurrent Reserve and the benefit of Category M Drug price concessions into the CCG’s bottom line surplus position at year end.

The table below identifies the CCG’s latest performance against key financial and performance indicators for 2018/19. This represents March performance information and April financial information. It is followed by exception reporting and an explanation of key issues where required.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statutory Finance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Resource Limit Control Total (£000's)</td>
<td>M</td>
<td>(10,004) Annual</td>
<td>(834)</td>
<td>(834)</td>
<td>(10,004)</td>
<td></td>
</tr>
<tr>
<td>Capital Resource Limit (£000's)</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Running Costs (£000's)</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cash Limit (£000's)</td>
<td>M</td>
<td>0</td>
<td>476</td>
<td>476</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Cash Limit (%)</td>
<td>M</td>
<td>&lt;1.25%</td>
<td>1.38%</td>
<td>1.38%</td>
<td>0.13%</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice: NHS (£000's)</td>
<td>M</td>
<td>&gt;95%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice: Non-NHS (£000's)</td>
<td>M</td>
<td>&gt;95%</td>
<td>99.29%</td>
<td>99.29%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td><strong>Referral to Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment)</td>
<td>M</td>
<td>&gt;92%</td>
<td>92.84%</td>
<td>94.00%</td>
<td>94.00%</td>
<td></td>
</tr>
<tr>
<td>Zero tolerance of over 52 week waiters</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>M</td>
<td>&lt;1%</td>
<td>0.55%</td>
<td>2.14%</td>
<td>2.14%</td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E Waits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>M</td>
<td>&gt;95%</td>
<td>86.30%</td>
<td>86.30%</td>
<td>94.37%</td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 12 hours of their arrival at an A&amp;E department (zero tolerance)</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Frequency</td>
<td>Target/Threshold</td>
<td>Latest Period</td>
<td>Direction</td>
<td>YTD</td>
<td>FOT</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------</td>
<td>------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Cancer Waits (2 Weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>M</td>
<td>&gt;93%</td>
<td>93.46%</td>
<td>↓</td>
<td>94.79%</td>
<td>94.79%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>M</td>
<td>&gt;93%</td>
<td>93.66%</td>
<td>↓</td>
<td>97.40%</td>
<td>97.40%</td>
</tr>
<tr>
<td>Cancer Waits (31 Days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>M</td>
<td>&gt;96%</td>
<td>99.30%</td>
<td>↑</td>
<td>98.83%</td>
<td>98.83%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>M</td>
<td>&gt;94%</td>
<td>95.83%</td>
<td>↑</td>
<td>98.98%</td>
<td>98.98%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is a anti-cancer drug regimen</td>
<td>M</td>
<td>&gt;98%</td>
<td>100%</td>
<td>↑</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer Waits (62 Days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two months (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>M</td>
<td>&gt;85%</td>
<td>86.25%</td>
<td>↑</td>
<td>85.44%</td>
<td>85.44%</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>M</td>
<td>&gt;90%</td>
<td>100%</td>
<td>↓</td>
<td>98.47%</td>
<td>98.47%</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient</td>
<td>M</td>
<td>No Target</td>
<td>91.58%</td>
<td>↑</td>
<td>93.32%</td>
<td>93.32%</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in national reporting from Sept-17 - Red ambulance calls resulting in an emergency response must have a mean average &lt;7 mins</td>
<td>M</td>
<td>&lt;7mins</td>
<td>6mins 25s</td>
<td>↓</td>
<td>6mins 10s</td>
<td>7mins</td>
</tr>
<tr>
<td>Ambulance Handovers: Breaches over 45 mins and less than 60 mins</td>
<td>M</td>
<td>0</td>
<td>33</td>
<td>↑</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Ambulance Handovers: Breaches over 60 mins</td>
<td>M</td>
<td>0</td>
<td>5</td>
<td>↑</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

### Finance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying Recurrent Surplus</td>
<td>M</td>
<td>(419) YTD</td>
<td>(423)</td>
<td>↓</td>
<td>(423)</td>
<td>(5,031)</td>
</tr>
<tr>
<td>Programme Spend</td>
<td>M</td>
<td>39,763 YTD</td>
<td>38,929</td>
<td>↑</td>
<td>38,929</td>
<td>472,427</td>
</tr>
<tr>
<td>Running Cost Spend</td>
<td>M</td>
<td>562 YTD</td>
<td>562</td>
<td></td>
<td>562</td>
<td>6,745</td>
</tr>
<tr>
<td>Programme Surplus</td>
<td>M</td>
<td>(834) YTD</td>
<td>(834)</td>
<td>↓</td>
<td>(834)</td>
<td>(10,004)</td>
</tr>
<tr>
<td>Running Costs Surplus</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>QIPP</td>
<td>M</td>
<td>(2,735) YTD</td>
<td>(3,435)</td>
<td>↓</td>
<td>(3,435)</td>
<td>(16,987)</td>
</tr>
</tbody>
</table>

### Mixed Sex Accommodation Breaches

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimise breaches - zero tolerance target</td>
<td>M</td>
<td>0</td>
<td>11</td>
<td>↓</td>
<td>51</td>
<td>51</td>
</tr>
</tbody>
</table>

### Cancelled Operations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days</td>
<td>M</td>
<td>0</td>
<td>2</td>
<td>↓</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>No urgent operation should be cancelled for a second time</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA): patients followed up within 7 days</td>
<td>Q</td>
<td>&gt;95%</td>
<td>97.58%</td>
<td>↑</td>
<td>96.54%</td>
<td>96.54%</td>
</tr>
<tr>
<td>IAPT Access: Number of people who receive psychological therapies</td>
<td>M (A)</td>
<td>≥1.40% (≥16.8%)</td>
<td>1.09%</td>
<td>↑</td>
<td>9.42%</td>
<td>12.95%</td>
</tr>
<tr>
<td>IAPT Recovery: Pts completing treatment who are moving to recovery</td>
<td>M</td>
<td>≥50%</td>
<td>51.52%</td>
<td>↑</td>
<td>52.42%</td>
<td>52.29%</td>
</tr>
<tr>
<td>Early Intervention Psychosis (EIP): Maximum 2 week wait</td>
<td>M</td>
<td>≥50%</td>
<td>50%</td>
<td></td>
<td>92.00%</td>
<td>92.00%</td>
</tr>
</tbody>
</table>

### Healthcare Associated Infections (HCAI)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.Difficile (DGFT): Reported monthly but measured annually</td>
<td>M</td>
<td>≤29</td>
<td>3</td>
<td>↓</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>MRSA (DGFT): Zero tolerance</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
3.0 STATUTORY FINANCIAL DUTIES

The Committee was advised that the CCG had an annual budget at April 2018 of £489.2m. This reflected the notified allocation from NHS England and CCG anticipated allocations. At this point in time, the CCG was underspent by £0.8m and is forecast to achieve a surplus on its Revenue Resource Limit of £10.0m in line with its financial plan and meeting the control total agreed with NHS England. The Committee were informed that the control total will increase to £12,651,000 the following month to reflect the increase of £2,647,000 in the in-year surplus the CCG was requested to achieve at the end of 2017/18 financial year from the release of the 0.5% non recurrent reserve and category M drug price concessions.

Capital budgets, cash limits and the CCG’s programme and administration expenditure targets are all expected to be achieved.
At a summary level there are three distinct areas of expenditure within the CCG, for which budget responsibility has been delegated to appropriate Committees. These are commissioning expenditure (Commissioning Development Committee - CDC), running/staffing costs and reserves (Finance, Performance and Business Intelligence Committee) and primary care commissioning/membership development (Primary Care Commissioning Committee).

Whilst the Finance, Performance and Business Intelligence Committee retains oversight of the financial position of the organisation and advises the Board regarding any mitigating actions that may need to be taken, the clinical and management leads of appropriate Committees are responsible and accountable for financial performance of their delegated portfolio.

The table below identifies the financial position to date by Committee;

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £m</th>
<th>Year to date Budget £m</th>
<th>Year to date Actual £m</th>
<th>Year to date Variance £m</th>
<th>Forecast Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Development Committee</td>
<td>413.7m</td>
<td>34.0m</td>
<td>34.0m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance, Performance &amp; BI Committee</td>
<td>20.7m</td>
<td>1.7m</td>
<td>1.7m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care Commissioning Committee</td>
<td>44.8m</td>
<td>3.8m</td>
<td>3.8m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Surplus</td>
<td>10.0m</td>
<td>0.8m</td>
<td>-</td>
<td>(0.8m)</td>
<td>(10.0m)</td>
</tr>
<tr>
<td>Total</td>
<td>489.2m</td>
<td>40.3m</td>
<td>39.5m</td>
<td>(0.8m)</td>
<td>(10.0m)</td>
</tr>
</tbody>
</table>

Based on month 1, the Clinical Development Committee (CDC) is forecast to break even against its delegated budget.

The table below illustrates the main areas contributing to the forecast being reported against CDC.

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £m</th>
<th>Year to date Budget £m</th>
<th>Year to date Actual £m</th>
<th>Year to date Variance £m</th>
<th>Forecast Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Electives</td>
<td>72.8m</td>
<td>6.1m</td>
<td>6.1m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Electives</td>
<td>43.8m</td>
<td>3.7m</td>
<td>3.7m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Outpatients</td>
<td>45.6m</td>
<td>3.8m</td>
<td>3.8m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>19.0m</td>
<td>1.6m</td>
<td>1.6m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Learning Disabilities (LD), Adult Mental Health (MH)</td>
<td>9.2m</td>
<td>0.8m</td>
<td>0.8m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Funded Nursing Care (FNC)</td>
<td>4.5m</td>
<td>0.4m</td>
<td>0.4m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other, including Prescribing</td>
<td>218.8m</td>
<td>17.6m</td>
<td>17.6m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>413.7m</td>
<td>34.0m</td>
<td>34.0m</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The latest position has been discussed at the CDC and Finance, Performance and Business Intelligence Committees. It was noted that due to limited financial data being available at the beginning of the financial year the CCG was reporting year to date and forecast year end break even positions across all service lines.

4.0 NHS CONSTITUTION STANDARDS/CCG ASSURANCE

The CCG has met all but one of the NHS Constitution standards in April 2018, the exception being A&E 4 hour waits.

4.1 A&E 4 Hour Waits

A&E waits failed to achieve the 95% national standard in April 2018, with 86.3% of patients admitted, transferred or discharged within 4 hours. A remedial action plan is in place with the Trust which aims to recover the 95% standard by March 2019 in line with national guidance.

5.0 PERFORMANCE EXCEPTION REPORTING

5.1 Ambulance Handovers

Both 45 and 60 minute handover breaches improved in April to 33 and 5 respectively. Ambulance handovers form part of the system wide Urgent Care Action plan, which is overseen by the A&E
Delivery Board. It is expected that the number of handover breaches will continue to reduce now the new Emergency Treatment Centre is operational.

5.2 IAPT Access
The Q3 position has been confirmed as 950 against a trajectory of 1,430 (an access rate of 2.8% against the national ambition of 4.2%). NHSE have confirmed that the access standard of 4.20% per quarter, which is equivalent to 16.8% annually, applies in Q4 only.

Provisional data for Q4 suggests no improvement in performance against the required access target

Bi-weekly meetings are taking place with the provider to establish a strong way forward; this is being supported by the utilisation of a national workforce tool developed by NHSE to better understand the staff capacity required to meet the 19% access target in 2018/19.

5.3 Dementia Diagnosis
The dementia diagnosis rate declined in March to 64.49%. The target of 66.7% has therefore not been achieved for 2017/18.

6.0 QIPP 2018/19
The CCG QIPP target for 2018/19 stands at £16.99m, equating to 3.5% of the CCG’s resource allocation.

In respect of future reporting, Commissioning Development Committee and Primary Care Commissioning Committee will receive detailed reports of the schemes. Finance, Performance and Business Intelligence Committee will have the role of reviewing and holding the other committees to account for the overall delivery of the QIPP programme.

