NHS Wolverhampton Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group

AGENDA ITEM: 3.1

EXTRAORDINARY GOVERNING BODY in COMMON PUBLIC MEETING

Tuesday 21ST January 2020
1.00pm to 3.00pm

Millichip Suite, West Bromwich Albion Football Club, Birmingham Road, West Bromwich B71 4LF

1. Present:	Walsall CCG	Attended	Apologies	Did not Attend
Dr A Rischie - Chair	Chair of Clinical Commissioning Group	✓		
Mr M Abel	Lay Member for Commissioning (Vice Chair)	✓		
Mr P Maubach	Accountable Officer for Black Country CCGs	✓		
Mr M Hartland	Chief Finance Officer/ Black Country Deputy Accountable Officer	✓		
Mrs Sarah Shingler	Chief Nurse	✓		
Dr N Asghar	North Locality Chair	✓		
Dr S Kaul	East Locality Chair		✓	
Dr A Khera	South Locality Lead	✓		
Mr P Tulley	Director of Commissioning	✓		
Miss R Barber	Lay Member for Patient and Public Involvement (PPI)	✓		
Dr H Baggri	Clinical Executive for Primary Care	✓		
Dr R Sandhu	West Locality Chair	✓		
Mrs D Macarthur	Director of Primary Care and Integration	✓		
Dr J Teoh	Clinical Executive for Integrated Assurance	✓		
Mr M Jhooty	Audit and Governance Chair, Lay Member		✓	
Dr H Lodhi	Clinical Executive for Commissioning	✓		
In attendance:				
Mrs Sara Saville	Head of Corporate Governance	✓		
Mrs Jackie Eades	Executive Assistant - notetaker	✓		
Mr John Taylor	Healthwatch Chair & Sandwell	✓		

* part meeting

Present:	Sandwell and West Birmingham CCG	Attended	Apologies	Did not Attend
Dr Ian Sykes	Chair of Clinical Commissioning Group	✓		
Mr Ranjit Sondhi	Vice Chair	✓		
Dr Ayaz Ahmed	GP Director – Sandwell		✓	

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Dr Priyanand Hallan	GP Director – Sandwell	✓		
Dr Manir Aslam	GP Director – West Birmingham	✓		
Dr Parmjit Marok	GP Director – West Birmingham	✓		
Mrs Julie Jasper	Lay Member	✓		
Mr James Green	Chief Finance Officer		✓	
Mrs Therese McMahon	Non- Executive Board Nurse	✓		
Mrs Janette Rawlinson	Lay Member	✓		
Dr Karl Gridulis	Secondary Care Consultant	✓		
In Attendance				
Mrs Sharon Liggins	Interim Chief Operating Officer		✓	
Mrs Rachael Ellis	Chief Officer for Transformation/Black Country Deputy Accountable Officer	✓		
Mr Rhod Mitchell	Co-opted Lay Member	✓		
Mrs Alice McGee	Director of Human Resources and Organisational Development	✓		
Dr Jonathon Bown	Co-opted Birmingham and Solihull CCG GP representative			✓
Ms Lucie Carrington	Arden & Gem CSU			✓
Miss Jodi Woodhouse	Governance Manager	✓		
Ms Jayne Salter-Scott	Head of Communication and Engagement	✓		
Ms Claire Parker	Chief Officer	✓		
Ms Michelle Carolan	Chief Officer Quality	✓		

Present:	**Wolverhampton CCG**	**Attended**	**Apologies**	**Did not Attend**
Dr Salma Reehana - Chair	Chair of Clinical Commissioning Group		✓	
Dr R Gulati	GP/Commissioning Committee Deputy Chair	✓		
Mrs Sally Roberts	Chief Nurse	✓		
Ms Helen Ryan	Practice Manager Representative	✓		
Mr Peter Price	Lay Member/Audit Chair	✓		
Mr Les Trigg	Lay Member for Finance and Performance	✓		
Mr Stephen Marshall	Director of Strategy and Transformation/Deputy AO	✓		
Mr Jim Oatridge	Lay Member	✓		
Mr A Mittel	Consultant in Public Health, Wolverhampton Council	✓		
Dr Asghar	GP representative	✓		
Ms Sue McKie	Vice Chair/lay Member	✓		
Mr Mike Hastings	Director of Operations	✓		
		✓		
In attendance:				
Mr Peter McKenzie	Corporate Operations Manager	✓		
Mrs Tracey Cresswell	Manager, Healthwatch Wolverhampton	✓		
		✓		

Present:	**Dudley CCG**	**Attended**	**Apologies**	**Did not Attend**
Dr D Hegarty	Chair of Clinical Commissioning Group		✓	

Prof. Chris Handy	Vice Chair	✓		
Mr Tony Allen	Lay Member	✓		
Mr Alan Johnson	Secondary Care Consultant	✓		
Dr Tim Horsburgh	GP Representative	✓		
Ms Caroline Brunt	Chief Nurse	✓		
Dr Ruth Edwards	GP Clinical Executive	✓		
Dr Mohit Mandiratta	GP Board Member	✓		
Ms Helen Mosley	Lay Member	✓		
Ms D Harkins	Chief Officer, Health and Wellbeing (DPH), Dudley Council		✓	
In attendance:				
Ms Emma Smith	Governance Manager	✓		
Jayne Emery	Chief Officer – Healthwatch Dudley	✓		
Mr Neill Bucktin	Director of Commissioning	✓		
Mrs Laura Broster	Director of Communications	✓		

2.	**Declaration of Interests** Dr Rischie, Chair of Walsall Clinical Commissioning Group (CCG) welcome members to the meeting and stated he will be Chairing the Extraordinary Governing Body meetings today. It was noted that Walsall, Dudley and Sandwell and West Birmingham CCGs were quorate and would be able to approve the papers presented for decision. Wolverhampton CCG were not quorate, Sue McKie, Vice Chair agreed to relay the decisions made by the other 3 CCGs to members of Wolverhampton's Governing Body that were unable to attend today's meeting. Claire Parker agreed to note the decisions made at the meeting and forward to Ms McKie. A formal decision from Wolverhampton colleagues is required by 5pm Wednesday 22nd January 2020. The feedback received will be included in the minutes. All Executive Directors of each CCG declared a conflict of interest when discussing item 6, Senior Management Team. The Directors were permitted to remain in the room whilst the report was discussed but could not contribute to the discussions. This does not apply to Mr Maubach, Mr Hartland and Mrs Ellis. A question was raised about Lay Members being conflicted in the Governance Arrangements item 4, it was agreed that the discussion is not specific about Lay Members therefore no declaration necessary.
3.	**Notification of any items of other business** None Declared.
4. **4.1**	**CCG Governance Arrangements** **Proposed future governance from 1st April 2020** Ms Claire Parker presented the report highlighting key points around the recent Listening exercise. A number of development sessions were arranged with executive management teams, GPs and Lay Members across the four CCGs and their feedback informed the decision for the Transition Board to recommend a hybrid model which is Governing Body in Common (GBiC) meetings and a Joint Health Commissioning Board (JHCB). The GBiC meetings will address the statutory responsibilities on behalf of all four CCGs and the JHCB will replace the current Joint Commissioning Committee (JCC). These Boards will be arranged in alternate months. It was noted that Birmingham and Solihull CCG were also approached for their feedback in

relation to the arrangements for Sandwell and West Birmingham CCG joining the Black Country arrangements.

Ms Parker asked members to note that the structure shown in this report is a work in progress and is not yet the final arrangement.

Ms Parker went on to explain the development of the first draft of the Scheme of Reservation and Delegation (SORD), this is required to be in place by 31st March to ensure that the GBiC and the JHCB can commence from April 2020. It was noted that if any changes to the membership are required there will be a formal process but at this point this is not required.

Work has commenced looking at establishing new working groups, the governance arrangements, Terms of Reference and proposed work structure are being developed. The work is alongside reviewing Committees. The transition process will need to be fully developed in line with the place structures for each CCG.

The Chair asked the members for questions.

Mr Abel, Lay Member for Walsall CCG stated as a member of the Transition Board, the hybrid option was introduced at the meeting in December 2019 following the Listening exercises, there was an understanding that this governance paper should have been presented at the next Transition Board in January for further discussion before this GBiC. The meeting was cancelled in January therefore there has been no opportunity to discuss this proposal prior to today's meeting. The Chair accepted Mr Abel's point and stated that unfortunately the paper was not ready for presentation or consideration at the Transition Board on the 9th January 2020.

Mr Les Trigg, Lay Member for Finance and Performance from Wolverhampton CCG stated that he understood that the SORD was not yet fully developed but pointed out that there are quite a few instances of delegation to Audit and Governance Committees. This Committee is not a decision making group, it has a remit of scrutiny and oversight. In response Ms Parker pointed out that there will be a working group set up to address this and work through the finer details. It was suggested that all Audit Chairs align themselves with this working group.

Mrs Julie Jasper, Lay Member for Sandwell and West Birmingham CCG, agreed with Ms Parker's invite for Audit Chairs to become members of this specific working group.

