**DUDLEY CLINICAL COMMISSIONING GROUP BOARD AGENDA**

**Thursday 8 January 2015**

1.00pm – 4.00pm

Boardroom, Brierley Hill Health & Social Care Centre, Venture Way, DY5 1RU

**QUORACY**
Meetings will be quorate when four elected GP clinical members and one other Board member are present, (one of whom shall be the CCG Chair, Chief Officer or Chief Finance Officer)

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Attachment</th>
<th>Presented By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1pm</td>
<td>1. Apologies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1pm</td>
<td>2. Declarations of Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To request members to disclose any interest they have, direct or indirect, in any 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 for discussion or vote on any questions relating to that item.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1pm</td>
<td>3. Minutes from 13 November 2014</td>
<td>Enclosed</td>
<td>Dr D Hegarty</td>
</tr>
<tr>
<td>1pm</td>
<td>4. Matters Outstanding</td>
<td>Enclosed</td>
<td>Dr D Hegarty</td>
</tr>
<tr>
<td>1.05pm</td>
<td>5. Public Voice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.1 Questions from the Public;</td>
<td>Verbal</td>
<td>Dr D Hegarty</td>
</tr>
<tr>
<td></td>
<td><em>To respond to questions from members of the public present at the meeting on the provision of health care to the population served by the CCG.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.15pm</td>
<td>5.2 #ME Festival Feedback</td>
<td>Presentation</td>
<td>Mrs L Broster</td>
</tr>
<tr>
<td>1.35pm</td>
<td>6. Chairman's &amp; Chief Executive Officer Report</td>
<td>Verbal</td>
<td>Mr P Maubach</td>
</tr>
<tr>
<td>1.50pm</td>
<td>7. Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.1 Development of the CCG long-term strategy</td>
<td>Enclosed</td>
<td>Mr P Maubach</td>
</tr>
<tr>
<td>2.00pm</td>
<td>8. Quality &amp; Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.1 Report from Quality and Safety Committee</td>
<td>Enclosed</td>
<td>Miss R Bartholomew</td>
</tr>
<tr>
<td></td>
<td>8.2 Unannounced Visit Report</td>
<td>Enclosed</td>
<td>Miss R Bartholomew</td>
</tr>
<tr>
<td>2.20pm</td>
<td>9. Commissioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9.1 Report from Clinical Development Committee</td>
<td>Enclosed</td>
<td>Dr S Mann</td>
</tr>
<tr>
<td></td>
<td>9.2 Health &amp; Wellbeing Report</td>
<td>Enclosed</td>
<td>Dr S Mann</td>
</tr>
<tr>
<td></td>
<td>9.3 Better Care Fund – Section 75</td>
<td>Enclosed</td>
<td>Dr S Mann</td>
</tr>
<tr>
<td>2.50pm</td>
<td><strong>BREAK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communications &amp; Engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>No report – Committee has not met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Report from Audit Committee</td>
</tr>
<tr>
<td>11.1</td>
<td>Enclosed</td>
</tr>
<tr>
<td>11.2</td>
<td>Mrs J Jasper</td>
</tr>
<tr>
<td>11.3</td>
<td>Audit Committee Terms of Reference</td>
</tr>
<tr>
<td>11.4</td>
<td>Enclosed</td>
</tr>
<tr>
<td>11.5</td>
<td>Mrs J Jasper</td>
</tr>
<tr>
<td>11.6</td>
<td>Combined Board Assurance Framework and Risk Register</td>
</tr>
<tr>
<td>11.7</td>
<td>Enclosed</td>
</tr>
<tr>
<td>11.8</td>
<td>Mrs J Jasper</td>
</tr>
<tr>
<td>11.9</td>
<td>Proposal For Devolved Commissioning Of General Medical Services</td>
</tr>
<tr>
<td>11.10</td>
<td>Enclosed</td>
</tr>
<tr>
<td>11.11</td>
<td>Mr S Wellings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Finance and Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Report from Finance &amp; Performance Committee</td>
</tr>
<tr>
<td>12.1</td>
<td>Enclosed</td>
</tr>
<tr>
<td>12.2</td>
<td>Dr J Rathore</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Report from Primary Care Development Committee</td>
</tr>
<tr>
<td>13.1</td>
<td>Enclosed</td>
</tr>
<tr>
<td>13.2</td>
<td>Dr J Rathore</td>
</tr>
</tbody>
</table>

Close

<table>
<thead>
<tr>
<th></th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>Glossary</td>
</tr>
<tr>
<td>14.1</td>
<td>Enclosed</td>
</tr>
</tbody>
</table>

**Time and Date of Next Meeting**

Thursday 12 March 2015  
1pm – 4pm, Boardroom, BHHSCC
MINUTES OF THE MEETING HELD IN PUBLIC ON THURSDAY 13 NOVEMBER 2014
AT 1.00 PM, BOARDROOM BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE

ATTENDEES:

Dr D Hegarty  Chair
Miss R Bartholomew  Chief Quality & Nursing Officer
Dr J Darby  GP Board Member (Halesowen & Quarry Bank)
Dr K Dawes  GP Board Member (Sedgley, Coseley & Gornal)
Dr R Edwards  GP Board Member (Kingswinford, Amblecote and Brierley Hill)
Ms J Emery  Chief Officer - Health Watch
Dr C Handy  Lay Member for Quality & Safety
Mr M Hartland  Chief Finance Officer
Dr M Heber  Secondary Care Clinician
Dr T Horsburgh  Interim Director of Public Health
Mrs K Jackson  LMC Representative
Mrs J Jasper  Lay Member for Patient & Public Engagement
Dr R Johnson  GP Board Member (Halesowen & Quarry Bank)
Dr M Mahfouz  GP Board Member (Dudley & Netherton)
Dr S Mann  Clinical Executive – Acute & Community Commissioning
Mr P Maubach  Chief Accountable Officer
Mr J Polychronakis  Chief Executive Officer - Dudley MBC
Dr J Rathore  Clinical Executive – Finance & Performance
Dr R Tapparo  GP Board Member (Kingswinford, Amblecote & Brierley Hill)
Mr S Wellings  Lay Member for Governance

IN ATTENDANCE:

Mrs L Broster  Head of Communication and Engagement
Mr N Bucktin  Head of Commissioning
Mrs S Cartwright  OD Practitioner
Dr R Gee  GP Engagement Lead
Ms S Johnson  Deputy Chief Finance Officer
Mr D King  Head of Membership & Primary Care
Mrs E Smith  Minute taker

CCG116/2014 APOLOGIES

Apologies were received from Dr Cartwright, Dr Gupta and Dr Gee.

CCG117/2014 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.
Mrs Jasper declared an interest in relation to her position on Sandwell & Dudley CCG’s Board.

Dr Hegarty welcomed Mrs Karen Jackson as the Interim Director for Public Health replacing Ms Little.

**CCG118/2014 MINUTES FROM 11 SEPTEMBER 2014**

The minutes of the meeting held on 11 September 2014 were accepted as a true and accurate record subject to the following amendments:

Dr Hegarty asked to note that Mr Steve Wellings chaired the meeting on the 11 September 2014.

Dr Dawes highlighted duplication on page 6 & 7, agreed that Mrs Smith would amend accordingly.

Mr Maubach felt that on page 11 the minutes do not accurately reflect the discussion and it was agreed that Mr Maubach would provide a summary to Mrs Smith.

Resolved:

1) The Board accepted the minutes from the 11 September 2014 as an accurate record subject to the amendments stated above.

**CCG119/2014 MATTERS OUTSTANDING**

**CCG040/2014 COMMUNICATIONS & ENGAGEMENT REPORT**

Mrs Broster confirmed that the Patient Opinion Panel’s (POP) meeting scheduled for the 27 November would have representation from the Area Team.

**CCG087/2014 COMMISSIONING FOR OUTCOMES**

Mr Maubach confirmed this would come to the January 2015 meeting

**CCG104/2014 CHAIRMANS & CHIEF OFFICER REPORT**

Mr Maubach confirmed that the Peer Review data was being processed and would come to the January 2015 meeting

**CCG106/2014 QUALITY & SAFETY COMMITTEE REPORT**

Mr Hartland and Miss Bartholomew confirmed that this has been completed.

Resolved:

1) The Board noted the matters outstanding

**PUBLIC VOICE**

**CCG120/2014 QUESTIONS FROM THE PUBLIC**

Patient Opinion Panel (POP)

**Question:** Why is “Pharmacy First” only in deprived areas?

Dr Hegarty confirmed that this scheme was targeting the highest areas of deprivation and those in greatest need. This was considered by all the localities, to engage and form opinion, and 18 practices have been excluded because they are not classified as being in a deprived area. The scheme has been targeted at the areas of greatest need. He understood that the item would be discussed at the next POPs panel.

**John Payne, Halesowen**

**Background:** Under item 7 Strategy (board meeting, Sept 11) there is a para. (8.4) referring to the “establishment of a Task & Finish group with the specific remit to establish governance arrangements for co-commissioning and develop the initial outcome objectives ... “.
**Question:** Against a background of alarming news items concerning the financial distress of the NHS, will the deliberations of the Task & Finish group be made available to the public, eg. in the form of a report to the CCG board which can be read by the public?

Mr Maubach confirmed that the first Task and Finish Group Board report would be coming to January’s meeting which will be available to the public as part of the papers. There is also a representative from Healthwatch and a Patient Participation Group’s (PPG) to ensure correct involvement in the deliberations.

**Resolved:**
1) The Board thanked the members of the public for their questions.

---

**CCG121/2014   FEET ON THE STREET – DISCHARGES**

Dr Hegarty introduced this item reporting that this was looking at patients’ experiences of being discharged from hospital.

Mr Maubach felt encouraged that 90% of the feedback from patients indicated that they had received a good experience. He felt that there is a need to go back to DGFT and highlight that there are still 10% proportion of patients that are not reporting a good experience. The feedback from staff demonstrates the pressures they are under.

Dr Mann noted the re-admission rates are below average and asked if this was correct? Mr Maubach confirmed he would look into this and check this information. He also felt that there was insufficient ambition in the DGFT response.

Dr Dawes suggested that a list of medication is given to the patient on discharge and Dr Heber said that she is aware of other systems in place where patients are given a list of medications at the time of their discharge. In addition, she felt it should be considered good practice for a health care worker to go through the medication with patients when they are first prescribed.

Dr Heber highlighted that a lot of patients felt they had been discharged too soon for their personal needs and felt that this needs to be put into context with this consideration. Some people actually like being in hospital and there is a need to address this with patients and educate them that their care will continue once they have left the hospital.

Dr Tapparo highlighted that a huge part of the delay in discharges is also down to the time it takes to arrange medication and it would be worthwhile going back to DGFT to establish what they are doing to improve this. Dr Heber agreed that whilst it was important to address all the issues this presentation raised, maybe a focus on Medicines Management in the first instance would be beneficial.

Mr Maubach suggested that a further discussion needed to take place outside the meeting about what is an acceptable compliance standard around discharges and establish what ambition DGFT have to improve this. Dr Edwards confirmed that the Quality & Safety Committee will be looking at this.

**Resolved:**
1) The Board noted the presentation for information
2) The Board agreed that this would be addressed further through the Quality & Safety Committee

---

**CCG122/2014   PUBLIC UPDATE**

Mrs Broster spoke to this item and confirmed that this new report was presented with the aim of keeping Board members up to date with important communications and engagement issues and ‘hot topics’ that may be outside or beyond the assurance required from the Communications and Engagement Committee Report.
Mrs Broster highlighted that the keys areas for the Board to note was around young people’s views on visiting a doctor’s surgery and representation at the Health Care Forum.

She confirmed that Healthwatch Dudley has a priority to champion the voice of children and young people and the CCG’s partnership with Dudley Youth Council has continued to grow. Following on from a joint piece of work where the views of more than 300 people from many different backgrounds were gathered, a group of Youth Council members presented their findings to Dudley’s Health and Wellbeing Board in September. Research highlighted that on average young people think that they cannot visit a doctor without a parent or carer under the age of 16. It further highlighted that 1 in 10 young people would not visit their doctor about general health concerns. The findings will inform the questions that will be asked at Dudley Youth Summit/ME Festival in November. This would be fed back to Board in January 2015.

Mrs Broster reported that feedback from the last event demonstrated that clinical representation needed to be stronger and more visible. She confirmed that the next Healthcare Forum was on the 11th December at 12-2.30pm at Brierley Hill Civic Hall. The event will give participants the opportunity to live a ‘day in the life’ of CCG decision makers. The attendees will be looking at commissioning decisions in key areas to understand and role play different perspectives and contribute views on how decisions should be made.

Mrs Emery reported that Healthwatch England tasked local Healthwatch to find out people’s experiences of discharge from hospital. It was important to note that the majority of people who responded to the Healthwatch Dudley survey of Russell’s Hall Hospital patients had positive experiences, the focus of the Special Enquiry was of unsafe discharge. As such, initial findings of key issues were shared with the Dudley Group NHS Foundation Trust and Dudley CCG to be included in ‘Feet on the Street’. A final report of local findings and the Healthwatch England Special Inquiry will be available by the end of 2014.

Mrs Emery also reported that the aim of the Patient Experience transition funding joint action plan was to ‘produce a richer and more comprehensive picture of the quality of the patient experience.’ This was the main business of Healthwatch Dudley and as such, it was reassuring to see how much importance partners are placing on this area of work.

Dr Hegarty encouraged as many of the Board members to attend the Healthcare Forum as possible.

Resolved:
1) The Board noted the report for assurance.

CHAIRMANS & CHIEF OFFICER REPORT

Mr Maubach updated the Board on the following:

**New GP appointments to the CCG**

- Dr David Hegarty has been re-elected as Chair of the CCG.
- Dr David Shukla has recently been appointed as the new GP Lead for Research and Innovation.
- Dr Adeela Bashir has been appointed as the new GP Lead for Safeguarding, supporting Dr Ruth Edwards on the Quality and Safety agenda
- GPs have been appointed to all five of the locality lead roles overseeing integrated working and final references are being established before formally announcing their appointments.

**System Resilience**

The CCGs system resilience plans for the winter period have been fully approved by NHS England which means the CCG will receive the full allocation of non-recurrent additional funds to support enhancement to services across health and social care.

**Better Care Fund**

The joint Better Care Fund Plan with Dudley MBC was approved by NHS England but subject to conditions. The key condition was that the plans were considered to be overly ambitious and so work is
being carried out with the local authority to modify the plans accordingly. The main consequence of this was that it will reduce the availability of funds which can be transferred from health to social care. A revised financial plan will be resubmitted to NHS England at the end of the month.

**Urgent Care Centre**
Mr Maubach confirmed that the CCG were pleased to confirm that Malling Health were the successful bidders to provide the new Urgent Care Centre and work is now being done with them on the plans for implementation. However, he reported that Dudley Group Foundation Trust (DGFT) were behind schedule in delivering the necessary capital plans for the new centre, so, with their agreement, Capita has been appointed to lead the capital development.

Dr Dawes asked if there had been any objections from the other bidders involved in the procurement process. Mr Maubach confirmed that there is a standstill period once the contract has been awarded and there were challenges but these were addressed.

**Monitor assessment of Dudley Group Foundation Trust**
Mr Hartland recently attended, with Monitor, NHS England and DGFT, a second round-table review to consider the Trust's long-term financial position. This meeting reinforced previous conclusions that there was a need to review the longer-term financial plans. Mr Maubach confirmed that the CCG has commissioned Deloitte to jointly review the long-term plans of all of its main providers so that clarity can be established about the extent of the financial challenge that will need to be addressed across the system. This is due to report in January 2015.

**NHS England’s Five Year Forward View**
NHS England published their forward view on 23rd October setting out both the challenges and opportunities for the NHS. The Forward View also provides examples of different types of new care models and encourages local areas to develop their own vision for the future.

**Revised 5-year Strategic Plan and the Future Model of Services**
The current longer-term financial challenges for the providers and the opportunity offered by the Forward View, means that the CCG will need to update the five year plan – and in particular consider how this develops the preferred model of care in Dudley and the consequential impact on the current organisational structures. It was anticipated bringing this to March Board.

**Health Services Journal (HSJ) Leaders’ Summit**
Mr Maubach confirmed that both himself and Dr Hegarty recently attended the HSJ summit to participate in debate and discussion on the future development of healthcare.

**ME Festival**
As Mrs Broster previously mentioned, the ME Festival scheduled for the 20th November 2014 was to be held at Himley Hall, Dudley and she reported that it was anticipated to be fantastic event where year 8 children from across the borough will be participating in a wide range of workshops and interactive sessions all on the theme of health and wellbeing.

**Provider Conference**
Mr Maubach reported that the second provider conference will be held on 26th November 2014 at the Copthorne Hotel in Brierley Hill. This will be an interactive workshop which will enable the CCG to hear from a wide range of providers about how plans are developing and to receive their input into how the CCG can improve service delivery.

**Co-commissioning**
NHS England has issued the document ‘Next Steps towards primary care co-commissioning’ and the CCG will be producing the response for approval at the January Board.

**NHS England PMS Reviews**
The CCG has agreed with NHS England that their intended review of all PMS practices will be carried out jointly with them. Mr Maubach confirmed that the CCG will be running a local workshop for all the PMS practices in the borough and this process will commence on 26th November 2014.
Liz Pope Memorial Fund
Mr Maubach confirmed that Three Villages Practice were organising a sponsored walk on 29th November 2014 in aid of the ‘Liz Pope Memorial Fund’. He reported that everyone one was welcome to attend and also to sponsor those walking.

NHS 111
The CCG believes it would be more economical to re-commission the service jointly with other CCGs but there is a need to see a greater emphasis on embracing the opportunities from new technology.

Performance
Mr Maubach reported that the University Hospital Birmingham continued to embargo access to elective care in a range of specialties. This is still being challenged contractually through Birmingham Cross City CCG as host commissioner for the contract.

Dr Handy asked if there were any specific challenges facing the CCG from the production of the Forward Plan and Dr Hegarty confirmed that there will be challenges, however as the CCG had an input into the development of the plan the CCG was already sighted on the issues.

Resolved:
  1) That the Board noted the report for assurance

STRATEGY

CCG124/2014 HEALTH & WELLBEING BOARD REPORT

Mr Bucktin spoke to this item and confirmed that the Health & Wellbeing Board (H&WB) met on the 30 September 2014. He reported that the Board considered initial verbal feedback about the “Peer Challenge” which was given to senior managers and Board members at the end of the process. Once the formal outcome is provided, a report will go to the Clinical Development Committee.

Mr Bucktin reported that the H&WB received a presentation on experiences of young people experiencing Primary Care and confirmed that this was very well received. It was agreed that some of the findings of this presentation would go to the Primary Care Development Care Committee in November.

Resolved:
  1) The Board noted the report for assurance

QUALITY & SAFETY

CCG125/2014 QUALITY & SAFETY COMMITTEE REPORT

Dr Edwards spoke to this item and confirmed that the report summarised the key issues raised at the Quality & Safety Committee on the 16 September and 21 October 2014 and the Board discussed the following items further:

DUDLEY GROUP FOUNDATION TRUST (DGFT)

Discharge information
Dr Edwards reported that a table-top review meeting in August 2014 in relation to a Serious Incident investigation, revealed a problem with electronic discharge letters whereby information was not reliably reaching GP practices. Further discussions took place at the Clinical Executive team meeting on 13 August 2014, and DGFT’s Chief Clinical Information Officer presented a report to the Clinical Executive on 8 October 2014. This highlighted the complexities of the electronic system and the interface with primary care.
Dr Edwards confirmed that DGFT have informed the CCG that discharge letters are not only posted to GP practices but that every patient is also given a paper copy of their discharge letter to confirm changes in treatment plan and medication updates. Plans are in place for DGFT and the CCG to carry out joint reviews of the electronic letter process. The initial audit suggests there may be problems with receipt and processing of letters in practices as well as the sending of information from DGFT. EMIS is undertaking an investigation within practices to understand and resolve the issue and an action plan has been developed and is being monitored by the Task & Finish Group.

Dr Tapparo raised a query with regards what DGFT are saying about all patients having paper discharges, yet the audit taken reveals this is not always the case and Dr Edwards confirmed that a larger audit is taking place to revisit this and establish what the situation is.

CONTINUING HEALTHCARE
Work is being undertaken to establish the number of outstanding assessments. Scheduled reviews have started and there is a plan in place to recruit additional staff to the Continuing Health Care team to reduce the number of outstanding assessments. Commitment remains to ensure all patients receive an annual review.

Mr Maubach asked for an update around the outstanding assessments and Miss Bartholomew reported that a baseline has been established on where the CCG is with the assessments and these are then being categorised into red/amber/green to support a priority action plan.

Resolved:
1. The Board noted the report for assurance.

COMMISSIONING

CCG126/2014 CLINICAL DEVELOPMENT COMMITTEE REPORT

Dr Mann spoke to this item and confirmed that the report summarised the key issues discussed at the Clinical Development Committees on 1st and 22nd October 2014.

The Big White Wall
Dr Mann confirmed that this was an online therapy service which has been commissioned by the CCG historically on a non-recurrent basis. The take up of the service, both in terms of online live therapy and the support network service had been good and feedback from service users and local GPs has been positive. The Committee agreed to commission the service until 31st March 2016, to align with the likely timetable for the re-procurement of primary care mental health services.

Specialist Continence Service – 7 Day Working
Dr Mann confirmed that the Committee had approved a proposal to invest additional resources in the Continence Service to support 7 day working and more effective input into care homes. It was anticipated that this would enhance the quality of care available to patients, enhance patient dignity and prevent unnecessary admissions.

GP Clinical Lead – End of Life and Palliative Care
Dr Mann confirmed that given the significance of end of life and palliative care to the CCG’s priorities, the Committee had agreed to pick up the funding of this post which had previously been funded by Macmillan Cancer Support.

Pilot Community Based Back Pain Clinic
The Committee approved in principle proposals for a Community Based Back Pain Clinic to operate on a 6 month interim basis, subject to the clarification of a number of technical issues. Dr Mann confirmed this was not a clinic for acute pain.

QIPP
Dr Mann reported that the Committee has noted current progress in relation to QIPP and an expected shortfall of £1.925m has been identified against the current QIPP target. This is attributable, in part, to delays with the implementation of some schemes including the Community Rapid Response service and savings in relation to prescribing not being achieved.
Mrs Jasper asked what the timescale was in relation to understanding how much this will impact on next year’s QIPP target. Mr Hartland reported that the next Clinical Development Committee (CDC) is intended to be a one agenda item based on QIPP. He confirmed that the £2m shortfall will be added making a £12m target next year, and he reported that this may slip slightly more. There will be a presentation to CDC next week which will encourage discussion around whether the schemes on the list still valid? What schemes need to be added now? Does the CCG need to change the way it works as a commissioning function? Mr Hartland confirmed this would come back to January Board through the Finance & Performance Committee paper.

Dr Rathore highlighted the lack of engagement from provider organisations which prevent these schemes from being achieved and raised concerns that there sometimes appears to be sign up to these schemes without real consideration of the commitment involved.

Dr Handy asked what was driving the IFR reduction and if there is a budget for this. Dr Mann confirmed that the Committee was requested to present this information to the Board as an item of interest on a 6 monthly basis. The value incurred has increased despite the reduction in numbers and the issues are becoming more complex. Mr Hartland confirmed that this was part of the overall CCG budget so could be spent on other things.

Mrs Broster asked if any patient engagement had taken place around the relocation of the Community Based Back Pain Clinic and Mr Bucktin confirmed that most of the patients will be first time users of the service so there will be no comparison on what things were like before.

Resolved:
   1) The Board noted the report for assurance

---

CCG127/2014 NHS 111 WEST MIDLANDS PROCUREMENT

Dr Mann spoke to this item and confirmed that the report provided an update on the status and progress of the NHS 111 West Midlands Procurement.

He reported that upon the collapse of NHS Direct as national provider for NHS111, step-in arrangements were made nationally to ensure the safe continuation of the service prior to commissioning of a market tested provider. In November 2013 West Midlands Ambulance Service (WMAS) provided step-in arrangements and took over the service for 22 CCGs within the West Midlands. Due to the nature and legalities of the step-in arrangements, all CCGs were required to go to open tender to procure the NHS111 service.

Dr Mann confirmed that WMAS are only able to continue delivery of the service until September 2015 and all CCGs were now charged with procuring a provider for NHS111 and mobilising the service by September 2015.

The infrastructure, liabilities and costs associated with providing the NHS111 service significantly challenges a CCG considering the commissioning of the service on an individual basis. A collaborative agreement offers the best option with regards to cost, stability and infrastructure costs.

Dr Mann stressed the importance that there be significant clinical input in the development of this procurement.

Dr Hegarty gave the Board's thanks to Jason Evans for all his hard work.

Resolved:
   1) The Board noted for assurance the comprehensive and robust procurement process planned for appointing a qualified provider for NHS111 West Midlands.
   2) The Board noted for assurance the work being undertaken at a local level to influence the service specification to ensure it is innovative and responsive to the needs of Dudley patients.
   3) The Board agreed to join in a planned procurement to be delivered through one combined
process for all West Midlands CCGs.

4) The Board agreed to a restrictive procurement process to be undertaken and led by Sandwell & West Birmingham CCG (S&WB CCG) with representation throughout from Dudley CCG.

5) The Board noted the procurement process deadlines and timeframe.

6) The Board agreed to sign the Memorandum of Understanding with Sandwell & West Birmingham CCG.

7) The Board noted the supply market briefing event to be held on 12th – 13th November 2014 and a CCG Board member would be nominated to attend these events.

8) The Board noted that the NHS111 West Midlands Service specification must be signed off by all CCGs before 9th January 2015 and where possible earlier.

9) The Board agreed for Jason Evans, Urgent Care Commissioning Manager, to be the nominated evaluator for Dudley CCG throughout the procurement process.

COMMUNICATIONS & ENGAGEMENT

CCG128/2014 COMMUNICATIONS & ENGAGEMENT COMMITTEE REPORT

Mrs Broster spoke to this item and confirmed that the report summarised the key issues discussed at the Communications & Engagement Committee on the 14th October 2014.

Mrs Broster highlighted that the Freedom of Information (FOI) Update was presented to the Committee and that the purpose of the report had been to provide an overview of the CCGs activity in relation to Freedom of Information requests received and to provide assurance that this key function is being managed well by the team. She confirmed that along with FOI, the whole complaints process was now being managed by the newly appointed Complaints and FOI Officer.

Mrs Broster also informed the Board that the Committee was continuing to progress towards the evolution of a locality structure for Patient Participation Groups (PPG), PPG/Patient Opportunity Panels (POPs) development sessions and the implementation of the scheme to award grants of up to £1,000 in direct funding for each of the CCG’s PPGs.

She confirmed that the last POPs meeting in July was well attended and Paul Maubach was available to answer any questions which arose. Mrs Broster confirmed that there was still development opportunities for the panel which the CCG Organisational Development Lead was supporting.

Resolved:

1) The Board noted the report for assurance

GOVERNANCE

CCG129/2014 AUDIT COMMITTEE REPORT

Mrs Jasper spoke to this item and confirmed that the report summarised the key issues discussed at the Audit Committee held on 26th September 2014.

Committee Effectiveness

The Committee received a report on the results of the committee self-assessment survey (based on contributions from committee lay members and auditors) and a verbal update on the checklist of processes from the Committee Chair. It was agreed that the Chair and governance lead would prepare an action plan for the next meeting drawn from the self-assessment survey and the checklist of processes.

Information Governance

Mrs Jasper highlighted that the Committee received an update on the future arrangements for Information governance support and was assured that the CCG would have continuity in provision. The Committee received and approved a new overarching Information Governance Policy which replaced 18 individual policies. She confirmed that a separate policy is still required for the Freedom of Information Act and this is currently being reviewed with the Communications and Engagement Team.
Evaluation of Consultant
Mrs Jasper informed the Board that the Committee received an evaluation report in respect of work carried out through consultancy appointments and requested more detail in respect of the costs incurred and the value of the outcomes that were described in the report. Concern was expressed regarding a lack of demonstrable outcomes and Mrs Jasper confirmed that the Committee noted that an evaluation framework was being developed to ensure all consultants were evaluated objectively. This will be conducted for all consultancy appointments retrospectively and for all future commissions.

The report highlighted that the Committee, with its delegated powers, approved:
- the Information Governance Policy
- the closure of risks 27 and 35 in the Combined BAF and Risk Register
- the Audit Plan 2014/15 including the use of 5 Contingency days and 5 additional days

Resolved:
1) The Board noted the report for assurance

CCG130/2014  COMBINED BOARD ASSURANCE FRAMEWORK & RISK REGISTER

Mrs Jasper spoke to this item and confirmed that the report highlighted the combined BAF and Risk Register for those risks scored 16 and over (which comprise the Board Assurance Framework). This was based on the position as at 7th October 2014.

She confirmed that the following amendments to risks 16 and over have been made since the Board received the BAF and Risk Register as at 7th August at its meeting on the 11th September. These reflect the decisions made at the last Board plus the addition of new risks and changes to existing risks approved by the CCG’s Committees:

New Risks – One new risk was approved for inclusion in the BAF & Risk Register by the Quality & Safety Committee:
- Risk 58 – This risk reflects the concerns that have been raised about Primary Care not receiving discharge letters for all patients.

Changes to the Risks – Following the annual review of the BAF & Risk Register in July, no changes to the scores or description of the risk had been made.

Closed Risks/Risks Proposed for Closure – The following risks had been closed following Board approval in September:
- Risk 1 – Failure to resolve potential mortality issues at Dudley Group results in avoidable deaths.
- Risk 9 – Risk of poor relationship management with the Area Team through the transition/bedding down resulting in breakdown of relationship with GPs and/or disconnected primary care/medical service priorities.
- Risk 20 – Failure of providers due to quality failures will result in inadequate care for the local population.
- Risk 32 – Current reorganisation of Health Visiting Service could result in breakdown in continuity of care to patients and consequent risks to safeguarding children.
- Risks 36 & 44 – Risk 44 “Overall achievement of the Quality Premium is impacted by performance issues with the delivery of Local and National Targets by the local provider and reduces the Quality Payment the CCG receives with the consequent financial and reputational impact” has been closed and merged with risk 36 following approval at the last Board meeting.

Resolved:
1) The Board noted the report for assurance

CCG131/2014  CCG CONSTITUTION
Mr Wellings spoke to this item and reported that guidance issued in May 2013 (procedures for clinical commissioning group constitution change, merger and dissolution) allowed CCGs two opportunities each year to request amendments to their Constitution, specifically 1st June and 1st November. Any application for a variation which would change a CCG’s boundary or its list of members, and therefore potentially impact on its financial allocation, can only be made at the 1st June deadline so that the change can be reflected in the allocations for the following financial year.

Mr Wellings reported that NHS England Local Area Team (LAT) is required to review new proposals for change at a local level to ensure that they fit with the national guidance on CCG Constitutions as well as taking an overview to make sure that suggested changes in CCG membership do not adjust CCG boundaries. They also have a requirement to ensure that the appropriate consultation with both patient and CCG members has been undertaken in relation to proposed changes that may involve more than one CCG in practice transfers.