7.0 LOCAL INDICATORS

7.1 Better Care Fund (BCF)
There are a number of conditions the health economy must meet to achieve performance within the Better Care Fund (BCF) plan;

- Non-elective admissions;
- Admissions to residential and care homes;
- Effectiveness of reablement;
- Delayed transfers of care.

The BCF plan is managed on a quarterly basis, with the CCG meeting 2 of the 4 indicators in 2017/18 Quarter 4. The 2 exceptions were: Reablement with performance of 84.16% against an 87% target, and residential admissions with a rate per 100,000 of 132 against a target of ≤126.

8.0 OTHER ITEMS DISCUSSED

8.1 Combined Board Assurance Framework and Risk Register
The risks assigned to the Committee were reviewed and accepted.

8.2 MOSS GROVE KINVER TRANSFER APPLICATION
The Committee received a report that outlined the potential financial implications of the proposed transfer of Moss Grove Surgery, Kinver from South East Staffs and Seisdon Peninsula (SESSP) to Dudley CCG. The report also provided the Committee with assurance on the other work streams within the remit of the Committee, namely performance; contracting; Business Intelligence; Estates; IT and Governance.

The Committee were informed of a legacy issue relating to an historic deficit in SESSP CCG of £51.9m; based upon Moss Grove’s weighted population it had been assessed that £1.49m of the deficit would be the practice’s proportion. The Committee were notified that following discussions with NHS England (NHSE) it was confirmed that deficits were held at CCG level and not practice level and there were no transfers of historic deficits or surpluses where practices transferred
between CCG’s. The Committee’s position remained unchanged and it confirmed that it would not support the transfer of the historic deficit.

The Committee heard the practice was performing generally well against NHSE key performance indicators, it had one of the lowest rates for A&E attendances and a relatively low rate of emergency admissions compared to Dudley practices. However, elective admissions were higher than most Dudley practices but the practice had agreed to work with the CCG and take corrective actions where necessary should the transfer be approved.

The Committee supported a suggestion made by Primary Care Commissioning Committee that, after transfer the surgery should remain open for a minimum of two years.

Following the presentation of the report the Committee supported the progression of the application to NHSE on the basis that it could not accept the transfer of the historic debt.

A paper was prepared that included the Committee’s views was presented to an extra-ordinary Board meeting on 7 June for final consideration.

9.0 REPORTS FROM GROUPS ACCOUNTABLE TO THE COMMITTEE

9.1 IT Strategy Sub-Committee
The Committee received an update on the issues discussed by the IT Strategy Group and noted good progress on implementing projects within the strategy. The main issues for the Board to note were:

• The usage of tQuest with latest usage figures for April proving extremely positive and a recommendation that paper referrals for Pathology should be stopped by end of May and agreement to be discussed at Clinical Executive;
• A draft document for a replacement telephone solution was being drafted and an electronic method to replace faxes was being considered however limitations were identified within Pharmacies relating to availability of computer equipment;
• Docman 10 is on hold pending a review of network capability, there is concern the current network capacity maybe overloaded;
• Patient Wi-Fi roll continues to progress well with 29 practices now installed and
• A project board was being established to discuss and implement online consultations in line with the GP Forward View plans.

9.2 Estates Strategy/Operational Group
The Committee received an update on the issues discussed by the Estates Operational Group and discussed a number of items in relation to the current year work programme as part of the Health Infrastructure Strategy. The main issues for the Board to note are:

• Planning consent for the modular units at High Oak Surgery has been granted until 2025;
• Continuous review of space utilisation across the Dudley Health Economy with an Estates Strategy meeting arranged with representatives from local providers and Local Authority in June;
• Outline business cases for Kingswinford and Lye were expected to be completed by December and are progressing well with the schedule of accommodation for Kingswinford scheme being almost complete from a Health perspective and awaiting further requirements from the Local Authority in respective of a community centre provision.

The Committee also received updates in respect of a number of ongoing premises projects, including Central Clinic, Wordsley Green and Ridge Hill.

10.0 RECOMMENDATION
The Board is asked to receive the report for assurance and to note there were no decisions taken under delegated powers.

Mr M Hartland
Chief Finance and Operating and Officer
July 2018
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 12 July 2018  
**Report:** Commissioning Development Committee Report  
**Agenda item No:** 10.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Commissioning Development Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To note matters considered by the Commissioning Development Committee</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr N Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr N Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr J Darby – Clinical Executive</td>
</tr>
</tbody>
</table>

## KEY POINTS:
1. QIPP programme for 2018/19 reviewed. Noted that most schemes are green or amber rated  
2. Application for Moss Grove, Kinver practice to join CCG supported  
3. Revised MSK pathway and QIPP scheme **approved**  
4. Model of care for people with learning disabilities in response to Transforming Care Programme (TCP) **approved**  
5. Revised reimbursement formula for Peer to Peer review **approved**  
6. Award report for AQP Ophthalmology procurement noted  
7. Young Health Champions scheme reviewed  
8. Six monthly IFR report received and level of compliance with commissioning policies noted

## RECOMMENDATION:
That the matters considered by the Commissioning Development Committee including items approved under delegated authority be noted for assurance

## FINANCIAL IMPLICATIONS:
None arising directly from this report

## WHAT ENGAGEMENT HAS TAKEN PLACE:
None

## ACTION REQUIRED:
- Decision  
- Approval  
- ✓ Assurance
1.0 PURPOSE OF REPORT

1.1 To note matters considered by the Commissioning Development Committee.

2.0 BACKGROUND

2.1 The Commissioning Development Committee met on 16 May 2018 and 20 June 2018. This report sets out the matters considered at these meetings.

3.0 QIPP

3.1 The Committee has reviewed an initial report on delivery of the 2018/19 programme. The QIPP target is £6.987m plus a stretch saving target of £3.089m

3.2 All schemes have been risk rated and following agreement in relation to the MSK business case referred to below, 5 schemes now remain red rated with the majority being green and amber rated. A number of schemes have been completed and savings delivered.

3.3 It is anticipated that following consideration of further business cases in July 2018 this position will improve further.

3.4 Clinical Executives, clinical leads and commissioning managers will shortly commence the process to identify schemes for 2019/20.

4.0 KINVER PRACTICE – APPLICATION TO JOIN DUDLEY CCG

4.1 The Committee has considered the commissioning implications of an application for Moss Grove Kinver practice to join this CCG.

4.2 The Committee noted potential issues in relation to patients registered with the practice continuing to be resident for local government purposes in Staffordshire. In the event of the application proceeding, suitable arrangements would need to continue for these patients to access both Public Health, Adult Social Care and Children’s Social Care Services that are the responsibility of Staffordshire County Council.

4.3 The Committee agreed to support the application and this was reported to the Board at its extraordinary meeting to consider this issue.

5.0 MUSCULOSKELETAL SERVICES (MSK) BUSINESS CASE

5.1 The Committee has considered a business case developed in conjunction with clinicians at Dudley Group NHS Foundation Trust which creates a new clinical model for MSK. This proposal forms a significant part of the QIPP programme and amongst other things addresses issues identified through the Right Care data where Dudley is an outlier in terms of expenditure on these services. The proposed model introduces the following features into the patient pathway:

1. STarT Back Tool - an assessment methodology
2. First Contact Practitioner services – enabling people to self-refer and speed up access to treatment
3. Self-referral for physiotherapy
4. MSK triage
5.2 The pathway involves 4 key components:

1. Access – how patients enter the pathway either through a referral by the clinician or self-referrals
2. Decision – once the patient has been referred services must be appropriate to ensure the patient is placed on the correct pathway from self-management to surgery.
3. Treatment – once the patient has been accepted for treatment this must be compliant with policy and best practice
4. Outcome – patients should be given the best opportunity to improve their health through self-management, in primary care, or in another service.

5.3 The associated QIPP target for 2018/19 is £1.237m with a full year effect of £1.795m.

5.4 Savings are anticipated from reductions in out-patient activity through the STarT Back Tool, First Contract Practitioner and self-referral physiotherapy. Current modelling shows a significant shift in out-patient activity with further shifts anticipated through changes to back injections, joint injections, rheumatology management and arthroplasty. Further business cases are due to be developed in relation to these service elements and will be considered in due course.

6.0 TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES

6.1 The Board has previously received reports on the Black Country Transforming Care Programme (TCP) designed to implement the national service model in response to events at Winterbourne View in 2011.

6.2 The Committee has now considered the proposed service model designed to reduce reliance on assessment and treatment in patient provision through access to appropriate community based services.

6.3 The Community model, in line with national policy, consists of:

- Community Learning Disability Service (redesign of existing service)
- Community Intensive Support Service (new)
- Community Forensic Service (new)

6.4 In addition it is proposed to reduce the total number of assessment and treatment in-patient beds across the Black Country to a total of 8.5 beds. These will be commissioned by the 4 CCGs on a "subscription" basis with the contractual payment for each CCG being based upon historic usage.

6.5 The Committee has supported the service model in principle, subject to final agreement being reached on the underpinning financial modelling and associated financial contributions from each CCG.

6.6 In addition appropriate patient and public engagement is required.

7.0 PEER TO PEER 2017/18 & 2018/19

7.1 The Committee has approved a revised funding formula to support clinical peer review which is considered to better reflect the work involved in conducting a peer review and provide an appropriate incentive to change referral behaviour.

8.0 OPHTHALMOLOGY

8.1 The Committee has noted the award report on the evaluation of bids received for the AQP Ophthalmology Service.
9.0 YOUNG HEALTH CHAMPIONS

9.1 The Committee has noted the work undertaken by the Young Health Champions.

9.2 Over 100 Young Health Champions have been recruited and involved in a number of initiatives working with a wide range of partners.

9.3 Whilst no recurrent resources had been identified by the CCG to continue the scheme, the Committee agreed to examine how existing resources were being used to support engagement with young people, in order to establish whether these resources might be redirected in such a way as to support the continued funding of the Young Health Champions.

10.0 INDIVIDUAL FUNDING REQUESTS (IFR)

10.1 The Committee has received a half yearly report on Individual Funding Requests (IFR).

10.2 The Committee was concerned to note that a significant amount of referral activity was in conflict with approved commissioning policies. This created a poor patient experience. As part of the contracting process Dudley Group NHS Foundation Trust was being challenged to provide evidence that referrals met the relevant criteria.

10.3 The Committee endorsed the continued use of EMIS templates and Peer to Peer review as a means of ensuring that policies are complied with.

11.0 RECOMMENDATION

11.1 That the report of the Commissioning Development Committee including items approved under delegated authority be noted for assurance.

Mr N Bucktin
Director of Commissioning
June 2018
Date of Board: 12 July 2018
Agenda item No: 10.2

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Report of the Health and Wellbeing Board</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To note matters considered by the Health and Wellbeing Board at its meeting on the 27 June 2018</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr N Bucktin - Director of Commissioning</td>
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<td>MANAGEMENT LEAD:</td>
<td>Mr N Bucktin - Director of Commissioning</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr D Hegarty - Chair</td>
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</table>
| KEY POINTS: | 1. Dudley Borough “Vision” considered  
2. Health and Wellbeing Board conference noted to further develop key themes for creating Resilient Communities  
3. Report on Dudley Disability Services development received  
4. Better Care Fund (BCF) performance for 2017/18 reviewed (reported under the Integrated Commissioning Executive report to Board) |
| RECOMMENDATION: | That the report be noted |
| FINANCIAL IMPLICATIONS: | None |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | None |
| ACTION REQUIRED: | Decision  
Approval  
✓ Assurance |
1.0 PURPOSE OF REPORT

1.1 To note matters considered by the Health and Wellbeing Board on its meeting on the 27 June 2018.

2.0 BACKGROUND

2.1 The Health and Wellbeing Board met on 27 June 2018, this report sets out the main matters considered by the Board.

3.0 DUDLEY BOROUGH VISION

3.1 The Board has received an update on the proposed vision for Dudley Borough and its associated consultation process.

3.2 The purpose of the vision is to set out a simple and compelling story which will be a long term vision to support short team decision making. It is intended to provide a basis for place shaping, priority setting, policy development, financial strategy and transformation of the borough for the people of Dudley.