ACTION: Mrs Jasper requested that a survey be carried out after this GBiC to give feedback on how this meeting was received. This action was agreed.

Mrs Jasper went on to ask how Lay members will be selected for the JHCB. Ms Parker confirmed that an appointment process will be undertaken. She also asked if there was enough money to initiate and establish the new structure within current financial budgets. The working assumption is yes but the question cannot be answered until the outcome is known from the discussion on the financial report in the private session later today. It was confirmed that more work will have to be completed before the end of March 2020.

Mr Jim Oatridge Lay Member for Wolverhampton CCG congratulated members involved with developing this paper and the transparency within it. Mr Oatridge then asked in section 3.9 Governing bodies approve of the non-commissioning functions, including the work of the Remuneration, Audit and the Primary Care Commissioning Committees responsibilities delegated by NHS England would be delivered through meetings in common.

Dr Tim Horsburgh, GP representative for Dudley CCG raised concerns that the clinical voice is being diluted and CCGs will lose the benefit of this in the new structure. Mr Maubach, Accountable Officer for all Black Country CCGs answered this by pointing out that the proposals for the working groups will address these concerns with the right balance of GPs, Lays and Management representation on each group.

Mrs Helen Mosley Lay Member for Dudley CCG echoed the point Mr Oatridge made and following Lay Member discussions where there has been resistance to the suggested

meetings in common. How will the CCGs be held to account by the public and which meetings will be held in public? It is suggested that the Primary Care Commissioning Committee, GBiC and JHCB will be held public as a minimum.

ACTION: Inclusion of the named committees that are recommended to be held in public to be added as a recommendation. This was agreed.

Professor Chris Handy, Vice Chair of Dudley CCG reiterated the point about clinical voice not being diluted and stated that it is critical that the correct tone is set from the beginning and to set the right values.

Mr Maubach replied by saying that with the CCGs coming together, this has stimulated a different discussion in the STP Board meetings on how we can encourage others to work collectively.

Mr Ranjit Sondhi, Vice Chair of Sandwell CCG stated that following the recent consultation in Sandwell tensions were raised around losing local place identity. How will tensions in our system be reconciled and what will be the mechanism for equally in our finances.

Mrs Janette Rawlinson, Lay Member for Sandwell and West Birmingham CCG requested that all members recognise that this governance work is work in progress. She reiterated the point made earlier about ensuring the right processes are in put in place for the Lay Members membership to Committees and working groups. There is a need to understand your specific local areas and this must be taken into consideration. There is also a need to allow time for members to understand the new arrangements. She also stated that any recommendations that are escalated to the GBiC must be circulated at least 5 working day prior to the meeting to allow time to consider the detail.

Dr Horsburgh affirmed that Local Authorities (social care) need to be part of the ICS but it is not clear how we are involving them in the new structure. Mr Maubach acknowledged Dr Horsbourgh’s comments and stated that there will be a strong local presence in each place and a meeting has been arranged with all the Directors of Public Health and Directors of Adult Social Care to discuss how the alignment will be made and how we strengthen the governance arrangements between the organisations. There will be a separate conversation on including the Local Authority colleagues in the working groups.

In terms of the JHCB arranging the times of the meeting is crucial and it was suggested that a workplan for the year be developed to allow for the agendas of the JHB not to be overloaded and to allow the Board to meet its deadlines. Consideration also given to the timings of the working groups to allow items to be escalated to the JHB and then to GBiC in a timely manner.

Mrs Jasper suggested that members of the Governing Bodies attend other CCGs Committees to increase the knowledge of the Black Country organisations.

Dr Karl Gridulis, Secondary Care Consultant for Sandwell and West Birmingham CCG reminded members about the variation all four CCGs have and local considerations must be made. He gave an example of recent Governing Body decisions that have been made in Sandwell and West Birmingham such as Home Oxygen and West Midlands Ambulance arrangements for 111 and 999 services. Assurance was given that all CCGs in the Black Country have also considered the same items but acknowledged that there will always be variation in place. Issues such as the examples given where the contracts/services affect all four CCGs will transfer to the JHB for consideration and the recommendations will be escalated to the GBiC for final approval.

Mrs Rawlinson asked that other specialities be considered for joint working such as Cancer and Continuing Health Care (CHC).
Mr Oatridge asked for clarity in the Terms of Reference of the size of the JHB, in terms of the membership equal balance of clinician, non-executive and management. He also asked about the process for appointing a Chair and who will be the core decision makers.

	The Chair asked members to bear in mind the pace and timelines to take this work forward and would appreciate where possible flexibility in availability for important meetings. This was accepted by all members. The Chairs of Walsall and Sandwell and West Birmingham and Vice Chair of Dudley together with the members in the meeting resolved to accept the recommendation with the additional two recommendations added. • Note the recommendation made by the Transition Board. • Approve the development of the proposed governance structure. • Approve the specific GB in common and the Joint Health Board in place from 1st April 2020 with work commencing from this point to ensure the reporting structure at system and place meets statutory duties and enables decision making. • Note the draft SORD • Note the draft JHCB Terms of reference • Approve alignment of the model constitutions • Governing Bodies note that an extraordinary Governing Body in common meeting beheld on 31st March 2020 to approve the SORD and the Terms of reference for the Health Commissioning Board. • To be added - Agree that Primary Care Commissioning, Remuneration and Audit Committees will meet in common (proposed at the meeting). • To be added - Agree that in addition to PCC and Governing Bodies, the Joint Health Commissioning Board will meet in public The Vice Chair of Wolverhampton CCG approved in principle, as Wolverhampton CCG's Governing Body was not quorate, the views of their Governing Body members that were not present will be sought after the meeting.
4.2	**Proposed Governing Body working groups on operational governance** Mr Maubach introduced this proposal which will provide a framework of assurance for the new management and governance arrangements. There are 9 working groups identified for consideration. Mr Maubach asked members to discuss the following questions: 1. Are these the right groups? 2. Is there anything fundamentally missing? Summary of feedback given: • Affordability reiterated by most of the members. • Group 2.2 New Governing Body and Committee membership - further discussion regarding membership to February GBiC. Interim step requested continued discussion at the Transition Board. • Do any of the decisions require the membership to approve? In reply not at this stage but it will be the responsibility of the Locality Chairs in each area to keep their respective members up to date with the proposed changes. • Group 2.3 Assurance on Statutory Duties - statutory and legal duties should be clear set out. • Group 2.7 Contract Harmonisation - Noted that not enough clinical input in the membership. • Clarification on the 5 places or 4, tensions between system and place. Where will these issues be discussed, this seems to be missing. • Concerns on how the complexities will be dealt with. • Where will the clinical voice be captured. • Capacity and commitment of the available Lay Members. • More clarity on whether the groups will be task and finish. • Prioritisation schedule with timelines required. Cannot do everything at once due to capacity. • Could Policy and Contract Harmonisation be one group?

	• Project plan, flow chart to reduce duplication. • Longer Transition Board and shorter JCC. • Clearly identified 'must dos' scrutiny, critical friend. Do not lose sight of our own scrutiny. • Clearly identified roles for the membership of groups to be set out in Terms of Reference. • How do we separate system and place within the groups? • Capacity to adequately input to Groups by GP clinicians. • Time commitment, pace. • Clear communication on who are the decision makers. • Consistent Public engagement to be considered. • Consistency as a whole. • Remove health jargon to enable easy understanding by LA colleagues. • Consider DASS or DPH to be added to the membership of some groups. In summary, Mr Maubach thanked members for their thoughts and comments. He responded to some of the points made. Governing Bodies are the ultimate decision makers, one Lay Member cannot be expected to represent all others or make decisions on their behalf. Place/system tensions will be addressed in Governing Body development sessions. Governing Bodies will set strategic objectives and governance. Scrutiny arrangements will be maintained. The Chairs of Walsall and Sandwell and West Birmingham and Vice Chair of Dudley together with the members in the meeting resolved to accept the recommendations: • Governing Bodies are asked to note the contents of the report • Governing Bodies are asked to approve the recommendations to set up working groups to oversee the transition governance of the CCGs. The Vice Chair of Wolverhampton CCG approved in principle, as Wolverhampton CCG's Governing Body was not quorate, the views of their Governing Body members that were not present will be sought after the meeting.
5. **5.1**	**CCG Future HQ** Mr Maubach presented the report which sets out the key principles for identifying a headquarters and other office space for the four CCGs staff working at place and the system. The restructuring will result in the single executive team requiring a single location to optimise efficient working. Then at place there will be 5 place-based teams who will required shared accommodation in their respective areas. It was noted that Sandwell would be mostly affected due to the creation of a West Birmingham office, co-locating close to Birmingham Council and Birmingham and Solihull CCG. Mr Maubach went on to say that getting the right technology to allow for more reliable agile working is also a priority. If video conferencing is made available, where staff are based is less of an issue. Mike Hastings is leading on this work. Members asked if 'headquarters' is the correct terminology, perhaps consider central services hub. Mr Abel the report does not cover 'sole occupancy' sites and the requirement is not to increase new premises but to look at reducing costs. Mr Maubach assured Mr Abel that these considerations have been made and there is no intention to have sole occupancy and increase costs. Mr Abel stated that he did not feel this was clearly set out in the report. Mr Sondhi indicated that an office in Landywood may not sit well with Sandwell and West Birmingham colleagues, from feedback gained in the recent consultation. In reply Mr Maubach outlined the combined statutory duties that the CCG and Local Authorities have,