As the Board has delegated authority to adopt any changes proposed and approve the application to the NHS Commissioning Board, Mr Wellings highlighted the recommendations in the report which were; the addition of details in respect of Co-Commissioning; the appointment of an additional Clinical Executive and to possibly request in the constitution to make a variation on member practices.

Resolved:
1) The Board agreed the changes to the Constitution in respect of eligibility for reappointment for Clinical Executives and the addition of a Co-Commissioning Committee.
2) The Board approved the delegation of authority to the Lay Member for Governance, Chief Accountable Officer and Chief Finance Officer/Chief Operating Officer to amend the Constitution as appropriate for:
   - the appointment of an additional Clinical Executive
   - governance arrangements for Co-Commissioning
   - additional practice to join CCG and submit this to NHS England (if required)

CCG132/2014 CCG STRUCTURES

Mr Maubach spoke to this item and reported that as a result of the decision to withdraw services from the CSU with effect from 1 October 2014, the internal structure of the CCG has been enhanced. This paper presented to the Committee the new structures, including additional support functions, and proposed alterations to titles of management posts within the structure.

Mr Maubach highlighted that one of the suggestions in the paper was to change the job titles as outlined below:

<table>
<thead>
<tr>
<th>Current:</th>
<th>Proposed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Accountable Officer</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Lay Members</td>
<td>Non Executives</td>
</tr>
<tr>
<td>Head of Communications</td>
<td>Head of Communications &amp; Public Insight</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>Chief Operating &amp; Finance Officer</td>
</tr>
<tr>
<td>OD Practitioner</td>
<td>Head of Organisational Development and Human Resources</td>
</tr>
<tr>
<td>Finance Manager (Corporate)</td>
<td>Head of Financial Management (Corporate)</td>
</tr>
<tr>
<td>Finance Manager (Commissioning)</td>
<td>Head of Financial Management (Commissioning)</td>
</tr>
<tr>
<td>Business &amp; Performance Manager</td>
<td>Head of Intelligence &amp; Analytics</td>
</tr>
</tbody>
</table>

Resolved:
1) The Board noted the report for assurance

FINANCE & PERFORMANCE

CCG133/2014 FINANCE & PERFORMANCE COMMITTEE REPORT

Dr Rathore spoke to this item and confirmed that the report summarised the issues discussed by the Finance and Performance Committee held on the 25th September 2014 and 30th October 2014.
Key areas highlighted to the Board were:

QIPP 2014/15
Dr Rathore reported that as previously mentioned, the QIPP target for 2014/15 was £7.166m. A shortfall of £1.925m has been identified against schemes in the plan, which is being covered non-recurrently by releasing funding from the QIPP reserve. This has resulted in a QIPP target of £11.186m in 2015/16. The CCG must identify additional savings initiatives or it will be in a position where all reserves are utilised to achieve its statutory duties, thus removing the ability to invest in new services on either a recurrent or non-recurrent nature. Dr Rathore reiterated that the next Clinical Development Committee will be using the whole of its next meeting to discuss next steps.

BETTER CARE FUND
Dr Rathore confirmed that the Committee received a report on the current position in relation to the Better Care Fund. It informed the group that Dudley’s plans had been approved with three conditions, two of which were of a technical and presentation nature. The third related to the CCG’s ambitions for reducing emergency admissions and Dudley will be expected to produce an action plan to address the three conditions by 14 November 2014.

A&E 4 HOUR WAITS
The Committee heard that DGFT failed the target in September and more recent data shows improvement in performance; however, this will need to be sustained if the target is to be met in Q3. The Trust needs to meet 96% daily between now and year-end to achieve the target. Dr Rathore reported that the Interim Operations Director at DGFT has recruited an additional Specialist Registrar into the Emergency Department.

IMPROVING ACCESS TO IAPT
Dr Rathore reported that Dudley and Walsall Mental Health Partnership Trust are achieving the service targets for this indicator. However, the Black Country Partnership Trust and Big White Wall IAPT providers do not currently submit IAPT information to UNIFY. Dudley CCG as a whole is not meeting the required trajectory which as mentioned earlier is being addressed. Dr Mahfouz felt that if the Big White Wall information is not being counted, this is actually discriminatory as these are people who are not able to discuss their issues face to face and nothing to do with how the service is being commissioned. Dr Hegarty suggested that together, with Mrs Broster, a letter is written to James Morris MP explaining the rationale as to why the consideration of this information is vital.

MORTALITY INDICATOR (DGFT)
The SHMI has shown continued improvement month on month and quarter on quarter. Also the hospital specific metric (HSMR) shows DGFT within normal variance of the number of expected deaths. Dr Rathore confirmed that mortality as an issue would be discussed in greater detail at the Quality and Safety Committee.

QUALITY PREMIUM INDICATORS
Mr Hartland reported that the estimated 2013/14 outturn had been estimated at £800k and it has come in at £722k. A full report will be made to Clinical Development Committee.

Resolved:
1) The Board noted the report for assurance.
2) The Board agreed that a letter would be written to James Morris MP regarding the issues around IAPT.

PRIMARY CARE

CCG134/2014 PRIMARY CARE DEVELOPMENT COMMITTEE REPORT
Dr Rathore spoke to this item and confirmed that the report summarised the key issues discussed by the Primary Care Development Committee at its meetings held on the 12th September 2014 and 16th October 2014.
**Quality Reporting Tool**
The Committee received a presentation on a tool being developed to measure primary care quality. The tool brings together quality measures from NHS England; the CCG; and the Office of Public Health with contract values, to look at the relationship between quality and cost in primary care.

A task and finish group has been established to develop the quality measures. The group developing the tool is predominantly clinical and involves representation from NHS England.

**Non Recurrent Spending Plans**
The Committee received and supported a spending plan for the non-recurrent primary care transition fund. The plan approved by the Committee would be sent to the Finance and Performance Committee for approval.

The Committee noted that the plan had been developed, prioritised and scored by clinical board members against the criteria that measured the compatibility of each bid against strategic fit; service integration; improvements workload and access within primary care; scale and sustainability; and quality improvement.

**Blue Stream Academy’s GP Practice eLearning Tool**
The Committee received a presentation from practice managers that had been piloting Blue Stream Academy’s GP Practice eLearning Suite. The tool helps practices to ensure CQC compliance; is module based; CPD accredited and provides 50 hours of training. The Committee supported the Dudley Practice Management Alliance purchasing licences for all member practices from its training budget.

**Extended Hours Plus Service Specification**
The Committee agreed the content for a proposed enhanced service to be commissioned to extend routine appointment access over and above extended hours commissioned by NHS England. The service specification has been considered by the Clinical Development Committee and further recommendations sent back to Primary Care Development Committee for final approval.

**NHS England Flu Vaccination Pilot**
Mr Wellings raised to the Board the issue in relation to the flu vaccination pilot, the way that this was introduced and subsequently managed has caused serious problems for the practices and how they manage the process. He felt that there are some important lessons to be learnt about the process in commissioning such a service and there has been a lot of interpretations of what is meant to be done. Mr Maubach reiterated Mr Wellings concerns and assured the Board that this had been addressed with NHS England directly.

**Resolved:**
1) The Board noted the report for assurance

---

**DATE OF NEXT MEETING**
Thursday 8 January 2015
1pm – 5pm
Boardroom, Brierley Hill Health & Social Care Centre

**MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td>Date</td>
</tr>
<tr>
<td>ITEM NO</td>
<td>AGENDA ITEM</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>CCG133/2014</td>
<td>Finance &amp; Performance Committee Report</td>
</tr>
</tbody>
</table>
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Report:** 8 January 2015  
**Report:** Development of the CCG long-term strategy  
**Agenda item No:** 7.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Development of the CCG long-term strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To propose next steps in updating the CCG long-term strategy</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Paul Maubach, Chief Executive Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Paul Maubach, Chief Executive Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>David Hegarty, Chair</td>
</tr>
</tbody>
</table>

**KEY POINTS:**
- The NHS England 5-year forward view invites local systems to propose co-creating new models of care locally
- The latest planning guidance for 15/16 indicates an intention to provide focussed support for vanguard sites
- Our current strategy develops a model of population-based health and wellbeing services which establishes integrated health and social care services with primary care at its heart
- We are making significant steps to support this model – for example: with joint commissioning of social care through the better care fund; and through devolved commissioning of GP services
- Our CCG should consider making a submission for national support to develop this model to its full potential

**RECOMMENDATION:**
- The Board to endorse the proposed next steps in developing the model of care
- The Board to approve that we make an initial submission to NHS England to develop our model of care as a national pilot

**FINANCIAL IMPLICATIONS:**
- Possible additional support for the implementation of the model

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
- Iteration of our existing strategy and consequent public and membership engagement

**ACTION REQUIRED:**
- Decision
- Approval
- Assurance
1.0 INTRODUCTION

1.1 This paper explores the current strategy and how we have begun implementing the core components of this. It then sets out proposals for the next iteration of the development of our strategy and the opportunities that arise from the NHS England document the ‘Five Year Forward View’ and subsequent guidance.

1.2 Key elements of our existing strategy

1.3 Our existing strategy starts with six key principles:

1. Patient centred with public involvement
2. A clinically led system starting with the coordination provided by the GP
3. Primary Care delivery at our heart
4. Working with partners in our communities
5. A focus on quality and continuous improvement
6. Living within available resources

1.4 In our existing strategy we use those principles to develop our model of care and state that: within the next five years will re-commission pro-active population-based healthcare services via a different model:

1.5 We need a step change in how primary care systematically manages long term conditions to deliver healthy life expectancy: so we will bring together all population-based care into one set of integrated services based upon the registered populations with general practice. GPs are at the heart of this model, as the key co-ordinators of care; and this recognises the dual roles of providing: on-going health and wellbeing care support which can be planned over time; as well as the need for more urgent access in times of illness or crisis. We will therefore commission these two types of activity separately:

   - For health and wellbeing care patients prefer continuity of clinician/professional.
   - For urgent care, speed and ease of access is important.

1.6 In addition we will differentiate between different levels of intensity of service. For example:

   - Proactive care is about supporting people to remain healthy and is linked to the Dudley Office of Public Health and Dudley MBC programmes for prevention
   - Long-term care support to those living with long-term conditions would include a mix of longer, pre-bookable appointments with GPs and/or specialists
   - Enhanced and End of Life care (including community care in the home, or nursing / residential care) will be improved through the use of risk stratification, partnership with social care and the voluntary sector.

1.7 The traditional organisational structures of healthcare are inadequate to meet the conflicting challenge of rising demand versus reducing resources. The existing separation of services into primary care, community services, mental health services and acute services is artificial, contributes to silo working and doesn’t reflect the needs of the modern population.

1.8 We have subsequently developed this into our new model of care:
2.0 THE MODEL OF CARE

2.1 Health and wellbeing has to be personalised to the individual so that they can fully engage in co-producing their care and in taking responsibility for their own health. So the design of our model is based on how we work with the individual person.

2.2 The public register with their GP as their main connection to health and wellbeing services. So the overall organisation of care starts with the GP and their practice.

2.3 However, to make it as easy as possible for other services to take shared responsibility for working in the best interests of patients and their carers; we will align other services to work with the same practice populations – so creating an aligned network of services or teams around each practice. This is the core level of integrated working.

2.4 These teams are based in the community; and once working together, they can develop a shared understanding, together with their population, of the shared benefits and outcomes that they are trying to achieve.

2.5 These shared outcomes will change over time – but they will include measures that reflect people’s health (such as improving life expectancy); wellbeing (such as social or mental wellbeing); and measures that demonstrate how we maintain people’s autonomy and independence (such as reducing the need for inappropriate emergency admissions to hospital).

2.6 So the organisation of care starts with the individual person, registered with their GP, supported by an aligned network of care that is working locally in their community.

2.7 This model uses a multi-professional team, oriented around a practice, who will work together to enable a patient or carer to access a joined up package of services and support which may come from any or all of the NHS, council, voluntary, community or private sector organisations involved in providing those services and support.

3.0 PROGRESS SO FAR

3.1 We have already made significant progress in improving the way services are delivered. There are a number of steps that are already well underway to develop this model, including:

- We have produced our primary care strategy which prioritises these services at the heart of our model of care;
  - The proposals for a comprehensive training and development programme have recently been discussed by the primary care development committee
  - The first draft estates strategy will be completed at the end of the financial year;
- We have transferred all GP practices on to a single IT platform to improve integrated working;
- We have set out our intent in our commissioning intentions to extend this single IT system to all community services that are part of the integrated model of care;
- We have worked with all our providers; with social services; and with the voluntary sector to put in place the multi-disciplinary teams that form the core infrastructure around our practices
  - Early adopters are already in place;
  - The OD programme will roll this out to all practices over the next few months;
- We have commissioned the new urgent care centre which will place a primary-care led triage in front of the emergency department as a critical part of the new urgent care pathway;
• The new community rapid response service starts at the beginning of January 2015;
• We have decided to bid for devolved commissioning of GP services from NHS England;
  o This needs to be secured to commence from 1st April 2015
• We have agreed in principle with Dudley MBC to jointly commission the social care that is part
  of the integrated service model through the Better Care Fund;
  o This also needs to be put in place ready for 1st April 2015
• We are developing a new long-term conditions framework to both enhance the role of primary
  care as well as ensure that it is appropriately supported to deliver more local care;
  o This includes the development of a new quality performance framework

3.2 However this model is not yet comprehensive. It does not take account of all areas of care (to
date we have focused predominantly on older adult care) and we have not determined the
best organisational mechanism to realise the model to its full potential.

4.0 HOW THIS MODEL OF CARE MIGHT DEVELOP

4.1 Our existing strategy starts with the person and adopts the principle that our system should be
clinically led.

4.2 The registration of the person with their GP reflects this. The GP is the clinician with lead
responsibility for the individual person for all care that is part of the population health and
wellbeing services:

• We have a primary care strategy that addresses the priorities for general practice
• We have an integrated model of care that wraps other community and social care based
  services around the practice
• The Board should consider how much further this model could and should be developed

4.3 If we start from the principle of who takes ultimate clinical responsibility for care then this
predominantly rests with two groups of clinicians:

• GPs: for population-based care of people in their community
• Consultants: for treatment based care of people in a hospital

4.4 So, following our strategic principles, our model of care for the whole system ought to be
based around these two groups and all services should be organised around one or the other:

Value-added Treatments

Planned Care

Urgent Care

Consultant-led care

Population health and wellbeing

Population

Patient

GP

MDT

Other services

GP-led care

UCC

Value-added Treatments

Population health and wellbeing

Consultant-led care

GP-led care

4.5

T

here

are
limitations, issues and opportunities with the current development of this model of care which need to be considered:

4.6 Firstly: the interaction between the two parts of the system - between GPs and consultants - is extremely important and we have faced significant problems recently with the management of discharge letters from consultants to GPs. However we are developing longer-term solutions to improving this key interaction:

- On urgent care we are commissioning the urgent care centre which is primary care-led and will be integrated with GPs through the use of the IT system;
- On planned care we are encouraging DGFT to move to 100% choose and book so that all referrals can be managed more efficiently and we are working with EMIS to develop standard templates in primary care to enable referrals to be more consistent.

4.7 Secondly: more services which are currently seen as part of hospital-based care, ought in reality to be part of the population-based health and wellbeing care:

- Recent modelling of planned care services provided by DGFT identified significant cohorts of patients who are receiving long-term on-going care which is in effect, long-term conditions management which could be seen as part of a population wellbeing service in the future;
- We are developing the long-term conditions framework which will more appropriately shift activity from secondary to primary care;
- Our recent workshop on the frail elderly pathway identified that we should move to a model which involves ‘retrieving’ patients from hospital back into the community rather than them being ‘discharged’ from one to the other – by in effect shifting the basis of most of the care (including that provided by consultants) from hospital to community;

4.8 So we need to consider how far, over time, the population-based services should be extended.

4.9 Thirdly, the current system has a significant number of organisations contributing to the model of care:

- This adds complexity and creates barriers to the pace of development;
- This also adds managerial cost to the system;
- Over time it would seem sensible to integrate the existing provision to reduce costs and organisational barriers

4.10 Fourthly, whilst we may be able to develop one integrated population-based service, or sets of services; our system – and in particular the CCG in commissioning the system - needs to be able to manage with more than one set of value-added treatment services:

- DGFT whilst the main provider, is not the only significant provider of these services to our population (eg: Ramsey, Royal Wolverhampton, Sandwell & West Birmingham, University Hospital Birmingham, etc…);
- We currently do not contract from providers for the integrated model of care – we contract for lines of activity rather than the way in which that activity should be delivered or for what benefit;
- Therefore the CCG needs to be able to commission and appropriately incentivise population-based care but also have systems in place for managing referrals and pathways to multiple value-added treatment providers.
- We have already commissioned Deloitte to develop a proof-of-concept for commissioning planned care in a different way – by connecting up individual components of care so that we commission best practice pathways rather than individual interventions. This could then utilise the electronic referrals to ensure we can monitor delivery against the pathways.
4.11 So the Board needs to consider whether this next iteration gives us a more comprehensive model of care; and in order to fulfil the implementation of this to its full potential, consider organisationally how this is delivered.

5.0 CCG LEADERSHIP TO THE MODEL

5.1 The CCG is integral to this model in several different ways:

- The GPs are both central to the model as well as members of the CCG
- The GP leadership is co-ordinating the whole-system approach that is required to deliver this model of care
- The CCG together with Dudley MBC are the only organisations in the system that have a whole population responsibility for care

5.2 The CCG will need to commission the population-based care in a different way:

- to incentivise the MDT approach by commissioning for teams to deliver shared outcomes for a shared population
- to develop whole-system outcomes which apply across organisational boundaries
- to ensure there is a personalised approach to care delivery for each individual
- to make best use of risk stratification and other tools to target priorities to those who need it the most

5.3 The CCG will also need to be able to control costs within overall available resources:

- By incentivising shifts in care to lower cost and preventative measures in primary and community services
- By commissioning for best practice pathways for elective care
- By ensuring that the new Urgent Care Centre maximises the potential for redirecting and delivering primary-care based solutions for patients

6.0 MODELS PROPOSED BY THE FIVE YEAR FORWARD VIEW

6.1 NHS England’s Five Year Forward View invites local systems to propose co-creating new models of care and organisation locally.

6.2 The document identifies (but does not limit us to) four possible models:

- Multispecialty community providers (MCPs), which may include a number of variants;
- Integrated primary and acute care systems (PACS);
- Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms such as specialist franchises and management chains;
- Models of enhanced health in care homes.

6.3 Our model of care does not match exactly with any of these models but is perhaps predominantly a variant of an MCP with some elements of PACS. Our model also requires the involvement and leadership of the CCG to enable a whole-system, population-based approach.

6.4 The subsequent document ‘The Forward View into action: planning for 2015/16’ states that for each of these care and organisational models NHS England will co-design a structured programme of support to accelerate change, assess progress and demonstrate proof of concept. They are inviting areas to become a prototype that can be adapted elsewhere, designed from the outset to be replicated by subsequent areas in the future.

6.5 Initial expressions of interest are being requested for the end of January. The approved sites will already have a significant track record (which we can demonstrate) and a credible plan in
place for 2015. So our Board needs to consider whether we should be putting a bid forward for this and the next steps in the process:

6.6 Likely benefits from doing this include:

• Possible additional national resources to support the development of the model;
• We need to move at pace in order to protect the sustainability of our core services – particularly primary and community care;
• We have the opportunity to shape a future model of care which works for Dudley rather than subsequently receiving direction in later years on a model of care which we should adopt.

7.0 PROPOSAL FOR NEXT STEPS

1. We already have a series of key meetings planned during January to develop our strategy further, regardless of whether we submit a proposal to NHS England:

   • A workshop with all providers to receive the outcome from the review into the long-term financial position of our local system
     o With a view to discussing how our care model is developed at pace; ensure we have strategic alignment across the system to the model; discuss how our providers can work better in partnership together; and what future organisational forms might look like
   • A workshop with Dudley MBC social services to further develop our joint vision for integrated health and social care
     o To ensure there is joint agreement to our care model; finalise the schedule of services which will form part of that model as a function of the Better Care Fund; and agree the formal joint commissioning arrangements to be submitted for approval to the Health and Wellbeing Board

2. We should also set up a joint process with Dudley MBC public health to consider what opportunities and benefits would exist through incorporating prevention services into the integrated care model.

3. We should modify the 15/16 contracts with all our providers to establish a partnership arrangement between them that ties our providers into delivering the integrated model. This should be seen as a first step towards more formal organisational integration of the services that are part of the model.

4. We should continue with our existing enabling activities - particularly the development of the IT infrastructure and systems; and our OD integration programme - to support this model.

5. We can test the market in 15/16 in some service areas where we would like to see improvements in capacity and delivery – such as physiotherapy and primary mental health services.

6. We should bring the work-in-progress together as the focus of a Board development session before updating our strategic plan accordingly for approval in March.

7. We should consider whether the model of care is developing in the right direction and therefore whether we should make an initial submission to NHS England:

   • delegated authority to be given to the CCG chair and chief executive officer to finalise the initial submission for making an expression of interest

Paul Maubach
Chief Executive Officer
December 2014
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Report:** 8 January 2015  
**Report:** Quality & Safety Committee Report  
**Agenda item No:** 8.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Report from the Quality &amp; Safety Committee</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: | Ruth Edwards, Clinical Executive Lead for Quality  
Rebecca Bartholomew, Chief Quality & Nursing Officer |
| MANAGEMENT LEAD: | Rebecca Bartholomew, Chief Quality & Nursing Officer |
| CLINICAL LEAD: | Ruth Edwards, Clinical Executive Lead for Quality |
| KEY POINTS: | Report of the Quality and Safety Committee Meetings held on 18 November 2014 and 16 December 2014  
- CQC report for Dudley Group  
- Never Event at Dudley Group  
- Announced visit to Black Country Partnership  
- Unannounced visit report submitted as a separate report |
| RECOMMENDATION: | The Board is asked to accept this report as a source of on-going assurance that the CCG Quality & Safety Committee continues to maintain forensic oversight of all clinical quality standards in line with the CCG’s statutory duties. |
| FINANCIAL IMPLICATIONS: | None to report |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | 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. |
| ACTION REQUIRED: | ✓ Assurance Approval Decision |
1. INTRODUCTION

1.1 The CCG Quality & Safety Committee meets monthly and is chaired by Dr Ruth Edwards, Clinical Executive Lead for Quality. This report is a material summation of the Committee’s meetings in November and December 2014.

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

2. NATIONAL ISSUES

Guidance on Safer Staffing issued

2.1 The Chief Nursing Officer for England has issued Safer Staffing: A Guide to Care Contact Time as part of the drive to deliver safe and effective care. The guide sets out the expectations of commissioners and providers to optimise nursing, midwifery and care staffing capacity and capability so that they can deliver high quality care and the best possible outcomes for their patients. Workforce plans and the safer staffing profile are to be monitored via CQRM.

Patients reporting better experience of A&E

2.2 A national Accident and Emergency survey published on 2 December 2014 by the Care Quality Commission has shown that patients are having a better overall experience at A&E departments. The majority of patients that completed the survey rated their overall experience as good with 80 per cent rating their visit at least seven out of ten.

2.3 DGFT scored eight out of ten for the overall A&E experience, which was “about the same” when compared with other Trusts. The results of the CQC survey were considered by the Quality & Safety Committee in December 2014. In light of the length of time since the data was collected, it was considered that the results were not as relevant as the ongoing monitoring which is undertaken by the Quality & Safety Committee via the Friends and Family Test results.

3. ITEMS DISCUSSED

3.1 The following sections provide a brief update on issues discussed by the Committee, or matters arising of which the Governing Body need to be aware.

4. DUDLEY GROUP FOUNDATION TRUST (DGFT)

Unannounced Visit

4.1 A separate report has been included in Board papers.

Discharge information

4.2 Work is ongoing between Dudley CCG and DGFT to resolve the issues with electronic discharge letters. Due to safety issues, Dudley CCG has requested that DGFT suspends electronic discharge letters and replace them with a patient held copy and a copy sent to the practice by courier for the foreseeable future. Dr Ruth Edwards is awaiting a response from Dr Jane Dale (DGFT Chief Clinical Information Officer) with a timeline for further actions.
Resolution is expected to be achieved by April 2015. This was viewed by the Quality & Safety Committee to be a reasonable timeframe. The alternative system will be subjected to testing.

**Serious Incident reporting and management**

4.3 Provider organisations reporting Serious Incidents (SIs) are required to submit a completed Root Cause Analysis (RCA) investigation tool to complete the investigation process and provide appropriate assurance to the CCG. There is a timeline of 45 working days for submission of RCAs related to SIs. The RCA should demonstrate learning which has taken place and improvements which have been introduced as a result of the SI.

4.4 An update of SIs reported by DGFT on the national Strategic Executive Information System (STEIS) for 2014/15 to date, 2013/14 (by quarter) and 2012/13 is shown below (Figure 1).

**Figure 1: Serious Incidents reported by DGFT**

<table>
<thead>
<tr>
<th>Subject</th>
<th>2012/13</th>
<th>Q1 2013/14</th>
<th>Q2 2013/14</th>
<th>Q3 2013/14</th>
<th>Q4 2013/14</th>
<th>2013/14</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
<th>YTD 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SIs reported</td>
<td>207</td>
<td>28</td>
<td>28</td>
<td>42</td>
<td>45</td>
<td>143</td>
<td>39</td>
<td>37</td>
<td>24</td>
<td>34</td>
<td>143</td>
</tr>
</tbody>
</table>

*Source: STEIS – by date reported*

4.5 A large proportion of SIs reported since July 2014 have been pressure ulcers, mainly due to an increase in the appropriate reporting of community pressure ulcers by DGFT, following considerable work with DGFT and the Area Team to establish and address this reporting issue.

**Never Events**

4.6 Never Events are defined by NHS England as “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented”. They include incidents such as wrong site surgery, retained instrument post operation, or wrong route administration of chemotherapy.

4.7 The number of Never Events reported by DGFT on the national Strategic Executive Information System (STEIS) for 2014/15 to date, 2013/14 (by quarter) and 2012/13 is shown below (Figure 2).

**Figure 2: Never Events reported by DGFT**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Events reported</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Source: STEIS – by date reported*

4.8 There have been no never events reported in Quarter 3 (to date).

4.9 Following receipt of the manufacturer’s report at the December 2014 CQRM, the medical equipment failure SI (reported in April 2014) has been upgraded to a never event, and is
shown in Figure 2 (above). The Quality team has informed the Area Team and CQC to appraise them of the situation and explain the reason for the delay in reporting this as a never event. The related actions will be followed up at CQRM.

4.10 DGFT reported a never event in September 2014 with regard to a retained piece of medical equipment. At the time of this report, the completed RCA has been received and further queries have been raised with DGFT. The Quality team does not have any immediate concerns about this incident.

**Falls resulting in Harm**

4.11 A month-by-month breakdown of Slips / Trips / Falls (resulting in harm) reported onto STEIS by DGFT to date during 2014/15, along with a quarterly breakdown of Slips / Trips / Falls (resulting in harm) reported onto STEIS by DGFT during 2013/14 is shown below (Figure 3).

4.12 “Severe injury” is consistently classified as a debilitating fracture, i.e. fractured neck of femur, fractured pelvis. This is a local indicator agreed by the Quality & Safety Committee.

**Figure 3: Falls resulting in harm recorded by date of entry onto STEIS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls resulting in harm</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>12</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls resulting in severe injury</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Falls</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>28</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: STEIS – by date reported

4.13 In October 2014, the fall resulting in severe injury involved a patient who slipped in the bathroom and suffered a fractured left fibula.

4.14 No falls were reported in November 2014.

4.15 Slips / trips / falls which do not result in harm are recorded by DGFT on their own internal incident reporting database. There is no requirement for Provider organisations to record details of all falls on STEIS.

4.16 The Quality team will continue to monitor and maintain oversight of falls data.

**Grade 3 and Grade 4 pressure ulcers**

4.17 DGFT continues to do a significant amount of work to eliminate avoidable pressure ulcers. From July 2014, acute and community services at DGFT have been consistently reporting pressure ulcers. This has resulted in the increase in SIs attributable to pressure ulcers, primarily reported from community settings. Work to further understand this trend and identify areas for improvement continues.

4.18 A month-by-month breakdown of pressure ulcers reported onto STEIS by DGFT to date during 2014/15, a quarterly breakdown of pressure ulcers reported onto STEIS by DGFT during 2013/14, and the number of pressure ulcers reported onto STEIS by DGFT during 2012/13 is shown below (Figures 4a and 4b). The tables also reflect the split between hospital-acquired and community-acquired pressure ulcers from July 2014 for reference purposes.
Figure 4a: Incidence of Grade 3 pressure ulcers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>13</td>
<td>7</td>
<td>13</td>
<td>33</td>
<td>15</td>
<td>8</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>25</td>
<td>5</td>
<td>7</td>
<td>37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>34</td>
<td>13</td>
<td>22</td>
<td>16</td>
<td>20</td>
<td>58</td>
<td>20</td>
<td>15</td>
<td>93</td>
</tr>
</tbody>
</table>

Source: STEIS – by date reported

Figure 4b: Incidence of Grade 4 pressure ulcers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: STEIS – by date reported

4.19 The number of pressure ulcers may be subject to change depending on the findings and outcomes of DGFT’s RCA investigations and whether the CCG Quality team agree with any request for reclassification or downgrading.

4.20 The numbers of pressure ulcers for 2014/15 shown in the tables above reflect categorisation at the time of this report.

4.21 A total of 96 pressure ulcers have been reported by DGFT year-to-date (April to November) during 2014/15, with 93 reported as Grade 3 and three reported as Grade 4.

Safety Thermometer

4.22 The NHS Safety Thermometer provides a quick and simple method for surveying patient harm free care and analysing results so that this can be measured and monitored over time. For acute providers this focuses on reducing the incidence of four harms; pressure ulcers, venous thromboembolism, catheter acquired urinary tract infections, and falls. This provides organisational context for the services we commission.

4.23 The methodology is to audit a sample of patients from across the Trust on a designated day each month. The percentage of sampled patients reported by DGFT as having no harm identified is shown below (Figure 5), and reflects the consistently high levels of harm free care reported by DGFT. The results reported by DGFT are in line with peer Trusts.
Friends and Family Test (FFT)

4.24 There are three indicators in 2014/15 – Inpatients, A&E and Maternity.

4.25 From 2 October 2014, presentation of data changed from Net Promoter Score (NPS) to the percentage of respondents who would / would not recommend the service. NPS was the only measurement used up to and including data for July 2014. In August 2014, both sets of data were published. From September 2014, only new ‘percentage recommended / not recommended’ measurement has been published. It is therefore difficult to present meaningful comparison of the different scoring measurements, and new graphics have been developed.