3.3 The vision states that in 2030 Dudley borough will be: -

1. a place of healthy confident and resilient communities
2. an affordable and attractive place to live, learn and work;
3. a place where everybody has the education and skills they need;
4. renowned as home to a host of innovative and prosperous businesses;
5. a unique visitor destination;
6. better connected to high quality and affordable transport;
7. full of vibrant local centres.

3.4 Extensive consultation on the vision took place during May and early June 2018. Dudley CVS is now leading an engagement exercise with local communities in relation to the 7 themes of the vision.

4.0 GROWING STRONG, CONNECTED RESILIENT COMMUNITIES

4.1 The Joint Health and Wellbeing Strategy identifies a new relationship with communities as one of its key principles.

4.2 Partners have recently discussed how community resilience can be increased in Dudley’s communities and this has led to the development of 3 themes as a basis for a shared understanding of community resilience. These are: -

1. we want people in Dudley to feel productive, valued and in control of their lives
2. we want people in Dudley to have strong and enduring relationships
3. we want people in Dudley to feel secure confident and independent where they live.

4.3 The Health and Wellbeing Board’s conference in the autumn will be invited to contribute further to the development of these themes.

5.0 DUDLEY DISABILITY SERVICE

5.1 The Board has received a report on the development of the Dudley Disability Service.
5.2 This provides an all age disability service across children and adults' social care and special educational needs services, to people with disabilities, from birth to end of life, or until the service is no longer the best one to meet their needs.

5.3 The service was developed because: -

1. national policy requires the Local Authority to facilitate an effective transition between children and adult social services, support people to lead more fulfilling lives in the community and prevent, reduce and delay the escalation of care and support needs;
2. the need to improve support for people coming through children & adult mental health services and special needs and disabilities services.
3. the need to improve the experience of young people and their carers through the transition process;
4. the need to deliver services more cost effectively;
5. the need to improve the planning and commissioning of all age disability services.

5.4 The service will be organised into 2 multi-disciplinary teams serving the north and south of the borough and aligned with the CCG’s localities.

6.0 INTEGRATION AND BCF PLAN 2017/19

6.1 The Board has considered a report on the performance of the Better Care Fund for 2017/18. This matter is considered elsewhere on this agenda.

7.0 RECOMMENDATION

7.1 That the report of the Health and Wellbeing Board be noted.

Neill Bucktin
Director of Commissioning
June 2018
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 July 2018  
**Report:** Integrated Commissioning Executive  
**Agenda item No:** 10.3

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<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Integrated Commissioning Executive</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To note matters considered by the Integrated Commissioning Executive (ICE)</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr G Griffiths-Dale – Deputy Director of Commissioning</td>
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<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr N Bucktin – Director of Commissioning</td>
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<tr>
<td>CLINICAL LEAD:</td>
<td>Dr D Hegarty, Chair</td>
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**KEY POINTS:**

1. The Integrated Commissioning Executive met on 2 May 2018.
2. ICE delivered the plans within the overall financial budget set as part of the Better Care Fund (BCF). The improvements reported in Quarter 3 have been sustained through the winter period. There has been a significant reduction in emergency admissions to Russell’s Hall Hospital, and Delayed Transfers of Care have been maintained below the target level of 3.5% for four months.
3. Quarterly monitoring by NHSE is in place, and the focus of the next quarter will be on concluding scheme evaluations and starting the planning process for the 2019-21 Better Care Fund.

**RECOMMENDATION:**

That the report of the Integrated Commissioning Executive be noted for assurance.

**FINANCIAL IMPLICATIONS:**

Expenditure to Month 12 (March 2018) was £67.92m against an annual Plan of £72.46m, This means that there is a forecast underspend of £130,000, before iBCF carry forward £4.415m. CCG spending exceeded budget by £386k whilst non-iBCF Council expenditure was £516,000 below budget.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

None

**ACTION REQUIRED:**

- [x] Decision  
  - Approval  
  - Assurance
1.0 PURPOSE OF REPORT

1.1 To note matters considered by the Integrated Commissioning Executive.

2.0 BACKGROUND

2.1 The Dudley Integration & Better Care Fund Plan 2017-19 was submitted to NHS England and the Local Government Association (LGA) for assurance on 11 September 2017 under delegated authority.

2.2 Integration & Better Care Fund (I&BCF) Plans provide the basis for integrated health and social care provision. The Dudley plan makes clear that this is happening in parallel with the emergence of the Dudley Multispecialty Community Provider. I&BCF activity will help establish the capabilities needed once the MCP is operational.

3.0 BCF PERFORMANCE

3.1 Further performance data demonstrates that the key areas of focus for the Better Care Fund are being delivered. There have been significant reductions in emergency admissions to hospital and delayed transfers of care for those who are admitted.

3.2 There are a number of programmes targeted at reducing emergency admissions to hospital which overlap with the BCF: multi-disciplinary team management in primary care; single point of access in care homes; telehealth and front of house services in social care and health.

3.3 Emergency Response Team – 8 diversion beds have been commissioned to prevent avoidable admissions to hospital. For the period 01/09/2017 to 27/04/2018, there have been 56 admissions and 48 discharges from this resource (all bed stock is used flexibly). The outcomes for the discharges are as follows:

- 20 people returned home,
- 21 people transferred to long term placements,
- 5 people were admitted to hospital.
- 2 people sadly died

3.4 For the period 01/10/2017 to 30/04/2018, 730 patients have been seen by Front of House staff, providing hospital diversions through non bed based activity. The breakdown of the outcomes is as follows:

- 77 diverted with nil services
- 50 into emergency bed placement
- 342 home with a package of care
- 157 signposted
- 104 hospital admission

3.5 85% of those people seen by the Emergency Response Team have not been admitted to hospital as a result of their initial hospital attendance.

3.6 75% of those people seen by the Emergency Response Team have not been admitted to hospital and returned to their own home as a result of the team's intervention.
3.7 Pathway 3 – 52 beds have been commissioned (Bed stock figure as at 27/04/2018), 16 residential, 31 nursing care beds and 5 complex beds for Dementia.

3.8 Some beds have been sourced for under 60 (years of age) placements to reduce hospital length of stay for these complex clients. There have been 262 admissions into these temporary placements, reducing the length of stay in hospital. There have been 226 people discharged from their Pathway 3 placement and the outcomes are as follows:

- 8 people returned home without care
- 29 people returned home, with a care package provided
- 92 people transferred to 24hrs placements
- 38 people were readmitted into hospital
- 30 people sadly died
- 29 people were in a self-funding position and received time away from the acute setting to identify their long term placements. All of these people achieved a timelier discharge. All these people were identified as requiring 24hrs placement, though with time away from hospital and the ability to be supported to recover with 16% of people returned to their own homes.

3.9 Improved Discharge Flow (IDF) – additional assessment and screening capacity (alongside increased reablement care hours in the community) have enabled the discharge team to increase the level of discharge activity.

3.10 The impact of the IDF scheme can be seen from the increase in average weekly discharges facilitated by DMBC:-

- For the period 04/09/2017 to 12/11/2017 (10 week period) the average weekly discharges were 48.4 p/w.
- For the last 10 week period 22/01/2018 to 01/04/2018 the average weekly discharges were 70.7 p/w.

3.11 This represents a 46% increase in average weekly discharges

3.12 Single Handed Care (SHC) – This project continues to be implemented. Recent progress includes:

- Single Handed Care Training organised with A1 Risk Solutions now completed.
• Community Equipment Store (CES) managing the stock of SHC equipment from 07/01/2018.
• There have been 10 staff appointed. Last one joined the team on 01/03/2017, ACC Social Worker.
• All staff in post have been trained.
• The pilot has started for the reviews of existing packages of care (PoC) and new referrals, with 72 assessments completed so far.

3.13 Palliative Care – Ongoing discussions at the Integrated Commissioning Executive in regard to the future needs for this service are yet to be determined. Agreement has been made for additional investment from the iBCF monies to be invested in this service for 2018/19. This will allow for service partners to scope, model and implement an updated model that will transfer to the MCP.

3.14 The Better Care Fund schemes have delivered a significant reduction in Delayed Transfers of Care (DTOCs). In March, Dudley had achieved the 3.5% DTOC target for the first time. The latest figures demonstrate that this improved performance has been sustained at Russell’s Hall Hospital.

3.15 The Local Authority measure saw a slight increase in March, but over Quarter 4 delivered an improvement on plan
3.16 In terms of national performance, the following is based on the most up to date available national DTOC data (February 2018).

- DMBC have improved our ranking from 121st out of 151 for January 2018, to **110th out of 151 in February** (based on all bed delays per 100,000 population and Adult Social Care responsible delays).

- DMBC resident performance has reduced, from 72nd out of 151 in January, to **87th out of 151 in February** (based on all bed delays per 100,000 population and all Dudley Resident responsible delays).

- Local performance has increased during August 2017 to March 2018, DMBC have reduced the Adult Social Care responsible delayed days at Dudley Group NHS Foundation Trust by **94.9%**.

4.0 SCHEME EVALUATIONS

4.1 In the past 2 months the main iBCF schemes have been evaluated to evidence delivery against their original targets. All iBCF schemes are scheduled to have been evaluated by the end of June 2018 to inform the winter planning process and the next BCF plan.

5.0 FINANCIAL IMPLICATIONS

5.1 Expenditure to Month 12 (March 2018) was £67.92m against an annual Plan of £72.46m, this means that there is a forecast underspend of £130,000 before iBCF carry forward £4.415m. CCG spending exceeded budget by £386,000 whilst non-iBCF Council expenditure was £516,000 below budget.

6.0 RECOMMENDATION

6.1 That the report of the Integrated Commissioning Executive be noted for assurance.

Neill Bucktin  
Director of Commissioning  
June 2018
**TITLE OF REPORT:** MCP Procurement and Evaluation of Final Bid

**PURPOSE OF REPORT:**

1. To consider the outcome of the bid submitted in response to the CCG’s and the Council’s proposal to commission and enter into a contract for the provision of integrated health and care services to be delivered by a Multi-Specialty Community Provider (MCP).

2. To identify for the CCG Governing Body those further issues to be addressed prior to entering into a contract with the MCP, should both the CCG and the Council be minded to appoint a preferred bidder.

**AUTHOR OF REPORT:**

Mr N Bucktin – Director of Commissioning – Dudley CCG
Ms D Harkins – Chief Officer, Health and Wellbeing (Director of Public Health – Dudley MBC)

**MANAGEMENT LEAD:**

Mr N Bucktin – Director of Commissioning – Dudley CCG

**CLINICAL LEAD:**

Dr D Hegarty - Chair

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1. The CCG and Council have jointly entered into a process to procure a set of integrated health and care services to be delivered by a MCP. This has been overseen by the MCP Procurement Project Board.

2. The dialogue phase of the procurement has now concluded and the final bid has been evaluated. The outcome of the evaluation is set out in paragraph 13.0, as approved by the MCP Procurement Project Board.

3. There are a number of further issues to be addressed before a contract can be entered into including regulatory approvals that are required on the part of the CCG through the Integrated Support and Assurance Process (ISAP) and the process associated with creating the NHS Foundation Trust to hold the contract.

4. The remainder of the process will be managed by the MCP Procurement Project Board with further reports to the CCG Board, Council Cabinet and the Health and Adult Social Care Scrutiny Committee.

5. A report on this matter will be submitted to the Council’s Cabinet on 26 July 2018. Any decisions taken by the Governing Body will be subject to the outcome of the Cabinet’s consideration.
**RECOMMENDATION:**

That the CCG Governing Body approve the identification of Dudley MCP as the preferred bidder to enter into a contract for the provision of integrated health and care services to be delivered by a Multi-Specialty Community Provider (MCP).