	having an office located in the same area will allow opportunities to increase working relationships and be nearer to the population West Birmingham serve. It was noted that work to harmonise Sandwell and Wests Birmingham has already been undertaken, to split it again may raise tensions. The members were also concerned about using Local Authority buildings. Mr Maubach confirmed that considerations have made but we need to ensure that the CCGs are getting the best value for the public pound. The Chairs of Walsall and Sandwell and West Birmingham and Vice Chair of Dudley together with the members in the meeting resolved to accept the recommendations, noting that arrangements are made with no need for extra funding: • Governing Bodies are asked to note the contents of the report • Governing Bodies confirm their authority to this working group to determine the preferred location of the HQ, in accordance with the criteria in the report, before the end of March 2020. The Vice Chair of Wolverhampton CCG approved in principle, as Wolverhampton CCG's Governing Body was not quorate, the views of their Governing Body members that were not present will be sought after the meeting.
6. **6.1**	**Senior Management Team** **Proposed structure and process** Mr Maubach proposed that the reduction of the Executive Team will broadly be in line with the 20% running cost reduction. Restructuring the team will give us the capacity to opportunities to undertake the complex remit of 5 places, 4 CCGs and 1 system. The report set out the proposal for which roles will form part of the single senior management team and which will work at place level. Mr Price pointed out that the Accountable Officer must have the team he requires but how can we consider this this proposal in full without knowing the financial implications. In response Mr Maubach stressed that the Remuneration Committee in Common on the 18th February will be discussing the salary levels but the full financial benefits will not be known until the GBiC on 31st March 2020. The recruitment process will commence in February but still needs to be completely developed. Members asked that Lay Members and GP Board members be invited to sit on the interview panels. Mr Maubach confirmed that Governing Body members will sit on all interview panels. Mrs McKie, Vice Chair of Wolverhampton reiterated the concerns raised by Mr Price around the financial aspects. She appreciated that Mr Maubach said that the 20% running costs will be broadly met but asked where this is demonstrated. Mr Maubach repeated that this will be discussed at the Remuneration Committee in February, then the recommendations will be presented at the GBiC on the same day. Dr Horsburgh drew attention to the roles and questioned whether there is enough capacity to deliver the vision for the CCGs both place and system. He stressed that reducing roles ultimately impacts what can be delivered and the quality of the delivery especially the quality and safety measures. Mr Maubach confirmed that he believes that this restructure will give us the best opportunity to deliver outcomes more efficiently. Mr Oatridge stressed that the Governing Bodies must support the Accountable Officer on his vision to deliver.

	It was questioned whether the Transition/Transformation Director role is time limited. It was also suggested that there was a Board Secretary role added who would report to the Chairs not the Accountable Officer for assurance and accountability. Ms Barber questioned if it was possible to carry on in the timeline for the Corporate Executives but pause the Managing Director roles until the Board members have more detail to consider. Mr Maubach answered the question by saying that it is difficult to stage the re-structuring but assured members that there will be more information ready for consideration and discussion at the Remuneration Committee in February. Mr Abel asked Mr Maubach to consider if Managing Director was the correct title for a CCG role. The Chairs of Walsall and Sandwell and West Birmingham and Vice Chair of Dudley together with the members in the meeting resolved to accept the recommendations: • Approve the proposed executive structure and the change to the voting membership for Officer roles on the Governing Bodies • Note the proposed senior leadership team structure • Note the management of change process and timeline The Vice Chair of Wolverhampton CCG approved in principle, as Wolverhampton CCG's Governing Body was not quorate, the views of their Governing Body members that were not present will be sought after the meeting.
19.	**Any other Business** None declared.

WALSALL CCG GOVERNING BODY PUBLIC MEETING

Tuesday 14th January 2020
1.00pm to 3.00pm

The Board Room, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL

1. Present:		Attended	Apologies	Did not Attend
Dr A Rischie - Chair	Chair of Clinical Commissioning Group	✓		
Mr M Abel	Lay Member for Commissioning (Vice Chair)	✓		
Mr P Maubach	Accountable Officer	✓		
Mr M Hartland	Chief Finance Officer	✓		
Mrs Sarah Shingler	Chief Nurse	✓		
Dr N Asghar	North Locality Chair	✓		
Dr S Kaul	East Locality Chair	✓		
Dr A Khera	South Locality Lead	✓		
Mr P Tulley	Director of Commissioning	✓		
Miss R Barber	Lay Member for Patient and Public Involvement (PPI)	✓		
Dr H Baggri	Clinical Executive for Primary Care	✓		
Dr R Sandhu	West Locality Chair	✓		
Mrs D Macarthur	Director of Primary Care and Integration	✓		
Dr J Teoh	Clinical Executive for Integrated Assurance	✓		
Mr M Jhooty	Audit and Governance Chair, Lay Member			✓
Dr H Lodhi	Clinical Executive for Commissioning	✓		
In attendance:				
Mrs Sara Saville	Head of Corporate Governance		✓	
Mrs Jackie Eades	Executive Assistant - notetaker	✓		
Mr John Taylor	Healthwatch Chair		✓	

* part meeting

2.	**Declaration of Interests** No declaration made today. The Chair asked that all members check their respective Declarations and send any amendments to the Governance department.
3.	**Notification of any items of other business** None declared.
4. **4.1** **4.2**	**Approval of Minutes** • The minutes from Tuesday 12th November 2019 were accepted as an accurate record of the meeting. There were 3 suggested wording alterations. • **Actions** ○ 8.1 21/5/19 – remains outstanding.

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	○ 10.3 10/9/19 – discussions with Council colleagues are ongoing. ○ 18.2 21/5/19 – The lease issues are now resolved, The Accountable Officer congratulated all members involved for their hard word to get to this resolution. ○ 9.1 21/5/19 x 2 – remains ongoing.
	Matters arising None declared.
6. **6.1** **6.2**	**Public Voice** **Questions from the Public** No questions raised today. **Patient Story** https://walsallccg.nhs.uk/get-involved/patient-stories/ The patient story was presented in the video by Paul Higgitt from Healthwatch and highlights a young mother diagnosed with cervical cancer and the care and support provided to her by the community palliative care therapy team. The Chair invited questions from members. The Chief Nurse raised concerns about the treatment this patient has received in terms of discharge planning, where was the follow up and where was the interface between the Community and Acute services. ACTION: The Chief Nurse requested the details of this patient to discuss with the Director of Nursing at Walsall Healthcare Trust (WHT). The GP colleagues at today's meeting were not surprised by this story, there are many patients discharged without proper planning. The Chief Nurse explained that processs are in place for WHT to adhere to so there is no excuse for this sort of treatment. The Lay Member for Commissioning stated that there are also patient's education aspects missing. Patients should know what to expect upon discharge. The Clinical Executive for the Safety and Quality team, who is also the Clinical Lead for Cancer for the CCG stated that we need more information about this specific case before making judgements. The Clinical Executive requested the name of the GP practice this patient is registered with, as each practice has a Cancer Champion. She did dispute the part in the video relating to the lack in knowledge in GP practices around palliative care, occupational and physiotherapy services. There are referral forms available and GPs make referrals on a daily basis. The Clinical Executive for Primary Care agreed with the comments made and reiterated the point that patients may not be asking the right questions of what they should expect at the point of discharge. Moreover patients are not having the right specialist care they need and are being referred back to the GP. The Director of Primary Care pointed out that perhaps the specialists were concentrating on her treatment and did not ask what is important to the patient therefore missing the fundamental day to day aspects of being at home following discharge. The Accountable Officer gave an example of discharge following a specialist procedure at Bristol and the Specialist Nurse telephoned the patient every day for a week post discharge then follow up calls for a month until they were satisfied he was fine. The Chief Nurse made a final comment stating that the CCG commissions all the services that should have been involved from discharge and this case needs to be followed up to see where it failed.