Inpatient

4.26 2014/15 CQUIN guidance confirms funding will be based on increasing and/or maintaining response rates in inpatient services (30% by Q4 2014/15), and for reducing (or maintaining at zero) negative responses from inpatient services.

4.27 DGFT’s Inpatient FFT ‘percentage recommended’ score remains above the national result and is shown below (Figure 6).

4.28 Whilst reflecting a slight increase from September, DGFT’s October response rate (24.8%) remains below the 2014/15 target of 30% of eligible patients for the sixth consecutive month, and remains below the national response rate (37.6%) for the seventh consecutive month. This will be addressed at the next CQRM to understand how improvement will be achieved.
Figure 6: FFT scores and response rate for inpatient services at DGFT

A&E

4.29 2014/15 CQUIN guidance confirms funding will be based on increasing and/or maintaining response rates in A&E (to 20% by Q4 2014/15), and for reducing (or maintaining at zero) negative responses from A&E.

4.30 DGFT’s ‘percentage not recommended’ score remains below the national result and is shown below (Figure 7).

4.31 DGFT’s response rate has increased from 12.8% (September 2014) to 27.9% (October 2014), its second highest response rate since measurement began in April 2013. The response rate has returned above the national response rate in October (19.6%) and the 2014/15 target (20%).
Maternity

4.32 FFT is operational in maternity services across four touch-points (antenatal, birth, postnatal ward and postnatal community).

4.33 For October 2014, DGFT performed better than the England score in all categories for ‘percentage recommended’, and better than the England score in three of the four categories for ‘percentage not recommended’.

4.34 The ‘percentage recommended’ and ‘percentage not recommended’ data for the four maternity categories is shown below (Figure 8).
Figure 8: FFT scores for maternity services at DGFT

Source: NHS England
Clinical Quality Review Meeting (CQRM)

4.35 CQRMs are held monthly with DGFT together with other associate commissioners and colleagues from the Office of Public Health as appropriate. All stakeholder commissioners receive copies of reports and minutes. Meetings are focused on reviewing the quality of care given supported by surveillance data and reports and data / analysis. Meetings are attended by senior management from DGFT and CCG(s) and operate on the basis of scrutiny and challenge. All providers are now subject to monthly meetings and have a schedule of dates going forward.

4.36 Any issues of concern are referred to Quality & Safety Committee and have been included in this report.

5. DUDLEY & WALSALL MENTAL HEALTH TRUST (D&WMHT)

Serious Incident reporting and management

5.1 Serious Incident (SI) notification and Root Cause Analysis (RCA) reports relating to Dudley patients are received directly from D&WMHT. Investigation reports are reviewed by the Quality Team. Issues are addressed via monthly CQRM.

Never Events

5.2 There have been no Never Events reported by D&WMHT during 2014/15

Safety Thermometer

5.3 The safety thermometer is a national initiative focused on reducing harm at the point of care – in mental health providers this focuses predominantly on reducing harm related pressure ulcers and falls, other work looks at reducing the risk of harm from violence and aggression and at the point of handover. This provides organisational context for the services we commission.

Figure 11: Harm Free Care reported by D&WMHT October 2013 – October 2014

5.4 There are no concerns relating to safety thermometer data.
Friends and Family Test

5.5 As previously reported, updated guidance from DoH confirms that reporting on Friends and Family Test (FFT) has been deferred to January 2015 for mental health trusts. The Quality team will continue to monitor this and present information to the Quality & Safety Committee when data has been published.

Clinical Quality Review Meetings

5.6 Items discussed at CQRM are reported to the Quality & Safety Committee.

Workforce issues / Mutually Agreed Resignation Scheme

5.7 D&WMHT is undergoing a staff realignment process, involving a Mutually Agreed Resignation Scheme (MARS). D&WMHT has been asked to provide further updated information about MARS at the January 2015 CQRM to provide assurance that the quality of care provided to patients would not be compromised. The Quality team continues to monitor this issue via CQRM.

6. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST (BCPFT)

Announced Visit

6.1 CCG staff undertook an announced visit to BCPFT on 11 December 2014, reviewing the Domestic Abuse Response Team (DART) and Occupational Therapy service (based at the Sunflower Centre, Stourbridge).

6.2 The findings during the visit were positive, and staff displayed clear passion and commitment to their patients and services. Verbal feedback was provided to BCPFT staff on the day of the visit. A full written report is being completed and will be sent to BCPFT in January 2015, with a report to Quality & Safety Committee to follow.

CQC Unannounced Visit

6.3 CQC undertook an unannounced visit to Penn Hospital on 21 August 2014, in response to a whistle-blowing allegation. BCPFT has reported that CQC indicated verbally after the visit that they were satisfied with compliance and no concerns were identified, and publication of the report confirms that all standards were met. There are currently no Dudley patients at Penn Hospital.

Serious incident reporting and management

6.4 Receipt of Serious Incident (SI) notification and Root Cause Analysis (RCA) reports continues via Wolverhampton CCG.

6.5 One SI was reported in October 2014 relating to storage of confidential information. Initial findings did not identify any patient harm or adverse effect on patients or staff. The RCA process remains underway at the time of reporting.

Never Events

6.6 There have been no Never Events reported by BCPFT during 2014/15
Patient Experience / Friends and Family Test

6.7 Reporting on Friends and Family Test (FFT) has been deferred to January 2015. The Quality team will continue to monitor this and present information to the Quality & Safety Committee when data has been published.

Clinical Quality Review Meetings

6.8 Monthly CQRMs continue to be held.

6.9 BCPFT’s remedial action plan to address the 18 week waiting list for Speech and Language Therapy (SALT) was presented at the December 2014 CQRM. It was noted at the Quality & Safety Committee that although a remedial action plan was in place, resolution would not be achieved until March 2015. Robust challenge will take place at CQRM should there be any delay in this timescale.

7. INDEPENDENT PROVIDERS UPDATE

7.1 Dudley CCG commissions services from Ramsay Healthcare at its West Midlands Hospital. There are no quality concerns to report.

8. HEALTHCARE ASSOCIATED INFECTION

8.1 The Office of Public Health (OPH) provide support and advice to the CCG on Infection, Prevention and Control matters, and provide epidemiology reports to the CCG which are discussed by the Quality & Safety Committee.

   C difficile

8.2 For 2014/15, C difficile thresholds have been set at 48 cases for DGFT and 108 cases for the CCG.

8.3 At the time of reporting, OPH had published their latest weekly report (dated 18 December 2014) and there have been 21 confirmed cases at DGFT and 50 confirmed cases within the community (CCG attributed), which are both below trajectory.

MRSA

8.4 In 2014/15 the MRSA threshold set is zero for DGFT and the CCG.

8.5 There has been one case of MRSA reported (in September 2014) to date during 2014/15. This has been assigned to Dudley CCG.

9. SAFEGUARDING CHILDREN

9.1 The CCG continues to ensure that it meets its statutory functions regarding the safeguarding of children. The Designated Children’s Safeguarding Senior Nurse post meets NHS England accountability framework and Working Together 2013 requirements and the post-holder works closely with other members of the team including the Designated Doctor. A Named GP for Children’s Safeguarding has been appointed by the CCG. The post will equate to two sessions per week and the post holder will work closely with the Designated Children’s Safeguarding Senior Nurse to engage GP practices in safeguarding children training and the wider safeguarding remit.

9.2 The final report of the safeguarding review commissioned by Dudley CCG will be presented to the Quality & Safety Committee in January 2015 and to the CCG Board in March 2015.
Lincolnshire Safeguarding Children Board is conducting a Serious Case Review (SCR) into the death of a young person who spent some time living in Dudley. The Designated Senior Nurse has completed an Agency Management Review on behalf of one of the CCG member practices. This has been signed off and forwarded to the business manager. Once the SCR has been published, findings and lessons to be learned will be disseminated to staff via the Dudley Safeguarding Children Board.

DGFT’s analysis of still birth rates has been received. It is noted that the rate is below both the regional and national averages.

10. SAFEGUARDING ADULTS

Care Homes

10.1 The Lead for Adult Safeguarding continues to work closely with the local authorities and other partner agencies to support the adult protection investigation process for care homes by providing Mental Capacity Act and safeguarding advice and guidance for complex cases. There has been an increase in the number of alerts from care homes. As commissioners, the CCG is required to ensure that adult placements are based on quality of care and safeguarding concerns, therefore health and social care colleagues are working collaboratively to develop and implement systems and processes that support a proactive approach to safeguarding. This includes proactively monitoring the number of alerts and other early warning signs to enable early intervention and the development of shared action plans in partnership with providers.

10.2 Learning from the substantiated safeguarding investigations has identified themes relating to Mental Capacity Act implementation, record keeping and care planning, management of resident to resident type incidents, pressure ulcer management, medicines management and institutional type issues.

10.3 The CCG has been actively involved in supporting Safeguarding Learning in Practice Workshops aimed at engaging nursing home providers and supporting learning around the emergent themes.

Serious Adult Reviews (SAR)

10.4 Currently there are two cases which reach the threshold for Serious Adult Review but these cannot be completed at present due to Police involvement.

10.5 There is one case which does not meet the threshold but the Dudley Safeguarding Adult Board has asked for a review. This is being carried out by the CCG’s Lead Nurse for Adult Safeguarding and is due for completion by January 2015.

Safeguarding Activity for Dudley

10.6 There are 312 alerts recorded, which is a significant increase and suggests that staff are becoming familiar with the alert process (online alert/referral form), the new web site and the recording of alerts. Where appropriate involvement of health is required, these alerts are managed through the appropriate channels.

Dudley Safeguarding Adults Board

10.7 The annual report has been received. It was noted at Quality & Safety Committee that training numbers for health were not included, causing the inaccuracy for the training numbers for health in the report.
11. CONTINUING HEALTH CARE AND INTERMEDIATE CARE

11.1 As previously reported to Board and Committee, there remains a backlog in the undertaking of 3 month CHC reviews and annual assessments. Staff consultation has recently ended on a proposal to expand the team to ensure appropriate assessments are undertaken on an ongoing basis and the Chief Quality and Nursing Officer is currently developing an action plan with the Commissioning Lead to address the backlog.

12. NATIONAL REGULATORS

Care Quality Commission (CQC)

Inspection at Dudley Group Foundation Trust (DGFT)

12.1 CQC undertook a visit to DGFT in March 2014 as part of a national review of the 14 Trusts reviewed by NHS England following identification of concerns regarding mortality rates.

12.2 CQC published its report on 3 December 2014, identifying that DGFT “requires improvement”, particularly in relation to the categories of “safe” and “responsive”, and the clinical areas of A&E, critical care, and maternity and family planning.

12.3 The themes identified by CQC aligned with the findings of the CCG unannounced visit (August 2014), and progress will be monitored via monthly CQRM.

13. COMPLAINTS TO CCG

13.1 There are currently six active complaints at the time of this report which are reviewed each week at the CCG’s Clinical Executive meeting. There are no common emergent themes.

14. RISK REGISTER

14.1 The Committee reviewed the Quality components of the CCG risk register, and added a new risk (61) during the December 2014 meeting. Changes will be submitted to the Audit Committee.

14.2 Risk 61 – Insufficient capacity of the Continuing Health care and Intermediate Care teams to review care packages for patients in care homes.
There is a plan to recruit additional staff to the teams to address and resolve the outstanding assessments.

14.3 The two risks noted below have residual ratings of above 15.

14.4 Risk 22 – Delivery of efficiency savings could impact the drive for quality in healthcare
Involvement of quality leads in QIPP projects through quality impact assessments.

14.5 Risk 58 – JAC electronic system not operating efficiently
Dudley CCG has requested that DGFT suspends electronic discharge letters and to replace this with a patient held copy and a copy to be sent to the practice by courier for the foreseeable future. Electronic discharge letters have been suspended from 17 December 2014.
15. **CONCLUSION**

15.1 The Quality & Safety Committee continues to provide forensic oversight of the quality agenda supported by the CCG Quality Team. Any matters of relevance are contained in this report to the Board. If there are material issues that arise after submission of this report, the Chair of the Quality & Safety Committee will provide an oral briefing to the Board.

16. **DECISIONS TAKEN BY COMMITTEE UNDER DELEGATED POWERS FROM BOARD**

16.1 The Quality & Safety Committee has requested that DGFT suspends electronic discharge letters and replace them with a patient held copy and a copy sent to the practice by courier for the foreseeable future.

17. **DECISIONS REFERRED TO THE BOARD**

17.1 None

18. **RECOMMENDATION**

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

Ruth Edwards, Clinical Executive Lead for Quality
Rebecca Bartholomew, Chief Quality & Nursing Officer

18 December 2014
<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>Unannounced Visit Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To advise the Board of the outcome and findings of the unannounced visit to Dudley Group Foundation Trust on 15 August 2014, and present the Trust’s action plan.</td>
</tr>
<tr>
<td><strong>AUTHOR(s) OF REPORT:</strong></td>
<td>Dr Ruth Edwards, Clinical Executive Lead for Quality Miss Rebecca Bartholomew, Chief Quality &amp; Nursing Officer</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Miss Rebecca Bartholomew, Chief Quality &amp; Nursing Officer</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr Ruth Edwards, Clinical Executive Lead for Quality</td>
</tr>
<tr>
<td><strong>KEY POINTS:</strong></td>
<td>The report addresses:</td>
</tr>
<tr>
<td></td>
<td>• Quality of care</td>
</tr>
<tr>
<td></td>
<td>• Experience of patients and relatives</td>
</tr>
<tr>
<td></td>
<td>• Staffing</td>
</tr>
<tr>
<td></td>
<td>• Good practice</td>
</tr>
<tr>
<td></td>
<td>• Concerns</td>
</tr>
<tr>
<td><strong>RECOMMENDATION:</strong></td>
<td>The Board is asked to note this report and action plan for assurance.</td>
</tr>
<tr>
<td><strong>FINANCIAL IMPLICATIONS:</strong></td>
<td>None to report</td>
</tr>
<tr>
<td><strong>WHAT ENGAGEMENT HAS TAKEN PLACE:</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>ACTION REQUIRED:</strong></td>
<td>✓ Assurance Approval Decision</td>
</tr>
</tbody>
</table>
1.0 INTRODUCTION

1.1 Dudley Clinical Commissioning Group (CCG) undertook an unannounced visit to Dudley Group Foundation Trust (DGFT) on Friday 15 August 2014. This was in response to:

- the observations and recommendations following an earlier announced visit by Dudley CCG to DGFT on 5 February 2014;
- recent whistle-blowing allegations regarding DGFT received anonymously by Dudley CCG from the Care Quality Commission in early August 2014, and which specifically mentioned the three wards focussed upon during this visit.

1.2 The purpose of the unannounced visit was to review and gain assurance regarding the care and treatment provided to patients on three identified wards:

1.3 The means of gaining assurance were:

- by attending the three ward areas and observing staff handover processes at 7.00am;
- by revisiting each ward later during the morning to gain further insight and undertake observations;
- by speaking with staff members to gain direct feedback about their experiences;
- by speaking with patients and relatives (where possible) to gain direct feedback about their perception of care provided;
- by reviewing patient management, medication and discharge processes.

1.4 The visiting team comprised of:

- Head of Quality & Effectiveness
- Lead Nurse for Quality and Safeguarding Vulnerable Adults
- Quality & Safety Manager

1.5 This report is a summary of the visit, highlighting both areas of good practice and issues of concern. The visiting team would like to emphasise that the headlines contained in this report focus on the observations of one day’s practice at the Dudley Group Foundation Trust. We were advised that the matrons are constantly reviewing the risks associated with patient care to ensure quality of care and safety is a high priority. It is accepted that there is a need for decisions around staffing and resources to be made swiftly in response to changing patient acuity and staff availability. These changes are viewed within the context of the whole hospital’s requirements.

2.0 FINDINGS

2.1 Quality of Care

- The visiting team observed compassionate, patient-focussed care.
- There were some delays in responding to patients’ needs.
- The visiting team spoke to a number of staff on the wards and identified that many of the patients are often highly dependent and at times it was difficult to provide support to patients in a timely manner.
- A number of the frailler patients had food served to them but it was apparent that they needed assistance and encouragement to eat their meals.
- All ward environments visited were friendly and hospitable.
- Patients seen appeared to be well cared for, with skin and falls bundles in place on one of the three wards visited. The remaining wards had incomplete documentation.
2.3 **Experience of Patients and Relatives**

- The visiting team spoke with patients and relatives.
- A relative stated that she had been impressed with the speed at which the call buzzer was answered as the patient told the team about experience at another hospital where he had been left for a long period but had been reassured by his experience at DGFT.
- A patient who had been on the ward for three days was extremely complimentary about his experience. He advised that all staff were very responsive and he felt that he had received excellent care and attention.
- One relative expressed concern as she had not been updated on the plans for her husband’s care.

2.4 **Staffing**

- Ward staff perceived the presence of therapy staff on the ward to be beneficial.
- Feedback from various staff members indicated that changes in the rota arrangements left them feeling there was less time to provide high quality care to patients at all times.
- There was a particular frustration reported amongst junior staff, who stated that morale was low.
- Observations of the duty rota on two wards showed a high level of agency nurses.

2.5 **Good practice**

- Each staff member had a printed electronic copy of the handover for patients on the ward which contained information about the care needs of each patient.
- These handovers are updated at the end of the shift by the nurse who has been caring for the specific patients.
- The Clinical Nurse Specialist and consultant were both very passionate about improving outcomes for patients on one of the wards visited.

2.6 **Concerns**

- The visiting team commended the on-line electronic booking system to cover unfilled shifts. The team noted that unfilled slots would further increase the workload pressures.
- One patient was observed to be waiting 15 minutes for attention which resulted in an impact on dignity and privacy.
- Timely support not always available for frailer patients at mealtimes.
- Staff acknowledged the ongoing challenge of delivering a more timely discharge process.
- All nurse grades interviewed were worried about the increased workload.

3.0 **CURRENT POSITION**

3.1 DGFT has undertaken their own unannounced visit following the CCG review and has prepared an action plan to adopt the recommendations agreed. The action plan is attached for information.

4.0 **ACKNOWLEDGMENT**

4.1 The visiting team thank all staff for their open and honest responses and for accommodating the team.

5.0 **RECOMMENDATION**

5.1 The Board is asked to note the above report and enclosed action plan for assurance.

**Dr Ruth Edwards**  
Clinical Executive for Quality & Safety  
December 2014
<table>
<thead>
<tr>
<th>CCG RECOMMENDATIONS/ CONCERNS</th>
<th>SOURCE OF MONITORING</th>
<th>DIRECTOR</th>
<th>SOURCE OF ASSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient waiting 15 minutes for attention – impact on dignity and privacy.</td>
<td>Call bell response time monitored via the Quality Accounts</td>
<td>D McMahon</td>
<td>Quarterly Quality Accounts report to the Trust Board</td>
</tr>
<tr>
<td>Delays in response times to the call buzzer.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Pressure ulcer – documentation vs perception on ward, availability of specialist advice, question whether formally requested / reported, seeming lack of escalation. | Pressure ulcer care is monitored via the Quality Accounts  
All grade 3/4 pressure ulcers are reviewed using RCA – learning from RCA is monitored via CQSPE committee (Care, Quality, Safety & Patient Experience) | D McMahon      | Monthly CQSPE committee                                  |
| Increased pressure placed on remaining ward staff with impending loss of nutritional support worker, along with loss of benefits to patients. | Nutrition care monitored via Quality Accounts  
NCI (Nurse Care Indicators) assessments completed monthly                                                   | D McMahon      | Monthly CQSPE committee                                  |
<p>| DGFT to review plans to remove the nutritional support role on wards.                           |                                                                                                               |                |                                                          |
| Timely support not available for frailer patients at mealtimes to ensure adequate hydration and dietary intake. |                                                                                                               |                |                                                          |
| Staff advised that they did not have the capacity to have a member of staff sit with a patient who appeared to be at the end of life stage. | Engaged in national End of Life work streams; led by Transformation Team                                      | J Scott        | Monthly CQSPE committee                                  |</p>
<table>
<thead>
<tr>
<th>CCG RECOMMENDATIONS/CONCERNS</th>
<th>SOURCE OF MONITORING</th>
<th>DIRECTOR</th>
<th>SOURCE OF ASSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WORKFORCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shifts remaining unbooked the night before – impact on ward team if shifts left uncovered.</td>
<td>Staffing information in response to ‘How to ensure the right people, with the right skills, are in the right place at the right time’ and ‘Hard Truths’</td>
<td>D McMahon</td>
<td>Monthly Board paper; publicised on Trust web site</td>
</tr>
<tr>
<td>Practicality of expecting staffing assistance from another ward.</td>
<td>Staffing information in response to ‘How to ensure the right people, with the right skills, are in the right place at the right time’ and ‘Hard Truths’</td>
<td>D McMahon</td>
<td>Monthly Board paper; publicised on Trust web site</td>
</tr>
<tr>
<td>DGFT to continue its plans to recruit to permanent roles and ensure full adherence to safer staffing ratios.</td>
<td>Monthly monitoring of shifts to identify shortfalls against planned staffing levels</td>
<td>D McMahon</td>
<td>BAF (Board Assurance Framework)</td>
</tr>
<tr>
<td>DGFT to provide assurance on plans to mitigate risks to safer staffing levels.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPERATIONAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses not fully aware of DGFT’s plans for managing challenging capacity issues</td>
<td>Urgent Care group responsible for planning and monitoring all aspects of capacity and discharge planning</td>
<td>J Scott</td>
<td>Monthly report to Finance &amp; Performance (F&amp;P) Committee</td>
</tr>
<tr>
<td>Some difficulties discharging patients</td>
<td>Urgent Care group responsible for planning and monitoring all aspects of capacity and discharge planning</td>
<td>J Scott</td>
<td>Monthly report to Finance &amp; Performance (F&amp;P) Committee</td>
</tr>
<tr>
<td>Relatives indicated that they were not informed of discharge plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG RECOMMENDATIONS/CONCERNS</td>
<td>SOURCE OF MONITORING</td>
<td>DIRECTOR</td>
<td>SOURCE OF ASSURANCE</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Discharge planning, including involvement of Social Services, should start as early as possible and plans should be formulated ready for when patients are medically fit for discharge. This requires DGFT to be proactive at the beginning and during the process.</td>
<td>Urgent Care group responsible for planning and monitoring all aspects of capacity and discharge planning</td>
<td>J Scott</td>
<td>Monthly report to Finance &amp; Performance (F&amp;P) Committee</td>
</tr>
<tr>
<td>Length of time patients wait to leave Discharge Lounge.</td>
<td>Urgent Care group responsible for planning and monitoring all aspects of capacity and discharge planning</td>
<td>J Scott</td>
<td>Monthly report to Finance &amp; Performance (F&amp;P) Committee</td>
</tr>
<tr>
<td>Lack of stimulation / interest for patients waiting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of signposted directions to the Discharge Lounge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior communication with Pharmacy Department to enable more timely departure from the Discharge Lounge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison with transport to be confirmed where possible, in advance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG RECOMMENDATIONS/CONCERNS</td>
<td>SOURCE OF MONITORING</td>
<td>DIRECTOR</td>
<td>SOURCE OF ASSURANCE</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>STAFF ENGAGEMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| DGFT to update staff fully on staffing intentions to alleviate anxiety and improve staff morale. | Chief Executive’s team brief  
Staff survey  
Agency for Healthcare Research and Quality survey | P Clark  
P Clark | Reported to Trust Board  
Reported to F&P |
| DGFT to update staff on the escalation process and ensure all staff are aware of appropriate communication pathways. | | | |
| The visiting team strongly recommend that senior staff take the time to listen to the voices of all staff members | | | |
**TITLE OF REPORT:** Report of the Clinical Development Committee

**PURPOSE OF REPORT:** The Clinical Development Committee met on 19th November and 17th December 2014. This report sets out the main items considered at those meetings.

**AUTHOR OF REPORT:** Neill Bucktin, Head of Commissioning

**MANAGEMENT LEAD:** Neill Bucktin, Head of Commissioning

**CLINICAL LEAD:** Dr Steve Mann, Clinical Executive – Acute & Community Services

**KEY POINTS:**

1. The Committee has approved a report on the future development of the QIPP programme. This matter is dealt with more fully in the Finance and Performance Committee's report.

2. The Committee has approved a proposal to commission an integrated model of diabetes care, designed to deliver more care in community based settings.

3. The Committee has approved, in principle, a proposal to integrate the district nursing and virtual ward community nursing teams.

4. The Committee has approved, in line with NICE recommendations, a proposal to DNA test patients with Familial Hyperlipidaemia.

5. The Committee has approved, in principle, a draft action plan for physical activity and sport.

6. The Committee has conducted a self-assessment of its effectiveness and agreed actions for improvement.

7. The Committee has noted the outcome of a peer review of the Dudley Health and Wellbeing Board. A further action plan will be considered in due course.

8. The Committee has recommended that the remuneration for the GP clinical lead for respiratory services should be amended to one session per week, in the light of the post's current role.

9. The Committee have recommended that the Board give delegated authority to the Clinical Executive – Acute and Community Services to approve the specification for the 111 service.
| RECOMMENDATION                                                                 | 1. That the report of the Clinical Development Committee be noted.  
                                                                                                                                   | 2. That the Clinical Executive - Acute and Community Services be authorised to approve the proposed service specification for the 111 service. |
| FINANCIAL IMPLICATIONS:                                                        | None arising directly from this report. QIPP is dealt with in the Finance and Performance Committee’s report. |
| WHAT ENGAGEMENT HAS TAKEN PLACE:                                               | Engagement has taken place in relation to individual proposals considered by the Committee as necessary through CCG locality meetings and with service users. |
| ACTION REQUIRED:                                                               | ✓ Decision  
 ✓ Approval  
 Assurance |
1.0 BACKGROUND

1.1 The Clinical Development Committee met on 19th November and 17th December 2014. This report sets out the main items considered at those meetings.

2.0 QIPP PROGRAMME

2.1 The Committee has considered a report examining the potential shortfall in the QIPP programme for 2015/16 and the resultant increase in the QIPP target to £11.19m.

2.2 The Committee agreed to reduce investment reserves to enable a reduction in the target and renegotiate the Better Care Fund transfer to the Council to potentially reduce the target.

2.3 In order to manage the programme for 2015/16, it was also agreed that commissioning managers should focus on one main QIPP priority each.

2.4 This matter is dealt with fully in the Finance and Performance Committee’s report.

3.0 INTEGRATED DIABETES MODEL OF CARE

3.1 The Committee has approved a proposal to commission an integrated model of care for diabetes. This will include:-

- all diabetes care being provided, wherever possible, in a community setting;
- a single point of access and triage of all diabetes referrals;
- de-commissioning routine annual reviews for type 2 diabetic patients in secondary care.

4.0 INTEGRATION OF DISTRICT NURSING AND VIRTUAL WARD TEAMS

4.1 The Committee has approved, in principle, a proposal to integrate the virtual ward and district nursing teams into one community nursing service.

4.2 The Committee noted that this would provide greater support to general practice; maintain specialist skills whilst broadening the general nursing base; enhance the visibility of the virtual ward and support the CCG’s integrated service model.

5.0 FAMILIAL HYPERLIPIDAEMIA (FH)

5.1 The Committee has approved a proposal to DNA test FH patients, in line with NICE recommendations. This was seen as an enhancement to the existing service implemented in 2008.

6.0 PHYSICAL ACTIVITY AND SPORT ACTION PLAN

6.1 The Committee have approved, in principle, a draft action plan.

6.2 A further report will be considered in January 2015 and the final proposed plan will be reported to the Board.
7.0 COMMITTEE EFFECTIVENESS REVIEW

7.1 The Committee has considered a report on the outcome of a self-assessment process into its effectiveness.

7.2 Key areas for further action are:-

- production of an annual report on its activities to the Board, including its effectiveness;
- agree a work programme for 2015/16 and review its achievement;
- review the timings of the Committee's meetings;
- address report writing and presentation skills for commissioning managers as part of the commissioning team's development programme.

8.0 DUDLEY HEALTH AND WELLBEING PEER REVIEW

8.1 The Committee has noted the outcome of a peer review of the Health and Wellbeing Board, conducted by the Local Government Association.

8.2 The CCG's contribution to this process included the view that the Board needed to put in place processes to hold the health and social care system to account on the basis of an agreed set of performance metrics, representing "one version of the truth". This is now reflected in a draft action plan that will be reviewed further by the Committee.

9.0 GP LEAD – RESPIRATORY SERVICES - REMUNERATION

9.1 The Committee have recommended that the remuneration for this role be amended to the equivalent of one session per week.

10.0 111 SPECIFICATION

10.1 The CCG is contributing to the development of the specification of the 111 Service due to be tendered in 2015.

10.2 In order to comply with the procurement timetable for this service, the Committee recommend that the Board delegate authority to the Clinical Executive – Acute and Community Services to approve the service specification for 111.

11.0 RECOMMENDATION

11.1 That the report of the Clinical Development Committee be noted.

11.2 That the Clinical Executive – Acute and Community Services be authorised to approve the proposed service specification for the 111 service.

Neill Bucktin
Head of Commissioning
December 2014
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Report:** 8 January 2015  
**Report:** Dudley Health and Wellbeing Board  
**Agenda item No:** 9.2

## TITLE OF REPORT:
Report of the Dudley Health and Wellbeing Board

## PURPOSE OF REPORT:
To advise the Board of matters considered by the Dudley Health and Wellbeing Board at its meeting on 16th December, 2014

## AUTHOR OF REPORT:
Mr Neill Bucktin, Head of Commissioning

## MANAGEMENT LEAD:
Mr Neill Bucktin, Head of Commissioning

## CLINICAL LEAD:
Dr David Hegarty, Chair of the Governing Body

## KEY POINTS:
1. The Board has received the annual reports of the Adults and Children safeguarding Boards.
2. The Board has received the Health Protection annual report.
3. The Board has approved its Community Engagement Plan.
4. The Board has approved the terms of reference of the Health and Social Care Leadership Group (which also acts as Dudley’s System Resilience Group).
5. The Board has approved Dudley’s resubmitted Better Care Fund Plan.
6. The Board has approved the draft Pharmaceutical Needs Assessment as a basis for public consultation.
7. The Board has considered the initial outcome of the Local Government Association’s peer review process of its progress.
8. The Board has noted progress with the development of the draft Children and Young People’s Plan 2015/17.
9. The Board has considered current issues in relation to delayed transfers of care.

## RECOMMENDATION:
That matters considered by the Health and Wellbeing Board be noted.

## FINANCIAL IMPLICATIONS:
None arising directly from this report. The financial implications of the BCF are dealt with in the finance report.