That, a contract be entered into with the preferred bidder subject to:-

a) The approval of the Council’s Cabinet to the identification of a preferred bidder;

b) agreement of the terms of a Section 75 partnership agreement;

c) conditions identified through the evaluation process being addressed;

d) successful completion of the NHS Integrated Support and Assurance Process (ISAP);

e) successful outcome of the Council’s scrutiny process;

f) a suitable contracting mechanism and required derogations

**FINANCIAL IMPLICATIONS:**

The possible MCP contract value range as published in the Contract Notice and based on 2016/17 budgets is expected to be between approximately £3,495,000,000 (£233m per annum) and £5,445,000,000 (£363m per annum), depending upon the extent Dudley CCG general practices are fully integrated with the MCP, the inclusion of other general practices, the inclusion of social care services and whether the contract runs to its potential full term of 15 years.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

1. Engagement with patients, public and clinicians to develop the service model, prospectus and outcomes framework.

2. Engagement with Health and Adult Social Care Scrutiny Committee.


**ACTION REQUIRED:**

- ✔ Decision
- ✔ Approval
- ✔ Assurance
CCG BOARD – 12 JULY 2018

MCP PROCUREMENT AND EVALUATION OF FINAL BID

Report of the Director of Commissioning, Dudley CCG and the Chief Officer, Health and Wellbeing (Director of Public Health), Dudley MBC

1.0 PURPOSE OF REPORT

1.1 To consider the outcome of the bid submitted in response to the CCG’s and the Council’s proposal to commission and enter into a contract for the provision of integrated health and care services to be delivered by a Multi-Specialty Community Provider (MCP).

1.2 To identify for the CCG Governing Body those further issues to be addressed prior to entering into a contract with the MCP, should both the CCG and the Council be minded to identify a preferred bidder.

2.0 BACKGROUND

2.1 The CCG Governing Body will be aware of the joint work that has taken place to procure a set of integrated health and care services delivered by a MCP (also described as an “Accountable Care Organisation”). This report sets out the background to this development and the evaluation of the final bid received in order to determine whether or not to identify a preferred bidder.

2.2 The Council Cabinet will consider a similar report at its meeting on 26 July 2018.

2.3 Because of the significance of the decision required, this report provides a reminder of the process of development, in order to place the decision in its full context.

2.4 As described in paragraph 8.0 below, the procurement process has been governed by the MCP Procurement Project Board consisting of CCG and Council representatives and supported by appropriate staff and external advisers. Subject to both bodies identifying a preferred bidder, the Project Board will be responsible for overseeing the next steps required to:-

- agree an appropriate form of final contract/sub-contracts;
- agree the Section 75 Agreement between the CCG and the Council which establishes the pooled fund arrangements and provides a mechanism to fund the public health services in the contract;
- agree a contract mobilisation plan with the bidder;
- resolve any outstanding issues resulting from the bid evaluation process;
- secure the necessary NHS regulatory approvals from NHS England/NHS Improvement (see paragraph 9.0 below);
- provide assurance to the Health and Adult Social Care Scrutiny Committee;
• create the MCP as a legal entity, including approval of its constitution (see paragraph 11.0 below).

2.5 As well as regular progress reports from the Project Board which will address outstanding issues, further specific reports to the CCG Governing Body and the Council Cabinet will be required as follows:-

a) CCG Governing Body

• GP Outcomes Framework for 2019/20
• Submissions for the Integrated Support and Assurance Process (see paragraph 9.0 below)

b) Council Cabinet

• Scrutiny through the Health and Adult Social Care Scrutiny Committee

c) CCG Governing Body and Cabinet

• FT Constitution – particularly in relation to public involvement mechanisms
• Commissioner Requested Services (see paragraph 14.23 below)
• Final contract/sub-contract form (to include gain/loss share arrangements)

3.0 DEVELOPMENT OF ORIGINAL PROPOSALS

3.1 Following NHS England’s publication of its Five Year Forward View in 2014, NHS bodies were invited to submit proposals to become “Vanguards” for the development of potential new models of care.

3.2 With the support of the Council, the CCG submitted a bid and was successful in being designated a Vanguard in March 2016. The proposal was to create a “Multi-Specialty Community Provider” (MCP) designed to integrate a number of health and care services within a single organisation. This proposal was consistent with the statutory responsibilities of the CCG, the Council and the Health and Wellbeing Board as follows:-

• **CCG’s duty to promote integration** – Section 14Z1 of the NHS Act 2006 – “each CCG has a statutory duty to exercise its functions with a view to securing that health services are provided in an integrated way”…;

• **Council’s responsibilities to promote integration of care and support with health services** – Section 3 of the Care Act 2014 – “a local authority must exercise its functions…with a view to ensuring the integration of care and support provision with health provision and health related provision…”

• **Health and Wellbeing Board’s duty to encourage integrated working** – Section 195 of the Health and Social Care Act 2012 – “a Health and
Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner”.

3.3 As part of its involvement in the national Vanguard Programme, Dudley was able to contribute to the development of national policy for this area, including the MCP “emerging care model and contract framework” published in July 2016.

4.0 MAIN FEATURES

4.1 From January 2016, during the period leading up to the production of the framework, the CCG began a process of dialogue and engagement with patients and the public on the concept of this type of service delivery model. As a result three themes emerged:-

- **Access** – people wanted to make sure they had rapid access to services when required;
- **Continuity** – people valued continuity of care – “only telling their story once” – particularly where they had an ongoing need for treatment due to a long term condition;
- **Co-ordination** – ensuring that where patients are in contact with more than one service, their care is co-ordinated effectively.

4.2 Work took place to develop a service model that reflected these principles. The proposal envisaged an organisation having responsibility for:-

- all community based physical health services for adults and children;
- all NHS commissioned mental health services;
- all NHS commissioned learning disability services;
- a number of out-patient services related mainly to the treatment of long term conditions;
- direct access tests and investigations;
- NHS Continuing Health Care and Intermediate Care;
- some Council commissioned public health services – including substance misuse, sexual health, health visiting, Family Nurse Partnership, school health advisers, wellness services;
- primary medical (GP) services;
- some voluntary sector services;
- adult social care services - to be potentially phased in over time, subject to the criteria agreed previously by the Council.
4.3 The integration of health and social care and the inclusion of social care within the scope of services is a key component of the care model. Already, social workers have been actively involved in the development of Multi-Disciplinary Teams and this work will continue. The Council had previously agreed that adult social care services would only be included within the scope of services once an agreed set of criteria were met. These were as follows:-

- the service can be transferred at a decreased cost to the Council;
- transfer of services can be affected within both regulatory and statutory requirements;
- modelling demonstrates improved outcomes for the people of Dudley;
- the services in question will adapt to decreasing resources throughout the contract period or taper;
- the transfer will not decrease income to the Council in the form of either VAT and/or client contributions.

4.4 The Council will apply these tests to adult social care services at regular intervals, to assess whether they should be phased into the scope of the MCP.

4.5 In addition, the CCG will conduct its own risk assessment in relation to each potential transfer before agreeing to its inclusion. Any transfer will be subject to final agreement with the successful bidder. Until such time as this takes place the MCP will be expected to align itself with social care services and this will be a requirement of the contract.

4.6 The MCP would be responsible for these services by receiving the “Whole Population Annual Payment” (in effect making this a fixed price contract). This is net of the CCG's BCF contribution to the Council which will remain a direct transfer from the CCG to the Council as required nationally. In some instances, rather than providing services directly, the MCP could choose to sub-contract (e.g. with voluntary sector bodies).

4.7 The contract held would be longer in terms of duration than historically has been the case (10 years with an option to extend for 5 years), to encourage investment in “up-stream” activities designed to support prevention and demand management.

4.8 The traditional activity based contract payment mechanism would be ceased with an element of the contractual payment (now agreed as 10%) linked to the delivery of a set of outcomes through an outcomes framework, consistent with those developed locally for use in the existing GP contract. In effect, ensuring the entire system is working towards the same outcome measures.
4.9 The financial mechanism would be further enhanced through the agreement of “gain/loss” share arrangements between the CCG, the MCP and other parts of the system. This would be designed to facilitate appropriate behaviour, such as taking action to reduce unnecessary emergency admissions, with the CCG, the Council and the MCP sharing any resultant gain or loss.

5.0 ROLE OF PRIMARY CARE

5.1 The MCP model has the potential to create a different set of contractual arrangements with GPs for the first time since 1948, the intention being to base the integration and co-ordination of service delivery around the registered list of general practice. This can happen in two ways:-

- **partial integration** – where practices retain their existing independent contractor status and enter into a voluntary integration agreement with the MCP;
- **full integration** – where practices relinquish their existing contracts and have a different relationship with the MCP – perhaps as employees.

5.2 In both cases general practice would have a significant role in service delivery and change and any potential MCP contract holder would need to generate the support and confidence of primary care.

6.0 PROSPECTUS, SERVICE SCOPE AND OUTCOMES FRAMEWORK

6.1 Discussions took place locally regarding the characteristics of the potential MCP organisation and the form it might take, focusing on the need for good governance; public accountability; the role it would play in the local health and care economy; its role as a “corporate citizen”; and its behaviour as a good employer. These were reflected in the MCP Prospectus.

6.2 In addition, work took place regarding the Outcomes Framework led by the CCG and supported by the Council’s Office of Public Health. This was also the subject of specialist external support to test out the local thinking.

6.3 The Prospectus, Service Scope (see 4.2 above) and Outcomes Framework were the subject of a further engagement process from July to September 2016 and formally agreed by the CCG Governing Body in September 2016.

7.0 CASE FOR SERVICE CHANGE

7.1 It is worth reminding the CCG Governing Body of the underlying case for change from service, outcomes and financial perspectives.

7.2 The Dudley population faces significant challenges in terms of:-
• the growing burden of disease affecting a frail elderly population;
• the complex nature of presenting conditions with patients having multiple physical health, mental health and social care needs;
• the demands that this places on the health and care system in general and on general practice in particular, at a time when the workforce is strained.

7.3 Managing this demand requires continuity of care for those with long term conditions and co-ordination of care for those with the most complex needs with the support of a sustainable primary care system where demand first manifests itself. The MCP care model provides the mechanism for addressing this set of circumstances and this was demonstrated at Checkpoint 1 of the Integrated Support and Assurance Process (see paragraph 9.0 below).

7.4 The MCP care model is based upon the delivery of a set of health outcomes. In meeting the contracted outcomes framework, analysis suggests that the MCP has the potential, within 5 years, to increase healthy life expectancy by 1.38 years, equivalent to 440,430 extra years of healthy life expectancy for the whole Dudley population.

7.5 The financial case for change submitted as part of the Checkpoint 1 documentation in March 2017 included the ‘do nothing’ scenario for the services included within the MCP scope. This identified an efficiency requirement for the MCP based on the Whole Population Budget and resource allocation methodology of £99m by 2032/33. This equates to approximately 2% per annum.

7.6 The chart below shows the efficiency requirement for the services within the scope of the MCP as at March 2017. The comments and analysis below relate solely to CCG and Council commissioned public health services. Adult social care services are excluded from this analysis, as no such services will be in scope at the contract start date. In the event that any adult social care service is considered for inclusion in future (in line with the criteria described at 4.3 above), a separate analysis will take place as part of the process to determine whether or not they should be included.
7.7 The case for change identified the main areas of expenditure growth for the anticipated contract period, as at March 2017 and shown below. This is based on forecast CCG allocation growth, projected demand growth and predicted cost pressures. The main areas where costs are expected to increase in excess of allocation growth are Prescribing and NHS Continuing Health Care.

7.8 The MCP will help to improve the access to services, coordination of complex care and management of long term conditions. This will be enabled through the integration of existing services, increased Multi-Disciplinary Team working, an outcome based contract and gain share agreements with the CCG and other providers.