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	The North Locality Chair suggested a snapshot discharge audit.
6.3	**Public Update** The Lay Member for PPI presented the report highlighting from November's Governing Body a plea for members to encourage their Practices Patient Participation Groups (PPG) to attend forthcoming events. This has been successful with new members attending events. The Chair of Healthwatch at the November's Governing Body asked about the destination of the Patient Advisory Group (PAG). The group has not met for over a year and there are no plans to resurrect due the changes in the CCG structure. For assurance it was noted that PAG members are consulted when necessary virtually. Harmonisation of Policies and the Listening Exercises are also detailed within the report. ACTION: The Healthwatch report was not submitted in time to be included with the papers for this meeting but will be shared electronically with members.
7.	**Report from Chair**
7.1	The Chair emphasised the merits of getting your flu vaccination and has developed a press release jointly with Public Health colleagues. Although the flu virulence will reduce over the coming months there are still opportunities to get vaccinated. The data shows that Walsall is still under the national targets for flu vaccination so please encourage patients especially those in the at risk group to get their vaccination. The Director of Primary Care confirmed that following the publication of the latest vaccination uptake data, individual practices are being contacted and are being encouraged to increase their rates. There is a national cancer audit underway and Dr Teoh has been leading on this for Walsall. Clinicians are encouraged to complete the audit. The E Consult programme has been used in the Chair's practice over the Christmas period with encouraging results and he encouraged other practices to sign up and use. The Lay Member for PPI stated that E Consult was discussed at November's PPG, the general consensus from the people that attended was scepticism around safeguarding issues. She asked the Chair if any feedback has been received from the patients. The Chair responded by saying he will discuss this with the Patient Representative Group (PRG) and feedback. There should also be data from the Patient survey in the next few months that can be analysed. The Chair invited the Lay Member to join the PRG at their monthly coffee afternoon.
7.2	**Report from Accountable Officer** The Accountable Officer highlighted to members' information relating to the delivery of Transforming Care Partnership (TCP) which relates to our patients with Learning Disabilities (LD). Over the Christmas period across the Black Country there have been 6 admissions which now puts our STP furthest from target in the whole of England. A telephone call was arranged with the National Lead of TCP to discuss the situation. It has been agreed with Helen Hibbs who is the current Senior Responsible Officer (SRO) for TCP to transfer this responsibility to Michelle Carolan, Chief Nurse of Sandwell and West Birmingham CCG to take the SRO role on an interim basis. Stephen Marshall, Director of Commissioning at Wolverhampton has been asked to coordinate the commissioning of LD services on a collective basis on behalf of all 4 CCGs. A summit has been arranged with our Council and Mental Health providers next week. The purpose of the summit will be to look at all the fundamental issues and what needs to be addressed to improve the position. It is understood that discharging these specific patients

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	back into the community is very difficult due to the natural of their conditions and circumstances. The Governing Body was made aware that TCP is a priority above any other for the Black Country CCGs. This is also a national priority given by the Secretary of State and the Chief Executive for the NHS that the whole NHS will work to reduce the number of patients in LD in-bed placements. The numbers of patients Walsall CCG have in Tier 4 beds is the same now as it was 2 years ago. The Accountable Officer announced that Matthew Hartland and Rachael Ellis have been appointed as Deputy Accountable Officers. Congratulations extended to Mr Hartland. Mark Axcell has been appointed as the Chief Executive Officer for Dudley and Walsall Mental Health Trust and Black Country Partnership Trust who are on trajectory to merge into one mental health service provider from 1st April 2020. This is subject to regulatory approval. There is a new Chair of West Midlands Ambulance Service, Sir Graham Meldrum is stepping down and Ian Cumming who was the Chief Executive of Health Education England will take up this role.
8. **8.1** **8.2**	**Strategy** **Black Country and West Birmingham Sustainability & Transformation Partnership (STP) update** The Accountable Officer stated that the Long Term Plan has now been submitted and we are now in a mobilisation phase. There will be more information later on the agenda, the Chief Finance Officer stated that it is expected that the publication of the Long Term Plan will not be until March 2020 at the earliest. The proposal of how the finances will be managed for 2020/21 will be presented at the Extraordinary Governing Body in Common on 21st January 2020. There are ongoing discussions around the governance arrangements for the STP working towards being an Integrated Care System (ICS). More information should be presented at the next STP Partnership Board meeting later this month. **Joint Commissioning Committee (JCC) Assurance report** There was no further update at the meeting.
9.	**Future Form Black Country and West Birmingham – Next Steps following the Engagement Listening Exercise** The Accountable Officer reported that item 9 illustrates the comprehensive work that was undertaken. The findings do highlight the need for more work to identify what are the important issues for working at place. The proposal is to continue this phased work with updates in due course but in parallel work on the new CCG governance arrangements and the management team re-structure.
10. **10.1**	**Integrated Assurance** The Chief Nurse presented the assurance report from the Integrated Assurance Committee (IAC), highlighting the dashboard and the key exceptions set out in the Executive summary. Section 1 access measure is being escalated to the Governing Body which is due to the A & E performance.

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	There are 2 measures being escalated in the experience section which are C-Difficile and VTE full details are written into the report. The Accountable Officer questioned the Chief Nurse about the ambulance handover position and stated that Richard Beeken, CEO of WHT has been tasked as Chair of the Urgent Care Board to coordinate the analysis of the comparative data between each of the Acute Trusts in the Black Country. It is unclear when this information will be available but it will help the CCG to establish any obvious unwarranted variances in the performance position. The Chief Nurse will be discussing this subject in a meeting with the Chief Nurse at WHT and whether any safety issues have been identified due to delays in handover. The members were happy with this explanation. In terms of the clinical harm agenda which has been highlighted in previous Governing Bodies, there has been significant progress with the Trust in this area. There is a process in place to review the backlog and the Clinical Executive for Safety and Quality is liaising with the Deputy Medical Director to progress this work. The Governing Body resolved to accept the 4 recommendations set out in the report.
11.	**Black Country Hub and Spoke Safeguarding arrangements and memorandum of understanding (MoU)** The Chief Nurse reminded members that at November's Governing Body there was a Safeguarding paper presented following a review of the CCGs statutory responsibilities. As part of that discussion it was noted that the four Chief Nurses in the Black Country were collaborating to develop a more resilient single safeguarding model. The model was presented and approved at the Black Country Executive Away Day. The proposal was to deliver a hub and spoke model for the Black Country. Walsall's statutory responsibilities as part of the partnership between the Council and Police will be maintained and strengthened in this model. As part of the plan there will be a Head of Safeguarding role who will work across the Black Country and report into 1 Chief Nurse, in order to do this a Memorandum of Understanding is required to ensure that the CCG is meeting its statutory responsibilities. The host CCG for this work is Sandwell and West Birmingham, Michelle Carolan, Chief Nurse will lead. The Lay Member for Commissioning asked for the rationale why Sandwell and West Birmingham were chosen as the host. He raised concerns that it appears due to the lack of rationale in the report that in general, CCGs are self-selecting the work they wish to lead on. The Chief Nurse responded by stating that several factors have been taken into consideration such as expertise and technical ability around safeguarding. Michelle Carolan has held national roles in safeguarding and is technically best placed to lead this work, together with the workforce capacity to take this work forward at pace. The Chief Nurse assured members that the CCG has been involved in the development of this proposal. The Accountable Officer then stressed that this is a temporary situation until the single management team is in place and a base is found for the team. There is a report being presented at the Extraordinary Public Governing Body in Common on 21st January 2020. The Chief Finance Officer pointed out that in terms of the finances there is a discrepancy between the report and the MoU. There needs to be a consistent narrative and what is set out in the report is the preferred option. ACTION: The Chief Nurse agreed and acknowledged the error and will amend accordingly. The Governing Body resolved to note and approve the recommendations with the caveat that the finance discrepancy noted is amended.

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12.	**Finance and Investment**
12.1	The Chief Finance Officer raised 3 points from the Finance and Investment report. The CCGs financial position is that the CCG is on target to achieve a surplus of £1m in-year. The half year review has been completed and the outcome of the review is that by managing our spending in Quarter 4 the CCG will achieve position as set out. There are risks that will need to be managed namely historical issues with the Council and WHT. The intension is to ensure that both are resolved by the end of this financial year. The Losses and Special Payments Policy has now been ratified. The APMS contract has now been signed by Modality which in turn has released NHS Property Service to undertake the work at the practice at Forrester Street. The Governing Body resolved to accept the report for assurance.
13.	**Governance**
13.1	**Audit and Governance Committee** The Chief Finance Officer presented the report in the absence of the Audit Chair. The finance focus was highlighted and the Committee received the revised scheme of delegation for the CCG which is now aligned to the new governance structure in the CCG but recognised that it will change again very soon. This will also be on the agenda for next week's Extraordinary Public Governing Body in Common on the 21st January 2020. The financial risk within the Long Term Plan was also discussed at the last Committee. Most of the risk have now been mitigated for the STP although this has not yet been fully concluded. There are ongoing discussions on how the CCGs are represented at the STP Board and what is appropriate. The Governing Body resolved to accept the report for assurance.
13.2	**Board Assurance Framework** The Accountable Officer raised the following point around TCP reiterating the levels of risk associated with this and the CCGs ability to affect the right changes for these individuals and the reputational risk for our organisation and the system as a whole on not delivering the outcomes. The level of risk needs to be reviewed and discussions as a whole system need to be undertaken. The changes to the SRO arrangements for adults with learning disabilities and organising the summit described earlier in the Accountable Officers update were noted. This needs to be logged as a significant risk. The Chief Nurse in Walsall remains the SRO for children and young people. In conclusion the Chief Finance Officer did point out that this TCP risk is likely to impact the CCGs assurance ratings at year end. ACTION: The Chief Nurse to liaise with the other Chief Nurses to ensure the same narrative is used across all 4 CCGs is entered against the risk to the trajectories for adult LD (TCP). It was noted that the risk rating was lowered due to Walsall CCG being able to demonstrate the work that has been undertaken to gain awareness of our local targets. The Lay Member for Commissioning requested to see the full paper that is presented at Joint Commissioning Committee (JCC) which shows the whole system picture. This was agreed and can be shared with members. He continued to state that the Black Country has struggled with the adult LD target for over 2 years and it is unclear why this is, with no data to benchmark us against the national position.