## WHAT ENGAGEMENT HAS TAKEN PLACE:
None

## ACTION REQUIRED:
- Decision
- Approval
- **Assurance**
1.0 INTRODUCTION

1.1 The Health and Wellbeing Board, a statutory committee of Dudley MBC, met on 16th December 2014.

1.2 This report sets out those issues considered by the Board.

2.0 ANNUAL REPORTS – DUDLEY SAFEGUARDING CHILDREN BOARD AND DUDLEY SAFEGUARDING ADULTS BOARD 2013/14

2.1 The Board has considered the annual report of the Safeguarding Children Board.

2.2 The Board holds partners to account on the effectiveness of their individual arrangements for safeguarding children. The report sets out how it has carried out its activities in relation to three key objectives:

- providing safe environments for children to promote their welfare and wellbeing;
- targeting action at vulnerable groups such as disabled children and children in care;
- ensuring effective and co-ordinated responses to children who have been harmed, in order to minimize lifelong impact.

2.3 The Board has considered the annual report of the Safeguarding Adults Board.

2.4 The Board’s work has focused upon the six principles of empowerment; prevention; proportionality; protection; partnership and accountability and the report identifies the contributions made by partners to the adult safeguarding agenda, including the local response to the inquiry into events at Winterbourne View and a peer review by colleagues from Stoke-on- Trent City Council.

2.5 The report notes that the Care Act 2014 has established the Board as a statutory body.

2.6 The Chief Quality and Nursing Officer is the CCG’s representative on the Board and issues are reported to the Quality and Safety Committee as appropriate.

3.0 HEALTH PROTECTION ANNUAL REPORT 2013/14

3.1 Health protection activity is delivered by the Council through both the Office of Public Health and the environmental health function.

3.2 The Board has considered the annual report for 2013/14 which sets out activities conducted in relation to:

- emergency planning and incident response;
- infection prevention and control;
- tuberculosis;
- immunization;
- environmental health.

4.0 HEALTH AND WELLBEING BOARD COMMUNITY ENGAGEMENT PLAN

4.1 The Board has approved its community engagement plan. The plan aims to:-

- increase awareness of the Board’s role;
- engage partners and the public in health and wellbeing priority setting and delivery;
- co-ordinate engagement activity across partners;
- make use of existing user and community networks.
5.0 HEALTH AND SOCIAL CARE LEADERSHIP GROUP – TERMS OF REFERENCE

5.1 The Board has approved the terms of reference for this group which brings together the chief officers/directors of the major health, social care and community sector organisations in Dudley.

5.2 This group has overseen a number of key issues affecting the health and social care system and responded collectively to system challenges. This group also acts as the local “System Resilience Group” in line with guidance issued in June 2014, overseeing performance in relation to the 4 hour ED target and the 18 month referral to treatment target.

5.3 The group will report to the Health and Wellbeing Board on issues including local system performance.

6.0 BETTER CARE FUND

6.1 The Board has approved the Better Care Fund Plan.

6.2 This plan, originally submitted in September 2014, was “approved with conditions”, the main condition being a requirement to re-profile the planned reduction in emergency admissions across four years rather than the original ambition of two.

6.3 This revision has limited the ability of the CCG to pool as much resource with the Council as originally anticipated, due to the resource required to achieve this being released through a reduction in admissions.

6.4 Following discussions with the Council, the CCG has agreed a revised financial and activity plan In response to the requirement to re-profile activity and this has been re-submitted to NHS England. Approval is expected in January, 2015.

6.5 This matter is also dealt with elsewhere on this agenda.

7.0 PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2014/15

7.1 The Board has a statutory responsibility to publish a statement of the need for pharmaceutical services for its population. This supports the commissioning of pharmaceutical services and is used by NHS England when making decisions on applications to open new pharmacies.

7.2 The draft PNA has now been approved for consultation and will be considered further by the Clinical Development Committee.

8.0 HEALTH AND WELLBEING BOARD PEER REVIEW

8.1 The Board has considered the outcome of a peer review process conducted by the Local Government Association. This has also been received by the Clinical Development Committee.

An action plan is being developed in response to the review’s findings and this will also be the subject of a further report to the Clinical Development Committee.

9.0 CHILDREN AND YOUNG PEOPLE – DRAFT PLAN

9.1 The Board has approved a proposal from the Children and Young People’s Partnership Board to develop a revised Children and Young People’s Plan based on a single priority of early help and support. This is on the basis that this will:-

- help to optimize the potential of young people to live healthy lives;
- reduce the risk to harm faced by more vulnerable groups;
- reduce the level of inappropriate referrals to services.
10.0 QUALITY TRANSFERS OF CARE BETWEEN HOSPITAL AND COMMUNITY SETTINGS

10.1 The Board has considered a report, previously presented to the Health Overview and Scrutiny Committee regarding the impact of delayed transfers of care, including the financial cost to the CCG. A detailed review of system issues is now being carried out by the System Resilience Group.

Neill Bucktin
Head of Commissioning
December 2014
<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Better Care Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To approve the current position in relation to the Better care Fund and its management</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Neill Bucktin, Head of Commissioning</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Neill Bucktin, Head of Commissioning</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr D Hegarty, Chair</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

1. Dudley's original BCF submission was "approved with conditions", the main requirement being to review the level of ambition associated with the planned reduction in emergency admissions.
2. The planned reduction has now been reviewed and the activity reduction re-profiled across 4 years.
3. This challenges both the CCG and Council:
   - the amount of resource the CCG can put into the BCF pooled budget is reduced as this is directly related to the resource freed up by reducing emergency admissions;
   - this in turn reduces the level of resource available to the Council to fulfil a national requirement to "protect adult social care".
4. The BCF Plan has been resubmitted on the basis of a revised activity Profile and is subject to the Council agreeing to reimburse the CCG for the cost of excess bed days where patients are medically fit for discharge.
5. The arrangements for the operation of the pooled budget require an agreement under Section 75 of the NHS Act 2006 and an agreed performance framework.

**RECOMMENDATION:**

1. That the revised financial plan for the Better Care Fund be approved.
2. That the proposed arrangements for the Section 75 Agreement and pooled budget be approved.

**FINANCIAL IMPLICATIONS:** These are set out in paragraph 3.0 of the report.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

Engagement has taken place with the Council, service providers, GPs, the Health and Wellbeing Board and the Health Overview and Scrutiny Committee.

**ACTION REQUIRED:**

- Decision
  - Approval
  - Assurance
1.0 BACKGROUND

1.1 The Board will recall that the Better Care Fund (BCF) requires the CCG to establish a pooled budget, under Section 75 of the NHS Act 2006, with the Council, designed to support the integration of health and social care.

1.2 There are a number of key system wide performance metrics associated with this including:

- reduction of emergency admissions (performance in relation to which has a direct bearing on releasing resources from the CCG);
- reduction of admissions to care homes;
- promotion of reablement;
- reduction in delayed transfers of care.

1.3 This has been viewed locally as a work-stream of our service integration programme which predates the BCF. The main vehicle for our programme is the establishment of integrated, practice based teams and associated services including the Community Rapid Response Team.

1.4 The CCG and the Council are required to go through an assurance process in order to gain approval to what is ultimately the Health and Wellbeing Board's BCF Plan. A submission was made in September 2014 which was "approved with conditions". The main condition was related to the extent of our ambition to reduce the number of emergency admissions and a requirement to re-profile the planned reduction over a longer timeframe.

1.5 This report sets out:

- the implications of this;
- the CCG's revised proposal in relation to the BCF Plan;
- the proposed arrangements for the Section 75 Agreement required to govern the pooled budget and the associated performance framework.

2.0 RE-PROFILED ACTIVITY PLAN

2.1 The required 15% reduction in emergency admissions presents the CCG and the Council with a financial challenge:

- the ability of the CCG to pool funding is directly related to the freeing up of resources as a result of reducing emergency admissions, including those associated with the performance element of the BCF;
- this in turn affects the ability of the Council to protect adult social care - a national condition of the BCF.

The original submission was deemed ambitious to achieve the 15% reduction over 2 years, therefore it is proposed to reprofile the activity reduction over 4 years equating to 3.5% per annum.

3.0 FINANCIAL PLAN

3.1 The plan designed to address this, with the reduction in emergency activity phased over 4 years, is now based upon the pooling of £4.625m from the CCG to be managed within a total pooled budget of £69.548m (see 4.1 below). This is built up of two elements:

- monies from the CCG baseline of £3.0m;
- performance fund of £1.625m (from the reduction in emergency admissions).
3.2 The £3.0m identified above is conditional upon the Council paying for excess bed day costs for patients medically fit for discharge.

4.0 SECTION 75 AGREEMENT

4.1 The proposed pooled budget, in total, is £69.548m. This has been constructed on the basis of identifying those services commissioned by both the Council and the CCG which contribute to the key performance metrics set out above. This is shown at Appendix 1.

4.2 Section 75 of the NHS Act 2006, enables CCGs and Councils to enter into agreements to:-

- create jointly managed teams of staff with associated secondment arrangements;
- enable one body to act as "lead commissioner" for a service;
- create pooled budgets.

It is the latter power that will be used in relation to the BCF.

4.3 There are two specific issues that such an agreement will need to address:-

- how the pooled budget will operate;
- how it will be governed.

5.0 POOLED BUDGET

5.1 The CCG needs to ensure that any risks associated with the pool are mitigated as well as ensuring that the budget facilitates the development of the service integration programme.

5.2 Therefore, the CCG's proposed requirements for the Section 75 Agreement are:-

- budgetary management to be hosted by the CCG;
- all decisions in relation to investment or disinvestment of services in the pool to be taken jointly by the Joint Management Group (see below);
- any decisions in relation to service changes as part of 2015/16 budget setting (i.e. prior to the Agreement becoming operational on 1st April 2015) to be taken jointly;
- any negotiations within the Council on adult services' share of any corporate savings target to take place on a tripartite basis with CCG involvement;
- any benefits/risks arising from the operation of the pool to be distributed between the partners in proportion to their relative contributions to the pool;
- performance framework to be developed and maintained by the CCG.

6.0 JOINT MANAGEMENT GROUP

6.1 A Joint Management Group will be established with the following membership to oversee the arrangements described above. The membership is proposed as follows:-

**CCG**
- Chief Executive Officer
- Chief Finance and Operating Officer
- Head of Commissioning

**Council**
- Strategic Director, People’s Services
- Chief Officer, Adult Social Care
- Finance Manager
Chairmanship - to be alternated on an annual basis

Reporting arrangements - reports to Health and Wellbeing Board

7.0 RECOMMENDATION

7.1 That the revised financial plan for the Better Care fund be approved.

7.2 That the proposed arrangements for the Section 75 Agreement and pooled budget be approved.

Enclosed:  Appendix 1

Neill Bucktin
Head of Commissioning
December 2014
null
AUDIT COMMITTEE REPORT

**TITLE OF REPORT:** Audit Committee Report

**PURPOSE OF REPORT:** To advise the Board of the key issues discussed and agreed at the Audit Committee on 2nd December 2014

**AUTHOR OF REPORT:** Mr M Hartland, Chief Operating and Finance Officer

**MANAGEMENT LEAD:** Mr M Hartland, Chief Operating and Finance Officer
Mrs J Jasper, Chair – Audit Committee

**CLINICAL LEAD:** Dr J Rathore, Clinical Lead for Finance and Performance

**KEY POINTS:**
- Update on Committee Reporting and Effectiveness.
- Report and update from Information Governance.
- Freedom of Information (FOI) and Engagement with Pharmaceutical Industry policies approved.
- Combined BAF & Risk Register as at 7th November reviewed; risk 21 recommended for closure.
- Updates from External Audit; Internal Audit; Anti-Fraud; and Local Security Management (LSM). LSM Work-plan 2014/15 approved.
- Approval for Co-Commissioning Group to report to Audit Committee.
- Prime Financial Policies-Assurance received.
- Other matters considered–Evaluation of Consultants; Independent review of FOI & Complaints; Annual Report & Accounts 2014/15

**RECOMMENDATION:**
- The Board is asked to receive this report on the issues discussed and the decisions taken under delegated powers at the Audit Committee on 2nd December 2014 for assurance.
- The Board is asked to approve the closure of risk 21 in the BAF & Risk Register

**FINANCIAL IMPLICATIONS:** None

**WHAT ENGAGEMENT HAS TAKEN PLACE:** None

**ACTION REQUIRED:**
- Decision
- Approval
- Assurance
1.0 INTRODUCTION
The report summarises the key issues discussed at the Audit Committee on 2nd December 2014.

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 Constitution and Terms of Reference.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Position</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regulation and Control</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>CCG Governance Arrangements – Constitution</td>
<td>Paper to Board 13/11/14-proposed changes agreed. Authority delegated to allow changes in respect of Primary Care Commissioning to be submitted to NHSE by national deadline.</td>
<td></td>
</tr>
<tr>
<td>Scheme of Delegation</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Compliance with Prime Financial Policies</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Board &amp; Committee Effectiveness</td>
<td>Committee effectiveness review underway. Plans in place for Board effectiveness review.</td>
<td></td>
</tr>
<tr>
<td>3. Operational &amp; Risk Management</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Counter Fraud and Security</td>
<td>Committee updated</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 Committee; Annual Review July 2014</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Report newly commissioned services</td>
<td>Revised Procurement Strategy approved by CCG Board 13/03/14</td>
<td></td>
</tr>
<tr>
<td>External Audit</td>
<td>Interim audit completed December – no significant issues raised.</td>
<td></td>
</tr>
<tr>
<td>Internal Audit</td>
<td>Updated 2014/15 Plan approved; 2014/15 audits progressing.</td>
<td></td>
</tr>
<tr>
<td>- Other Policies – 6 of total of 7 received and approved</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>- Other Policies – Business Continuity Policy</td>
<td>Work progressing</td>
<td></td>
</tr>
<tr>
<td>4. Information Governance</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>Information Governance Group established</td>
<td>Meetings to be established once CSU IG Team fully in place.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Breaches – Provider</td>
<td>Regular updates</td>
<td></td>
</tr>
<tr>
<td>Compliance with Information Governance toolkit</td>
<td>Improvement Plan agreed &amp; work progressing</td>
<td></td>
</tr>
<tr>
<td>Information Asset Management structure to be established with IAOs and IAAs identified from CCG staff</td>
<td>IAOs identified, IAAs identified by IAOs. Training starting shortly.</td>
<td></td>
</tr>
<tr>
<td>IG Policies – 18 policies replaced by overarching IG policy supported by handbook. FOI and Engagement with the Pharmaceutical Industry policies approved 02/12/14.</td>
<td>Policies being regularly reviewed and updated.</td>
<td></td>
</tr>
</tbody>
</table>
3.0 ITEMS DISCUSSED – 2nd DECEMBER 2014

3.1 Committee Reporting/Effectiveness
The Audit Committee received the final results of the review of its effectiveness and approved an action plan to address the issues raised. This included the production of a Committee Annual Report 2014/15.

The Committee also received an update on progress with the reviews being undertaken for other CCG committees. There had been a good response to the effectiveness survey by members of the committees and most of the checklists for committee processes had been returned by the management leads. The CCG’s independent governance adviser and Deputy Chief Finance Officer would be observing the next round of committees, mostly in December, and would be feeding back on the outcome of the surveys and checklists.

3.2 Information Governance
The Audit Committee received a report from the Information Governance Manager, Midlands & Lancashire CSU. This described the current position within the CSU information governance team; the process that was underway to restructure the team and ensure any gaps were filled; and how the CCG was currently being supported.

It was noted that more than half of the CCG salaried staff had attended an IG training session the previous week and that the training had been well received.

The next significant steps in the annual work programme were considered which included:

- Circulation of IG Policy & handbook to all staff
- Training for all Information Asset Owners (IAOs) and Information Asset Administrators (IAAs)
- Completion of Information Asset Registers and Data flows
- Delivery of training to CCG Board at Board Development Session
- Delivery of training to all other staff

3.3 Policies
The Committee received a revised Freedom of Information Policy and a Complaints Policy from the Head of Communications & Public Insight

Freedom of Information - This reflected that the service had been brought in-house from the CSU on 1st October. This was approved under delegated authority subject to some minor amendments.

Complaints Policy – Although this policy fell under the responsibility of the Quality & Safety Committee, it was brought to the Audit Committee for assurance following a recent audit. The Committee suggested some changes.

Policy for Engagement with the Pharmaceutical Industry – The Audit Committee was asked to approve this new policy given the close links with the Standards for Business Conduct. It had previously been approved by the Prescribing Sub-Committee and Clinical Development Committee. It was approved under delegated authority subject to it referencing both the Gifts & Hospitality Policy and Standards for Business Conduct Policy.

3.4 Board Assurance Framework and Risk Register
The Committee received the Combined Board Assurance Framework (BAF) and Risk Register as at 7th November 2014 for assurance. It also agreed to recommend the closure of Risk 21 in respect of CSU Quality & Safety support to the Board for approval.

It was noted that clinical and management leads for each CCG committee would be invited to future Audit Committee meetings to discuss the risks identified to their committee.

3.5 Internal Audit
The Committee received a number of documents from Internal Audit for information, assurance and approval:

- Progress Report December 2014. The current cumulative position on the Head of Internal Audit Opinion continued to be significant assurance. The Committee noted the current status in terms of recommendation tracking. The Committee considered the section on key developments to be very useful and asked that it be shared with other colleagues.
• Audit Report-Personal Health Budgets (Payment Arrangements) Phase 1. This report had been given significant assurance.
• Draft protocol for internal audit reports. This was received for information. The Committee asked that timescales be added to the protocol.

3.6 Local Anti-Fraud and Security Managements
The Committee received the Anti-Fraud Progress Report 2014/15 for assurance and approved the 2014/15 Work-plan from the Local Security Management Specialist.

3.7 External Audit
The Committee received a report on progress and emerging issues and developments. It noted that there was a change in the lead auditor for final accounts and that she would be undertaking an interim audit the following week.

The Committee noted the arrangements for the Auditor’s conclusion on Value for Money in 2014/15 which was different to 2013/14.

3.8 Evaluation of Consultants
The Committee received a report on the evaluation of consultants paid for the period 1st April to 30th September 2014. Members made a number of observations but due to limited timescale were asked to:
- feedback on the responses made and any specific queries would be directed to the relevant management lead
- confirm if they considered all the relevant data was being requested as this would inform the process for appointing consultant and interim staff.

3.9 Co-Commissioning Governance Update
The Committee received an update on the establishment of a task and finish group for the Co-commissioning of Primary Medical Services with the intention of achieving delegated responsibility by 31st March 2015. The report provided details of progress and sought confirmation from the Audit Committee that it should report through the Audit Committee to the Board as the matters within the terms of reference mostly related to governance and potential conflicts of interest. The Audit Committee approved this request.

3.10 Other Issues
The Audit Committee considered and received assurance in respect of:
- Waivers and No Orders authorised
- Scheme of Delegation
- Aged Receivables and Payables
- Compliance with laws and regulations governing the NHS
- Independent review of arrangements for FOI & complaints
- Production of the Annual Report & Accounts 2014/15

4. DECISIONS TAKEN BY COMMITTEE UNDER DELEGATED POWERS FROM BOARD
• Approval of the Freedom of Information Policy
• Approval of the Policy for Engagement with the Pharmaceutical Industry
• Approval of the 2014/15 Work-plan from the Local Security Management Specialist
• Approval for the Co-Commissioning Task & Finish Group to report to the Audit Committee

5. DECISIONS REFERRED TO THE BOARD
• Recommended the closure of risk 21 to the Board.

6. RECOMMENDATION
• The Board is asked to receive this report on the issues discussed and the decisions taken under delegated powers at the Audit Committee on 2nd December 2014 for assurance.
• The Board is asked to approve the closure of risk 21 in the BAF & Risk Register

M Hartland
Chief Operating & Finance Officer
December 2014
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Report:** 8 January 2015  
**Report:** Audit Committee Terms of Reference  
**Agenda item No:** 11.2

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Audit Committee Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To present revised Audit Committee Terms of Reference to the Board for approval</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 Committee. |
| CLINICAL LEAD: | Dr J Rathore, Clinical Lead for Finance and Performance |

## KEY POINTS:
- Review of Audit Committee Terms of Reference against Healthcare Financial Management Association (HFMA) Audit Committee Handbook and the CCG’s Constitution  
- Draft Terms of Reference approved by the Audit Committee at its meeting on 26th September presented to Board for approval.

## RECOMMENDATION:
- The Board is asked to approve the revised Audit Committee Terms of Reference

## FINANCIAL IMPLICATIONS:
None

## WHAT ENGAGEMENT HAS TAKEN PLACE:
None

## ACTION REQUIRED:
- Decision  
- Approval  
- Assurance
1.0 INTRODUCTION
At its meeting on 31st July the Audit Committee considered a number of proposed changes to its Terms of Reference. Draft revised Terms of Reference reflecting the changes agreed were then approved by the Audit Committee at its meeting on 26th September.

The revised Audit Committee Terms of Reference are now presented to the Board for approval as this is a decision reserved to the Board.

2.0 BASIS OF REVIEW
To support the review, the current Terms of Reference were compared with the example included in the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook issued in May 2014.

Additionally the Terms of Reference were considered against extracts from the CCG’s Constitution relating to the responsibilities identified to the Audit Committee, specifically:

1. Specific responsibilities within the main body of the Constitution
2. Matters delegated to the Audit Committee in the Scheme of Reservation & Delegation
3. Relevant sections of the Prime Financial Policies requiring Audit Committee approval or oversight.

3.0 CHANGES AGREED BY THE AUDIT COMMITTEE FOLLOWING COMPARISON WITH HFMA HANDBOOK

Broadly the CCG’s Terms of Reference followed the HFMA example version with most of the differences being due to where the HFMA Terms of Reference had been updated or where there had been local tailoring of the CCG version. The Terms of Reference have been amended as follows:

1. Minor difference in words - Where the individual sections broadly matched but the wording was slightly different, the CCG Terms of Reference were brought into line with the HFMA version.
2. Specific sections unique to either version – the CCG Terms of Reference have been revised for the HFMA sections that were missing but any CCG additions that enhanced the HFMA version have been left in.
3. Sections requiring further consideration by, and input from, the Audit Committee – in particular:
   • Membership – number of members
   • Attendance – clinical representation
   • Frequency – minimum number of meetings
   • Secretary – clarification in respect of secretarial / governance lead role and location in the Terms of Reference.

4.0 CHANGES AGREED BY THE AUDIT COMMITTEE FOLLOWING COMPARISON WITH THE CCG’S CONSTITUTION

The comparison highlighted a number of areas of responsibility delegated to the Audit Committee which did not specifically feature in the CCG or HFMA example Terms of Reference and these have been incorporated into the revised CCG version. These included:

1. Review of any suspension of Standing Orders
2. Approval of the operational scheme of delegation
3. Approval of the arrangements for business continuity
4. Approve arrangements in respect of Information Governance

The latter is an important inclusion as this is an essential requirement to support the CCG’s Information Governance Toolkit submission.

5.0 DECISIONS REFERRED TO THE BOARD

* Approval of the revised Audit Committee Terms of Reference

6.0 RECOMMENDATION

* The Board is asked to approve the revised Audit Committee Terms of Reference

M Hartland
Chief Operating and Finance Officer
December 2014
NHS Dudley
Clinical Commissioning Group

Governing Body’s
Audit Committee

Terms of Reference

1. Introduction

The Audit Committee (the ‘Committee’) is established in accordance with paragraph 6.6.3(a) of NHS Dudley Clinical Commissioning Group's constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and will have effect as if incorporated into the constitution. The Committee will review its own performance and terms of reference annually. Any resulting changes to the terms of reference will be approved by the governing body or the group if they relate to the membership of the committee (Standing Order 4.1) before becoming part of an application for change to be approved by the group and submitted to the NHS Commissioning Board (constitution 1.4).

2. Membership

The lay member of the governing body appointed under Standing Order 2.2.4 by virtue of the qualifications, expertise or experience enabling them to express informed views about financial management and audit matters will be the Chair of the Committee for as long as they hold that position.

In the event of the Chair of the Committee being unable to attend all or part of a meeting, they will nominate a replacement from within the membership to deputise for that meeting.

The other members of the Committee will be appointed by the group such that the Committee has at least three members, of whom at least two, including the Chair, are members of the governing body. The second lay member will be appointed as Vice-Chair of the Committee.

The chair of the governing body, GP governing body members, the Chief Accountable Officer, the Chief Finance Officer and any employees of the group (including the Chief Quality & Nursing Officer) will not be eligible for membership of the Committee.
No individual who could not be a member of the group’s governing body by virtue of Schedule 5 of the 2012 Regulations (SI 2012/1631) will be eligible to be a non-governing body member of the Committee.

Always provided that they remain eligible as described above, other members of the Committee will hold office for a term of three years and will only be eligible to serve two consecutive terms.

3. In attendance

The Chief Finance Officer, the Designated GP Lead, appointed external auditor and head of internal audit will be invited to attend or be represented at all or part of each meeting of the Committee. At least once a year the members should meet privately with the external and internal auditors.

The Accountable Officer will be invited to attend meetings and should discuss at least annually with the Audit Committee the process for assurance that supports the governance statement. They will also attend when the committee considers the draft annual governance statement and the annual report and accounts.

Other employees of the group or persons providing services to it may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that person.

4. Access

Representatives from other organisations (for example, NHS Protect) and other individuals may be invited to attend on occasion. The local counter fraud specialist should attend at least two meetings a year. The chair of the governing body may also be invited to attend one meeting each year in order to have an understanding of, the committee’s business, as well as the meeting at which the Committee considers the annual accounts.

The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

5. Secretary

A named individual will be responsible for supporting the Chair in the management of the Committee’s business and for drawing members’ attention to best practice, national guidance and other relevant documents as appropriate.

6. Quorum

A meeting of the Committee will be quorate provided that two members are present of which at least one is the Chair or Vice-Chair of the Committee.
7. Frequency and notice of meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

The Committee will meet at least four times per annum with meeting dates scheduled in advance for at least 12 months. No unscheduled or rescheduled meetings will take place without members having at least one week’s notice of the date. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place.

The Governing Body, Accountable Officer, external auditors or Head of Internal Audit can request a meeting in addition to those scheduled if they consider that one is necessary.

8. Authority

The Committee is authorised by the Governing body to investigate any activity within its terms of reference. This includes specific responsibilities that have been delegated to the Audit Committee by the Governing Body in its Constitution. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain outside legal or independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

9. Remit, duties and responsibilities

The Committee is accountable to the group’s governing body and its remit is to provide the governing body with an independent and objective view of the group’s systems, information and compliance with laws, regulations and directions governing the group. It will deliver this remit in the context of the group’s priorities, as they emerge and develop, and the risks associated with achieving them. It’s responsibilities are categorised as follows:

9.1 Integrated governance, risk management and internal control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (clinical and non-clinical), that supports the achievement of the organisation’s objectives.

In particular, the Committee will review the adequacy and effectiveness of:
• All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body
• The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
• The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications
• The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality & Safety Committee) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

9.2 Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Accountable Officer and governing body. This will be achieved by:

• Considering the provision of the internal audit service and the costs involved
• Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
• Considering the major findings of internal audit work (and management’s response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
• Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
• Monitoring the effectiveness of internal audit and carrying out an annual review.
9.3 External audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate).
- Discussing and agreeing with the external audit, before the audit commences, the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is a clear policy for the engagement of external auditors to supply non audit services.

9.4 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. The Committee will approve any changes to the provision or delivery of assurance services to the group.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee’s own areas of responsibility. In particular, this will include the Quality & Safety Committee in fulfilling its role in respect of clinical governance, risk management and quality.

In reviewing the work of the Quality & Safety Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also undertake the following governance-related duties:
- Review and approval of the write-off of bad debt
- Monitor compliance with Standing Orders and Prime Financial Duties
- Review (and where required approval) of schedules of losses and special payments
- Review (and where required receive reports on) the appointment of consultancy support
- Monitor compliance with the group’s Registering Interests & Managing Conflicts of Interest Policy and Hospitality Policy, including review of the group’s registers of interest and hospitality register.
- Review of any suspension of Standing Orders
- Approve the group’s Operational Scheme of Delegation
- Approve the group’s arrangements for Business Continuity
- Approve the group’s arrangements in respect of Information Governance
- Approve policies identified as the responsibility of the Audit Committee

9.5 Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect’s standards and shall review the outcomes of work in these areas.

9.6 Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation.

9.7 Financial reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided. The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
• Significant judgements in preparation of the financial statements
• Significant adjustments resulting from the audit
• Letters of representation
• Explanations for significant variances.

9.8 Whistle blowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure such concerns are investigated proportionately and independently.

9.9 Reporting

For the next meeting of the governing body following each meeting of the Committee, the Chair of the Committee will provide a written summary of the key matters covered by the meeting, including any actions or decisions reserved for the governing body.

The minutes of each meeting of the Committee, as agreed at the subsequent meeting, will be presented to the next meeting of the governing body for information.

The Chair of the Committee shall draw to the attention of the governing body any issues that require disclosure to the full governing body, or require executive action.

The Committee will report to the governing body at least annually on its work in support of the annual governance statement, specifically commenting on:

• The fitness for purpose of the assurance framework
• The completeness and ‘embeddedness’ of risk management in the organisation
• The integration of governance arrangements
• The appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

These terms of reference will be reviewed at least annually to ensure they remain fit for purpose.
10. Administrative Support
The Committee shall be supported by the organisation’s governance lead (GL) with appropriate secretarial support (PA). The duties in this respect will include:

- Agreement of agendas with the Chair and attendees (GL)
- Preparation, collation and circulation of papers in good time (GL/PA)
- Ensuring that those invited to the meeting attend (PA)
- Taking the minutes and helping the Chair to prepare reports to the governing body (GL/PA)
- Keeping a record of matters arising and issues to be carried forward (PA)
- Arranging meetings for the Chair—for example, with the internal/external auditors or local counter fraud specialists (PA)
- Maintaining records of members’ appointments and renewal dates etc (GL/PA)
- Advising the Committee on pertinent issues/areas of interest/policy developments (GL)
- Ensuring that action points are taken forward between meetings (GL/PA)
- Ensuring that Committee members receive the development and training they need (GL)
### DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Report:** 8 January 2015  
**Report:** Combined Board Assurance Framework and Risk Register  
**Agenda item No:** 11.3

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Combined Board Assurance Framework and Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Board on the combined Board Assurance Framework (BAF) and Risk Register and present it as at 5th December 2014.</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:              | • Update on combined BAF & Risk Register  
                          | • Summary of risks as at 5th December 2014 presented  
                          | • Details provided of changes made since 7th October 2014 |
| RECOMMENDATION:          | • The Board is asked to receive the report for assurance  
                          | • The Board is asked to approve the closure of risk 21 |
| FINANCIAL IMPLICATIONS:  | None direct. Potential consequence if risks materialise. |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | None |
| ACTION REQUIRED:         | ✔ Decision  
                          | ✔ Approval  
                          | ✔ Assurance |

---
1.0 INTRODUCTION
In accordance with the CCG’s Risk Management Strategy, the combined BAF and Risk Register for those risks scored 16 and over (which comprise the Board Assurance Framework) is presented to the CCG Board. This is based on the position as at 5th December 2014.

The Audit Committee received the overall combined BAF and Risk Register as at 7th October 2014 at its meeting on 13th November.