7.9 The following main areas were identified as efficiency opportunities for the MCP in the first year of operation:

- prescribing;
- reduction in emergency admissions from care homes;
- reduction in emergency admissions for falls;
- reduction in Ambulatory Care Sensitive (ACS) emergency admissions.
8.0 PROCUREMENT PROCESS AND GOVERNANCE

8.1 It was agreed that the nature, scope and scale of change required would necessitate a full procurement process and arrangements were put in place to enable this.

8.2 A Project Board and Project Team were established with a membership consisting of both CCG and Council representatives. Both bodies had access to further specialist support on areas including procurement, legal advice, governance advice, finance and clinical issues. In order to address potential conflict of interest issues created by the involvement of GPs both as CCG Governing Body members and key players in the service delivery model, the CCG agreed that the Project Board would have delegated authority to deal with all matters relating to the procurement with the exception of the decisions to begin the procurement and ultimately award the contract.

8.3 The Project Board was mindful of the lessons arising from the collapse of the Uniting Care contract in Cambridgeshire and Peterborough following a flawed procurement exercise. This had been the subject of reports from NHS England and an enquiry by the Public Accounts Committee. The recommendations from the relevant reports were reviewed and the local response in relation to them noted. This has been the subject of previous reports to the Governing Body.

9.0 REGULATORY APPROVALS

9.1 The Uniting Care contract collapse resulted in NHS England and NHS Improvement developing a process to ensure procurements of this nature were properly managed – the Integrated Support and Assurance Process (ISAP). This consists of 4 stages:-

• Early Engagement – should the process be applied?
• Check Point 1 – has the procurement been set up properly?
• Check Point 2 – has the procurement been conducted properly?
• Check Point 3 – is the contract ready to commence?

9.2 Early Engagement and Check Point 1 were completed in November 2016 and March 2017 respectively. It should be noted that this is an assurance process that applies to the NHS only and the first line of assurance should come from the CCG Governing Body. However, Council colleagues may take some comfort from the fact that the CCG is required to complete this process satisfactorily before the contract can commence. The specific “lines of enquiry” that will be addressed at Checkpoint 2, following the decisions of the CCG Governing Body and the Council Cabinet, are:-
- Are there clear clinical transformational benefits?
- Have legal risks been identified and mitigated?
- Is the governance and management appropriate?
- Are the contracted services financially sustainable?
- Is there an appropriate provider structure, financial capacity, governance and capability to transform and deliver?
- Is the procurement and contract documentation appropriate?
- In the event of provider failure, are contingency plans in place?

9.3 There is a further set of regulatory approvals required in relation to the creation of the organisation that will hold the MCP contract as described in paragraph 11.0 below.

10.0 PRE-QUALIFICATION PROCESS

10.1 Prior to publication of the contract notice, a market engagement event took place in January 2017 involving 69 interested suppliers - both potential main contractors and sub-contractors. This was followed by a period during which potential contract holders were given the opportunity to engage with primary care in recognition of the issues identified at 5.0 above.

10.2 The original contract notice was published on 9 June 2017 with potential bidders invited to complete a Pre-Qualification Questionnaire (PQQ) before proceeding to the next stage. One bid was submitted by a consortium involving Dudley Group NHS Foundation Trust (DGFT), Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT), Birmingham Community Services NHS Foundation Trust (BCNHSFT), Black Country Partnership NHS Foundation Trust (BCPNHSFT) and the local GP Collaborative. This bid successfully completed this stage of the process and the bidder was invited to participate in dialogue (see 12.0 below).

11.0 ORGANISATIONAL FORM

11.1 The prospectus set out the expectations in terms of the style and characteristics of the organisation from which the CCG and Council wished to commission services. The intention being to establish an organisation which:-

- had strong local roots;
- contributed to the wider health and care economy;
- was an employer of choice;
- displayed a set of governance arrangements which recognised the role that primary care played in the creation of a MCP and gave credence to public sector values including local accountability;
- recognised its role as a corporate citizen and placed an emphasis on “social value”.

-
11.2 The original bid submitted at the Pre-Qualification Stage was based on the establishment of a community interest company as the means of achieving this. However, it soon became apparent that this would create VAT implications resulting in monies intended to be spent on the provision of care being spent on VAT. Therefore, it was considered that the creation of a NHS Foundation Trust provided the most appropriate organisational form.

11.3 The mechanism for achieving this is for an existing Foundation Trust to “separate”, creating two new Foundation Trusts, one of which will hold the MCP contract and one of which will deliver the remainder of the services currently provided by the existing Foundation Trust. The existing Foundation Trust will then dissolve. In our case it has been agreed that Dudley Group NHS Foundation Trust will apply to do this. This will be the subject of further regulatory approval by NHS Improvement.

11.4 This has changed the nature of the bidding entity such that the bid is now in the name of Dudley MCP (a yet to be created NHS Foundation Trust) with two material sub-contractors – Dudley Group NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and two other main sub-contractors - Black Country Partnership NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust.

12.0 COMPETITIVE DIALOGUE

12.1 The agreed process for conducting the procurement was one of “competitive dialogue” where commissioner and bidder discuss the proposal submitted to the point where the commissioner is satisfied that the bidder is clear on what is required and is in a position to make a final submission for evaluation.

12.2 A single bidder was therefore invited to participate in dialogue and this began in early September 2017. Dialogue meetings covered the following areas:-

• service model
• outcomes
• organisational form
• finance
• IT/IG
• contract and mobilisation

12.3 Dialogue concluded at the end of March 2018 and the bidder was invited to submit its final tender.

13.0 EVALUATION

13.1 Evaluation of the bid was conducted by a team of staff from both the CCG and the Council. In addition, external advisers contributed to the evaluation as follows:-
• advice in relation to clinical aspects including outcomes framework – Commissioning Outcomes Based Incentivised Contracts (COBIC)
• clinical advice – Dr S Mitchell (senior GP – Sandwell and West Birmingham CCG)
• legal advice to CCG – Mrs R Vandrill, Partner - Mills and Reeve
• legal advice to Council - Weightmanns
• governance advice – Mr D Grayson – Good Governance Institute
• financial advice – Ms K Eaves – independent financial adviser

Internal clinical advice was provided by:-

• Mrs C Brunt – Chief Nurse - Dudley CCG
• Dr R Gee – GP Engagement Lead - Dudley CCG
• Dr D Jenkins – Specialist in Pharmaceutical Public Health – Dudley CCG
• Ms D Harkins – Chief Officer - Health and Wellbeing (Director of Public Health) - Dudley MBC
• Ms K Jackson – Deputy Director of Public Health - Dudley MBC
• Dr M Abu Affan Consultant in Public Health Medicine - Dudley MBC
• Mrs B Kaur – Consultant in Public Health – Dudley MBC

13.2 The evaluation process resulted in the bid scoring a total of 61 points out of a possible 100 and was deemed by the Project Board to have met the necessary criteria to progress.

13.3 The favoured organisational form of an NHS Foundation Trust has already been explained. The bid sets out the rationale behind this and the options appraisal used to determine this. In addition, the bid recognises inherent conflicts of interest and describes how these will be managed.

13.4 The clinical model to be utilised at the heart of the MCP recognises the role of the Multi-Disciplinary Team. The bid describes the operating model for ten “Integrated Care Teams” working across a defined practice based geography and led by a “triumvirate” of a GP, community nurse and a manager. The bid sets out how these teams connect to other services, the key operational principles and the use of technology to support the delivery of services as well as to meet the requirements of the Outcomes Framework. As such, this model reflects the requirements set out in the procurement documentation.

13.5 From a clinical safety and risk management perspective, the proposed approach to medicines safety, antimicrobial stewardship and the associated governance arrangements are excellent.

13.6 The role of primary care in the MCP has also been described above. The bid provided a clear articulation of the benefits to be delivered through a partially integrated model, the key features of the Integration Agreement between the
MCP and practices as well as the incentives to be used. The submitted bid obtained the support of 40 of Dudley’s 45 practices, indicating through a letter of intent, their willingness to enter into an Integration Agreement with the MCP. This represents a population coverage of 294,745 patients registered with a Dudley GP, or 92.4% of the total population registered with a Dudley GP. In the event of any practice wishing to become fully integrated the MCP will need to consider how a fully integrated model will work.

13.7 The bid provides a good description of how the MCP plans to operate within the local health and care economy and its approach to social value. It also demonstrates a good understanding of more innovative approaches to stakeholder involvement including participatory budgeting.

13.8 In terms of being a good employer, workforce engagement and involvement and the approach to training and education are clearly set out. The bid provides a clear plan and arrangements for staff consultation, engagement and involvement, as well as how healthy workplace practices will be implemented. In addition, the bidding partnership’s track record in relation to links with relevant training bodies and having a strong education and training culture is articulated.

13.9 The bidder has set out a clear implementation plan in the event of being awarded the contract which provides the appropriate assurance to commissioners in terms of maintaining service delivery and safety. Risks have been identified and logged in a risk register. This is supported by appropriate governance arrangements to oversee the transition. Further work will be required in terms of a firm mobilisation timetable, including the appointment of a Chair, other Non-Executive Directors and the Council of Governors.

13.10 The bidder has also correctly addressed the potential requirements in terms of extending the scope of MCP service provision in line with the parameters of the original Contract Notice.

13.11 Subject to the CCG Governing Body and the Cabinet agreeing to identify the bidder as the preferred bidder, the evaluation and the requirements of the ISAP identifies a number of areas where further work will be required with the appointed bidder as part of the due diligence and mobilisation processes. These are shown at paragraph 14.1 below.

14.0 CONDITIONS

14.1 Having considered this report, should the CCG Governing Body be minded to identify a preferred bidder, there are a number of issues to be resolved prior to contract signature. If appropriate, these will be included as “condition precedents” within the actual contract – items that require completion before the contract can go live. These are identified below and
will be overseen by the MCP Procurement Project Board:-

a) Issues for the bidder

• All requirements for ISAP Checkpoint 2 completed.
• Production of a consolidated financial strategy.
• FT Constitution to be agreed with commissioners.
• Assurance for commissioners in relation to any issues arising from the bid evaluation.
• Quantification of FT separation costs.
• Agreement of the form of sub-contracts to be entered into with material sub-contractors for commissioners approval.

b) Issues for the CCG

• All requirements for ISAP Checkpoint 2 to be completed.
• Approval of GP Outcomes Framework for 2019/20.
• Section 75 Agreement to be agreed with the Council (including apportionment of liability in the event of any legal challenge to the procurement process).

c) Issues for CCG and Council

• Scrutiny process completed by Health and Adult Social Care Scrutiny Committee.
• Approval of Commissioner Requested Services.
• Approval of the form of sub-contracts to be entered into with material sub-contractors.
• Approval of Section 75 Agreement.

d) Issues for bidder, CCG and Council

• Agreed system wide financial model, including assessment/plan for stranded costs and any gain/loss share.
• Appropriate due diligence to meet ISAP requirements completed.
• Combined risk analysis and risk register produced, supported by external advice.
• Contract populated.

15.0 COUNCIL DECISION-MAKING

15.1 This matter will be reported to the Council Cabinet on 26 July 2018 when the Cabinet will consider the identification of a preferred bidder. Any decisions taken by the Governing Body will be subject to the outcome of the Cabinet’s consideration.

16.0 RECOMMENDATION

16.1 That the CCG Governing Body approve the identification of Dudley MCP as the preferred bidder to enter into a contract for the provision of
integrated health and care services to be delivered by a Multi-Specialty Community Provider (MCP).

16.2 That, a contract be entered into with the preferred bidder subject to:-

a) the approval of the Council’s Cabinet to the identification of a preferred bidder;
b) agreement of the terms of a Section 75 partnership agreement;
c) conditions identified through the evaluation process;
d) successful completion of the NHS Integrated Support and Assurance Process (ISAP);
e) successful outcome of the Council’s scrutiny process;
f) a suitable contracting mechanism and required derogations being available.