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	The Accountable Officer responded by saying this is a complex subject and at the summit there will be discussions on what needs to change with our main provider. It was identified over Christmas with some of the admissions, patients had been admitted into Dudley and Walsall Mental Health Trust and yet there is no collaboration with the Black Country Partnership Trust even though in a few months' time they should be merging these organisations. Therefore, it seems that there is a clinical collaboration leadership issue within the services. There are issues in the way the Councils interact with services and also Ministry of Justice (MoJ) orders that all hinder discharges but with good reason. It has been observed that although numbers of patients being admitted has gone down in other areas, the numbers in the Black Country have remained the same. The Chief Nurse stated that there will be a full performance report presented at the Governing Body Private in Common meeting on 21st January. Clinical Leadership within our main provider is challenging and the Accountable Officer has raised this with Mark Axcell, CEO of Dudley and Walsall Mental Health Trust. The report was accepted for assurance with the above risk noted and joint narrative to be included once the 4 Chair Nurses have met to agree the wording.
14. **14.1**	**Commissioning** **Policy and Commissioning Committee Assurance report** *Mr Tulley joined the meeting at 2.20pm* No further update given therefore the report accepted for assurance. The Lay Member for Commissioning requested more information regarding the decommissioned falls service and where the funding will come from for next year as the CCG did provide additional funding to continue the service this year following Public Health's decision to decommission. In reply the Chief Finance Officer pointed out that the information is in the report and the funding for the falls service has been added into the planning process for next year. The Lay Member appreciated this action but asked whether there would be a contribution from Public Health as this was previously their commissioned service. The Director of Commissioning informed members that these discussions had not yet taken place with Public Health. The Policy and Commissioning Committee have reviewed the falls service and considered a new specification but the decision does fall into the planning process. The CCG has clearly reiterated to the Council that there does need to be a 50/50 split by health and council. The Lay Member for Commissioning then stated that when the Primary Care Trust was dissolved and the Public Health team transferred to the Council the funding/grant was transferred in full with them. The Director of Commissioning clarified that the Council do not have a specific legal responsibility to provide a falls service but in Walsall it is a service that was transferred to the Council. Although there is a moral requirement to continue to fund a falls prevention service. The Accountable Officer said we need to establish if there is a need for the service and who is using it, this will give the CCG the impetus and evidence to take to the Council. It was agreed that the CCG need to look at the information that was given to the Council last year as part of their consultation and write to the Council with our concerns.

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15.	**Clinical Treatment Policies**
15.1	*Mr Dave Whatton, Commissioning Lead and Kathryn Drysdale from the CSU joined the meeting.* The Director of Commissioning gave an overview of the report. The proposed policies will mean that two procedures arthroscopic shoulder decompression and image guided high volume intra-articular injections are not routinely commissioned. The proposals have been presented at the Black Country Joint Commissioning Committee (JCC) and December's Policy and Commissioning Committee, both have recommended that it is ratified at today's Governing Body. The North Locality Chair asked what the perspective of the Royal College of Orthopaedics or the general opinion of the orthopaedic surgeons. In reply Kathryn Drysdale responded to say that from the shoulder surgery perspective, NHS England produced some restricted criteria in April which was entirely supported by the Royal College and the British Association of Orthopaedics. Clinical feedback was requested on these policies but no feedback was received. It is generally accepted that there is no clinical effectiveness for these procedures. The 'you said we did' report enclosed with the report, does document all feedback received. The Governing Body resolved to approve the recommendation to approve the three policies detailed in this report in readiness for implementation in April 2020.
16.	**Primary Care Commissioning**
16.1	**Primary Care Commissioning Committee (PCCC)** The Director of Primary Care highlighted the section on the Primary Care Networks (PCNs). Regular meetings are taking place between the PCN Chairs and the CCG. The CCG has supported the PCNs in the first phase of their development. The additional roles are being advertised and 7 clinical pharmacists have been secured and the recruitment of social prescribers was progressing but has had some setbacks. Following the meeting with the PCN Chairs yesterday the discussions with OneWalsall have stalled and a different route to recruit social prescribers is being investigated. The CCG is working with individual practices around their flu immunisation uptake rates. Some practices should be commended for reaching the national targets. In terms of the GP patient survey results, all practices have received individual reports on their performance and have been encouraged to share the information within the practice to address and improve the areas highlighted. The survey is live again for this year. The online consultation E Consult scheme that has been rolled out, feedback is encouraging. The extended access service will be discussed in full in the private session of the Governing Body but the members were informed that the necessary due diligence exercise is underway and the CCG is receiving good levels of assurance from the PCNs. The Primary Care offer is coming to an end for the first year and a review is underway to develop the offer for next year. The priorities are being reviewed and will be aligned with the priorities from the STP Clinical Leadership Board. The Chair asked about the integration of Primary Care and 111 services. The Director of Primary Care stated that the test site was identified just before Christmas therefore the evaluation is not available yet. Following a conversation at the Local Medical Committee (LMC) last week there will be more work undertaken to look at the 2-hour disposition to GP practices. There have been concerns raised across the country regarding this and if a patient wants to see a GP within 2 hours, this is deemed as urgent not routine.

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	The Lay Member for Commissioning stated that following the breakdown in communication between OneWalsall and the PCNs, the Committee will require an update on these issues. The Chair will meet with the Lay Member outside this meeting to clarify the issues. The Governing Body resolved to accept the report for assurance.
17.	**Governing Body Risk Register** The members reviewed: • GB01 – this remains the same. • GB04 – this will be discussed at the Governing Body in Common (21st January) therefore remains the same. • GB06 – this remains as it an STP issue. • GB05 – the scoring to remain the same but the narrative to change. Consider poor performance. How do the providers work better together (patient experience, understanding the effectiveness of our providers and within the STP?) Risk is now different, with new arrangements. It was agreed that this action to be closed and replaced by 2 actions place and system. • GB07 – continues in the transition phase, score remains but wording needs to be updated by communications department. • GB08 – this action needs to be split into 2 parts, system – taken by Matt Hartland and Place taken by Rachael Ellis. • GB10 – Action to be taken by Matt Hartland who will update the information around the financial issues for next year and what the CCG can invest in next year. • GB 09 – in hand and remains the same.
18. **18.1** **18.2**	**For information Only** **Health and Wellbeing Board Minutes** **Health Overview and Scrutiny Committee Minutes**
19.	**Any other Business** None declared.

Next meeting: Tuesday 31st January 2020 at 1pm, Board Room, Jubilee House - TBC

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Agenda Item 3.3.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 11 February 2020
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~

Dr S Reehana	Chair
Clinical	
Dr M Asghar	Board Member
Dr D Bush	Board Member
Dr R Gulati	Board Member
Dr M Kainth	Board Member
Dr R Rajcholan	Board member
Management	
Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Mr J Green	Joint Chief Finance Officer for Sandwell/Wolverhampton CCG
Mr M Hastings	Director of Operations
Mr M Hartland	Deputy Accountable Officer
Ms S Roberts	Chief Nurse Director of Quality
Lay Members/Consultant	
Ms S McKie	Lay Member
Mr P Price	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member
In Attendance	
Ms K Garbutt	Business Operations Officer
Mr P McKenzie	Corporate Operations Manager
Ms A Smith	Head of Integrated Commissioning (part)

Apologies for absence

Apologies were received from Mr J Oatridge, Mr J Denley, Mr D Watts, Ms S Gill, Dr Mittal and Mr P Maubach.

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Declarations of Interest

WCCG.2523 No declarations of interest were declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body

WCCG.2524 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group (WCCG) Governing Body meetings held on the 12 November 2019 be approved as a correct record.

Matters arising from the Minutes

WCCG.2525 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2526 There were no Committee Actions

RESOLVED: That the above is noted.

Chief Officer Report

WCCG.2527 Mr M Hartland tabled a document "Chief Executive Briefing" to the Governing Body. He highlighted the appointments across the system.

He pointed out that a number of people in England have now tested positive for Coronavirus with none identified in the Black Country to date. The NHS in Wolverhampton and Public Health England are extremely well prepared for outbreaks of new infectious diseases.

Mr Hartland gave a brief overview of the local planning in Wolverhampton contained within the report.

We continue to monitor the performance of our providers over the winter period to ensure that people are getting the best quality service and experience.

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RESOLVED: That the above is noted.

Dr Kainth arrived

Safeguarding Memorandum of Understanding

WCCG.2528 Ms S Roberts presented the report, she pointed out that safeguarding across the Black Country needs to continue to work collaboratively, whilst maintaining local leadership and representation within the Clinical Commissioning Groups (CCGs) as four legal entities, as well as supporting our statutory partners, including each of the Local Authorities. She added this has now been shared across the four CCGs.