2.0 COMBINED BOARD ASSURANCE FRAMEWORK (BAF) & RISK REGISTER
Those risks with an initial or residual score (after actions having been taken and controls implemented) of 16 or higher are presented to the Board in detail at Appendix 1. These risks are also summarised in the table below.

<table>
<thead>
<tr>
<th>Risks 16 or higher as at 5th December 2014</th>
<th>Initial Risk</th>
<th>Residual Risk</th>
<th>Accountable Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Failure of a main provider (Dudley Group NHS FT) due to financial pressures will result in inadequate care for the local population (note: this accounts for legacy risk brought forward from Cluster regarding failure to manage demand, creating financial pressures within the local health system).</td>
<td>20</td>
<td>20</td>
<td>Finance &amp; Performance</td>
</tr>
<tr>
<td>10. Failure of the health economy to work together to implement service changes which will adversely impact commissioning and delivery of health services.</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>14. Failure to engage with Public Health, Health and Well Being Board and the Local Authority will limit the effectiveness of health care commissioning.</td>
<td>16</td>
<td>6</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>16. Providers may be reluctant to develop and implement alternative approaches to service delivery</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>17. Tensions between innovation, quality and financial pressures could limit the innovation shown by the CCG</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>19. Failure to ensure meaningful public engagement will prevent effective commissioning and patient centred services</td>
<td>16</td>
<td>8</td>
<td>Communications &amp; Engagement</td>
</tr>
<tr>
<td>21. Challenges to resources within the CSU to deliver a service offering that delivers the CCG’s requirements (particularly quality framework) which underpin the CCG strategy. <strong>PROPOSED THAT THIS RISK BE CLOSED</strong></td>
<td>20</td>
<td>12</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>22. The delivery of efficiency savings could impact the drive for quality in health care</td>
<td>20</td>
<td>20</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>26. Risks to women and neonates as a result of increased volume of patients which has led to inadequate staffing levels at certain times with particular issues around specialist medical staffing and capacity issues in triage area.</td>
<td>16</td>
<td>4</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>34. Being unsighted on significant performance issues identified by the Area Team in relation to primary medical services that could result in removal of GP member from the Performers’ List.</td>
<td>16</td>
<td>6</td>
<td>Primary Care Development</td>
</tr>
<tr>
<td>36. Failure to achieve whole of Quality Premium resulting in lost income and reputational damage.</td>
<td>16</td>
<td>16</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>39. Lack of a systematic approach to ascertaining the quality of the care in our commissioned nursing homes, potentially resulting in harm to vulnerable adults.</td>
<td>16</td>
<td>12</td>
<td>Quality &amp; Safety</td>
</tr>
</tbody>
</table>
### 3.0 RECENT AMENDMENTS TO THE BAF AND RISK REGISTER

The following amendments to risks 16 and over have been made since the Board received the BAF and Risk Register as at 7th October at its meeting on the 13th November:

**New Risks** – No new risks scored 16 and over have been approved for inclusion in the BAF & Risk Register.

**Changes to Risks** – There has only been one change to the risks scored 16 and over since the last Board meeting as detailed below:

**Risk 58 – JAC Electronic System Discharge Letters** – Following further discussion at the November Quality & Safety Committee, both the initial and residual risk scores for this new risk have been increased to 20 from 16. This reflects further concerns around delays in updates to the NHS spine. The Committee also agreed that the electronic discharge letters function should be switched off whilst changes are made to the JAC system and to avoid duplication of processes in GP practices. Dudley Group NHS Foundation Trust (DGH FT) has agreed to this. Manual letters will be couriered to GP practices in addition to sending a letter with the patient.

The DGH FT has now placed this risk on its risk register and the risk is being monitored by its Board. The CCG has oversight of the arrangements the trust is putting place. The medicines management team is continuing to monitor high risk medicines and retrospective and prospective reviews are underway.

The risk continues to be monitored closely by the chair and management lead of the Quality & Safety Committee and the committee receives detailed updates.

**Closed Risks/Risks Proposed for Closure** – The following risk is proposed for closure and approval from the Board is requested:

- **Risk 21** – “Challenges to resources within the CSU to deliver a service offering that delivers the CCG’s requirements (particularly quality framework) which underpin the CCG strategy.” The Quality & Safety Committee recommended that this risk be closed on the basis that it is no longer relevant as the service has been brought in-house. A new risk has been raised around the resources available in the CCG team but the risk score is less than 16.
4.0 RECOMMENDATIONS
- The Board is asked to receive the report for assurance
- The Board is asked to approve the closure of risk 21

5.0 APPENDICES
Appendix 1 – Combined BAF & Risk Register as at 5th December 2014 (risks 16 and over)

M Hartland
Chief Operating and Finance Officer
December 2014
<table>
<thead>
<tr>
<th>ID</th>
<th>Original Date</th>
<th>Last Update</th>
<th>Description</th>
<th>Accountable Officers</th>
<th>Accountability Sponsor</th>
<th>Management Level</th>
<th>Risk Score</th>
<th>Risk Category</th>
<th>Risk Description</th>
<th>Accountable</th>
<th>Owner</th>
<th>Score</th>
<th>Risk Type</th>
<th>Board Reports, Minutes</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1 | 01/05/2013 | 06/11/2014 | 2 Failure to ensure meaningful public engagement and involvement will prevent effective Joint Approach to QIPP | Director of Finance | CFO | Level 2 | 6 | Level 2 | Risk - High to Critical | Risk Manager, Joint Board | Richard Johnson | 6 | 3, 5, 20 | Robust contract management via CDC | 2 | **NOTE: TREND IN RESIDUAL RISK AGAINST PREVIOUS MONTH IS SHOWN**

### Risk Score Calculation

Risk Score = (PxI) = (Probability of Occurrence x Impact of Occurrence)

### Risk Trend

- **Residual Risk**: The remaining risk after control measures have been implemented.
- **Score**: The calculated risk score based on probability and impact.
- **Risk Type**: The level of risk (Level 1, 2, or 3).
- **Board Reports, Minutes**: Reports and minutes related to the risk.
- **Comments**: Additional notes or information about the risk.

### Key Controls

- Ensure effective public engagement and involvement.
- Develop and implement robust contract management systems.
- Regular meetings with CSU.
- Performance report across Business Case Process (CRM and QRM meetings).

### Corporate Objectives

1. Reducing health inequalities
2. Delivering best possible outcomes
3. Improving quality and safety
4. System effectiveness

### Dudley CCG Combined Assurance Framework and Corporate Risk Register 2014/15

- **Jun-13**: Staff & Services now in house.
- **Oct-14**: Staff & Services now in house.
- **2014**: New risk added relating to internal control and audits (DPCC and OAG).
- **2015**: New risk added relating to internal control and audits (DPCC and OAG).

### Risk Management

- **What controls/systems are in place to manage the risk?**
- **What are the factors that could cause the risk to occur?**
- **What are the consequences of the risk?**

### Implementation

- **Key Risk Indicators (KRI)**: Indicators used to monitor the risk.
- **Target Output**: The expected outcome of the risk.
- **Actual Output**: The actual outcome of the risk.

### Conclusion

- **Engaging with Stakeholders**: Active engagement with stakeholders to ensure the risk is effectively managed.
- **Review and Update**: Regular review and update of the risk management plan to ensure it remains relevant and effective.
| ID | Original Date | Last Update | Risk Description | Accountability Committee | Accountability Officer & Designation | Management Level | P | I | T | E | Standardised Risk (P+I) | Commentary | Risk Trend | Internal Assurance | External Assurance | Actions | Timescale | Comments |
|----|---------------|-------------|-----------------|--------------------------|-------------------------------------|------------------|---|---|---|---|----------------------------|-------------|------------|------------------|------------------|--------|----------|----------|---------|
| 32 | 15/09/2015    | 15/09/2015  | The inability of primary care teams to respond promptly to the needs of patients. | CCG                      | Senior Clinical Director             | Director         | 2 | 1 | 4 | 4 | 16 | None = High, 1 = Board meetings. Meet with Members and assures they are performing against QIPP target delivery. | Resolved = no further work required. An action plan is in place | QIPP target reached | | | | | |
| 33 | 06/09/2015    | 15/09/2015  | A lack of a systematic approach to identifying and addressing system failures. | CCG                      | Chief Nurse                    | Director         | 2 | 1 | 4 | 4 | 16 | None = High, 1 = Board meetings. Meet with Members and assures they are performing against QIPP target delivery. | Resolved = no further work required. An action plan is in place | QIPP target reached | | | | | |
| 34 | 16/04/2014    | 16/04/2014  | A lack of a systematic approach to identifying and addressing system failures. | CCG                      | Chief Nurse                    | Director         | 2 | 1 | 4 | 4 | 16 | None = High, 1 = Board meetings. Meet with Members and assures they are performing against QIPP target delivery. | Resolved = no further work required. An action plan is in place | QIPP target reached | | | | | |
DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Report: 8 January 2015
Report: Proposal for devolved commissioning of general medical services
Agenda item No: 11.4

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Proposal for devolved commissioning of general medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To seek approval from the Board for our submission to NHS England to take on devolved commissioning of GP services</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Paul Maubach, Chief Executive Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Daniel King, Head of Membership Development and Primary Care Steve Wellings, Lay Member for Governance</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr Richard Bramble, GP Lay Member, Co Commissioning Task and Finish Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY POINTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Board have previously determined our intention to take on devolved commissioning from NHS England and this has also been endorsed by Dudley Health and Wellbeing Board</td>
</tr>
<tr>
<td>• We established a Task and Finish Group to put together our submission – which has to be sent to NHS England on 9th January 2015.</td>
</tr>
<tr>
<td>• There are a number of potential financial risks which arise due to omissions from the draft financial information that we have received from NHS England</td>
</tr>
<tr>
<td>• The Task and Finish Group has established Terms of Reference for a new Primary Care Commissioning Committee to take on responsibility for commissioning general medical services.</td>
</tr>
<tr>
<td>• The Task and Finish Group has agreed revisions to CCG Constitution</td>
</tr>
<tr>
<td>• We believe our current policy on managing Conflicts of Interest is consistent with the recently released guidance by NHS England.</td>
</tr>
<tr>
<td>• We will revise our conflicts of interest management processes and procedures in light of the statutory guidance on managing conflicts of interest to ensure that it meets the requirements.</td>
</tr>
<tr>
<td>RECOMMENDATION:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>FINANCIAL IMPLICATIONS:</td>
</tr>
<tr>
<td>WHAT ENGAGEMENT HAS TAKEN PLACE:</td>
</tr>
<tr>
<td>ACTION REQUIRED:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
DUDLEY CLINICAL COMMISSIONING GROUP BOARD – 8 JANUARY 2015
PROPOSAL FOR DEVOLVED COMMISSIONING OF GENERAL MEDICAL SERVICES

1.0 Introduction

1.1 Our CCG previously expressed an interest in full devolved commissioning of GP services (excluding the performance management of individual GPs). NHS England have now issued details of the further submission that they require on 9th January 2015 which includes:

- An updated constitution, CCG governance structure and information about our conflicts of interest policy and IG toolkit;
- Details of the financial arrangements;
- A 400-word description of the intended benefits of co-commissioning.

1.2 The CCG Board had already established a Task and Finish Group, chaired by Steve Wellings, to oversee this work.

2.0 Financial Submission

2.1 The proposed financial component of the submission is as follows:

<table>
<thead>
<tr>
<th>Dudley CCG’s Co-commissioning financial submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified delegated budget</td>
</tr>
<tr>
<td>(£’000)</td>
</tr>
<tr>
<td>GP Services</td>
</tr>
<tr>
<td>General Practice - GMS</td>
</tr>
<tr>
<td>General Practice - PMS</td>
</tr>
<tr>
<td>Other list based services (APMS)</td>
</tr>
<tr>
<td>Premises cost reimbursements</td>
</tr>
<tr>
<td>Other premises costs</td>
</tr>
<tr>
<td>Enhanced services</td>
</tr>
<tr>
<td>QOF</td>
</tr>
<tr>
<td>Other GP services</td>
</tr>
<tr>
<td>Primary care NHS property services - GP</td>
</tr>
<tr>
<td>Sub total GP services</td>
</tr>
<tr>
<td>Acute services</td>
</tr>
<tr>
<td>Mental health services</td>
</tr>
<tr>
<td>Community health services</td>
</tr>
<tr>
<td>Primary care services</td>
</tr>
<tr>
<td>Continuing care services</td>
</tr>
<tr>
<td>Other care services</td>
</tr>
<tr>
<td>Sub total CCG programme costs</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

2.2 The financial information included in the above table is that submitted as appendix b as part of the delegated commissioning of Primary Care medical services submission.

2.3 The financial information has been provided by NHS England’s central team and is being reviewed to ensure no cost pressures are being passed onto the CCG if we are successful in our bid for full delegation of Primary Care Commissioning budgets from 1st April 2015. Therefore the submission was made on a number of conditions and will be open to change to reflect ongoing discussions with NHS England to agree the final delegated budgets.
2.4 Dudley CCG's share of the planning framework assumptions is still to be agreed and therefore it is assumed that a share of the Contingency reserve, 15/16 Growth funding and other reserves relevant to primary care such as premises and investments will be in addition to the budget figures being reported in the appendix above. This has been stipulated as one of the underlying conditions of the CCG submission.

2.5 Additionally the Capital funding for primary care is still yet to be finalised and is assumed to be in addition to the figures contained in the table presented.

2.6 The impact to the CCG on the recent PMS reviews relates to a potential release of funding of approximately £1.8m after a 7 year transitional period, this equates to £257,000 per year.

2.7 The transitional funding arrangements agreed by NHS England during the PMS reviews however undermines the CCG's premises strategy and will require additional premises investment funding to be set aside in the 2015/16 financial plan and on-going. This will be subject to agreement of the overall CCG financial plan.

2.8 With regard to administrational support the structures agreed by board effective from 1st October 2014 were based upon the CCG's current functions. The addition of Primary Care Commissioning to the CCG's portfolio will require additional investment in support functions to deliver the services required to support this additional activity. The structure will now be reviewed to identify any additional capacity that may be required to deliver the services required to support our new duties under Primary Care Commissioning. It is expected that this will cost up to £400,000.

2.9 We are in negotiations with NHS England to obtain additional Running Cost allowance resource but this may not be forthcoming. Additional investment may therefore become a cost pressure to the CCG.

3.0 Proposed Benefits of devolved commissioning

3.1 We are ideally placed to take full advantage of the opportunities such a partnership would offer for our patients – including better quality of care, improved outcomes, reduced inequalities, more integrated services and greater patient and public involvement.

3.2 Our Primary Care development strategy was approved at the Sept 2013 Dudley Health and Wellbeing Board (H&WBB); and subsequently, following further consultation resulted in approval at the January 2014 H&WBB for Dudley CCG to approach NHS England to jointly commission GP Services as the best means to delivering the benefits set out in the strategy. This was subsequently incorporated into both the CCG five-year strategy (approved at the March 2014 H&WBB) and the local Area Team strategy.

3.3 The primary care development strategy sets out six priority benefits which devolved commissioning will help us deliver:

   • **Managing workload and improving access**
     We have already conducted a comprehensive audit for improvement with the Primary Care Foundation

   • **Developing integrated locally-based services**
     Primary care is at the heart of our integrated model which we have developed in partnership with Dudley MBC

   • **Managing the shift from secondary to primary care service provision**
     We have achieved our local quality premium targets and are developing a new LTC framework to develop provision in primary care
• **Developing primary care’s role in urgent care**
  We are already implementing a new primary care led urgent care centre

• **Building resilient primary care and supporting practices to thrive**
  We have invested in a single IT system for all practices and established a premises development strategy to underpin delivering primary care at scale

• **Reducing unwarranted variation and rewarding excellence**
  We have already established a comprehensive practice support programme and a new quality performance tool

3.4 Our proposal for full delegated authority is predicated on three areas

1. 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.

2. 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.

3. 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.

3.5 We have well developed plans to redefine and improve the quality standards for primary care, including a 3rd option for re investing PMS premium into a local quality improvement scheme, and we have the engagement infrastructure with our GP membership to support performance improvement in a way that NHS England just does not have the capacity for.

3.6 We have well established patient and public involvement in the commissioning of our services with 42 out of 47 practices with active PPGs and already engage with patients elected from our constituent PPGs in reviewing commissioning priorities.

3.7 We have developed robust governance arrangements that have been independently assessed by the Good Governance Institute: these include a revised and conflict of interest policy, standards of business conduct policy and amended constitution that have been agreed by the Governing Body on the 8th January 2015.

3.8 The ability of the CCG to lead this process of change will be supported through our education, training, mentorship, engagement activities. We have an Organisational Development plan that describes the support we will provide to ensure that our ambitions for devolved commissioning can be realised.

4.0 **Recommendations**

4.1 That the Board

• Approve our proposed submission to NHS England to take on devolved commissioning of GP services.
• Approve the revisions to the Constitution as agreed by the Task and Finish Group. The proposed changes to the group’s constitution are set out in Appendix 1.
• Approve the Terms of Reference for the Primary Care Commissioning Committee as agreed by the Task and Finish Group. The Terms of Reference are set out in Appendix 2.
• Note that NHS England has released new Conflict of Interest guidance in December 2014. The Conflict of Interest guidance is set out in Appendix 3.
• Devolve responsibility to the chief executive officer and chief finance officer; in conjunction with the chair of the Task and Finish group; to negotiate with NHS England on mitigating the risks

Paul Maubach
Chief Executive Officer
December 2014
Appendix 1: Proposed changes to the group’s Constitution December 2014 – IMPACT ASSESSMENT

INTRODUCTION
This paper provides an impact assessment of the changes required to the group’s Constitution (mainly to reflect new primary care co-commissioning arrangements due to be implemented from 1 April 2015). The NHS (Clinical Commissioning Groups) Regulations 2012 sets out the factors which NHS England must consider when reviewing an application for changes to a CCG’s Constitution. A review of the impact of proposed changes has taken place drawing upon independent, external expert advice.

IMPACT ASSESSMENT AGAINST REVIEW CRITERIA

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Impact of changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The constitution meets the requirements of legislation and is otherwise appropriate.</td>
<td>The constitution continues to meet legislative requirements and remains otherwise appropriate after the proposed changes to the Constitution are made. Changes are required to reflect co-commissioning arrangements soon to be put in place.</td>
</tr>
<tr>
<td>Each of the members is a provider of primary medical services.</td>
<td>This is the case</td>
</tr>
<tr>
<td>The area is appropriate (ie that there are no overlapping CCGs and no gaps).</td>
<td>This remains the case</td>
</tr>
<tr>
<td>The proposed Accountable Officer is appropriate</td>
<td>No changes have been made</td>
</tr>
<tr>
<td>The CCG has made appropriate arrangements to ensure it is able to discharge its functions</td>
<td>Proposed changes have a positive impact upon our ability to discharge our functions, particularly in relation to commissioning of primary medical services</td>
</tr>
<tr>
<td>Arrangements are in place to ensure that its governing body is correctly constituted and otherwise appropriate</td>
<td>The proposed addition of a further Clinical Executive (for Systems Redesign) is intended to strengthen the governing body membership</td>
</tr>
<tr>
<td>The likely impact of the requested variation on the persons for whom the CCG has responsibility – so the registered and resident population of the CCG</td>
<td>The changes sought regarding primary medical service commissioning going forward are reflected in the Constitution, and these will benefit our registered and resident population.</td>
</tr>
<tr>
<td>The likely impact on financial allocations of the CCG and any other CCG affected for the financial year in which the variation would take effect</td>
<td>No variation in CCG membership that would require ant financial variation to be enacted</td>
</tr>
<tr>
<td>The likely impact on NHS England’s functions</td>
<td>The proposed changes reflect the delegation of primary care medical services for Dudley, from NHS England to the CCG.</td>
</tr>
</tbody>
</table>

The extent to which the CCG has sought the views of the following, what those views are, and how the CCG has taken them into account:
• any unitary local authority whose area covers the whole or any part of the CCG’s area;
• any other CCG which would be affected; and
• any other person or body which in the CCG’s view might be affected by the variation requested
• patients and the public; what those views are; and how the CCG has taken them into account

The group has sought the views of appropriate stakeholders in relation to changes to primary care medical service commissioning and agreement at our Primary Care Commissioning Task & Finish Group of proposed changes to the Constitution. The Governing Body will adopt the changes to the Constitution at its 8 January 2015 meeting.
CONCLUSION
The proposed changes are required to ensure that our governance arrangements are fit for purpose and properly described within our Constitution. This impact assessment confirms that the proposed changes satisfy the requirements of NHS England to support constitutional changes.
Appendix 2: Primary Care Commissioning Committee Terms of Reference

NHS Dudley
Clinical Commissioning Group

Governing Body’s
Primary Care Commissioning Committee

Terms of Reference

Introduction

1. The Primary Care Commissioning Committee (the ‘Committee’) is established in accordance with paragraph 6.9.3(h) of NHS Dudley Clinical Commissioning Group’s (CCG) constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and will have effect as if incorporated into the constitution. The Committee terms of reference will be reviewed annually. Any changes to the terms of reference will be approved by the Governing Body.

2. The Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

3. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these terms of reference to NHS Dudley CCG. The delegation is set out in Schedule 1.

4. The CCG has established the NHS Dudley CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

5. It is a committee comprising representatives of the following organisations:
   - NHS Dudley CCG; and
   - The Office of Public Health, Dudley Metropolitan Borough Council

Statutory Framework

6. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

7. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

8. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act,
including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

9. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:
   - Duty to have regard to impact on services in certain areas (section 13O);
   - Duty as respects variation in provision of health services (section 13P).

10. The Committee is established as a committee of the Governing Body of NHS Dudley CCG in accordance with Schedule 1A of the “NHS Act”.

11. The CCG (and Committee) is subject to directions made by NHS England or by the Secretary of State for Health.

Role of the Committee

12. The Committee has been established in accordance with the above statutory provisions to enable decisions on the review, planning and procurement of primary care services in Dudley, under delegated authority from NHS England.

13. In performing its role the Committee will exercise its management of the functions in accordance with the agreement between NHS England and NHS Dudley CCG.

14. The functions of the Committee are undertaken in the context of continually improving the quality of care provided to patients within the resources available. This is underpinned by equality of access to services, increased efficiency, productivity, value for money and to minimise bureaucracy.

15. The Committee will have at its heart three key principles, of shared ownership, shared responsibility and shared benefits to create jointly the best healthcare for the registered patients of Dudley.

16. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

17. This includes the following:

   • 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);
   • Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
   • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
   • Decision making on whether to establish new GP practices in an area;
   • Approving practice mergers; and
   • Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).
18. The CCG will also carry out the following activities:

   a) To plan for sustainable primary medical care services in Dudley;
   b) To review primary medical care services in Dudley with the aim of further improving the care provided to patients
   c) To co-ordinate the approach to the commissioning of primary care services generally;
   d) To manage the budget for commissioning of primary medical care services in Dudley.

Geographical Coverage

19. The Committee will be responsible for commissioning primary care medical services coterminous with the geographical boundaries of NHS Dudley CCG.

Partnership

20. The Committee will be responsible for working with other statutory and voluntary agencies to maximise the benefits from investment in primary care services for the people served by the CCG.

Membership

21. The Committee shall consist of those individuals included as Schedule 3. All independent members of the governing body except the Chair of the Audit Committee will be eligible for membership. That is, the lay members for Governance and Quality & Safety and the Secondary Care Specialist Doctor. The Chief Finance Officer, Chief Quality & Nursing Officer, an NHS England Area Team representative and a Public Health representative will also be members of the Committee.

22. The Chair of the Committee will be appointed by the Governing Body. Unless there are any material reasons for not doing so this person will be the Governing Body lay member responsible for governance matters. Where the latter is not the case the material reasons must be documented.

23. The Vice Chair of the Committee will be appointed by the Committee members.

24. Other people that will normally be in attendance (but non-voting) will include a HealthWatch representative, a Health and Wellbeing Board representative, a representative of the Patient Opportunity Panel and an LMC representative.

25. Governing Body elected GPs, Clinical Executives or other GP members will only be in attendance for those agenda items that the Committee membership has deemed appropriate for their input. This will be in an advisory and non-voting capacity. The CCG’s “Registering Interests and Managing Conflicts of Interest Policy” will be observed and complied with at all times.

Meetings and Voting

26. The Committee will operate in accordance with the CCG’s Standing Orders and “Registering Interests and Managing Conflicts of Interest Policy”. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify. The reasons for calling a meeting at short notice will be recorded in the minutes of the meeting.

27. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary.
Quorum

28. A meeting of the Committee will be quorate provided that at least 4 members are present of which:
   • One must be either the Chair or Vice-Chair of the Committee
   • One must be the Chief Finance Officer or Chief Nursing Officer

Frequency of meetings

29. The Committee will formally meet on a monthly basis. There may be a need for the Committee to meet informally from time to time. Any informal meetings will support the work of the Committee and will have no delegated decision-making authority.

30. Initially the Committee will meet in private, reporting in public to the next Governing Body meeting about matters discussed and decisions taken under delegated authority. This is consistent with other committees of the CCG.

Operation of the Committee

31. GPs and patients are represented in the committee through the inclusion of non-voting members from the LMC; Healthwatch and the Patient Opportunity Panel.

32. Members of the Committee have a collective responsibility for the operation of the Committee.

33. The Committee may delegate tasks to such people, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the CCG’s relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

34. The Committee may call experts, as required, to attend meetings and inform discussions.

35. Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Constitution, and comply with Section 8 of the Constitution: Standards of Business Conduct and Managing Conflicts of Interest.

36. Following each meeting, the Committee will present its minutes to the Area Team of NHS England and report to the governing body of the CCG (including the minutes of any sub-committees to which tasks have been delegated under paragraph 32 above).

37. The Committee will also comply with any reporting requirements set out in the CCG Constitution.

Accountability of the Committee

38. The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG’s responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

39. For the avoidance of doubt, the CCG’s Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.
Procurement of Agreed Services

40. The procurement arrangements will be set out in the delegation agreement (Schedule 1 and Schedule 2 to this Terms of Reference) between NHS Dudley CCG and NHS England.

Decisions

41. The Committee will make decisions within the bounds of its terms of reference.

42. The decisions of the Committee shall be binding on NHS England and NHS Dudley CCG where they are within the bounds of the terms of reference.

Review of Committee Effectiveness

43. The Committee will annually self-assess and report to the governing body and NHS England on its performance in the delivery of its objectives.

Review of Terms of Reference

44. The Committee’s terms of reference will be reviewed annually.

45. Any changes to the terms of reference will be approved by the governing body.

[Signature provisions]

Schedule 1 – Delegation

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:

- 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);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

Schedule 2 - Delegated functions-to be added when final arrangement confirmed

Schedule 3 - List of Members

Chief Finance Officer
Chief Quality & Nursing Officer
Lay Member for Governance
Lay Member for Quality & Safety
Secondary Care Specialist Doctor
NHS England Representative
Office of Public Health Dudley MBC representative
MANAGING CONFLICTS OF INTEREST: STATUTORY GUIDANCE FOR CCGs
This statutory guidance sets out how CCGs should manage conflicts of interest. It contains specific provisions in relation to co-commissioning primary care services but the guidance is relevant to CCG responsibilities generally.

Next steps towards primary care co-commissioning (November 2014)

Managing conflicts of interest: statutory guidance for CCGs

CCGs must have regard to this guidance

For CCGs seeking delegated or joint commissioning responsibilities-January 2015.

Julia Simon
Co-commissioning of primary care
Skipton House
London
SE1 6LH
0113 824 8413
www.england.nhs.uk/commissioning.pc-co-comms/
Managing conflicts of interest: statutory guidance for CCGs

Version number: 2
First published: March 2013
Updated: December 2014
Prepared by: Commissioning Strategy Directorate
Classification: OFFICIAL
Contents

Contents ................................................................................................................................. 4
Introduction ............................................................................................................................ 5
Aims of the guidance ............................................................................................................. 7
What are conflicts of interest? .............................................................................................. 8
Legislative framework .......................................................................................................... 10
Principles and general safeguards ..................................................................................... 11
Maintaining a register of interests and a register of decisions ........................................ 13
Procurement issues ............................................................................................................ 15
General considerations and use of the template ............................................................... 16
Designing service requirements .......................................................................................... 17
Governance and decision-making processes ..................................................................... 18
Decision-making when a conflict of interest arises: general approaches ....................... 20
Decision-making when a conflict of interest arises: primary medical care ..................... 22
Record keeping .................................................................................................................... 23
Role of commissioning support ......................................................................................... 24
Role of NHS England .......................................................................................................... 24
Transparency of GP earnings .............................................................................................. 25
Statement of conduct expected of individuals in the CCG ............................................... 25
Annexes ............................................................................................................................... 26
Introduction

“If conflicts of interest are not managed effectively by CCGs, confidence in the probity of commissioning decisions and the integrity of clinicians involved could be seriously undermined. However, with good planning and governance, CCGs should be able to avoid these risks.”

RCGP and NHS Confederation’s briefing paper on managing conflicts of interest
September 2011

1. Clinical commissioning groups (CCGs) manage conflicts of interest as part of their day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, Parliament and tax payers that CCG commissioning decisions are robust, fair, transparent and offer value for money.

2. In May 2014, NHS England offered CCGs the opportunity to take on an increased responsibility for the commissioning of primary care. Those CCGs who opt to do so will be able to commission care for their patients and populations in more coherent and joined-up ways — but they are also exposing themselves to a greater risk of conflicts of interest, both real and perceived, especially if they are opting to take on delegated budgets and functions from NHS England. The details of this policy initiative can be found in Next steps towards primary care co-commissioning.

3. In light of this new development, NHS England, in consultation with national stakeholders, has developed strengthened guidance for the management of conflicts of interest. This guidance builds on and incorporates relevant aspects of existing NHS England guidance, and supersedes the extant NHS England guidance. In other words, this guidance will supplant the previously issued NHS England guidance for CCGs.

4. Equality and diversity are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- Reduce health inequalities in access and outcomes of healthcare services
- Integrate services where this might reduce health inequalities

1 Managing conflicts of interest in clinical commissioning groups: http://www.rcgp.org.uk/~/media/Files/CIRC/Managing_conflicts_of_interest.ashx
- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

5. In its own commissioning decisions and day-to-day business, NHS England is bound by the code set out in the Standards of Business Conduct\(^4\) (and supplemented by the Standing Orders). However, when serving on a joint committee with one or more CCGs, NHS England staff also need to adhere to the guidance set out in this document.

6. This guidance also builds on guidance issued by other national bodies, in particular Monitor’s guidance on the Procurement, Patient Choice and Competition Regulations\(^5\), and guidance issued by GP professional bodies such as the British Medical Association (BMA), the General Medical Council (GMC)\(^6\) and the Royal College of General Practitioners (RCGP).

7. This document is issued as statutory guidance under sections 14O and 14Z8 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) (“the Act”). This means that CCGs must have regard to such guidance with the onus on them to explain any non-adherence.