Neill Bucktin
Director of Commissioning
Dudley CCG

Deborah Harkins
Chief Officer - Health and Wellbeing (Director of Public Health)
Dudley MBC

June 2018
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 July 2018  
**Report:** Report from the Primary Care Commissioning Committee  
**Agenda Item No:** 11.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Report from the Primary Care Commissioning Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board on key issues discussed at the meetings of the Primary Care Commissioning Committee on 25 May 2018 and 22 June 2018</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs J Robinson, Primary Care Contracts Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
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</tbody>
</table>

**KEY POINTS:**

The Committee:
- Received assurance from the Primary Care Operational Group (PCOG) that there were no contractual breaches to be issued
- Approved 1 contractual variation in respect of a partnership change as recommended by the Primary Care Operational Group
- Made a recommendation to the Governing Body that the CCG should make an application to NHS England to change its constitution and boundary to include Moss Grove Kinver as a member of Dudley CCG; and at such time as Kinver becomes a member of Dudley CCG, approved in principle the merger of Moss Grove, Kingswinford with Moss Grove
- Received a summary from PCOG in respect of the General Practice IT best practice review and training needs assessment of Primary Care nursing workforce
- Received the Dudley Quality Outcomes for Health end of year monitoring report and discussed the detailed findings in private
- Approved a 12 month roll forward of the Directed Enhanced Service for Out of Area Registration – In Hours Urgent Primary Medical Care
- Received for assurance the Quality and Safety Report
- Received options regarding the excluded patients scheme
- Noted the reported financial position for 2017/18 and approved the baseline budgets for 2018/19
- Approved the draft Primary Care Commissioning Committee annual report (Appendix 1)
- Considered and accepted the current risk register ratings

**RECOMMENDATIONS:**

- The Board is asked to note for assurance the issues discussed, and decisions taken by the Primary Care Commissioning Committee

**FINANCIAL IMPLICATIONS:**

- The budget delegated to the Committee is £45,175,000

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

- NHS England
- CQC
- Member practices
- Local Medical Committee

**ACTION REQUIRED:**

☑️ Assurance
1.0 **INTRODUCTION**

1.1 This report summarises the key issues discussed at the Primary Care Commissioning Committees held on 25 May 2018 and 22 June 2018.

### PRIMARY CARE CONTRACTING

1.2 Committee received assurance from the Primary Care Operational Group (PCOG) regarding the GMS contract monitoring process and that there were no contractual breaches to be issued.

1.3 Committee accepted the recommendation from PCOG and approved a contractual change in respect of the retirement of two GP’s from one practice.

1.4 PCOG presented information to Committee in respect of a training needs assessment for the Primary Care Nursing workforce and the key findings were noted. Nursing workforce is a priority and is being managed by the GP Forward View Workforce Project Group and as such the Primary Care Strategy Group will report to Committee. However concerns were raised regarding whether there was sufficient nursing staff to support both the DQOFH and the MCP. A detailed report was requested to include the number of nurses moving back into secondary care, university nurse recruitment, training needs and the actions being taken by the GPFV Workforce Project Group to implement the ten point action plan for General Practice Nursing.

1.5 In addition, PCOG presented Committee with a summary of the outcome of the IT Best Practice Review undertaken by the CCG IT team. Committee noted that there were improvements in the way that practices are using IT against the best practice guidance and that the IT Strategy Group provides the mechanism for the recommendations to be taken forward.

**Moss Grove**

1.6 Committee made a recommendation to the Governing Body that the CCG should make an application to NHS England to change its constitution and boundary to include Moss Grove Kinver as a member of Dudley CCG. At such time as Kinver becomes a member of Dudley CCG, Committee approved in principle the merger of Moss Grove, Kingswinford with Moss Grove, Kinver on the basis that the premises at Kinver, that will become the branch, will provide existing services and remain open.

1.7 A summary of the recommendation was presented to the Governing Body at its meeting held on 7 June 2018 and as such the detail is not included in this update.

### Procedure for Closing Branch Surgeries

1.8 Committee approved an update to the CCG procedure for closing branch surgeries. The procedure is revised to reflect changes following review of recent branch closures and revised NHS England Primary Medical Care Policy and Guidance. The procedure now sets out the process in detail providing a planned approach, potential timeframe and responsibilities of the Contractor and CCG.

2.0 **PRIMARY CARE COMMISSIONING**

#### Dudley Quality Outcomes for Health (DQOFH)

2.1 Committee received the DQOFH end of year performance monitoring report and discussed the detailed findings in private.

2.2 Where practices have under achieved against those indicators generating payment, a clawback has been made.
2.3 A number of practices have been identified for DQOFH monitoring visits and prioritisation was agreed.

Out of Area Registration – In Hours Urgent Primary Medical Care, Directed Enhanced Service

2.4 Under the Directed Enhanced Services Regulations, the CCG is required to commission this DES to ensure that any patient who is registered as an out of area patient can receive medical care “in hours” should they need urgent care when they are unable to attend their registered practice.

2.5 One practice from each locality has been commissioned to provide the DES since 2015. Committee approved a roll forward for another 12 months.

3.0 QUALITY

3.1 The Quality and Safety report to the Board will set out in more detail those areas pertinent to primary care.

3.2 Committee received an options appraisal in respect of the Excluded Patient Scheme in private. The recommended option was approved subject to clarification regarding governance arrangements.

4.0 FINANCE

4.1 The 2017/18 end of year position in respect of the budgets delegated to Committee was noted as:
- Primary Care Co-Commissioning - £17,000 underspend
- Core CCG Budgets - £4,000 overspend
- Net Committee position - £13,000 underspend

4.2 Committee approved the baseline budgets for the financial year 2018/19 totalling £44.8m as:
- Primary Care Co-Commissioning - £41,842,000
- Primary Care Development - £531,000
- GP Forward View - £2,399,000

5.0 PRIMARY CARE PREMISES

5.1 Committee received two reports relating to Primary Care Premises.

Review of alternative service locations

5.2 A review has been carried out of the alternative service locations included in practices’ Business Continuity Plans, in order to assess their appropriateness and in part to respond to risk 137 (There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to unplanned loss of Estates or IT infrastructure)

5.3 Most practices have plans in place, although these are of varying robustness and appropriateness. Committee expressed serious concerns with regards to the lack of emergency preparedness and that some practices had failed to respond.

5.4 It was agreed that the CCG’s proposed approach should be for each premise to have two agreed alternative locations in place, one as close as possible to the premises with a second site further away to provide support in case of an incident of wider impact. Committee noted for assurance the availability of space within Health Centres, and the ability of the CCG to make this space available at short notice if required.

5.5 In addition, Committee noted that the CCG have plans in place to deliver emergency preparedness training to GP Practices via the Dudley Practice Managers Association. This will help practices to develop more robust business continuity plans and to be able to plan for and respond to a number of wide ranging incidents that may interrupt the delivery of patient care such as extreme weather conditions, workforce issues etc.
Premises Survey

5.6 The second premises report received was in respect of a survey of all primary care premises within Dudley, assessing their condition, functional suitability and compliance with statutory standards.

5.7 The report provided an outline of the key findings and the steps which have already been taken to rectify high risk items and those that will be taken over coming months to address other issues identified by the survey.

5.8 Committee expressed their concerns in relation to the number of practices that fell below the minimum acceptable level of compliance with Statutory Standards. Consideration was given to issuing contract remedial breach notices, however after discussion, it was agreed that practices will be required to present action plans to the CCG within one month and will be allowed three months’ to become fully compliant. If practices fail to comply then Committee will take contractual actions. In addition Committee requested that the report should be shared at the next Clinical Executive Team meeting.

5.9 The Primary Care Finance Manager was commended for the content of both reports and was asked to correlate the two, incorporate the findings in the Primary Care Assurance Tool (PCAT) and present back to Committee as a follow up report.

6.0 ANNUAL REPORT 2017/18

6.1 Committee approved the draft Primary Care Commissioning Committee Annual Report (Appendix 1). The report provided assurance that the statutory functions in relation to its delegated functions from NHS England relating to commissioning and contracting of primary medical services had been met.

6.2 Significant progress has been made towards delivery of the GP Forward View plan and in the development and improvement of the quality of primary medical services in Dudley.

7.0 RISK REGISTER

7.1 Considerable discussion was held with regard to the workforce risk where a single point of failure was identified relating to the IT support to DQOF. Committee amended the existing risk description and controls and noted that the Dudley CCG IT team are discussing the most appropriate way to mitigate the risk and will update Committee accordingly.

7.2 The remaining risks assigned to Committee were considered and the updates accepted.

8.0 RECOMMENDATIONS

8.1 The Board is asked to note for assurance the issues discussed, and decisions taken by the Primary Care Commissioning Committees on 25 May 2018 and 22 June 2018.

Julie Robinson
Primary Care Contracts Manager
June 2018
**DUDLEY CLINICAL COMMISSIONING GROUP**  
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Date of Committee:** 25 May 2018  
**Report:** Primary Care Commissioning Committee Annual Report  
**Agenda Item:** 12.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Commissioning Committee Annual Report</th>
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</table>
| PURPOSE OF REPORT: | To present the draft Annual Report 2017/18 for the approval of the Committee  
To provide assurance that the Committee has discharged its responsibilities and met its Terms of Reference |
| AUTHOR OF REPORT: | Mrs J Taylor, Primary Care Commissioning Manager |
| MANAGEMENT LEAD: | Mrs C Brunt, Chief Nurse |
| CLINICAL LEAD: | Dr T Horsburgh, Clinical Executive for Primary Care |
| KEY POINTS: | The report summarises the Committee’s work during the year and confirms that:  
- The Committee has fulfilled its statutory functions in relation to its delegated functions from NHS England relating to the commissioning and contracting of primary medical services  
- The Committee has fulfilled its delegated functions in accordance with scheme of delegation as set out in the CCG constitution  
- The Committee has made significant progress in developing and improving the quality of primary medical services in Dudley – as set out in the report  
- The Committee has made significant progress towards delivery of the GP Forward View plan |
| RECOMMENDATION: | • The Committee is asked to confirm that it is assured that the Committee has discharged its responsibilities  
• The Committee is asked to approve this Annual Report |
| FINANCIAL IMPLICATIONS: | The Committee has achieved its financial targets, remaining within the resource limit delegated to it by the CCG Board |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | • All members of the Primary Care Team  
• Sue Johnson, deputy Chief Finance Officer |
| ACTION REQUIRED: | Decision ✓  
Approval ✓  
Assurance ✓ |
1.0 BACKGROUND

1.0 Dudley CCG took the responsibility of commissioning primary care services across Dudley so that we could focus on local issues and ensure high quality primary care services for our local people. In line with statutory guidance, the CCG established a Primary Care Commissioning Committee (the Committee) as a corporate decision making body to make collective decisions on the review, planning and procurement of primary medical services in the Dudley borough.

1.1 The Committee meets in public on a monthly basis, and all papers are published on the CCG web-site in advance of the meetings. Over the last year the Committee has held meetings in those areas affected by changes to the local GP services to ensure that the decisions are debated locally, and that the Committee has been able to make decisions informed by patient opinion.

1.2 Over the past three years we have developed a strong emphasis on putting the patient at the centre of our planning and encouraging primary care to work together innovatively to achieve improved population based health and well-being. We are recognised as one of the National leaders of how the future model of primary care can be delivered.

1.3 This year’s Annual Report shows how much has already been achieved, and gives an indication of the exciting times ahead.

2.0 PURPOSE

2.1 The Committee will recall that its stated purpose and application to NHS England to take on full delegated authority for the commissioning of primary medical services was predicated on three areas set out in the table below.