Mr L Trigg referred to page 17 regarding agreed costs. Mr Hartland stated that this will be split across the four CCGs and additional costs are still to be determined. This is a technical exercise; the allocation process in finance will be used in the future.

RESOLVED: That the Governing Body noted the report and approved the Memorandum of Understanding to facilitate a single head of service for safeguarding across the Black Country, ensuring operational oversight of the safeguarding statutory functions.

Better Care Fund (BCF) Quarterly report / BCF Section 75

WCCG.2529 Ms A Smith referred to the report which is to inform the Governing Body on the work being undertaken within the Better Care Fund Programme.

She referred to the Delayed Transfers of Care and the relative performance between December 2016 and October 2019 graph.

The latest reported number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of December is 47% lower than in the previous year.

There is a continued reduction of non-elective admissions that are aligned to the schemes within the BCF programme. For Care Close to Home there has been a reduction of 1728 emergency admissions against the gross plan and 1181 against the net plan from April 2019.

Ms Smith referred to the Adult Community Care. Space has been identified at Bilston Health Centre and floor plans have been drawn up.

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Following a recent presentation by Dementia UK, funding has been found to pilot an Admiral Nurse working in the City. Admiral Nurses are specialist Dementia nurses. Discussions are ongoing to determine the model of delivery. There will one Admiral Nurse carrying this role out over a pilot period of 2 years.

Ms Smith stated that the final version of the BCF Section 75 should be available at the end of today. There is no significant change and requested if the Governing Body would give delegated authority for Dr S Reehana/Mr P Maubach to sign this off.

RESOLVED: That the Governing Body agreed to give delegated authority for Dr S Reehana/Mr P Maubach to sign off the BCF Section 75.

Ms A Smith left

Update from Transition Board Future Form Black Country and West Birmingham – Next steps following listening exercise

WCCG.2530 The Transition Board established by the Governing Bodies of the four Black Country and West Birmingham CCGs have undertaken a listening exercise on the future form of the CCGs as a Single Commissioning Voice in an Integrated Care System. Mr Hastings pointed out Phase one and Phase two on pages 119-120. Currently all executives are going through a process to secure a position within the new executive team hopefully by 1 April 2020.

The Black Country and West Birmingham Transitions Board was formed at the beginning of 2019. The membership at the beginning comprising of the 4 Chairs and the 3 Accountable Officers together with a Lay Representative from each CCG. When the Transition Board first met, it was important to define the Terms of Reference and to have each CCG Governing Body approve these. A listening exercise took place which was a focused exercise undertaken with the intention to listen to what people had to say.

Mr Hastings referred to the Engagement Approach and Methodology detailed on page 123 of the report. He gave an overview of the next steps within the report. On page 150 this details individual feedback by CCG and Stakeholder group.

Ms Mckie asked if there will be a process in place for GP practices to question the process. Mr Hastings stated Communication and Engagement will be communicating with Primary Care and Governing

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Bodies in Common. Mr Hartland added that there will be more involvement from practices with Phase 2. Mr Price asked when we make a decision for the four CCGs to become one CCG. Mr Hartland stated there is a clear strong view not to become one CCG at this stage.

RESOLVED: That the above is noted

Board Assurance Framework (BAF)

WCCG.2531 Mr P McKenzie referred to the report and the Governing Body are asked to consider whether the risk ratings for each domain remain appropriate.

This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives. The overhaul assurance framework on the latest review headline ratings remain the same. Last quarter we took a deep dive risk around Primary Care. The next deep dive will be around Integrated Care Alliance. This will be reported at the next Audit and Governance meeting.

Mr McKenzie pointed out that the CCG BAF and Risk register ongoing refresh work is critical, as failure to identify and manage risk is a risk to the achievement of the CCG's strategic objectives.

RESOLVED: That the above is noted

Commissioning Committee

WCCG.2532 Dr M Kainth referred to the report from November and pointed out Medicines of Limited Clinical Value. The Committee was presented with a report for approval to NHS guidance on 7 new additional items which should not be routinely prescribed in Primary Care. An engagement exercise took place in October 2019 via survey monkey. The results show that patients agreed that reviews should be conducted by a health care professional for these medicines.

He pointed out the 111 service. This integration transferred on the 5 November 2019 to West Midlands Ambulance Service (WMAS). With the associated planned reduction in conveyances, there exists a potential for a significant saving for the CCG.

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Dr Kainth referred to the February 2020 report. He highlighted the Ophthalmology Cataract provision in Wolverhampton. .

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2533 Ms Roberts presented the report which has been reformatted. She reported on the main areas for focus. Cancer performance at Royal Wolverhampton Hospital Trust (RWT) against 62 and 104 day cancer pathways, although improving, remains below trajectory. No reports of harm for patients waiting for treatment. Referral to treatment time incomplete pathway performance at RWT has not achieved the 92% target. There are no reported waits over 52 weeks and the referral backlog is reducing.

The Standardised Hospital Mortality Index for RWT has now returned to within expected range.

The Care Quality Commission (CQC) report for Black Country Partnership was good. The RWT CQC will be reported on Friday 14 February 2020.

Ms Roberts pointed out Transforming Care Partnership (TCP). Although the Black Country and West Birmingham system has achieved significant discharges over the lifetime of the TCP, it is recognised that there is a significant number of adults with learning disabilities and/or autism who are currently inpatients in mental health or learning disabilities services. Wolverhampton has not had an admission to an inpatient bed for 16 months.

Ms Roberts pointed out that 2 Wolverhampton nursing homes require improvement. Dr Gulati pointed out that the Delayed Transfers of Care beds do not assess the risk of patients. Ms Roberts stated work is currently in process to smooth the discharge arrangements. Dr Bush highlighted the fact that the new Primary Care Network Directed Enhanced Service specification calls for earlier diagnosis of cancer. This is likely to lead to an increase in referral rates, reduced conversion rates, and risks increasing delays to cancer *patients*. Ms Roberts stated there is currently a Cancer Board who will be managing additional monies and to look at all challenges. Mr Hartland added in terms of the governance how we manage challenges, is to stress test the cancer alliance which is provider focus to the Cancer Board. Ms Roberts passed around a booklet to the Governing Body “Best Practice Guideline” for information.

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RESOLVED: That the above is noted.

Dr Asghar arrivevd

Finance and Performance Committee

WCCG.2534 Mr T Gallagher presented the reports. He focused on the January report. We are continuing to meet all our financial metrics. He referred to Quality, Innovation, Productivity and Prevention (QIPP). The submitted financial plan, prior to the request to increase the control totally, required a QIPP of £13.536m or 3.5% of allocation. We are actually meeting that target and this is shown in green. The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686 million.

Work is ongoing around achieving the Referral to Treatment (RTT) standard as near as possible. As a result the financial risk dealt with in reserves. He referred to page 245 and the extract from month 9. The CCG achieved its plan, achieving 1.0% recurrent underlying surplus after adjusting for Co Commissioning.

Within the CCG £1 million has been identified as a development fund to start new programmes. In terms of risk on page 258, the financial position of the CCG as at month 9, the CCG has adjusted the risk profile as well as reducing the level of risk not reflected in the reported position.

Mr Price asked if the QIPP target increase will return to £13 million next year. Mr Gallagher stated this will increase again to £20 million. It is about managing the process in the next financial year. Mr J Green added there is differentially impact on the 4 CCGs, this will be a real challenge for next year.

RESOLVED: That the above is noted.

Mr S Marshall arrived

Audit and Governance Committee

WCCG.2535 Mr Price presented the paper. He pointed out Cybersecurity. This was rated as a red and that it had been particularly difficult to obtain the contract held by Wolverhampton CCG and The Royal Wolverhampton Hospitals Trust. The report now contained information regarding outstanding actions which had been requested previously by the Committee.

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RESOLVED: That the above is noted.

Remuneration Committee

WCCG.2536 Mr Price referred to the report and asked if there were any questions. No questions were raised.

RESOLVED: That the above is noted

Primary Care Commissioning Committee

WCCG.2537 Ms S McKie referred to the report pointing out this is a summary of 2 meetings. She pointed out the successful outcome regarding the potential closure of Wood Road Surgery. A proposal was put forward to not close the surgery but to reduce the number of sessions from 7 to 4. She added that a lot of good work was undertaken relating to this and this will continue to be monitored. Mr Hartland stated that the right outcome was achieved and this could be used as 'best practice' across the other CCGs. Mr Marshall supported this.