8. The Act sets out clear requirements for CCGs to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect, or appear to affect, the integrity of the CCG’s decision making processes. These requirements are supplemented by procurement-specific requirements in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

When a CCG is seeking to take on delegated or joint commissioning responsibilities, their audit committee chair and accountable officer will be required to provide direct formal attestation to NHS England that the CCG has complied with this guidance. Subsequently, this attestation will form part of an annual certification. CCG approaches to management of conflicts of interest will also be considered on an ongoing basis as part of CCG assurance. Further details will be issued early in 2015 as to the forms that the initial attestation, the annual certification and ongoing assurance will take.


Aims of the guidance

9. The aims of this guidance are to:

- enable CCGs and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;

- ensure that CCGs operate within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;

- safeguard clinically led commissioning, whilst ensuring objective investment decisions;

- provide the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners’ decisions; and

- uphold the confidence and trust between patients and GP, in the recognition that individual commissioners want to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.

10. In developing this guidance, NHS England has worked closely with NHS Clinical Commissioners, and has engaged with the following stakeholders:

- HealthWatch England;
- Monitor;
- the National Audit Office (in an informal capacity);
- General Practitioners Committee;
- Royal College of General Practitioners;
- General Medical Council; and
- CCG representatives.

11. The guidance incorporates the safeguards for the management of conflicts of interest set out in the previously issued guidance, including:

- the nature of conflicts of interest;
- arrangements for declaring interests;
12. In addition, it sets out:

- the additional factors that CCGs should address when commissioning primary medical care services, either under joint commissioning or delegated commissioning arrangements. This includes the factors CCGs should consider when drawing up plans for services that might be provided by GP practices; and it also includes the necessary aspects of the make-up of the decision-making committee which must have a lay and executive member majority;

- the steps that CCGs should take to assure their Audit Committee, Health and Wellbeing Board(s), NHS England and, where necessary, their auditors, that these services are appropriately commissioned from GP practices;

- procedures for decision-making in cases where all the GPs (or other practice representatives) sitting on a decision-making group have a potential financial interest in the decision;

- arrangements for publishing details of payments to GP practices;

- the potential role of commissioning support services; and

- the supporting role of NHS England.

**What are conflicts of interest?**

13. A conflict of interest occurs where an individual’s ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur.
"For the purposes of Regulation 6 [National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013], a conflict will arise where an individual’s ability to exercise judgement or act in their role in the commissioning of services is impaired or influenced by their interests in the provision of those services."

Monitor - Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)

14. As well as direct financial interests, conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or with which they have an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual’s judgement or actions, or could be perceived to do so. Depending upon the individual circumstances, these factors can all give rise to potential or actual conflicts of interest.

15. For a commissioner, a conflict of interest may therefore arise when their judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider. In the case of a GP involved in commissioning, an obvious example is the award of a new contract to a provider in which the individual GP has a financial stake. However, the same considerations, and the approaches set out in this guidance, apply when deciding whether to extend a contract.

16. NHS Clinical Commissioners has carried out a review of current guidance on conflicts of interest management and, together with the Royal College of General Practitioners and the British Medical Association, has developed a set of key principles that apply in this context. These principles are set out in Annex 1.

17. CCGs should provide clear guidance to their members and employees on what might constitute a conflict of interest, providing examples of situations that may arise. Pertinent issues to bear in mind include:

- a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;

---

7 http://www.legislation.gov.uk/uksi/2013/257/contents/made
8 Following the linguistic convention of the Act, within this guidance ‘member’ generally refers collectively to the members of a CCG, members of its governing body and to members of the committees or sub-committees of the CCG or its governing body. Where a member of a specific body is being referred to, this is made clear within the context. However the appropriate actions for a CCG to take in managing conflicts of interest will vary according to the role of particular members, including their role in influencing decision-making processes.
if in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it; and
for a conflict of interest to exist, financial gain is not necessary.

Legislative framework

18. The starting point for CCGs is section 14O of the Act. This sets out the minimum requirements in terms of what both NHS England and CCGs must do in terms of managing conflicts of interest. For CCGs, this means that they must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
- Have regard to guidance published by NHS England and Monitor in relation to conflicts of interest.

19. Section 14O also imposes a duty on NHS England to publish guidance for CCGs on the discharge of their functions under this section.

20. Section 14O is supplemented by the procurement specific requirements set out in the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. In particular, regulation 6 requires the following:

- CCGs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and
- CCGs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into. (As set out in section 8 below, details of this should also be published by the CCG.)

---

9 http://www.legislation.gov.uk/uksi/2013/500/contents/made
21. An interest is defined for the purposes of regulation 6 as including an interest of the following:

- a member of the commissioner organisation;
- a member of the governing body of the commissioner;
- a member of its committees or sub-committees or committees or sub-committees of its governing body; or
- an employee.

22. As with section 14O, regulation 6 sets out the basic framework within which CCGs must operate. The detailed requirements are set out in the guidance issued by Monitor (Substantive guidance on the Procurement, Patient Choice and Competition Regulations) and, in particular, section 7 of that statutory guidance (included as Annex 6 to this guidance).

23. Monitor’s view is that care must be taken to ensure that conflicts do not affect, or appear to affect, the integrity of the award of commissioning contracts. It is important to ensure that the management of conflicts of interest includes the management of perceived conflicts and that there is an appropriate record of how such issues are managed, particularly in the context of specific procurement decisions. Please see below for further guidance on how such information should be recorded and published. Clear and robust decision-making processes must be put in place to deliver co-commissioning and give the public and providers confidence in the integrity of the decisions made.

24. Finally, as explained above, section 14Z8 gives NHS England the ability to issue statutory guidance regarding commissioning. CCGs must have regard to such guidance with the onus on them to explain any departure from the guidance.

**Principles and general safeguards**

25. The general safeguards that will be needed to manage conflicts of interest will vary to some extent, depending on at what stage in the commissioning cycle decisions are being made. The following principles will need to be integral to the commissioning of all services, including decisions on whether to continue to commission a service, such as by contact extension.

26. Conflicts of interest can be managed by:

- **Doing business appropriately.** If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and
procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

- **Being proactive, not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:
  
  o considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;
  o ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest.

They should establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise;

- **Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest.** Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

- **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome;

- **Openness.** Ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards, in relation to proposed commissioning plans;

- **Responsiveness and best practice.** Ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing ‘buy in’ from local stakeholders to the clinical case for change;

- **Transparency.** Documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident;

- **Securing expert advice.** Ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around formal consultations and for procurement processes;

- **Engaging with providers.** Early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population;
• **Creating clear and transparent commissioning specifications** that reflect the depth of engagement and set out the basis on which any contract will be awarded;

• **Following proper procurement processes and legal arrangements**, including even-handed approaches to providers;

• **Ensuring sound record-keeping**, including up to date registers of interests; and

• **A clear, recognised and easily enacted system for dispute resolution.**

27. These general processes and safeguards should apply at all stages of the commissioning process, but will be particularly important at key decision points, e.g., whether and how to go out to procurement of new or additional services.

28. Particular considerations pertain to CCGs who hold responsibilities for delegated or joint commissioning of primary care. These are set out later in this guidance.

**Maintaining a register of interests and a register of decisions**

**Statutory requirements**

CCGs must maintain one or more registers of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees. CCGs must publish, and make arrangements to ensure that members of the public have access to these registers on request.

CCGs must make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days. CCGs must record the interest in the registers as soon as they become aware of it.

29. CCGs must ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG’s decisions.

30. When entering an interest on its register of interests, the CCG should ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.
31. CCGs will need to ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

**On appointment:**
Applicants for any appointment to the CCG or its governing body should be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests should again be made and recorded.

**At meetings:**
All attendees should be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest should be recorded in minutes of meetings.

**Quarterly:**
CCGs should have systems in place to satisfy themselves on a quarterly basis that their register of interests is accurate and up to date.

**On changing role or responsibility:**
Where an individual changes role or responsibility within a CCG or its governing body, any change to the individual’s interests should be declared.

**On any other change of circumstances:**
Wherever an individual’s circumstances change in a way that affects the individual’s interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.

32. In keeping with the regulations, individuals who have a conflict should declare this as soon as they become aware of it, and in any event not later than 28 days after becoming aware.

33. Whenever interests are declared, they should be reported to the person designated with responsibility for the register of interests (as identified by the CCG or its governing body), who should then update the register accordingly.

**Note:** CCGs will need to set out the process that they will follow if an individual fails to comply with its policies on managing conflicts of interest as set out in its constitution. This could include that individual being removed from office.

See Annexes 2 and 3 for declaration of interests templates

34. CCGs must update their register of interests whenever a new or revised interest is declared.
Register of procurement decisions

35. CCGs also need to maintain a register of procurement decisions\(^\text{10}\) taken, including:

- the details of the decision;
- who was involved in making the decision (i.e. governing body or committee members and others with decision-making responsibility); and
- a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.

36. The register should be updated whenever a procurement decision is taken.

37. In the interests of transparency, the register of interests and the register of decisions will need to be publicly available and easily accessible to patients and the public including by:

- ensuring that both registers are available in a prominent place on the CCG’s website; and
- CCGs making both registers available upon request for inspection at their headquarters.

38. CCGs will also need to consider any particular access needs that their stakeholders have. For example, individuals without internet access could be directed to the local library or invited to view the register(s) at the CCG’s headquarters.

39. The registers will form part of the CCG’s annual accounts and will thus be signed off by external auditors. Further work will be carried out by NHS England on the specific arrangements for this.

Procurement issues

40. CCGs will need to be able to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to procurement.

\(^{10}\) Regulation 9 of the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 requires that a record of procurement decisions is maintained on an NHS England website. The register of decisions described above is intended to supplement this as a more detailed record of the decision.
41. The NHS Act, the Health and Social Care Act ("the HSCA") and associated regulations\(^{11}\) set out the statutory rules with which commissioners are required to comply when procuring and contracting for the provision of clinical services. They need to be considered alongside the Public Contract Regulations\(^{12}\) and, where appropriate, EU procurement rules. Monitor's \textit{Substantive guidance on the Procurement, Patient Choice and Competition Regulations} advises that the requirements within these create a framework for decision making that will assist commissioners to comply with a range of other relevant legislative requirements.

42. The Procurement, Patient Choice and Competition Regulations place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare.

43. The regulations set out that commissioners must:

- manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict; and
- keep appropriate records of how they have managed any conflicts in individual cases.

44. Monitor has a statutory duty under section 78 of the HSCA to produce guidance on compliance with any requirements imposed by the regulations and how it intends to exercise the powers conferred on it by these regulations. Monitor's \textit{Substantive guidance on the Procurement, Patient Choice and Competition Regulations} is the relevant statutory guidance. NHS England works closely with Monitor with regard to these matters and has engaged with Monitor in developing this revised guidance.

### General considerations and use of the template

45. The most obvious area in which conflicts could arise is where a CCG commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the CCG has a financial or other interest. This may most often arise in the context of co-commissioning of primary care, particularly with regard to delegated or joint arrangements, but it will also need to be considered in respect of any commissioning issue where GPs are current or possible providers. CCGs are advised to address the

\(^{11}\) The NHS (Procurement, Patient Choice and Competition) Regulations (No. 2) 2013, issued under section 75 of the HSCA

\(^{12}\) \url{http://www.legislation.gov.uk/uksi/2006/5/contents/made}. It is also important to bear aware that, at the time of issuing this guidance, draft new public contract regulations have been issued \(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356494/Draft_Public_Contracts_Regulations_2015.pdf\). CCGs should ensure that they observe the final version of these when they come into effect.
factors set out in the procurement template at annex 4 when drawing up their plans to commission services where this potentially is the case.

46. CCGs will be expected to make evidence of their deliberations on conflicts publicly available. The template is one way of CCGs evidencing this and will support CCGs in fulfilling their duty in relation to public involvement. It will further provide appropriate assurance:

- that the CCG is seeking and encouraging scrutiny of its decision-making process;
- to Health and Wellbeing Boards, local Healthwatch and to local communities that the proposed service meets local needs and priorities; it will enable them to raise questions if they have concerns about the approach being taken;
- to the audit committee and, where necessary, external auditors, that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts; and
- to NHS England in their role as assurers of the co-commissioning arrangements.

**Designing service requirements**

47. It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient need. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest can occur if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid.

48. Commissioners should seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services.

49. Such engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all.

50. Other steps include:
• advertise the fact that a service design/re-design exercise is taking place widely and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions);

• as the service design develops, engage with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the commissioner’s website or via workshops with interested parties;

• use engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s);

• if appropriate, engage the advice of an independent clinical adviser on the design of the service;

• be transparent about procedures;

• ensure at all stages that potential providers are aware of how the service will be commissioned; and

• maintain commercial confidentiality of information received from providers.

51. When engaging providers on service design, CCGs should bear in mind that they have ultimate responsibility for service design and for selecting the provider of services. Monitor has issued guidance on the use of provider boards in service design.¹³

52. CCGs will also need to ensure that they have systems in place for managing conflicts of interest on an ongoing basis, for instance, by monitoring a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

Governance and decision-making processes

Statutory requirement

CCGs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group’s decision-making.

53. CCGs should review their governance structures for managing conflicts of interest to ensure that they reflect current guidance and are appropriate, particularly in relation to any co-commissioning roles which the CCG proposes to undertake. This should include consideration of the following:

- the make-up of their governing body and committee structures (including, where relevant, the approach set out below for decision-making in delegated or joint commissioning of primary care);

- whether there are sufficient management and internal controls to detect breaches of the CCG’s conflicts of interest policy, including appropriate external oversight and adequate provision for whistleblowing;

- how non-compliance with policies and procedures relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, CCGs should also have procedures in place to review any lessons to be learned from such cases, e.g., by the CCG’s audit committee conducting an incident review;

- reviewing and revising approaches to the CCG’s registers of interest, together with the introduction of a record of decisions, as set out above;

- whether any training or other programmes are required to assist with compliance, including participation in the training offered by NHS England, as set out below.

### Appointing governing body or committee members

54. CCGs will need to consider whether conflicts of interest should exclude individuals from being appointed to the governing body or to a committee or sub-committee of the CCG or governing body. These will need to be considered on a case-by-case basis but the CCG’s constitution should reflect the CCG’s general principles.

55. The CCG will need to assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the governing body might make. This will be particularly relevant for any profit sharing member of any organisation but should also be considered for all employees and especially those operating at senior or governing body level.

56. The CCG will also need to determine the extent of the interest. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the governing body, that individual should not become a member of the governing body.
57. Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a CCG (either as a provider of healthcare or commissioning support services) should not be a member of the governing body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively operate as a governing body member. Specific considerations in relation to delegated or joint commissioning of primary care are set out below.

**Decision-making when a conflict of interest arises: general approaches**

58. Where certain members of a decision-making body (be it the governing body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).

59. The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to conflicts of interest. All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting and published in the registers.

60. CCGs will need to decide in advance who will take the chair’s role for discussions and decision-making in the event that the chair of a meeting is conflicted, or how that will be decided at a meeting where that situation arises.

61. Depending on the nature of the conflict, GPs or other practice representatives could be permitted to join in discussions by the governing body, or such other decision-making body as the CCG has created, about the proposed decision, but should not take part in any vote on the decision.

62. In many cases, e.g., where a limited number of GPs have an interest, it should be straightforward for relevant individuals to be excluded from decision-making. In the context of delegated and joint commissioning, the committee structure set out below in relation to decision making for primary medical care below has been designed to ensure that lay member and executive involvement ensures that robust decisions can be taken even where there are actual or potential conflicts of interest identified.

63. In some cases, all of the GPs or other practice representatives on a decision-making body could have a material interest in a decision, e.g., where the CCG is proposing to commission services on a direct award basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP. Where such a situation relates to primary medical services, the arrangements set out below provide a mechanism for decision-making. (It could also be used for any other CCG
responsibilities where decision-making has been delegated to the committee responsible for primary medical care decision making and where such a conflict of interest arises).

64. For decision making where such a conflict arises and which are not covered by the primary medical care arrangements, CCGs are advised to:

- where the initial responsibility for the decision does not rest with the governing body, refer the decision to the governing body and exclude all GPs or other practice representatives with an interest from the decision-making process, i.e., so that the decision is made only by the non-GP members of the governing body including the lay and executive members and the registered nurse and secondary care doctor;

- where the decision rests with the governing body, consider
  
a) co-opting individuals from a Health and Wellbeing Board or from another CCG onto it (although care should be taken to ensure, particularly if the other CCG is from a nearby locality, that their representatives do not also have a conflict of interest and are not excluded from governing body membership under the relevant regulations. It would also be necessary for the CCG’s constitution to allow such an arrangement); or
  
b) inviting the Health and Wellbeing Board or another CCG to review the proposal – to provide additional scrutiny. Any such arrangements would need to be compliant with the CCG’s constitution; and

- ensure that rules on quoracy (set out in the CCG’s constitution) enable decisions to be made.

65. CCGs will need also to have arrangements in place where more than 50% of the members of a governing body or committee are prevented from taking a decision because of conflicted interests. Decisions could still be made by the remaining members of the governing body or committee (assuming that the meeting remains quorate), especially if constituted with lay, executive or other independent members. CCGs may need to have arrangements to secure additional external involvement in these decisions, perhaps through the involvement of a neighbouring CCG. These arrangements should be set out in the CCG’s constitution.

66. Specific issues and potential approaches in relation to delegated or joint commissioning of primary care are set out below.
Decision-making when a conflict of interest arises: primary medical care

67. Procurement decisions relating to the commissioning of primary medical services should be made by a committee of the CCG’s governing body. This should:

- for joint commissioning take the form of a joint committee established between the CCG (or CCGs) and NHS England; and
- in the case of delegated commissioning, be a committee established by the CCG.

68. In either case, the membership of the committee should be constituted so as to ensure that the majority is held by lay and executive members. In addition to existing CCG lay members, members may be drawn from the CCG’s executive members, except where these members may themselves have a conflict of interest (e.g. if they are GPs or have other conflicts of interest). Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of conflicts of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCG’s secondary care specialist and/or governing body nurse lead).

69. Any conflicts of interest issues would need to be considered on an individual basis. CCGs could also consider reciprocal arrangements with other CCGs in order to support effective clinical representation within the committee. The specific composition is a matter of determination for individual CCGs, subject to the provisions of their constitution. However, the chair and vice-chair must always be lay members of the committee.

Examples

- Regulations require that a CCG governing body has at least 6 members, including its chair and deputy chair. The members must include the CCG’s Accountable Officer, chief financial officer, registered nurse, secondary care specialist and two lay members. The committee with responsibility for commissioning primary care could consist of the above plus GP members. If GP members had to withdraw from decision making for conflict of interest reasons, the committee would still be quorate with a lay and executive majority.

- Alternatively the committee could be made up of the CCG’s two lay members, two additional lay people (not members or employees of the CCG), the chief financial officer, a GP member of the governing body and one other CCG member (executive or otherwise). That would create a committee of seven people and ensure that lay and executive membership was in the majority.
70. A standing invitation must be made to the CCG’s local Healthwatch and Health and Wellbeing Board\(^{14}\) to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

71. As a general rule, meetings of these committees, including the decision-making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public).\(^{15}\)

72. In joint commissioning arrangements, the joint role of NHS England in decision-making will provide an additional safeguard in managing conflicts of interest. However, CCGs should still satisfy themselves that they have appropriate arrangements in place in relation to conflicts of interest with regard to their own role in the decision-making process.

73. CCGs may wish to include decisions on other commissioning issues within the remit of the committee. They also may wish to designate an existing committee to incorporate the above responsibilities within their remit. Where a CCG does this, they should ensure that the membership and chairing arrangements are compliant with the above requirements, or that, when dealing with primary care procurement issues, the participating membership and chairing arrangements are adjusted to meet these requirements. Where an existing committee is so designated, the above requirements on Healthwatch and Health and Wellbeing Board participation and on meeting in public would apply for co-commissioning decisions.

74. The arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

**Record keeping**

75. As set out above a clear record of any conflicts of interest should be kept by the CCG in its register of interests. It must also ensure that it records procurement decisions made, and details of how any conflicts that arose in the context of the decision have been managed. These registers should be available for public inspection as detailed above.

\(^{14}\) Where there is more than one local Healthwatch or Health and Wellbeing Board for a CCG’s area, the CCG should agree with them which should be invited to attend the committee.

\(^{15}\) As per the process for governing body meetings in paragraph 8(3), Schedule 1A of the NHS Act 2006 (as amended). In joint commissioning arrangements, NHS England should follow the process in the Public Bodies (Admission to Meetings) Act 1960.
76. CCGs should ensure that details of all contracts, including the contract value, are published on their website as soon as contracts are agreed. Where CCGs decide to commission services through Any Qualified Provider (AQP), they should publish on their website the type of services they are commissioning and the agreed price for each service. Further, CCGs should ensure that such details are also set out in their annual report. Where services are commissioned through an AQP approach, they should ensure that there is information publicly available about those providers who qualify to provide the service.

Role of commissioning support

77. Commissioning support services (CSSs) can play an important role in helping CCGs decide the most appropriate procurement route, undertake procurements and manage contracts in ways that manage conflicts of interest and preserve integrity of decision-making. CCGs are advised to ensure that any services they commission from CSSs, or that they secure through in-house provision, include this type of support. When using a CSS, CCGs should have systems to assure themselves that a CSS’ business processes are robust and enable the CCG to meet its duties in relation to procurement (including those relating to the management of conflicts of interest).

78. Where a CCG is undertaking procurement, one way to demonstrate that the CCG is acting fairly and transparently is for the CSSs to prepare and present information on bids, including an assessment of whether providers meet pre-qualifying criteria and an assessment of which provider provides best value for money.

79. A CCG cannot, however, lawfully delegate commissioning decisions to an external provider of commissioning support. Although CSSs are likely to play a key role in helping to develop specifications, preparing tender documentation, inviting expressions of interest and inviting tenders, the CCG itself will need to:

- determine and sign off the specification and evaluation criteria;
- decide and sign off decisions on which providers to invite to tender; and
- make final decisions on the selection of the provider.

Role of NHS England

80. NHS England will support CCGs, where necessary, in meeting their duties in relation to managing conflicts of interest. In the context of co-commissioning,

---

16 In doing so, CCGs will need to comply with the requirements of regulation 9 of the Procurement, Patient Choice and Competition Regulations.
NHS England will work with NHS Clinical Commissioners to develop a governance training programme for lay members to assist them with their role as members of joint or delegated commissioning committees. It will be important for CCGs to support their lay members to attend this training.

81. NHS England will also need to assure itself that CCGs are meeting their statutory duties in managing conflicts of interest, including having regard to the statutory guidance published by Monitor and NHS England. Where there are any concerns that a CCG is not meeting these duties, NHS England or Monitor could ask for further information or explanation from the CCG or take such other action as is deemed appropriate.

82. During 2015/16, NHS England will work with a randomly selected sample of a small number of CCGs who have taken on delegated or joint commissioning responsibilities in order to jointly review with them the effectiveness of this guidance and the practical experiences in implementing it. Further details of this process will be issued early in 2015.

**Transparency of GP earnings**

83. As previously advised\(^\text{17}\), in line with commitments on transparency of GP earnings, there will be a new contractual requirement for GP practices to publish on their practice website by 31 March 2016, the mean net earnings of GPs in their practice (to include contractor and salaried GPs) relating to 2014/15 financial year. Alongside the mean figure, practices must publish the number of full and part time GPs associated with the published figure. The figure will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract and which would have previously been commissioned by PCTs. Costs relating to premises will not be included. Fuller details will be included in the implementation guidance for the 2015/16 GP contract, due to be published in February 2015. This is an interim solution until arrangements are finalised for publishing individual GP net earnings in 2016/17.

**Statement of conduct expected of individuals in the CCG**

84. We recommend that CCGs set out in their constitution a statement of the conduct expected of individuals involved in the CCG, e.g. members of the governing body, members of committees and employees, which reflect the safeguards in this guidance. This should reflect the expectations set out in the *Standards for Members of NHS Boards and Clinical Commissioning Groups*.\(^\text{18}\)

See Annex 4 for the procurement template


Annexes

**Annex 1**: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association principles on conflicts of interest

**Annex 2**: Declaration of conflict of interests for bidders/contractors template

**Annex 3**: Declaration of interests for members/employees template

**Annex 4**: Procurement template

**Annex 5**: 10 key questions for commissioners

**Annex 6**: Section 7 of Monitor’s *Substantive Guidance on the Procurement, Patient Choice and Competition Regulations*
Annex 1: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association - Shared principles on conflicts of interest when CCGs are commissioning from member practices

December 2014

1. Introduction

The ability for CCGs to become involved in co-commissioning General Practice and primary care services has the potential to bring many benefits but it also brings with it the potential for perceived and actual conflicts of interest.

NHS Clinical Commissioners (NHSCC), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) have decided to collectively outline their high level starting principles in managing conflicts of interest when CCGs commission from member practices. In large part this has brought together principles articulated in previous lines/guidance/steer from the above organisations and NHS England.

Our principles are applicable to each of the three primary care commissioning models open to CCGs and should not be seen as being directive or be interpreted to mean that we prefer one model over another. These decisions need to remain a local, professionally led, decision.

In developing these shared principles we would like them to sit alongside NHS England’s updated guidance on Managing Conflicts of Interest (December 2014). We are on a journey regarding the co-commissioning of primary care and we will review these principles when needed and as CCGs work through the guidance.

It should be noted that this paper is not designed to address the issue of perceived or actual conflicts of interest in CCGs holding and performance managing GP contracts under co-commissioning arrangements.
2. Our headline shared principles around conflicts of interest

We collectively agree the following in relation to managing conflicts of interest when CCGs commission from member practices:

- If CCGs are doing business properly (needs assessments, consultation mechanisms, commissioning strategies and procurement procedures), then the rationale for what and how they are commissioning is clearer and easier to withstand scrutiny. Decisions regarding resource allocation should be evidence-based, and there should be robust mechanisms to ensure open and transparent decision making.
- CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.
- CCGs should assume that those making commissioning decisions will behave ethically, but individuals may not realise that they are conflicted, or lack awareness of rules and procedures. To mitigate against this, CCGs should ensure that formal prompts, training and checks are implemented to make sure people are complying with the rules. As a rule of thumb, ‘if in doubt, disclose’
- CCGs should anticipate many possible conflicts when electing/selecting individuals to commissioning roles, and where necessary provide commissioners with training to ensure individuals understand and agree in advance how different scenarios will be dealt with.
- It is important to be balanced and proportionate – the purpose of these tools is not to constrain decision-making to be complex or slow.

3. Addressing perceived as well as actual conflicts of interest

Conflicts of interest in the NHS are not new and they are not always avoidable. The documents we reviewed to produce this paper were all clear that the existence of a conflict is not the same as impropriety and focus on how to avoid potential or perceived wrongdoing. Most importantly all acknowledge that perceived wrongdoing can be as detrimental as actual wrongdoing, and risks losing confidence in the probity of CCGs and the integrity of wider clinicians such as GPs in networks/federations, individual practices and partners.

The RCGP/NHS Confederation also notes evidence from the BMJ that people think they aren’t biased by potential conflicts but often are so the common theme is - *if in any doubt it’s important to disclose.*

The RCGP/NHS Confederation and NHS England Guidance identify four types of potential conflict of interest:

- direct financial;
- indirect financial (for example a spouse has a financial interest in a provider);
- non-financial (i.e. reputation) and;
- loyalty (i.e., to professional bodies).

The BMA recognises that for CCGs there will be situations where the best decision for the population and taxpayers is not in the best interest of individual patients (for
whom GPs are required to advocate) and that this can create a perceived conflict. The RCGP/NHS Confederation paper acknowledges this but in terms of the governance when commissioning services.

4. Planning for populations

CCGs must always demonstrate that their commissioned services meet the needs of their local populations, as such CCGs will need to work with their Health and Wellbeing Board’s or other local strategic bodies to ensure there is alignment to local strategic plans.

What is clear from all the existing guidance is that CCGs will need to identify the situations where they are involving their governing body clinicians to strategically plan for their population, and situations where their governing body clinicians need to be separated from procurement, planning and decision-making processes. In the former it is critically important to secure clinical expertise. In the latter, the CCG will need to manage risks around perceived and actual conflicts in relation to the tendering of services.

The BMA outlines that decisions regarding resource allocation should be evidence based, and there should be robust mechanisms to ensure open and transparent decision making. As such, GP involvement must be agreed at each stage of the commissioning and procurement process so that potential risks of conflicts are appropriately defined and mitigated early on.

5. Good practice – for CCGs

All the guidance suggests CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.

The RCGP/NHS Confederation suggests using existing NHS guidance as a starting point:

- Identify potential conflicts
- Declare interests in a register
  Exclude individuals from discussion or decision making if financial interest exceeds 1% equity in the provider organisation - depending on the nature of the discussion (we would also add that includes considering the share of the contract value to make sure there are no loopholes, this might also apply to practices with profit sharing arrangements).
- Continue to manage conflicts post-decision i.e. contract managing (carefully separating overall strategy development for populations from individual procurement processes. The former will be important for CCG lay involvement will be important and include secondary care clinicians and non-executive board nurses, the latter can be managed by managers).

NHS England guidance also says that an individual with a ‘material interest’ in an organisation which provides or is likely to provide significant business should not be member of CCG governing body. The BMA suggests anything above 5% equity is a material interest. The RCGP/NHS Confederation reference this threshold but also
say that something lower than a 1% stake could also be a material interest (if the size of the bid is significant).

Clearly these thresholds need to be considered in relation to individual practices and GP partners once co-commissioning is in place. The perceived risks must be recognised early on and we feel some worked case study examples would be helpful for CCGs as they work through the updated guidance. NHSCC, the RCGP and the BMA are planning to work with NHS England and Monitor to identify these examples.

NHSCC believe that CCG lay members, secondary care doctors and nurses on governing bodies play a vital role in both the design, implementation, leadership and monitoring of conflicts of interest systems and processes. They can provide robust challenge and ultimately a protection for GPs working in both the commissioning and provision of health care. Enabling them to carry out their roles in this regard is vital.

CCGs should also be proactive in their approach when considering conflicts when electing/selecting people, doing a proper induction (i.e. include continuous training and review at both Governing Body and membership (assembly level) and ensuring understanding from individuals, and agree in advance how different scenarios will be dealt with. The CCG should ensure individuals are prompted to declare an interest but not absolved from their responsibility to declare as well. Again, CCG lay members, secondary care doctors and nurse members of the governing body have a critical role in this process, as an independent arbiter and as those providing appropriate scrutiny and oversight.

NHS England’s Code of Conduct guidance specifically explores when CCGs are commissioning services from their own GP member practices. When CCGs are commissioning from federations of practices, the same guidance should apply.

As practical support NHS England have also produced an updated code of conduct template for use when drawing up local plans (see their updated guidance). The template asks a series of questions to provide assurance to Health and Wellbeing Boards that the service meets local needs, and to the Audit Committee or external auditors that robust process was used to commission the service, select the appropriate procurement route and address potential conflicts of interest.