2.2 Table: Application to NHS England to take on delegated functions for commissioning primary medical services

<table>
<thead>
<tr>
<th>Area</th>
<th>Outcome</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>To effectively review and pilot new ways of commissioning outside of the core requirements of GMS – setting one set of outcome measures that will apply to all those services commissioned and working as part of an integrated population based health and wellbeing service with primary care at the heart of the model</td>
<td>Achieved</td>
<td>New contractual framework (Dudley Quality Outcomes for Health) developed and offered to practices in 2017/18 to replace QOF, DES and LISs.</td>
</tr>
<tr>
<td>To commission for shared outcomes across the whole system of integrated care to ensure that all the organisations working in Dudley are working to the same outcome objectives for our population.</td>
<td>Achieved</td>
<td>Outcome measures within Dudley Quality Outcomes for Health being used as part in the MCP contract service specifications for the management of LTC</td>
</tr>
<tr>
<td>To lead and manage the process for review and revising all GP contracted activity outside of GMS (so including QOF, enhanced services and PMS resource allocations), and retain any surplus within Dudley to reinvest within Dudley to improve the quality of primary care services and support the delivery of our service integration model.</td>
<td>Achieved</td>
<td>PMS premium fully re-invested in General Practice through the new Dudley Quality Outcomes for Health contract.</td>
</tr>
</tbody>
</table>
Table: Functions delegated to the Primary Care Commissioning Committee as set out within the CCG Constitution

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
</table>
| COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES | 1. Determination of arrangements for the review, planning and procurement of primary care medical services (under delegated authority from NHS England). To include:  
  - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and removing a contract);  
  - Newly designed enhanced services (“Local Enhanced Services (LES)” and “Directed Enhanced Services (DES)”);  
  - Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);  
  - The ability to establish new GP practices in an area;  
  - Approving practice mergers; and  
  - Making decisions on ‘discretionary’ payments (e.g., returner/retainer schemes) | Achieved | • All DESs and LISs reviewed and relevant schemes have been incorporated into ‘Dudley Quality for Outcomes Health’ contract.  
• Full range of contractual issues (mergers, branch surgery closure applications) considered in full compliance with statutory duties and in accordance with the relevant policies and procedures of NHS England.  
• GMS contractual review process developed and implemented in full compliance with statutory duties and in accordance with the relevant policies and procedures of NHS England.  
• Extended access Local Improvement Scheme commissioned in line with NHSE requirements of 30 mins per 1000 population per week additional capacity for pre-routine GP appointments.  
• Excluded patients scheme and out of area registrations (in hours urgent medical care) commissioned |

3.0 GOVERNANCE

3.1 The Primary Care Commissioning meetings continue to be held in public session during 2017/18

3.2 The membership of the Committee has continued to be constituted to make sure that the majority is lay and executive members. No GP members are members of the Committee. The clinical input into the Committee is obtained through a secondary care clinician, the secretary of the LMC (who has no voting rights) and a local GP who represents GP members (the GP has not voting rights and is not a member of the CCG Board).

3.3 The commissioning and governance arrangements for Primary Care have been audited internally during our 3rd year of delegation, which did not highlight any weaknesses that would impact on the achievement of the systems key objectives.
3.4 The statutory guidance reinforces the obligation to comply with section 14O of the National Health Service Act 2006 which sets out the minimum requirements in terms of what CCGs must do in terms of managing conflicts of interest as set out in the table below

### Table: Summary of minimum statutory requirements for managing conflict of interests

<table>
<thead>
<tr>
<th>Area</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain appropriate registers of interest</td>
<td>Compliant</td>
<td>• The CCG maintains a Register of Interests which is published on the CCG website/made available for public access.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The CCG maintains a Register of Procurement Decisions detailing the decision made, who was involved in making the decision, a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.</td>
</tr>
<tr>
<td>Publish and make arrangements for the public to access those registers</td>
<td>Compliant</td>
<td>• As above</td>
</tr>
<tr>
<td>Make arrangements requiring the prompt declaration of interests by members and employees and ensure that these interests are entered into the relevant register</td>
<td>Compliant</td>
<td>• The CCG has produced its conflict of interest’s policy which details the processes to follow to manage conflicts of interest.</td>
</tr>
<tr>
<td></td>
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<td>• The policy is publically available on the CCG website.</td>
</tr>
<tr>
<td></td>
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<td>• The CCG has arrangements in place for continuing to manage any conflicts of interest post-decisions being made i.e. contract management processes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CCG members and officers have received appropriate training on conflicts of interest.</td>
</tr>
<tr>
<td>Have regard to guidance published by NHS England and Monitor on conflicts of interest</td>
<td>Compliant</td>
<td>• As above – all policies and processes are reviewed annually and are updated when required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The CCG produces a quarterly self-assessment and assurance statement for NHS England with the approval of the Committee</td>
</tr>
</tbody>
</table>

4.0 **COMMISSIONING**

This relates to the services we directly commission from primary care from this we have improved outcomes and experience for patients.

**Improving outcomes for patients of Dudley**

4.1 As part of our vision for transforming primary care, Dudley CCG previously developed a new contractual framework for primary medical services, ‘Dudley Quality Outcomes for Health’ (DQOFH);

4.2 The outcomes in this framework form the foundations of our new model of care which will be commissioned from the Multi-speciality Community Provider (MCP). The DQOFH framework is designed to develop a local evidence based outcomes contract which focuses on the needs of our local population. This will drive up standards, address unwarranted variation, fit around patients and be focused on outcomes that make a difference to their lives. Patients will be supported to increase
management of their own condition and to set personalised goals of what they would like to achieve for their health;

4.3 The focus on goal setting and holistic management of patients requires a significant change in the way that our practices, and our patients, engage with this new way of working. In order to ensure a smooth transition for patient care, over the last 12 months the CCG has invested in supporting practices to successfully and efficiently implement the DQOFH framework;

4.4 Following on from the original evaluation last year, ICF (an independent research company), the Health Services Management Centre, Birmingham University and the Strategy Unit of the Midlands and Lancashire Commissioning Support Unit have undertaken a further evaluation of the DQOFH framework in 2017/18. This has been predominately to understand its impact on General Practice in comparison to the previous GP National contract, ‘Quality Outcomes Framework’ (QoF). Key findings included:

- There is still variation between individual practice approaches to implementing the DQOFH framework
- The framework enables a streamlined and standardisation approach to Long Term Conditions (LTC) reviews
- It reduces the number of individual appointments required for people with multiple LTCs
- It increases the patient contact time which will be of benefit to person centred care planning

4.5 In 2018/19 Dudley CCG will continue to commission the DQOFH framework as a mechanism to improve LTC management for the whole of our population.

**Improving access for patients of Dudley**

4.6 As one of our mandatory requirements from NHSE in 2017/18 the CCG commissioned extended primary care access (in line with the guidance) to provide additional primary care capacity (additional 30 mins per thousand population per week) from 1 September 2017 to 31 March 2018. The provision of primary care medical services was extended to include Saturdays and Sundays and from 6.30pm – 8.00pm Monday to Friday;

4.7 Prior to implementation we worked with our public to fully understand their needs in terms of access to primary medical services, so that we could commission sufficient primary care to meet the needs of our local population;

4.8 This scheme has been a huge success and was the first time that practices had worked collaboratively to provide services on a locality geographical basis. Each of our five localities participates in the scheme providing 100% coverage for our Dudley population, offering an additional 159 hours of clinical consultation time per week;

4.9 Our local scheme gained full assurance from NHSE in October 2017 and is regarded as an example of good practice across the region;

4.10 In addition in 2017/18, the Dudley economy experienced substantial pressures on its emergency care system particularly over the winter period. In response the CCG increased capacity within the extended access scheme from 30 to 45 mins (per thousand population per week) from 1 December 2017 to 31 March 2018, and commissioned additional primary care capacity over the Christmas Bank Holiday period. The Bank Holiday scheme included re-direction and direct booking from the Urgent Care Centre (UCC) and 111 and was extremely successful in providing additional support to the emergency care system and very popular with the public;

4.11 In 2018/19 the CCG will continue to commission both the locality based extended access and the Bank Holiday extended access schemes to ensure our local population has 365 day access to primary medical services.
5.0 ‘GENERAL PRACTICE FORWARD VIEW’ AND PRIMARY CARE DEVELOPMENT

5.1 In 2016, NHS England published the General Practice Forward View (GPFV). It set out a National five year plan to make changes and improvements across general practice and primary care so to deliver care in the right way for the people who need it;

5.2 In response to this the CCG consulted widely with our patients and our practices to produce a plan to implement the GPFV in Dudley. This was fully assured by NHSE in April 2017;

5.3 GPFV is an area where four CCGs within the Sustainability Transformation Partnership (STP) footprint have embraced opportunities to work collaboratively. This has included:

- Development of a joint STP workforce strategy (which has now gained partial assurance in line with the other STP areas across the West Midlands) and agreement to work collaboratively on its implementation
- Jointly commissioning practice manager training
- Agreement regarding future arrangements for closer working with the local Community Provider Education Networks (CPEN)
- Submitting an STP-wide bid for the Phase 3 GP International Recruitment Programme

5.4 On a local level the Primary Care Development Group (PCDG) oversees the day to day delivery of the GPFV and includes representation from GPs, practice managers and practice nurses;

5.5 During 2017/18, the CCG has made significant progress towards delivery of the GPFV work programme which has included:

- A comprehensive training needs assessment for nurses to inform the future educational needs of the workforce
- Investment in increasing the number of non-medical prescribers in primary care
- Investment in clinical correspondence training for practice staff to reduce GP administration time
- Development of a ‘patient on-line’ toolkit to improve uptake of patients registered in using patient online services
- Investment in both clinical and non-clinical telephone consultation training to have a standardised approach and improve effective conversation with the public
- Development of best practice guidance for utilisation of primary care IT systems
- Care Navigation training for frontline reception staff delivered by our local Healthwatch, so that the public may be signposted to more appropriate services, in particular the voluntary sector
- Supporting practices who are struggling to obtain NHSE funding and help through the GP resilience programme
- Exploring the use of alternative consultation types such as on-line and group consultations
- Commissioning training and development programmes for practice managers including coaching training for our mentorship team

5.6 In 2018/19 the PCDG will continue to support delivery of the GPFV work plan and will have a key focus around implementation of the STP workforce strategy, practice manager development training and delivery of a suitable solution for on-line consultation.

6.0 CONTRACTING

6.1 Under the delegated functions agreement between NHS England and Dudley CCG, the CCG has to discharge its responsibility of seeking and confirming contractual compliance of all primary medical contracts that fall under its governance. In order to help fulfil this responsibility we develop an annual contract review process. Over the last three year period, all Dudley practices have received a comprehensive contract compliance review. The process for 2017/18 and for next year concentrates on monitoring the key themes that have either been highlighted from previous monitoring exercises or are new contractual obligations;

6.2 All but one of the GP practices in Dudley operates under a General Medical Services (GMS) Contract and each year changes are agreed by NHS Employers, on behalf of NHS England and the British
Medical Association GP’s Committee. Practices find the monitoring exercise useful in understanding any new contractual obligations. The monitoring process also helps our practices in preparation for Care Quality Commission visits. All of our GP practices are encouraged to share good practice and this is often achieved through standardising polices with support from the Dudley Practice Managers Association (DPMA). All Dudley practices are also required to complete an annual e-declaration against a wide range of GMS contract clauses;

6.3 The Committee has considered a wide range of contracting issues during the year including the resignation of a GP working alone that resulted in a practice closure. It has approved 19 contract variations and has had to consider significant issues relating to an application from two practices to merge and from one practice applying to close both of its branch surgeries;

6.4 All Committee meetings have been held in public session. In order to inform the decisions regarding merger and closure, and to give local people an opportunity to share their feedback, public consultations have been held. The plans for the consultations were accepted by the Health and Adult Social Care Committee at the beginning of the consultation period. The consultations included:

- Local community forums to explain the process, answer questions and direct people to future engagement opportunities.
- Public consultation surveys, which local residents could complete in writing or online. Open public meetings, held at venues local to patients.
- Informal drop-in sessions
- Meetings with community groups.