Ms Mckie stated that all 6 Primary Care networks now had an allocated Link Worker based within practices to provide a social prescribing service at neighbourhood level. Ms H Ryan pointed out that this is growing slowly. Mr Hastings added that work is being carried out for digitation of records which would free up space within practices for new staff. Work is currently in process for a priority scheme which should encourage practices to commit to using staff in the areas that have been vacated from records. Ms R Gulati asked who are referred to this service as staff are not quite sure also how do we assess the wellbeing of an individual. Currently patients are unable to self-refer however practice staff can do this. More work is being carried out regarding this service.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2538 Ms McKie presented the report. She referred to item 2.1.2 Christmas and New Year opening. Patients were very pleased with this campaign and this will be repeated for Easter. She highlighted that the CCG had promoted campaigns on behalf of NHS Blood and Transplant services to request if more men could donate blood in Wolverhampton. It is extremely difficult to donate blood locally as sessions have been reduced and she asked if there was anything else the CCG could do to promote this work. Ms Roberts stated this could be looked into.

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Patient Participation Group (PPG) Chair meetings are now conducted at Primary Care Network (PCN) level with improving but variable attendance. Representation from practices is wider than was previously seen at the Bi-Monthly City wide meeting but there is still work to do to increase attendance. CCG officers are providing support to the PCN Clinical Directors to manage and develop these meetings which are proving to be very informative to the PPG Chairs that attend. The production of a newsletter to inform our Citizens Forum representatives and a wider range of stakeholders is in its final stages. However this does not work for everybody. Work is in progress to update a more comprehensive list of which organisations and agencies might benefit from the newsletter, minutes and put forward agenda items.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.2539 RESOLVED: That the above minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2540 RESOLVED: That the above minutes are noted

Minutes of the Primary Care Commissioning Committee

WCCG.2541 RESOLVED: That the above minutes are noted

Minutes of the Commissioning Committee

WCCG.2542 RESOLVED: That the above minutes are noted

Minutes of the Audit and Governance Committee

WCCG.2543 RESOLVED: That the above minutes are noted

Black Country and West Birmingham Joint Commissioning Committee Minutes

WCCG.2544 RESOLVED: That the above minutes are noted

Health and Wellbeing Board minutes

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WCCG.2545 RESOLVED: That the above minutes are noted

Any Other Business

WCCG.2546 Ms Roberts referred to the Coronavirus and the picture is changing daily. At present there are low numbers in England and updates are received each day. Dr Bush asked if there was anything in place if there were any incidents. Mr Hastings reported this is being handled through the Emergency Planning team and any communications would come from Public Health England.

RESOLVED: That the above is noted.

Members of the Public/Press to address any questions to the Governing Board

WCCG.2547 There were no questions from the public or press present at the meeting.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2548 The Board noted that the next meeting was due to be held on **Tuesday 14 April 2020** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.30 pm

Chair..…………………………………..

Date ……………………………………

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Wolverhampton Clinical Commissioning Group | Sandwell and West Birmingham Clinical Commissioning Group | Walsall Clinical Commissioning Group | Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 5.0

Title of Report:	**Walsall CCG – Committee Assurance**
Purpose of Report:	To set out details of the work of Walsall CCG's Governing Body Committees since the last meeting of the Governing Body on 14 January 2020
Author of Report:	Sara Saville Head of Corporate Governance Walsall CCG
Management Lead/Signed off by:	Anand Rishie, Chair Walsall CCG
Public or Private:	Public
Key Points:	This report sets out, for a assurance, summaries of the following meetings of the Committees of the Walsall CCG Governing Body: • Audit and Governance Committee, 11 February 2020 • Policy and Commissioning Committee, 20 February 2020 • Finance and Performance Committee, 29 January and 26 February 2020 • Primary Care Commissioning Committee, 20 February 2020 • Integrated Assurance Committee, 28 January, and 26 February 2020 • Remuneration Committee 18 February 2020
Recommendation:	**That Walsall CCG's Governing Body receives the Summary report for Assurance.**
Conflicts of Interest:	There are no conflict of interest issues identified in relation to this report.
Links to Corporate Objectives:	The Governing Body Committees support the Governing Body in delivering all of the CCG's Corporate Objectives
Action Required:	☒ Assurance ☐ Approval ☐ For Information
Implications:	
Financial	There are no financial implications arising from this report
Assurance Framework	The Governing Body Committees support the Governing Body in managing the CCG's Assurance Framework and the risks associated with it.
Risks and Legal Obligations	The report is submitted in line with the Committee's Constitutional responsibility to report on their work to the Governing Body
Equality & Diversity	There are no specific Equality and Diversity Implications arising from this report
Other	There are no other implications arising from this report.

1. BACKGROUND AND INTRODUCTION

1.1. The Governing Body Committees of Walsall CCG are required to report on their activity to each ordinary meeting of the CCG's Governing Body. This report has been produced to summarise the activity of the Committees since the last ordinary meeting of the Governing Body in January 2020.

1.2. The report includes details of the following meetings:-

- **Audit and Governance Committee –** 11 February 2020
- **Policy and Commissioning Committee –** 20 February 2020
- **Finance and Investment Committee –** 29 January and 26 February 2020
- **Primary Care Commissioning Committee –** 20 February 2020
- **Integrated Assurance Committee** – 28 January and 26 February 2020
- **Remuneration Committee –** 18 February 2020

2. AUDIT AND GOVERNANCE COMMITTEE

2.1. The Audit and Governance Committee met on 25 February 2020 and considered the following items of business:-

- **Compliance report -** The Compliance Report sets out the key activities for the Information Governance including Freedom of Information, Complaints, and EPRR. Also included was the Information Governance Steering Group Terms of Reference which the committee approved.
- **Internal Audit –** The committee received an update on the work of the CCG's Internal Auditors, including the final reports on Financial Systems – significant assurance, Finance Management – full assurance and Safeguarding which received significant assurance for the arrangements and moderate assurance for mandatory posts. Assurance was given that since the report the mandatory posts have been addressed.
- **Counter fraud –** The committee received an update from the Counter Fraud Specialist, which identified no new issues.
- **External Audit –** The Committee received details of the External Audit Plan for 2019/20, including the audit risk assessment which were endorsed by the committee
- **Governing Body Assurance Framework –** The committee received the latest version of the Governing Body Assurance Framework, noting that as the work across the four CCGs progresses this will become aligned.
- **Risk register -** The committee reviewed the risk register and added a risk around alignment of the Black County and West Birmingham CCGs risk management and assurance framework.

3. POLICY AND COMMISSIONING COMMITTEE

3.1. The Committee met on 20 February 2020 and considered the following items of business:-

- **Financial monitoring report –** the committee received a finance update for month 10 for its delegated budget. The QIPP target is forecast to over achieve by £649K against its revised plan however the overall delegated budget is forecast to be overspent by 1.28% requiring a review to mitigate this cost pressure.
- **Shared care record and EPACCS –** the committee received an update on the progress of the shared care record and noted the mitigation actions taken to resolve the data sharing agreement issues between Walsall and Wolverhampton
- **Community Inpatient Stroke Rehabilitation Service –** the committee were informed that Walsall Hospital Trust were preparing a business case proposing the relocation of this service to Hollybank House in Willenhall. This proposal will be submitted to the Clinical Senate in March 2020.
- **Risk Register –** the register was reviewed with the closure of 12 risks and the addition of a risk regarding the uncertainty of the falls service

4. FINANCE AND INVESTMENT COMMITTEE

4.1. The committee met on 29 January and 25 February 2020 and considered it's regular items of business, these include an update on Performance in Commissioned Services, Financial Performance and Contractual activity. The Committee also considered the risks under its purview.

- The committee informed that the CCG was achieving its control total overall and that the QIPP programmes were currently ahead of target. A number of overspends were reported which were being offset by reserves. The committee received an update on digital and estates.
- The risk register was reviewed with no new risks identified

5. PRIMARY CARE COMMISSIONING COMMITTEE

5.1. The Committee met on 20 February 2020 and received a number of reports for assurance and information:-

- **Assurance Reports –** The committee received reports on Primary Care finance which included a reported underspend; The Primary Care Operational Group which included details of work to improve Primary Care Estate; NHSE GP hub offer, PRG and public voice report which included an update on the listening exercise; digital programme update, national extended access update; direct booking from 111 into in hours GP practices; GPFV;
- **Private Session –** The Committee met in private session and received an update Coronavirus, contract variation and estates.
- **Risk register –** this was reviewed with a number of closures being made

6. INTEGRATION AND ASSURANCE COMMITTEE

6.1. The Committee met on 11 February 2020 and considered the following items of business:-

- **Quality Issues –** The committee received an overview report of quality which included a new concern regarding capacity for tuberculosis, infection control and prevention with an outbreak of norovirus, psychological therapy access and lack of assurance in reporting health assessments for looked after children.
- **Performance –** the report discussed access measures and agreed to escalate IAPT performance
- **Risk register –** the register was reviewed and updated. Three new risks relating to the discussed quality issues were added.

7. REMUNERATION COMMITTEE

7.1. The Remuneration Committee met in common with its counterparts the other three Black Country and West Birmingham CCGs on 18 February 2020. It made a number of recommendations in relation to the remuneration arrangements for the new Single Executive Team that were considered by a meeting of the Governing Bodies in Common on 18 February 2020

8. ASSURANCE FRAMEWORK

8.1 The Board Assurance Framework brings together the red rated residual committee risks into one register to give the Governing Body a summary of the risks against the corporate objectives which are being actively managed by the organisation.