6. Good practice - for individuals

The current guidance suggests that individuals making decisions in CCGs do so with the Nolan principles of public life in mind: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

They also refer to the guidance the General Medical Council (GMC) has produced for doctors including:

- You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.
- If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest informally, and you should be prepared to exclude yourself from decision making.
You must not try to influence patients’ choice of healthcare services to benefit you, someone close to you, or your employer. If you plan to refer a patient for investigation, treatment or care at an organization in.

NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days. More informally, the RCGP/NHS Confederation also suggested the simple ‘Paxman test’ - whether explaining the situation to an investigative reporter/journalist like Jeremy Paxman would cause embarrassment. We think it would be helpful to develop this type of text into a tool for CCGs to use locally.

NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days.

Finally, the BMA suggested that commissioner doctors:

- Declare all interests, even if they are potential conflicts or the individual is unsure whether it counts as a conflict, as soon as possible.
- Update a register of interests every three months.
- Doctors must be familiar with their organisation’s formal guidance.
- If individual doctors have any questions, they should seek advice from colleagues, err on the side of being open about conflicts of interest, or seek external advice from professional or regulatory bodies.

In addition to the above, the RCGP suggests there should also be a requirement to update the register of interests if a material difference arises in the circumstances of an individual at any point.

7. Procurement processes – CCGs and member practices

According to the BMA guidance, when CCGs are procuring community level services, these contracts are often below threshold requiring a competitive tender process.

There are a number of procurement options for CCGs in this situation – for example a few may include:

1. Competitive tender where GP practices are likely to bid
2. AQP where GP providers are likely to be among the qualified providers
3. Single tender from GP practices

From the guidance that exists different questions arise around conflicts of interest when the above procurement processes are used. For example:

- Identifying whether approaches such as AQP are being used with the safeguards to ensure that patients are aware of the choices available to them.
- If single tender is the route used, CCGs will need to demonstrate a few things – depending on the nature of the procurement. For example that there are no other capable providers, why the successful bid was preferred to the others and the impact of disproportionate tendering costs. (Monitor’s procurement guidance provides many useful steers on what CCGs will need to demonstrate)
For primary care co-commissioning, NHSCC believes one of the elements to include on procurement processes are the issues around standing financial orders and schemes of delegation which should not allow CCGs to divide primary care budgets into smaller budgets to circumvent the procurement process. NHSCC’s lay member network will have examples/steer on the correct wording to use from previous local experiences.

Regardless of what the local application is the most important part of this process is transparency. NHS England says to set out the details, including the value of all contracts on the CCG website. If they are using AQP, the types and prices of services they are commissioning should be on the website. All of this information should also be in the CCG’s annual report.

When making procurement decisions, the current guidance suggests that anyone with a perceived or material conflict should be excluded from decision making, either both excluded from voting or from discussion and voting. What is not clear in the guidance is how far back this rule goes – i.e. to the planning stage or just the development of the specification and procurement. CCGs will need to agree that line locally.

According to the reviewed guidance if all GPs and practice representatives due to make a decision are conflicted, then the CCG should be:

- Referring decisions to the governing body, so that lay members / the nurse / the secondary care doctor can make the final decision. However this may weaken GP clinical input into decision making.
- Co-opting individuals from the HWB or another CCG onto the governing body, or invite the HWB / another CCG to review proposal to provide additional scrutiny (these individuals would only be able to participate in decision making if this was set out in the CCG constitution)
- Ensure that quoracy rules enable decisions to be made in this circumstance
- Plan ahead to ensure that agreed processes are followed.
- Use an appropriately constituted arms-length external scrutiny committee to ensure probity (recommended by the BMA)

CCGs can use commissioning support services (CSS) to reduce potential conflicts, for example a CSS can help select the best procurement route and prepare bids etc. However, this cannot completely eliminate the conflict as CCGs are responsible for signing off specification and evaluation criteria, signing off which providers to invite to tender, and making the final decision on the selection of the provider. The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England also suggest any questions about the service going beyond the scope of the GP contract should be discussed with NHS England area teams, clearly that would need review in light of new delegated co-commissioning arrangements.

**Networks and Federations**

We note that the increasing number of GP networks and federations could potentially present an added complication to local procurement processes. If most or all CCG
member practices are part of the local federation, then this could mean that a practice not part of the federation/excluded from a federation may not have the opportunity to win contracts through competitive tender – because the process is more suited to federated organisations. One way to mitigate this would be for the CCG to always design and procure service specifications according to best practice (with openness and transparency), thereby supporting all practices to bid. One area to be careful about is when all the GPs on a governing body have a declared interest in local federations – this makes decision making and accountability complex and the CCG will need to work that through carefully with the input of its lay members and wider clinicians on the governing body. Again, an external scrutiny committee with non-conflicted clinicians such as from a neighbouring CCG may be helpful.

8. Local engagement
Separately, the BMA suggests that LMCs should be involved in CCGs either by formal consultation, a non-voting seat on governing body, or as an observer on governing body. They indicate that a non-voting governing body seat would be the best option. Neither of the other two papers we reviewed address this.

9. Other conflicts of interest issues for consideration

**Personal conflict**
The RCGP/NHS Confederation highlight that in CCG governing bodies a personal conflict can arise because CCG leaders are elected by their constituent GP members. There could be a perception that CCG governing bodies are favouring the most vocal or influential of their GP practice members. Related to this is the potential indirect interest for elected GPs to build a constituency of supporters within their CCG.

The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England guidance suggests that in the case of every GP governing body member being conflicted, the lay members, registered nurse and secondary care doctor make the decision (and that the constitution is written so that this is quorate). This could however mean that decisions would be taken without a GP perspective. Alternatively, CCGs may bring in members of the Health and Wellbeing Board or another CCG to provide oversight, or as the BMA suggests use an external scrutiny committee to make decisions.

**Use of primary care incentive schemes**
In its guidance, the BMA highlights its concerns about the professional and ethical implications of CCGs applying incentive schemes to reduce referral or prescribing activity. The BMA urges any doctor, whether commissioner or provider, to consider the schemes carefully and ensure that scheme is based on clinical evidence. NHSCC suggests that one solution is to ensure the expertise of secondary care clinicians and nurses on governing bodies plays an important part in providing clinical input and lay members can scrutinize commercial/financial and performance data.
The RCGP acknowledge that it is not ethical to under-treat or under-refer for financial gain, but is not unethical to ‘review and reflect’ on variations in referral/prescribing rates and try to reduce referrals in line with evidence or best practice.

**Note to the reader:**

This paper has been developed from a review of three guidance documents and brings together previous lines/guidance from NHSCC, NHS England, the RCGP and the BMA.

- **BMA** ‘Conflicts of interest in the new commissioning system: Doctors in commissioning roles’ April 2013
- **RCGP/NHS Confederation** ‘Managing conflicts of interest in clinical commissioning groups’ September 2011
- **NHS England** ‘Managing conflicts of interest: guidance for clinical commissioning groups.’ March 2013 (includes Commissioning Board Document that precedes it). We have also read across the paper to the new version of this document published December 2014.

NHSCC have also supplemented the principles raised in this paper with some points for steer that have been raised by members of its lay member network.
Annex 2: Declaration of conflict of interests for bidders/contractors template

NHS [geographical reference] Clinical Commissioning Group
Bidders/potential contractors/service providers declaration form: financial and other interests

This form is required to be completed in accordance with the CCG’s Constitution, and s140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance.

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG, or with NHS England in circumstances where the CCG is jointly commissioning the service with, or acting under a delegation from, NHS England. If any assistance is required in order to complete this form, then the Relevant Organisation should contact [specify].
- The completed form should be sent to [specify].
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form and submitting it to [specify].
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the CCG, NHS England and also a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG or NHS England (including the award of a contract) might arise.
- If in doubt as to whether a conflict of interests could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG or NHS England;
- a Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- the Relevant Organisation or any Relevant Person has any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions.

**Declarations:**

<table>
<thead>
<tr>
<th>Name of Relevant Organisation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interests</td>
<td>Details</td>
</tr>
<tr>
<td>Type of Interest</td>
<td>Details</td>
</tr>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions</td>
<td></td>
</tr>
<tr>
<td>Name of Relevant Person</td>
<td>[complete for all Relevant Persons]</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td><strong>Interests</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Interest</strong></td>
<td><strong>Details</strong></td>
</tr>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions</td>
<td></td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:
Annex 3: Declaration of interests for members/employees template

NHS [geographical reference] Clinical Commissioning Group
Member / employee/ governing body member / committee or sub-committee member (including committees and sub-committees of the governing body) [delete as appropriate] declaration form: financial and other interests

This form is required to be completed in accordance with the CCG’s Constitution and section 14O of The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations

Notes:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and/or NHS England and the public for whom they commission services in relation to a decision to be made by the CCG and/or NHS England or which may affect or appear to affect the integrity of the award of any contract by the CCG and/or NHS England.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact [specify].
- The completed form should be sent by both email and signed hard copy to [specify].
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published [specify how, or how otherwise made available to the public and whether there will be any circumstances where information will be redacted].
- Any individual – and in particular members and employees of the CCG and/or NHS England- must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and/or NHS England and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:
- roles and responsibilities held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
• ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England
• shareholdings (more than 5%) of companies in the field of health and social care;
• a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
• any connection with a voluntary or other organisation (public or private) contracting for NHS services;
• research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
• any other role or relationship which the public could perceive would impair or otherwise influence the individual’s judgment or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

**Declaration:**

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position within or relationship with, the CCG or NHS England:</td>
<td></td>
</tr>
</tbody>
</table>

### Interests

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
<th>Personal interest or that of a family member, close friend or other acquaintance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles and responsibilities held within member practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directorships, including non-executive directorships, held in private companies or PLCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shareholdings (more than 5%) of companies in the field of health and social care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any connection with a voluntary or other organisation contracting for NHS services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research funding/grants that may be received by the individual or any organisation they have an interest or role in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Other specific interests?]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the CCG and/or with NHS England.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

Signed:

Date:
Annex 4: Procurement template

Template
[To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest]

NHS [geographical reference] Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment/Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG’s proposed commissioning priorities? How does it comply with the CCG’s commissioning obligations?</td>
<td></td>
</tr>
<tr>
<td>How have you involved the public in the decision to commission this service?</td>
<td></td>
</tr>
<tr>
<td>What range of health professionals have been involved in designing the proposed service?</td>
<td></td>
</tr>
<tr>
<td>What range of potential providers have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?</td>
<td></td>
</tr>
<tr>
<td>What are the proposals for monitoring the quality of the service?</td>
<td></td>
</tr>
<tr>
<td>What systems will there be to monitor and publish data on referral patterns?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?</td>
<td></td>
</tr>
<tr>
<td>Why have you chosen this procurement route?(^{19})</td>
<td></td>
</tr>
<tr>
<td>What additional external involvement will there be in scrutinising the proposed decisions?</td>
<td></td>
</tr>
<tr>
<td>How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?</td>
<td></td>
</tr>
<tr>
<td>Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)</td>
<td>How have you determined a fair price for the service?</td>
</tr>
<tr>
<td>Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers</td>
<td>How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?</td>
</tr>
<tr>
<td>Additional questions for proposed direct awards to GP providers</td>
<td></td>
</tr>
<tr>
<td>What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?</td>
<td></td>
</tr>
<tr>
<td>In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?</td>
<td></td>
</tr>
</tbody>
</table>

\(^{19}\) Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?
Annex 5: 10 key questions

These questions are provided as a prompt to CCGs in considering key issues when reviewing their current arrangements for managing conflicts of interest.

1. Do you have a process to identify, manage and record potential (real or perceived) conflicts of interest that could affect, or appear to affect, the integrity of an award of a contract, including those that could arise in relation to co-commissioning of primary care?

2. How will the CCG make its final commissioning decisions in ways that preserve the integrity of the decision-making process?

3. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers, including an explanation of how the conflict has been managed?

4. Have you made arrangements to make registers of interest accessible to the public?

5. Have you set out how you will ensure fair, open and transparent decisions about:
   - priorities for investment in new services
   - the specification of services and outcomes
   - the choice of procurement route?

6. How will you involve patients, and the public, and work with your partners on the Health and Wellbeing Boards and providers (old and new) in informing these decisions?

7. What process will you use to resolve disputes with potential providers?

8. Have you summarised your intended approach in your constitution, and thought through how your governing body will be empowered to oversee these systems and processes – both how they will be put in place and how they will be implemented?

9. What systems will there be to monitor the patterns of decision making and how any conflicts of interest were managed?

10. Has your decision making body identified and documented in the constitution the process for remaining quorate where multiple members are conflicted?
Annex 6: Section 7 of Monitor’s Substantive Guidance on the Procurement, Patient Choice and Competition Regulations

7.1 Introduction

This section provides guidance for commissioners on handling conflicts of interest. Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations prohibits commissioners from awarding a contract for NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests in providing them affect, or appear to affect, the integrity of the award of that contract.

Regulation 6(2) requires commissioners to maintain a record of how any conflicts that have arisen have been managed.

S.14O of the National Health Service Act 2006 includes further requirements relating to conflicts of interest. Guidance on how to comply with these requirements (including managing conflicts of interest) has been published by NHS England and is available on NHS England’s website.

Members of commissioning organisations that are registered doctors will also need to ensure that they comply with their professional obligations, including those relating to conflicts of interest. These are described in the General Medical Council’s guidance, Good Medical Practice and Financial and commercial arrangements and conflicts of interest. These are available on the General Medical Council’s website.

7.2 What is a conflict?

Broadly, a conflict of interest is a situation where an individual’s ability to exercise judgment or act in one role is/could be impaired or influenced by that individual’s involvement in another role.

For the purposes of Regulation 6, a conflict will arise where an individual’s ability to exercise judgment or act in their role in the commissioning of services is impaired or influenced by their interests in the provision of those services.

7.3 What constitutes an interest?

Regulation 6 of the Procurement, Patient Choice and Competition Regulations makes it clear that an interest includes an interest of:

- a member of the commissioner;
- a member of the governing body of the commissioner;
- a member of the commissioner’s committees or sub-committees, or committees or sub-committees of its governing body; or
- an employee.

Other interests that might give rise to a conflict include the interests of any individuals or organisations providing commissioning support to the commissioner, such as CSUs, who may be in a position to influence the decisions reached by the commissioner as a result of their role.

### 7.4 What interests in the provision of services may conflict with the interests in commissioning them?

A range of interests in the provision of services may give rise to a conflict with the interests in commissioning them, including:

- **Direct financial interest** - for example, a member of a CCG or NHS England who has a financial interest in a provider that is interested in providing the services being commissioned or that has an interest in other competing providers not being awarded a contract to provide those services. Financial interests will include, for example, being a shareholder, director, partner or employee of a provider, acting as a consultant for a provider, being in receipt of a grant from a provider and having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

- **Indirect financial interest** - for example, a member of a CCG or NHS England whose spouse has a financial interest in a provider that may be affected by a decision to reconfigure services. Whether an interest held by another person gives rise to a conflict of interests will depend on the nature of the relationship between that person and the member of the CCG or NHS England. Depending on the circumstances, interests held by a range of individuals could give rise to a conflict including, for example, the interests of a parent, child, sibling, friend or business partner.

- **Non-financial or personal interests** - for example, a member of a CCG or NHS England whose reputation or standing as a practitioner may be affected by a decision to award a contract for services or who is an advocate or representative for a particular group of patients.

- **Professional duties or responsibilities**. For example, a member of a CCG who has an interest in the award of a contract for services because of the interests of a particular patient at that member’s practice.

Commissioners will also need to consider whether any previous or prospective roles or relationships may give rise to a conflict of interest. A conflict of interest may arise, for example, where a person has an expectation of future work or employment with a provider that is bidding for a contract.
7.5 Conflicts that affect or appear to affect the integrity of an award

Even if a conflict of interest does not actually affect the integrity of a contract award, a conflict of interest that appears to do so can damage a commissioner’s reputation and public confidence in the NHS. Regulation 6 of the Procurement, Patient Choice and Competition Regulations therefore also prohibits commissioners from awarding contracts in these circumstances.

As well as affecting the decision to award a contract and to which provider, a conflict of interest may affect a variety of decisions made by a commissioner during the commissioning cycle in a way that affects, or appears to affect, the integrity of a contract award decision taken at a later point in time. For example, conflicts of interest might affect the prioritisation of services to be procured, the assessment of patients’ needs, the decision about what services to procure, the service specification/design, the determination of qualification criteria, as well as the award decision itself.

Conflicts might arise in many different situations. A conflict of interest might arise, for example where the spouse of a staff member of a local area team at NHS England is employed by a provider that is bidding for a contract. A conflict could also arise where a CCG is deciding whether to procure particular services from GP practices in the area or from a wider pool of providers, or where it is deciding whether to commission services that would reduce demand for services provided by GP practices under the NHS General Medical Services contract.

Depending on the circumstances of the case, there may be a number of different ways of managing a conflict or potential conflict of interest in order to prevent that conflict affecting or appearing to affect the integrity of the award of the contract.

It will often be straightforward to exclude a conflicted individual from taking part in decisions or activities where that individual’s involvement might affect or appear to affect the integrity of the award of a contract. The commissioner will need to consider whether in the circumstances of the case it would be appropriate to exclude the individual from involvement in any meetings or activities in the lead up to the award of a contract in relation to which the individual is conflicted, or whether it would be appropriate for the individual concerned to attend meetings and take part in discussions, having declared an interest, but not to take part in any decision-making (not having a vote in relation to relevant decisions). It is difficult to envisage circumstances where it would be appropriate for an individual with a material conflict of interest to vote on relevant decisions.

Where it is not practicable to manage a conflict by simply excluding the individual concerned from taking part in relevant decisions or activities, for example because of the number of conflicted individuals, the commissioner will need to consider alternative ways of managing the conflict. For example, depending on the circumstances of the case, it may be possible for a CCG to manage a conflict affecting a substantial proportion of its members by:
• involving third parties who are not conflicted in the decision-making by the CCG, such as out-of-area GPs, other clinicians with relevant experience, individuals from a Health and Wellbeing Board or independent lay persons; or

• inviting third parties who are not conflicted to review decisions throughout the process to provide ongoing scrutiny, for example the Health and Wellbeing Board or another CCG.

Whether a conflict of interests affects or appears to affect the integrity of a contract award (such that the commissioner may not award the contract) will depend on the circumstances of the case. The list of factors in the box below is not exhaustive, but covers some of the core factors that a commissioner is likely to need to consider in deciding whether it is appropriate to award a contract. See box below.

Conflicts that affect or appear to affect the integrity of a contract award:
Examples of factors that a commissioner is likely to need to consider in deciding whether or not it can award a contract:

• the nature of the individual’s interest in the provision of services, including whether the interest is direct or indirect, financial or personal, and the magnitude of any interest;

• whether and how the interest is declared, including at what stage in the process and to whom;

• the extent of the individual’s involvement in the procurement process, including, for example, whether the individual has had a significant influence on service design/specification, has played a key role in setting award criteria, has been involved in deliberations about which provider or providers to award the contract to and/or has voted on the decision to award the contract; and

• what steps have been taken to manage the actual or potential conflict (or example, via an external review of the decisions taken throughout the procurement process, including whether a conflict of a member of a CCG has been dealt with in accordance with the CCG’s constitution).

7.6 Recording how conflicts have been managed

Regulation 6 of the Procurement, Patient Choice and Competition Regulations also requires commissioners to maintain a record of how any conflicts that have arisen have been managed.

Commissioners will need to include all relevant information to demonstrate that the conflict was appropriately managed. See box below.
Examples of what information a record might contain:
Commissioners might include the following information in a record of how a conflict of interest has been managed:

- the nature of the individual’s interest in the provision of services, including whether the interest is direct or indirect, financial or personal, and the magnitude of any interest;

- whether and how the interest is declared, including at what stage in the process and to whom;

- the extent of the individual’s involvement in the procurement process, including, for example, whether the individual has had a significant influence on service design/specification, has played a key role in setting award criteria, has been involved in deliberations about which provider or providers to award the contract to and/or has voted on the decision to award the contract; and

- what steps have been taken to manage the actual or potential conflict (or example, via an external review of the decisions taken throughout the procurement process, including whether a conflict of a member of a CCG has been dealt with in accordance with the CCG’s constitution).
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Report:** 8 January 2015  
**Report:** Finance and Performance Committee Report  
**Agenda item No:** 12.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Finance and Performance Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of key issues discussed at the Finance and Performance Committee on 27 November 2014 and 18 December 2014</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 J Rathore, Clinical Executive for Finance and Performance</td>
</tr>
</tbody>
</table>

**KEY POINTS:**
- CCG expects to meet all its statutory financial duties by 31 March 2015.
- CCG expects to achieve its control total of £5.4m as agreed with the Area Team, which reflects the carry forward of the surplus achieved in 2013/14.
- CCG is achieving all its Area Team assurance indicators.
- Shortfall identified against the QIPP target in 2014/15 which will increase the value of the target in 2015/16.
- Actions agreed to address the increased QIPP target in 2015/16
- Actions agreed to address the over-performance at Dudley Group Foundation Trust
- Action agreed to meet the 18 weeks from Referral to Treatment target in certain specialties.
- Action agreed to achieve the diagnostic waiting time target.
- Outcomes of self-assessment of Committee effectiveness and processes agreed.
- Performance exceptions noted and discussed
- Scorecard report presented and the position of practices against key indicators noted.
- Reports from IT Strategy Group and Estates Strategy Group received.

**RECOMMENDATION:**
The Board is asked to approve the report

**FINANCIAL IMPLICATIONS:**
As described in the report.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
None

**ACTION REQUIRED:**
- Decision
  - Approval
  - Assurance
1.0 INTRODUCTION
The report summarises the key issues discussed by the Finance and Performance Committee at its meetings on 27 November 2014 and 18 December 2014.

The following items are indicators 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. The finance indicators summarise the CCG’s key financial indicators and performance against its statutory financial duties to 30 November 2014 as reported to Committee on 18 December 2014.

2.0 KEY INDICATOR SUMMARY
The table below identifies key financial indicators as at 30 November 2014.

<table>
<thead>
<tr>
<th>Performance Item</th>
<th>Plan £000’s</th>
<th>Year To Date £000’s</th>
<th>Forecast Variance £000’s</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Financial Duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve Revenue Resource Limit Control Total</td>
<td>(5,400)</td>
<td>(3,186)</td>
<td>(5,400)</td>
<td></td>
</tr>
<tr>
<td>Capital Resource Limit</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Running Costs</td>
<td>7,647</td>
<td>(452)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cash Limit</td>
<td>0</td>
<td>74</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code - NHS</td>
<td>95%</td>
<td>99.56%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code - Non NHS</td>
<td>95%</td>
<td>98.95%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>LAT Assurance Indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underlying Recurrent Surplus</td>
<td>(11,937)</td>
<td>(7,440)</td>
<td>(11,160)</td>
<td></td>
</tr>
<tr>
<td>Programme Surplus - Year to date performance</td>
<td>(2,731)</td>
<td>(2,734)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Cost Surplus - Year to date performance</td>
<td>(448)</td>
<td>(452)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Surplus - Full year forecast</td>
<td>(5,400)</td>
<td>(5,400)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Cost Surplus - Full year forecast</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of 2% Non Recurrent funds within agreed processes</td>
<td>Yes</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>QIPP - Year to date delivery</td>
<td>(2,713)</td>
<td>(3,493)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QIPP - Full year forecast</td>
<td>(7,166)</td>
<td>(7,166)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity trends - Year to date (IP/ OP / A&amp;E)</td>
<td>379</td>
<td>378</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity trends - Full year forecast (IP/ OP/ A&amp;E)</td>
<td>569</td>
<td>567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear identification of risks against financial delivery and mitigations</td>
<td>Met in full</td>
<td>Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal &amp; External Audit Opinions and an assessment of the timeliness and quality of returns</td>
<td></td>
<td>There were no exceptions to report this month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance Sheet indicators including cash management and BPCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Resource Limit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>170,398</td>
<td>1,887</td>
<td>2,859</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>80,304</td>
<td>2,406</td>
<td>3,610</td>
<td></td>
</tr>
<tr>
<td>Preventative Care</td>
<td>37,900</td>
<td>524</td>
<td>320</td>
<td></td>
</tr>
<tr>
<td>Reablement</td>
<td>22,277</td>
<td>(8)</td>
<td>(255)</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>7,647</td>
<td>(452)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Non Recurrent</td>
<td>7,439</td>
<td>(830)</td>
<td>(592)</td>
<td></td>
</tr>
<tr>
<td>Reserves including Surplus</td>
<td>13,582</td>
<td>(5,140)</td>
<td>(9,340)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>45,981</td>
<td>(1,573)</td>
<td>(2,002)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>385,526</td>
<td>(3,186)</td>
<td>(5,400)</td>
<td></td>
</tr>
</tbody>
</table>
3.0 EXCEPTION REPORTING

3.1 Statutory Financial Duties
The CCG is on target to achieve all statutory duties by 31 March 2015 and is expected to achieve its control total of £5.4m at the year-end as agreed with the Area Team.

The CCG achieved its financial performance target of ensuring the month end cash balance was within 5% of the cash drawn down from NHS England (NHSE).

3.2 Area Team Assurance Indicators
The CCG is currently achieving all its Area Team Assurance indicators.

3.3 Local Indicators
Urgent care was reported as red mainly due to over-performance in emergency activity and the purchase of additional walk in centre activity.

Kingswinford, Amblecote and Lye Locality and Halesowen and Quality Bank Locality reported an over-performance and therefore rated red. The main reason for the over-performance was an increase in urgent care costs. Sedgley, Coseley and Gornal also reported a small overspend and rated amber.

4.0 ITEMS DISCUSSED – FINANCE

4.1 Revenue Resource Limit
At the end of November 2014 the CCG’s commissioning budget was £385,526,481.

4.2 Capital Resource Limit
The CCG has submitted a nil return for capital plans and therefore is not planning to receive a capital allocation for 2014/15.

4.3 Running Costs
The CCG has a running cost allowance of £7,647,000 for 2014/15 and reported a year to date underspend of £452,000. It is expected that the full running cost allowance will be utilised by the end of the year.

<table>
<thead>
<tr>
<th>Performance Item</th>
<th>Plan £000's</th>
<th>Year To Date £000's</th>
<th>Forecast Variance £000's</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Locality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudley &amp; Netherton</td>
<td>34,297</td>
<td>(155)</td>
<td>(310)</td>
<td></td>
</tr>
<tr>
<td>Sedgley, Coseley &amp; Gornal</td>
<td>25,875</td>
<td>300</td>
<td>600</td>
<td></td>
</tr>
<tr>
<td>Halesowen &amp; Quarry Bank</td>
<td>32,223</td>
<td>167</td>
<td>334</td>
<td></td>
</tr>
<tr>
<td>Stourbridge, Wollescote &amp; Lye</td>
<td>30,867</td>
<td>(162)</td>
<td>(324)</td>
<td></td>
</tr>
<tr>
<td>Kingswinford, Amblecote &amp; Brierley Hill</td>
<td>41,366</td>
<td>1,832</td>
<td>3,664</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>164,628</td>
<td>4,195</td>
<td>4,943</td>
<td></td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Activity</td>
<td>34</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Elective Activity</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Activity</td>
<td>73</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Outpatient Activity</td>
<td>424</td>
<td>(6)</td>
<td>(8)</td>
<td></td>
</tr>
<tr>
<td>Total Activity</td>
<td>569</td>
<td>(1)</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td><strong>Memorandum Items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue Resource Limit</td>
<td>385,526</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movement in Revenue Resource Limit since last month</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.4 Cash Limit
The CCG is required to meet two targets in relation to cash management - to remain within the allocated cash limit and to ensure that monthly cash balances are within 5% of the cash requested from NHSE. The CCG achieved its cash target. The target reduces to 1.25% from January 2015.

4.5 Better Payment Practice Code
Compliance with the prompt payment code requires the CCG to pay all NHS and non-NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The CCG has a target of 95% for these transactions, which are both being achieved as described below:

4.5.1 Better Payment Practice Code – NHS
At the end of November 2014 the CCG’s cumulative performance was 99.56%.

4.5.2 Better Payment Practice Code – non-NHS
At the end of November 2014 the CCG’s cumulative performance was 98.95%.

4.6 QIPP 2014/15
The QIPP target for 2014/15 is £7.166m. A shortfall of £2.0m has been identified against schemes in the plan, which is being covered non-recurrently by releasing funding from the QIPP reserve. The QIPP position for next year is described in section 5 of this report.

4.7 Statement of Financial Position
The Committee noted the statement of the financial position of the CCG at the end of November 2014. No areas of concern were reported.

4.8 Workforce
An establishment register has been constructed with employees and contracted staff reported against the funded established posts. Workforce issues pertinent to provider organisations are managed by the Quality and Safety Committee.

4.9 Localities
Three of the localities – Sedgley, Coseley and Gornal, Halesowen and Quarry Bank and Kingswinford, Amblecote and Brierley Hill are currently overspent.

The latter was significantly overspent and was mainly due to an increase in urgent care costs. At the last locality meeting it received a presentation highlighting the main areas causing the overspend. The finance team is now working to produce further information to allow practices to investigate activity increases down to patient level.

4.10 Area Team Assurance
The CCG has achieved green ratings for all Area Team financial indicators for quarters 1, 2 and 3 of 2014/15.

4.11 Risks
The main risks facing the CCG financial position relate to further slippage in the QIPP programme; cost pressure relating to NHS 111; increased prescribing costs and over-performance on acute service level agreements. As the year progresses, these risks reduce. None of the risks are expected to have a material impact on the CCG meeting its financial duties should they arise.

4.12 Non-Recurrent Spend/Balance of Reserves
£1.5m of the uncommitted non-recurrent spend plans held in contingency have been released this month to offset the increase in acute over-performance. The balance is being held in a contingency reserve should further slippage against the QIPP plans or deterioration in the acute over-performance materialise over the remaining months.
5.0 QIPP 2015/16
The 2015/16 QIPP target has increased from £9.2m to £11.2m because of the shortfall in the achievement of the 2014/15 target. The Committee considered and agreed recommendations for addressing the QIPP target in 2015/16. These included:-

• to develop a QIPP programme for 2015/16 based on significant service change delivering quality and financial improvements, but limit the number of initiatives to those that deliver the most benefit;
• to reduce the value of reserves to mitigate against an increasing savings target;
• to develop a prioritisation tool to aid the re-commissioning and decommissioning of services;
• to adopt an ‘invest to save’ principle for services developments and business cases.

The detail of the above will be presented to the Board prior to agreeing the financial plan for 2015/16. The importance of achieving the QIPP target must be emphasised to Board; however if we wish to deliver the vision outlined in our Strategic Plan.

6.0 PRESCRIBING AND MEDICINES MANAGEMENT REPORT
A report on the current prescribing position was received for information.