6.5 Written MP’s submissions were also made to the CCG during the consultations, including contributions from local councillors, GPs and neighbouring CCGs;

6.6 Obligations under the Equality Act 2010 have been fulfilled, and to ensure compliance an equality impact assessment was conducted alongside the public consultation to assess whether any of the protected characteristic groups identified in the 2010 Equality Act would be disproportionately affected by the proposed changes;

7.0 QUALITY

7.1 By the end of 2017/18 all practices in Dudley had been visited by the Care Quality Commission (CQC). This has resulted in:

- 42 practices being rated as good overall (one practice has since closed)
- Three rated as requires improvement
- One practice rated as outstanding

7.2 This represents just over 93% of practices being rated as good or outstanding at the end of the year, compared with 80% at the end of 2016/17;

7.3 During the year we had two practices that were initially rated as inadequate but, with support and advice from the CCG, they were able to focus efforts on improving their systems and processes which resulted in both improving their ratings on re-inspection.

Improving Primary Care

7.4 Our dedicated Primary Care Development Team includes GPs, nurses and practice managers who play a key role in delivering the training, development and mentorship which drives service improvement;

7.5 A development programme called “Enabling Practices to Improve and Change” (EPIC) has also helped to accelerate improvements across practices in quality, efficiency, communication between staff and with patients, engagement with patient groups and collaboration between practices;
As well as delivering a better experience for large numbers of patients, the EPIC initiative has also helped to free up more GP time to see patients, improved practice productivity and supported enhanced training and career development for clinical and non-clinical staff.

**Primary Care and the Multi-speciality Community Provider (MCP)**

The MCP-related primary care development work is GP led and driven by a Steering Group on behalf of a Collaborative of Dudley GP practices who have focussed on:

- Engaging with potential partners in the MCP
- Developing the integration agreement which set outs in detail the relationship between the Dudley practices and the MCP
- Preparing the collective primary care response to the MCP procurement

The work of the Steering Group and wider Collaborative has a number of defining characteristics:

- Strong clinical leadership – the lead GPs on the Steering Group combine management and leadership expertise with a genuine understanding of the issues affecting GP’s
- A shared vision and commitment to the MCP across the wider GP community – our GP leads communicate regularly with colleagues from across the borough to ensure that views from primary care are accurately and authentically represented
- Robust governance structures – The Steering Group draws its authority from a mandate from the Primary Care Collaborative, which in turn comprises those practices who are signed up to a detailed Memorandum of Understanding (MOU)
- Independent programme management support – including dedicated management leads from the CCG who are not involved in the procurement process and a programme support team drawn from the Strategy Unit at Midlands and Lancashire Commissioning Support Unit (CSU) as well as other specialist service providers

The CCG has made it clear that organisations wishing to bid for the role of main contractor in the MCP will require support from primary care. Over the course of 2017/18 the GP Collaborative Steering Group, on behalf of Dudley GP practices, has:

- Selected their MCP partners; Dudley Group NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust
- Produced an integration agreement that has been developed with significant engagement with the Collaborative GP practices – defining the way in which Dudley practices will integrate with the MCP
- Developed the proposed Clinical Model for the MCP
- Developed with MCP bid partners, a response to the MCP procurement

**8.0 PRIMARY CARE PERFORMANCE**

The performance of Primary Care in Dudley is reported through the Primary Care Analysis Tool (PCAT) and the Committee has been assured over the course of 2017/18 regarding the high performance and quality of primary care in Dudley. In those cases where there are exceptions, these are reported, and the CCG has effective systems and processes in place to address performance issues through the activities of the Membership engagement team;

In 2017/18 the CCG has developed a Primary Care Assurance Framework which forms the basis of the contractual monitoring visits, this will continue to be further developed and utilised as a mechanism for monitoring the performance of Primary Care.
9.0 ENGAGEMENT

Engagement with primary care

9.1 Through Committee primary care has continued the annual programme of GP Engagement visits that have informed the way in which services are commissioned by the CCG on behalf of member practices;

9.2 We have continued to meet with the GP membership on a monthly basis through our locality meetings, and bi-monthly with the wider membership events;

9.3 We have engaged with practice managers on a regular basis at the Dudley Practice Management Alliance to discuss practice management development and the commissioning of primary care schemes.

Engagement with patients

9.4 As part of our responsibilities as a CCG we have to engage with our patients. During 2017/18 the Committee has continued to welcome the opportunity to engage directly with the public on matters which are most important to them. This has included holding public meetings directly in the neighbouring area in matters relating to branch closures, mergers and relocation of a branch surgery to make improvements and efficiencies for our population;

9.5 Our local Healthwatch continues to work in collaboration with the Committee to ensure we constantly continue to consider the patient voice in any decisions we make;

9.6 Direct engagement with our Patient Participation Groups through our Patient Opportunity Panel meetings takes place on an on-going regular basis.

10.0 FINANCE

10.1 The budget delegated to Dudley CCG in 2017/18 for the commissioning of Primary Care was £41.2m and the CCG has successfully discharged its responsibility to operate within this financial allocation, meeting the required break-even position against this budget.

The main areas of expenditure against the delegated budget have been:

<table>
<thead>
<tr>
<th>Item</th>
<th>Expenditure (£m)</th>
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<tr>
<td>GP Contract Payments</td>
<td>27.3</td>
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<tr>
<td>Quality &amp; Outcome Framework and Enhanced Services</td>
<td>6.4</td>
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<tr>
<td>Premises Costs</td>
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<td>Other Services</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>41.2</strong></td>
</tr>
</tbody>
</table>

10.2 Among the key investments made by the CCG during this financial year have been:

- The commissioning of additional evening and weekend opening at GP practices across Dudley
- An additional £230,000 investment into improving the care of patients with long term conditions
- A continuation of the scheme to increase the diagnosis of dementia among patients

10.3 Dudley CCG believes that Primary Care Services are the cornerstone of effective patient care. Our aspiration is to increase the amount of resources spent in primary care to provide better value for money across the health economy.
11.0 ATTENDANCE AND QUORACY

11.1 The Committee has met monthly in public between 1st April 2017 and 31st March 2018.

11.2 A register of attendance is set out in appendix a.

12.0 DECISION REGISTER

12.1 In line with statutory guidance, the Committee as a corporate decision making body keeps a register of procurement decisions. The following key procurement decisions have been extended by the Committee between 1st April 2017 and 31st March 2018:

- A 12 month contract for the provision of an ‘out of area registrations’ in hours urgent primary care (including home visits) enhanced service.
- A twelve month contract for the provision of excluded patients (violent and aggressive patients) service.
- A seven month contract for the provision of extended access for primary medical services local improvement scheme (LIS) meeting the 7 NHSE core requirements.
- A 6 month contract for the provision of LTC Prevalence local improvement scheme (LIS).

13.0 RECOMMENDATION

13.1 The Committee is asked to confirm that it is assured that the Committee has discharged its responsibilities.

13.2 The Committee is asked to approve this Annual Report.
# Dudley CCG - Primary Care Commissioning Committee Attendance Schedule 2017/2018

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Title</th>
<th>Commenced Membership</th>
<th>24/06/2017</th>
<th>26/06/2017</th>
<th>18/06/2017</th>
<th>14/07/2017</th>
<th>11/08/2017</th>
<th>29/09/2017</th>
<th>20/10/2017</th>
<th>17/11/2017</th>
<th>15/12/2017</th>
<th>19/01/2018</th>
<th>16/02/2018</th>
<th>16/03/2018</th>
<th>Attendance Percentage</th>
<th>Are they on the DOI Register?</th>
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<tr>
<td>Steve Wellings</td>
<td>Lay Member for Governance (Chair)</td>
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<td>Caroline Brunt</td>
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<td>Matt Hartland</td>
<td>Chief Operating &amp; Finance Officer *</td>
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<td>Daniel King</td>
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**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 July 2018  
**Report:** Locality Feedback Report – June 2018  
**Agenda item No:** 11.2

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<tr>
<th>TITLE OF REPORT:</th>
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<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of themes emerging from discussions held at Locality meetings in June 2018</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr D King, Director of Membership Development and Primary Care</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr D King, Director of Membership Development and Primary Care</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr R Gee, GP Engagement Lead</td>
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**KEY POINTS:**

- The Governing Body received a membership engagement action plan in May 2018 following the CCG Stakeholder Survey
- One component of the action plan was that there would be a Locality Feedback Report directly into CCG Governing body
- This report summarises the themes emerging from the locality meetings for the month of June 2018 during which localities discussed:
  - The proposals for establishing Integrated Community Teams (ICTs)
  - The areas of the Primary Care Analysis Tool (PCAT) they would collectively focus on at next meeting
  - The prescribing performance position
  - The way in which extended access is operating within the locality
  - Practice specific issues and sharing best practice
- The themes relating to these discussions are that:
  - There is broad support for the ICTs providing they can be operated flexibly within each locality
  - There is broad support from the Prescription Ordering Direct (POD) and all localities have requested the detail on the roll out plan and timetable for implementation.
  - All localities have selected Dudley Quality Outcomes for Health achievement to date as the area from the PCAT tool that they would like to discuss at the July meetings

**RECOMMENDATION:**

1) The Board is asked to note the Locality Feedback Report for assurance

**FINANCIAL IMPLICATIONS:** None

**WHAT ENGAGEMENT HAS TAKEN PLACE:** Dudley and Netherton Locality  
Sedgley, Coseley and Gornal Locality  
Halesowen and Quarry Bank Locality  
Stourbridge, Wollescote and Lye Locality  
Kingswinford, Amblecote and Brierley Hill Locality

**ACTION REQUIRED:** ✓ Assurance
1.0 INTRODUCTION

1.1 The CCG stakeholder survey results were discussed with GP members at the member’s event in May 2018. As a result GP members proposed a number of actions that were presented and agreed at the Governing Body in May 2018 as part of a membership engagement action plan. One component of the action plan was that there would be direct feedback from locality meetings into the Governing Body.

1.2 This report summarises the themes emerging from the locality forum meetings that took place in June 2018.

2.0 SUMMARY

2.1 The main items and themes emerging from locality discussions in June were as follows:

Integrated Care Teams (ICTs)

2.2 Dr Rebecca Lewis, Integration Lead for Halesowen attended all locality meetings to present and seek feedback on the proposals to develop the ICTs.

2.3 The feedback from localities was generally very positive and supportive – a number of practical and operational issues were raised at the meetings relating to clinical governance; remit of the lead GP; IT infrastructure in place to support new way of working; understanding the way in which ICTs would support delivery of the MCP outcomes framework. All of the localities expressed their desire to retain the benefits of their MDTs.

2.4 There was concern expressed from Dudley and Netherton locality specifically in relation to how ICTs would operate across their locality of small practices. It was agreed that the practices would give thought to how to operate the ICT and discuss this at their next locality meeting.

2.5 All of the feedback will inform the ICT ‘pilot’ site in Halesowen and Quarry Bank.

Prescribing – Prescription Ordering Direct (POD)

2.7 The Practice Based Pharmacist Lead attended each locality and presented the prescribing performance report. The prescribing performance is contained in the Finance, Performance and Business Intelligence report.

2.8 All localities have requested details on the roll out plan for the POD by practice and timescale. The practices are keen to realise the benefits of the POD for their patients and the practice. This will be discussed at the locality meetings in July.

Primary Care Analysis Tool (PCAT)

2.9 Member practices have requested more targeted commissioning information at a practice, and locality level for discussion at locality meetings.

2.10 The Performance team has therefore produced ‘practice packs’ that have been shared at locality meetings to enable an in depth discussion on areas of variation. Each locality has agreed to select an area for discussion at each meeting – using information contained within the PCAT tool.

2.11 All localities have agreed to focus on the achievement of the Dudley Quality Outcomes for Health Framework at their next meeting in July.
3.0 RECOMMENDATION

3.1 The Board is asked to receive the report for assurance.

Mr D King
Director of Membership Development and Primary Care
July 2018
## Dudley Clinical Commissioning Group
### GLOSSARY - APRIL 2018

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<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<td>Fractured Neck of Femur</td>
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<td>£K</td>
<td>£1,000 equivalent</td>
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<td>Antimicrobial resistance</td>
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<td>An antibody occurring in pregnancy</td>
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<td>COPD</td>
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