The prescribing overspend in the Kingswinford, Amblecote and Brierley Hill locality was discussed and the prescribing team had been asked to look to review this further.

7.0 OVER-PERFORMANCE AT DUDLEY GROUP FOUNDATION TRUST (DGFT)
The Committee considered a report on the main areas of over-performance at DGFT. Actions to address the over-performance were discussed and agreed.

8.0 SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS AND PROCEDURES
The Committee considered the outcomes of the self-assessment of the Committee effectiveness and processes, which was positive. The review identified areas for the Committee to focus, which would be developed into an action plan.

9.0 COMBINED BOARD ASSURANCE FRAMEWORK AND RISK REGISTER
The risks assigned to the Committee were reviewed and accepted. No new risks were added to the register.

10.0 REFERRAL TO TREATMENT PERFORMANCE AT DUDLEY GROUP FOUNDATION TRUST
The Committee considered a report regarding DGFT’s performance in order to achieve the 18 weeks from referral to treatment target. The acute trust achieved the aggregate targets to date, but at specialty level failed the target in ophthalmology, trauma and orthopaedics and urology. The CCG would continue to monitor the position. It was agreed that additional activity would be purchased from the independent sector.

11.0 DIAGNOSTIC WAITS AT DUDLEY GROUP FOUNDATION TRUST
The Committee considered a report on performance issues at DGFT for CT scans, non-obstetric ultrasound, sigmoidoscopy, colonoscopy and gastroscopy. The CCG would continue to monitor the position. For the treatments where DGFT was not achieving the target it was agreed that additional activity would be purchased from the independent sector.

12.0 KEY INDICATOR SUMMARY – PERFORMANCE
The table below identifies key performance indicators as at September 2014, (October where available) the last period for which validated data has been received.
### Dudley Group of Hospitals Foundation Trust

#### National Quality Requirements

| Indicator | Target/Threshold | Apr | May | Jun | Jul | Aug | Sep | Oct | YTD | RAG |
|-----------|------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| MRSA Acute | <=48 Annum       | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |
| Clostridium difficile Acute | <=48 Annum | 3 | 1 | 1 | 2 | 6 | 0 | 4 | 21 | | |
| RTT waits over 32 weeks (Incomplete) | | 0 | 0 | 0 | 1 | 1 | 2 | 3 | 1 | 8 | |
| Ambulance Handover between 30mins & 60mins | Target 15m, Threshold <=30m | 277 | 277 | 386 | 207 | 195 | 305 | 274 | | |
| Ambulance Handover > 60mins | Target 15m, Threshold <=60m | 29 | 28 | 24 | 9 | 7 | 13 | 35 | 154 | |
| Trolley Waits in A&E | Any trolley wait > 12 hours | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Cancelled Operations (Urgent) | Number of urgent operations cancelled for a second time | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Publication of Formulary | | Yes/No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| Duty of Candour | Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident (as per guidance) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |

#### Operational Standards

| Indicator | Target/Threshold | Apr | May | Jun | Jul | Aug | Sep | Oct | YTD | RAG |
|-----------|------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 18 Weeks RTT (Admitted) | 90% | 90.13% | 90.04% | 90.06% | 90.03% | 90.31% | 91.73% | 92.08% | 90.86% | |
| 18 Weeks RTT (Non Admitted) | 95% | 99.22% | 99.17% | 99.21% | 99.19% | 98.97% | 99.10% | 99.88% | 99.10% | |
| 18 Weeks RTT (Incomplete) | 92% | 93.00% | 95.60% | 95.20% | 96.00% | 95.93% | 95.63% | 95.86% | 94.67% | |
| Diagnostic Waits | 99% | 98.78% | 98.93% | 97.38% | 97.82% | 95.46% | 94.74% | 97.78% | 97.28% | |
| A&E 4 Hour Wait | 95% | 91.4% | 91.4% | 93.4% | 94.6% | 92.7% | 94.20% | 93.30% | 94.17% | |
| Cancer 2 Week Waits | 91% | 97.7% | 97.8% | 95.3% | 96.27% | 96.8% | 95.20% | 95.41% | 96.38% | |
| Breast Symptoms 2 Week Waits | 91% | 96.8% | 97.2% | 97.3% | 93.45% | 95.9% | 95.16% | 96.13% | 96.08% | |
| Cancer 31 day Waits | 96% | 100% | 100% | 100% | 99% | 100% | 100% | 99% | 95.28% | 99.40% |
| 33 day - Suspect surgeon surgery | 94% | 100% | 94.7% | 100% | 100% | 100% | 100% | 100% | 100.00% | 99% |
| 31 day Anti Cancer Drug Regimens | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.00% | 100% |
| 31 day - Radiotherapy | 94% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| 62 day - RTT Cancer | 85% | 92.6% | 87.4% | 87.3% | 86.8% | 87.7% | 88.3% | 87.50% | 88.20% | |
| 62 day - RTT (Screening) | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 95.24% | 90.3% |
| 62 day - RTT (Upgraded/Priority) | 85% | 99.1% | 95.8% | 100% | 99% | 100% | 98.3% | 97.73% | 98.52% | |
| MSA Breaches | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Cancellations of Operations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

#### Dudley & Walsall Mental Health

| Indicator | Target/Threshold | Apr | May | Jun | Jul | Aug | Sep | Oct | YTD | RAG |
|-----------|------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Improved Access to Psychological Therapies | Trust 108.8% (582 referrals) | 100% | 925 | 1955 | 877 | 796 | 1104 | 1057 | | |
| IAPT - 2 Sessions completed - Dudley | 20.0% | 50.0% | 34.0% | 50.8% | 52.0% | 41.3% | 57.5% | 52.0% | 46.8% | |
13.0 EXCEPTION REPORTING

13.1 National Quality Requirements - Dudley Group Foundation Trust

- Ambulance Handovers >30 minutes
- Ambulance Handovers >60 minutes
- RTT Waits over 52 Weeks

13.2 Ambulance Handover
The breaches at +30 minutes and +60 minutes have continued at the previous levels. A&E turnaround measures are likely to have a positive impact on this performance. The Trust has been fined based on previously agreed methodology.

13.3 RTT Waits over 52 Weeks
There is one remaining patient at the time of reporting who has waited longer than 52 weeks. This patient has a treatment date booked in. All patients who wait longer than 40 weeks are reported to the CCG who then monitor progress on these patients weekly until treatment dates are confirmed.

13.4 National Operational Standards
DGFT is failing two National Operational Standards:

- A&E 4 hour waits
- Diagnostics.

13.5 A&E 4 hour waits
DGFT failed the target in October. However, early data for November confirms that the target was achieved for this month and it also appears highly likely that DGFT will achieve the target in December. A Remedial Action Plan is currently in place for this performance target which requires the Provider to achieve the target for Quarter 3 and Quarter 4.
13.6 **Diagnostics**  
The 6 week Diagnostic target was not achieved in October with the following tests failing to achieve:

- CT Scans
- Non-Obstetric Ultrasound
- Sigmoidoscopy
- Colonoscopy
- Gastroscopy

The November figures show that Non-Obstetric Ultrasound tests are now meeting the target. For the other target failing tests we have received a rectification plan from DGFT; however the independent sector is being scoped for further capacity.

13.7 **18 Weeks Referral to Treatment (RTT) Performance (DGFT)**  
As previously discussed, DGFT achieved the aggregate RTT targets year to date, but at specialty level failed the 90% target in Ophthalmology, Trauma and Orthopaedics and Urology for admitted patients. Trauma and Orthopaedics continue to improve but Ophthalmology and Urology performance has not met the expected recovery trajectory. The independent sector is being scoped for further capacity.

13.8 **Emergency Admissions**  
Emergency admissions have increased in 2014/15 compared to the previous year. This trend is against the intention the CCG has described in its Strategic and Operational Plans for a significant reduction in admissions. 8.2% of emergency admissions are from the care home environment. The Community Rapid Response Team is a key intervention to reduce emergency admissions as part of the Better Care Fund, Integration and QIPP programmes. A reduced ambition on the timeframe within which we expect to achieve our declared ambitions has been submitted. The Board will be kept informed of progress.

13.9 **Winterbourne View**  
The CCG continues to monitor Tier 1 CCG funded placements ensuring patients within a hospital setting with a learning disability who no longer require this level of care are transferred to care within a community setting. There are no areas of concern to date.

13.10 **Improving Access to Psychological Therapies (IAPT) (Dudley and Walsall Mental Health Trust)**  
Dudley and Walsall Mental Health Partnership are achieving the service targets for this indicator. However the Black Country Partnership Trust and Big White Wall IAPT providers do not currently submit IAPT information to UNIFY. Dudley CCG is exploring how such data can be recorded on UNIFY. The CCG is also procuring additional capacity in order to meet the target set by NHSE.

13.11 **Dementia**  
NHS England figures show that Dudley CCG has increased the dementia diagnosis against estimated prevalence rate from 42.88% to 50%. However, there is a data harmonisation programme currently in progress which demonstrates that the true rate will be higher than 50%. The year-end target is 67%, which is expected to be achieved.

13.12 **Other indicators**  

**Mortality Indicator (DGFT)**  
The hospital specific metric (HSMR) shows DGFT within normal variance of the number of expected deaths.

Mortality as an issue is discussed in detail at the Quality and Safety Committee.

13.13 **Quality Premium Indicators (CCG Focused Indicators)**  
The final confirmed Quality Premium figures show that Dudley CCG has achieved 62.5%. However, due to DGFT not meeting the 4 hour wait standard a reduction was applied meaning that the
revised achievement was 46.88%. Plans are being constructed on how to utilise the funding now confirmed by the Department of Health.

14.0 **SCORECARD REPORT**
The CCG Scorecard Report was presented to the Committee.

14.1 **Community Indicators**
Almost all of the aggregated practice scores for localities demonstrated performance at the Platinum or Gold levels. However, it is worth noting that many of the percentage achievements at practice level were derived from very low levels of activity. This is less of an issue with the aggregated locality view, but is important when comparing individual practices.

14.2 **Secondary Care Indicators**
Emergency admissions are the one indicator which demonstrated a Red category performance.

14.3 **Primary Care Indicators**
All localities performed between the Silver and Platinum standard for primary care indicators.

14.4 **Finance Indicators**
There is a forecast over performance of 2.5%. This is predominantly due to Urgent care over-performance.

Balanced scorecard performance exceptions are reported at the Finance and Performance Committee and addressed in the Practice Performance reviews. The scorecard is being reviewed and a revised version is to be submitted to Committee and localities in due course.

15.0 **REPORTS FROM GROUPS ACCOUNTABLE TO THE COMMITTEE**

15.1 **IT Strategy Group**
The Committee received a report on the issues discussed by the IT Strategy Group. The main items relate to the roll out of patient check-in screens; digital signage, SMS text messaging; the mobile devices pilot; shared record/community information system and a partnering agreement with EMIS.

15.2 **Estates Strategy/Operational Group**
The Health Infrastructure Strategy is developing well with a further round of discussions at localities in February prior to presentation to the Board in the new financial year.

16.0 **DECISIONS TAKEN UNDER DELEGATED POWERS**
None

17.0 **RECOMMENDATION**
The Board is asked to approve the report.

Matthew Hartland
Chief Operating and Finance Officer
December 2014
### DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Report:** 8 January 2015  
**Report:** Primary Care Development Committee Report  
**Agenda Item No:** 13.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Development Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board on key issues discussed at the Primary Care Development Committee on 14th November 2014 and 11th December 2014</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr D King, Head of Membership</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr D King, Head of Membership</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr J Rathore, Clinical Executive for Finance and Performance</td>
</tr>
</tbody>
</table>

#### KEY POINTS:
- The Committee received interim evaluations on the ‘productive general practice’ pilots that are taking place in 6 member practices in Dudley.
- The interim evaluations demonstrate that:
  - The pilots are having a positive impact in improving practice efficiency and the quality of care provided by the practice teams.
  - The maximum benefit from the pilots is being achieved where the CCG have funded backfill and development support.
- The Committee will receive full evaluations in January and will put in place actions to roll out and share the learning from the pilots.
- An extended hours plus enhanced service specification has been developed and offered to member practices to provide additional primary care appointment capacity throughout the winter.
- The Committee received an evaluation of primary care education services. The recommendations from the evaluation have been passed on to the Executive Management Team for action.
- The first wave of CQC inspections were discussed – the Committee has put in place training and education for all practices in preparation and will be offering face to face meetings with all practices in advance.
- The Committee received an update on non-recurrent spending plans and anticipate slippage of £592k against the £1.5M transition budget. Any planned slippage remaining at the end of November 2014 will be returned to central reserves.
- The Committee completed a self-assessment of Committee effectiveness that highlighted no significant issues.

#### RECOMMENDATION:
The Board is asked to note, for assurance, the issues discussed at the Primary Care Development Committee.

#### FINANCIAL IMPLICATIONS:
None

#### WHAT ENGAGEMENT HAS TAKEN PLACE:
None

#### ACTION REQUIRED:
✓ Assurance
1.0 INTRODUCTION
This report summarises the key issues discussed at the Primary Care Development Committee on 14th November 2014 and 11th December 2014.

2.0 ITEMS DISCUSSED

2.1 Productive General Practice – the Wychbury Experience
The Committee received a presentation from members of Wychbury Medical Practice on their experiences and progress with the productive general practice pilot. The practice has received project support commissioned by the CCG to support the practice develop an effective project team, develop the capacity and capability to provide a resource to support other practices in Dudley, develop a local evidence base to demonstrate how improvement in primary care can be developed for sharing, and identify learning needs to support primary care education and training.

The practice were able to demonstrate interim findings in the following areas

- **Improvements to practice efficiency**
  - Home visits saving GP time & reducing staff stress
  - Call answering reducing patient complaints & frustration
  - Meeting protocols improving productivity of practice meetings

- **Improvements to Relationships**
  - Better communication with staff improving morale & engagement in service improvement leadership
  - Greater PPG involvement has given the practice access to a previously untapped reservoir of knowledge, skills & ideas
  - Improved communication between clinical and non-clinical staff resulting in a better understanding of the whole business process

- **Development of Project Team**
  - Learning project management skills & tools
  - Training on leadership, service improvement and sustainability
  - 1:1 coaching to ensure they are using the right tools and methodology's
  - Learning leadership is shared which has resulted in more staff being engaged, learning the skills and sharing the workload resulting in more capacity to bring about service improvement

2.2 Productive General Practice – a Qualitative Evaluation
The Committee received a presentation on a qualitative assessment of six practices using focus groups. The purpose of the assessment was to assess the barriers and facilitators to signing up to and implementing the Productive GP programme and to understand ‘what works’ in order to support sign-up, progress implementation and realise the benefits of the Productive GP programme.

The lessons learnt, presented back to the Committee were as follows

**Engagement - essential**
- A whole practice approach to delivery and capturing benefits
- A project team with representation from different staff groups especially doctors
- A tailored process so that they fit the need or are relevant to staff
- The need to deliver tangible ‘quick wins’
- The need to sustain momentum by reducing delay between modules
Delivery and Sustainability

- “Time to release time” – requires dedicated time (to include backfill)
- Offer support as a shared resource across practices
- Provide staff training for skills including leadership and IT
- Reward excellence
- Feedback, communicate and share

A full and complete evaluation on productive general practice will be ready for January at which point the Committee will make a decision on the wider roll out of the learning and support that is required for member practices.

2.3 Extended Hours Plus Service Specification

The Committee agreed the content for an enhanced service to be commissioned to extend routine appointment access over and above extended hours commissioned by NHS England. The service specification has been approved by the Clinical Development Committee and offered to all practices already participating in the NHS England scheme. As at 11th December there are 7 practices that have signed up to participate in the enhanced service.

2.4 Evaluation of Primary Care Education

The Committee received a presentation and report of a review of education services provided to member practices. The review was commissioned by the CCG in August 2014 and the recommendations from the review presented to the Committee were as follows:

- Dudley CCG develops an integrated education strategy that encompasses all elements of the primary care workforce. The strategy should extend beyond the provision of training and other development interventions to provide a broader organisational development context in which the identification and provision of development needs form a core dimension.

- Dudley CCG seeks to establish a central role in managing the provision of this strategy within their operating area through the provision of funds and management of the process. This is seen as critical in breaking the culture of short term thinking.

- Dudley CCG seeks to exert greater influence on the development and funding of primary care education through forging more focussed links with the LETC and other external stakeholders including crucially secondary care. We suggest that Dudley CCG create a working party and co-opt both representatives from the LETC and LETB thus establishing the agenda and being more directive in the nature of LETB support for primary care.

- Dudley CCG actively promotes the benefits of engagement with the strategy to GPs through the enhancement of existing practice based development discussions. The creation of practice development plans will be of increasing importance for GPs and support should be provided for this with particular emphasis on ‘younger principles’. There is a significant danger that without this engagement any strategy could fail to be implemented and this will require close attention.

- Scope of strategy and key success factors have been identified within the full report. A graduated approach to engagement would need to be established.

The Committee thanked Dr Griffiths for her work in producing the report and agreed that given the recommendations and options within the report, that this was shared with the Clinical Executive to determine how to act on the recommendations.

2.5 Care Quality Commission Inspections

The Committee received an update on the CQC inspection process and the ‘intelligent monitoring’ reports produced by the CQC on member practices. The Committee noted that the CQC had to remove some of the bandings following a review, and that this had changed the banding profile 60 practices nationally. At the time of the Committee meeting the CQC could not advise whether this had changed the banding for Dudley practices.
The Committee noted the work of the membership engagement team to support practices in advance of CQC inspection, specifically

- learning from CQC visits under the new inspection process had been collected and shared with member practices
- a video of practice experiences has been produced and shared by the communications and engagement team
- the CCG has purchased Blue Stream academy online learning tool for all practice staff to ensure CQC compliance for training

2.6 Non Recurrent Spending Plans
The Committee received an update on non-recurrent spending plans. Against a budget of £1.5m spend of £908,000 is anticipated resulting in an anticipated slippage of £592,000 at year end. This slippage anticipates full uptake of the extended hour’s enhanced service. The Committee were informed that any planned slippage remaining at the end of November 2014 will be returned to central reserves.

2.7 Self-Assessment of Committee Effectiveness
The Committee received a summary of its self-assessment survey.

Areas to focus upon for the Committee include:

At the end of each meeting we discuss the outcomes and reflect back upon decisions made and what worked well, not so well etc.
There is a formal appraisal of the committee’s effectiveness each year which is evidence based and takes into account my views

The Committee agreed to act upon these recommendations.

2.8 Risk Register
The committee made the following recommendations to the Audit Committee to add the following risk to the register

- The ability of member practices to fulfil their contractual obligations to NHS England as a result of difficulties recruiting substantive GPs resulting in contractual breach, or termination of contract.

3.0 DECISIONS TAKEN BY THE COMMITTEE UNDER DELEGATED POWERS FROM BOARD
None

4.0 DECISIONS REFERRED TO BOARD
None.

5.0 RECOMMENDATION
The Board is asked to note the issues discussed at the Primary Care Development Committee on 14th November 2014 and 11th December 2014

Dr J Rathore
Clinical Executive, Finance and Performance
January 2015
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>#NOF</td>
<td>Fractured Neck of Femur</td>
</tr>
<tr>
<td>£K</td>
<td>£1,000 equivalent</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABC / ABCD</td>
<td>Above and Beyond the Call of Duty (Local surveys which include praise for nominated staff members as well as assessment of services)</td>
</tr>
<tr>
<td>ACRA</td>
<td>Advisory Committee on Resource Allocation</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>AD</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>AfC</td>
<td>Agenda for Change</td>
</tr>
<tr>
<td>AHSN</td>
<td>Academic Health Science Networks</td>
</tr>
<tr>
<td>ALE</td>
<td>Auditors Local Evaluation</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length of Stay (in hospital)</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute Myocardial Infarction</td>
</tr>
<tr>
<td>AMMC</td>
<td>Area Medicines Management Committee</td>
</tr>
<tr>
<td>Anti-D</td>
<td>An antibody occurring in pregnancy</td>
</tr>
<tr>
<td>Anti-TNF</td>
<td>Drugs used in the treatment of rheumatoid arthritis and Crohn’s disease</td>
</tr>
<tr>
<td>ARIF</td>
<td>Aggressive Research Intelligence Facility</td>
</tr>
<tr>
<td>ASAP</td>
<td>As soon as possible</td>
</tr>
<tr>
<td>AVE</td>
<td>Advertising Value equivalent</td>
</tr>
<tr>
<td>BACs</td>
<td>Bank Automated Credit</td>
</tr>
<tr>
<td>BCC</td>
<td>Black Country Cluster</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guerin</td>
</tr>
<tr>
<td>BCPFT</td>
<td>Black Country Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>BCUCG</td>
<td>Black Country Urgent Care Group</td>
</tr>
<tr>
<td>BFT</td>
<td>Behavioural Family Therapy</td>
</tr>
<tr>
<td>BLCCB</td>
<td>Black Country Local Collaborative Commissioning Board</td>
</tr>
<tr>
<td>BME</td>
<td>Black Minority Ethnic</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Board</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>BSCCP</td>
<td>British Society of Colposcopy and Cervical Pathology</td>
</tr>
<tr>
<td>CAB</td>
<td>Citizens Advise Bureau</td>
</tr>
<tr>
<td>CABG</td>
<td>Coronary Artery Bypass Graft</td>
</tr>
<tr>
<td>CAO</td>
<td>Chief Accountable Officer</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CASH</td>
<td>Contraception and Sexual Health</td>
</tr>
<tr>
<td>CAT</td>
<td>Change Agent Team</td>
</tr>
<tr>
<td>CBSA</td>
<td>Commissioning Business Support Agency</td>
</tr>
<tr>
<td>CCBT (CBT)</td>
<td>Computerised Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CCF</td>
<td>Capable Care Forum</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCRN</td>
<td>Comprehensive Clinical Research Networks</td>
</tr>
<tr>
<td>CDC</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>CHADD</td>
<td>The Churches Housing Association of Dudley &amp; District Ltd</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Healthcare</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CIS</td>
<td>Community Investment Strategy</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
</tr>
<tr>
<td>CNT</td>
<td>Community Nursing Team</td>
</tr>
<tr>
<td>CONNECT</td>
<td>Mental Health information website for staff</td>
</tr>
<tr>
<td>COSHH</td>
<td>Control of Substances Hazardous to Health Regulations 2002</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resource Limit</td>
</tr>
<tr>
<td>CRRT</td>
<td>Community Rapid Response Team</td>
</tr>
<tr>
<td>CSSD</td>
<td>Central Sterile Services Department</td>
</tr>
<tr>
<td>CT scan</td>
<td>Computer Topography</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CQRM</td>
<td>Clinical Quality Review Meeting</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardio Vascular Disease</td>
</tr>
<tr>
<td>CWAS</td>
<td>Coventry and Warwickshire Audit Services</td>
</tr>
<tr>
<td>DACHS</td>
<td>Directorate of Adult Children and Housing Services</td>
</tr>
<tr>
<td>DCS</td>
<td>Dudley Community Services</td>
</tr>
<tr>
<td>DCVS</td>
<td>Dudley Community Voluntary Service</td>
</tr>
<tr>
<td>DES</td>
<td>Directed Enhanced Service</td>
</tr>
<tr>
<td>DfES</td>
<td>Department for Education and Skills</td>
</tr>
<tr>
<td>DGFT</td>
<td>Dudley Group Foundation Trust</td>
</tr>
</tbody>
</table>
DNA  Did not attend
DoH  Department of Health
DoLS  Deprivation of Liberty Safeguards
DoS  Directory of Service
DTC  Diagnostic and Treatment Centre
DWMHPT  Dudley and Walsall Mental Health Partnership Trust
DXA  Dual X-ray Absorptiometry (measures bone density).
E&D  Equality and Diversity
EAU  Emergency Assessment Unit
EBME  Electro Bio-Mechanical Engineer
ECA  Extra Care Area
ECM  Every Child Matters
ECT  Electroconvulsive Therapy
ED  Emergency Department
EI  Early Implementer
EI  Early Intervention
EMI  Older People with Mental Illness (Elderly Mentally Ill)
EPP  Expert Patients Programme
EPR  Electronic Patient Record
ERMA  Emergency Response & Management Arrangements
ERT  Enzyme Replacement Therapy
ESR  Electronic Staff Record
FCEs  Finished Consultant Episodes
FED  Forum for Education and Development
FHS  Family Health Services
FIP  Computerised data collection facility used by community health teams.
FMC  Facility Management Centre
FOI  Freedom of Information
FYE  Full Year Effect
GMS  General Medical Services
GOWM  Government Office for the West Midlands
GP  General Practitioner
GPAQ  General Practice Assessment of Quality
GPwSI  GPs with Special Interest
GU  Genito-urinary
GUM  Genito-urinary Medicine
HCAI  Healthcare Associated Infections
HENIG  Health Economy NICE Implementation Group
HF  Heart Failure
HIC  Health Improvement Centre
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNG</td>
<td>Local Negotiating Committee</td>
</tr>
<tr>
<td>LPS</td>
<td>Local Pharmaceutical Scheme</td>
</tr>
<tr>
<td>LRF</td>
<td>Local Resilience Forum</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Conditions</td>
</tr>
<tr>
<td>LVD</td>
<td>Left Ventricular Dysfunction</td>
</tr>
<tr>
<td>LVSD</td>
<td>Left Ventricular Systolic Dysfunction</td>
</tr>
<tr>
<td>MAPA</td>
<td>Management of Actual and Potential Aggression</td>
</tr>
<tr>
<td>MAU</td>
<td>Medical Assessment Unit</td>
</tr>
<tr>
<td>MBC</td>
<td>Metropolitan Borough Council</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi Disciplinary Team</td>
</tr>
<tr>
<td>MIMT</td>
<td>Major Incident Management Team</td>
</tr>
<tr>
<td>MIRE</td>
<td>Major Incident Response Executive</td>
</tr>
<tr>
<td>MLSOs</td>
<td>Medical Laboratory Scientific Officers</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
</tr>
<tr>
<td>MSS</td>
<td>Medium Secure Service</td>
</tr>
<tr>
<td>NCA</td>
<td>Non contract activity</td>
</tr>
<tr>
<td>NCB</td>
<td>National Commissioning Board</td>
</tr>
<tr>
<td>NCRS</td>
<td>National Care Record System</td>
</tr>
<tr>
<td>NELHI</td>
<td>National Electronic Library for Health Information</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NGMS</td>
<td>New General Medical Services</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSCPT</td>
<td>NHS Community Practice Teacher</td>
</tr>
<tr>
<td>NHSCSP</td>
<td>NHS Cancer Screening Programme</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSLA</td>
<td>NHS Litigation Authority</td>
</tr>
<tr>
<td>NHSP</td>
<td>National Healthy Schools Programme</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NOF</td>
<td>New Opportunities Fund</td>
</tr>
<tr>
<td>NPfIT</td>
<td>National Programme for IT</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>NRF</td>
<td>Neighbourhood Renewal Fund</td>
</tr>
<tr>
<td>NRLS</td>
<td>National Reporting and Learning System</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Products</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>OAT</td>
<td>Out of Area Treatment</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day</td>
</tr>
<tr>
<td>OD</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>ODM</td>
<td>Oesophageal Doppler Monitoring</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>OSC</td>
<td>Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>PAF</td>
<td>Positive Assurance Framework</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>PAU</td>
<td>Paediatric Assessment Unit</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PC</td>
<td>Personal Computer</td>
</tr>
<tr>
<td>PCDB</td>
<td>Primary Care Delivery Board</td>
</tr>
<tr>
<td>PCDC</td>
<td>Primary Care Development Committee</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format</td>
</tr>
<tr>
<td>PDP</td>
<td>Personal Development Plan</td>
</tr>
<tr>
<td>PDS</td>
<td>Personal Dental Services</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
</tr>
<tr>
<td>PDU</td>
<td>Professional Development Unit</td>
</tr>
<tr>
<td>PE</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>PEAK</td>
<td>Database holding the main registered details of patients and associated referral, contact, caseload, outpatient, inpatient, MH Act and clinic information.</td>
</tr>
<tr>
<td>PEAT</td>
<td>Patient Environment Action Team</td>
</tr>
<tr>
<td>PEC</td>
<td>Professional Executive Committee</td>
</tr>
<tr>
<td>PEPP</td>
<td>Pooled Budget External Placement Panel</td>
</tr>
<tr>
<td>PFI</td>
<td>Private Finance Initiative</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Directives</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PID</td>
<td>Project Initiation Document</td>
</tr>
<tr>
<td>PIN</td>
<td>Personal Identification Number</td>
</tr>
<tr>
<td>PMLD</td>
<td>Profound and Multiple Learning Difficulties</td>
</tr>
<tr>
<td>PMS</td>
<td>Primary Medical Services</td>
</tr>
<tr>
<td>PPA</td>
<td>Prescription Pricing Authority</td>
</tr>
<tr>
<td>PPG</td>
<td>Patient Participation Group</td>
</tr>
<tr>
<td>PPIF</td>
<td>Patient and Public Involvement Forum</td>
</tr>
<tr>
<td>PSA</td>
<td>Public Service Agreement</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal and Social Health Education</td>
</tr>
<tr>
<td>PTCA</td>
<td>Percutaneous Transluminary Coronary Angioplasty</td>
</tr>
<tr>
<td>Q&amp;A</td>
<td>Questions and Answers</td>
</tr>
<tr>
<td>Q&amp;S</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
<tr>
<td>QMAS</td>
<td>Quality Management and Analysis System</td>
</tr>
</tbody>
</table>
QOF  Quality and Outcome Framework
QPDT  Quality and Practice Development Teams
RACPC  Rapid Access Chest Pain Clinic
RAS  Respiratory Assessment Service
RCA  Root Cause Analysis
RES  Race Equality Scheme
RHH  Russells Hall Hospital
RIDDOR  Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RMO  Responsible Medical Officer
RRL  Revenue Resource Limit
RSL  Register Social Landlords
RTT  Referral to Treatment Target
SAP  Single Assessment Process
SEPIA  Mental health computer system
SFBH  Standards for Better Health
SFI  Standing Financial Instructions
SIC  Statement of Internal Control
SLA  Service Level Agreement
SRE  Sex and Relationship Education
SSD  Social Services Department
SSDP  Strategic Services Development Plan
STI  Sexually Transmitted Disease
STRW  Support, Time & Recovery Worker
TB  Tuberculosis
TIA  Transient Ischaemic Attack
TP  Teenage Pregnancy
TPT  Teenage Pregnancy Team
TTO  To Take Out
UHBT  University Hospital Birmingham Trust
Vaccs & Imms  Vaccinations and Immunisations
WAN  Wide Area Network
WCC  World Class Commissioning
WIC  Walk in Centre
WMAS  West Midlands Ambulance Service
WMCSU  West Midlands Commissioning Support Unit
WMHTAC  West Midlands Health Technology Advisory Committee
WMSCG  West Midlands Strategic Commissioning Group
WMSSA  West Midlands Specialised Services Agency
WTE  Whole Time Equivalent