8.2 Red risks rated 20 and above

Of the 71 risks held by the committee registers there are 28 red rated residual risks which feature on the BAF.

The six risks rated at 20 are detailed below:

Risk	Initial rating	Residual rating	Update
PCCC 16 NHS Property Services ongoing disputes between general practices and NHSPS regarding charges, lease arrangements and non payment of invoices has exposed a financial risk.	4x4=16	4x5=20	Meetings with NHS PS continue - progress still slow. CCG met with LMC reps to discuss concerns. Still problems with getting timely responses from NHS PS many outstanding actions. NHS PS threatening escalation
PCCC 21 Forrester St - CCG made aware of premises issues at site and patient concerns	4x5=20	4x5=20	Ongoing support from both PC commissioning and quality teams to address concerns. Consideration given to a a package of support to improve resilience and sustainability. Risk of loss of provider and plan for alternative options to be considered.
IA 62 Infection control WHT There is a potential risk to patient safety through the lack of compliance with infection prevention and control measures at the Trust.	4x4=16	4x5=20	Jan 2020 - Further IPC issues and reported MRSA outbreak therefore risk to remain. Feb 2020 - risk reviewed and to remain.
IA83 As per National Requirements there is a shortfall of Designated Doctors for Safeguarding Children due to failure to recruit.	5x4=20	5x4=20	Dec 19 - risk reviewed at IAC, to remain until the newly appointed Safeguarding Doctor is in post. Jan 2020 - although the post has been filled there is not start date, therefore risk to remain. Feb 2020 - risk reviewed and to remain.
I&A 87 Failure to meet statutory obligations for Adult and Child Safeguarding and to inform associated risks with executing these responsibilities.	4x5=20	4x5=20	Jan 2020 - risk to be reviewed by Chief Nurse (not present at IAC during the reviewing of this risk). Feb 2020 - risk reviewed and to remain
IA 70 –Transforming Care Achieving safe discharges to support people back into community placements. The original aim was by March 2019 to reduce inpatient beds to 4 for Walsall, this increased to 7 due to further clinical admissions. Trajectory for 2020 is now 4 but current risk be use is 13.	3 x 4 = 12	5 x 4 = 20	January 2020 - The achievement of trajectory has the potential to impact on the CCG ratings. Chief Nurse advised that the risk needs to be increased from 16 to 20. Feb 2020 - risk reviewed and to remain

8.4 Risk management

The number of risks on the BAF that have a residual risk rating higher than the initial rating has decreased from 7 to 6. Five of the risks were included in the last report (PCCC16, IA62, GB06, IA89 and IA70) and there have been no changes to these risks since the last report.

Risk	Initial rating	Residual rating	Update
PCCC 16 NHS Property Services ongoing disputes between general practices and NHSPS regarding charges, lease arrangements and non payment of invoices has exposed a financial risk.	16	20	Meetings with NHS PS continue - progress still slow. CCG met with LMC reps to discuss concerns Still problems with getting timely responses from NHS PS many outstanding actions. NHS PS threatening escalation
IA91 CHC – New There is a risk to the delivery of CHC targets due to the staff shortages within the CHC team. The risk would be potential non compliance with CHC DATA statutory reporting	12	16	January 2020 - risk reviewed at IAC - there is capacity / admin issues. Risk to be re-reviewed at IAOG and recommendations made to IAC if required. Feb 2020 - Risk reviewed and agreed to revise description and increase risk due to gaps within CHC.
IA 62 Infection control WHT There is a potential risk to patient safety through the lack of compliance with infection prevention and control measures at the Trust.	16	20	Jan 2020 - Further IPC issues and reported MRSA outbreak therefore risk to remain. Feb 2020 - risk reviewed and to remain.
GB 06 There is a risk that if the STP does not implement appropriate governance arrangements this will impact on Walsall ability to make appropriate contributions and this may affect our assurance rating	15	16	Regular meetings and briefings with all staff and Governing Body members WCCG GB comments back to STP to address comments on MOU
IA 70 –Transforming Care Achieving safe discharges to support people back into community placements. The original aim was by March 2019 to reduce inpatient beds to 4 for Walsall, this increased to 7 due to further clinical admissions. Trajectory for 2020 is now 4 but current risk be use is 13.	12	20	January 2020 - The achievement of trajectory has the potential to impact on the CCG ratings. Chief Nurse advised that the risk needs to be increased from 16 to 20. Feb 2020 - risk reviewed and to remain
IA 89 VTE There is a risk that patients have the potential to come to harm due to the Trust failing to achieve 95% compliance with VTE risk assessment (not achieved since Feb 19)	9	16	February 2020 - risk reviewed and to remain. Revised CPN received and agreed by the CCG

9.0 Recommendation

That the committee note the report for assurance

Wolverhampton Clinical Commissioning Group | Sandwell and West Birmingham Clinical Commissioning Group | Walsall Clinical Commissioning Group | Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 7.0

Title of Report:	**Wolverhampton CCG – Committee Assurance**
Purpose of Report:	To set out details of the work of Wolverhampton CCG's Governing Body Committees since the last meeting of the Governing Body on 11 February 2020
Author of Report:	Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG
Management Lead/Signed off by:	Salma Reehana, Chair Wolverhampton CCG
Public or Private:	Public
Key Points:	This report sets out, for a assurance, summaries of the following meetings of the Committees of the Wolverhampton CCG Governing Body: • Audit and Governance Committee, 25 February 2020 • Commissioning Committee, 27 February 2020 • Finance and Performance Committee, 25 February 2020 • Primary Care Commissioning Committee, 4 February and 3 March 2020 • Quality and Safety Committee, 11 February 2020 • Remuneration Committee 18 February 2020 It also provides details of matters circulated for virtual committee meetings at the following meetings:- • Commissioning Committee, 26 March 2020 • Finance and Performance Committee, 31 March 2020 • Quality and Safety Committee, 10 March 2020
Recommendation:	**That Wolverhampton CCG's Governing Body receives the Summary report for Assurance.**
Conflicts of Interest:	There are no conflict of interest issues identified in relation to this report.
Links to Corporate Objectives:	The Governing Body Committees support the Governing Body in delivering all of the CCG's Corporate Objectives
Action Required:	☒ Assurance ☐ Approval ☐ For Information
Implications:	
Financial	There are no financial implications arising from this report
Assurance Framework	The Governing Body Committees support the Governing Body in managing the CCG's Assurance Framework and the risks associated with it.
Risks and Legal Obligations	The report is submitted in line with the Committee's Constitutional responsibility to report on their work to the Governing Body
Equality & Diversity	There are no specific Equality and Diversity Implications arising from this report
Other	There are no other implications arising from this report.

1. BACKGROUND AND INTRODUCTION

1.1. The Governing Body Committees of Wolverhampton CCG are required to report on their activity to each ordinary meeting of the CCG's Governing Body. As the Governing Body is not scheduled to meet again until May, this report has been produced to summarise the activity of the Committees since the last ordinary meeting of the Governing Body in February 2020.

1.2. The report includes details of the following meetings:-

- **Audit and Governance Committee –** 25 February 2020
- **Commissioning Committee –** 27 February and 26 February 2020
- **Finance and Performance Committee –** 25 February and 31 March 2020
- **Primary Care Commissioning Committee –** 4 February and 3 March 2020
- **Quality and Safety Committee –** 11 February and 10 March 2020
- **Remuneration Committee –** 18 February 2020

2. AUDIT AND GOVERNANCE COMMITTEE

2.1. The Audit and Governance Committee met on 25 February 2020 and considered the following items of business:-

- **Internal Audit –** The committee received an update on the work of the CCG's Internal Auditors, including the final reports on Management of Conflict of Interest and Continuing Healthcare, both of which had been rated as low risk
- **Counter fraud –** The committee received an update from the Counter Fraud Specialist, which set out work completed in the last quarter. This included a staff survey which had highlighted a strong understanding across CCG staff of the work of the counter fraud team.
- **External Audit –** The Committee received details of the External Audit Plan for 2019/20, including the risk assessment and management representation letter, which was endorsed by the committee
- **Governing Body Assurance Framework –** The committee received the latest version of the Governing Body Assurance Framework, noting that as the work across the four CCGs progresses this will become aligned.
- **Progress with the CCG's Annual Report and Accounts –** The committee received an update on progress with the CCG's Annual Report, including the Annual Governance Statement and the Month 9 Accounts submission to NHS England
- **Feedback to and from other Forums –** The committee were given an update on the governance arrangements being developed as part of the CCG Transition arrangements.
- **Financial Governance Arrangements –** The committee received details of losses and compensation payments, receivables and payables and waivers in line with its role in monitoring the CCG's Financial Governance arrangements.

3. COMMISSIONING COMMITTEE

3.1. The Commissioning Committee met on 27 February 2020 and considered the following items of business:-

- **Attention Deficit Hyperactivity Disorder –** the committee approved a new service specification for this service.
- **Quality Incentive Scheme –** the committee approved the continuation of a scheme for prescribing incentives in Primary Care
- **Contracting Update –** the committee received an update on the management of the CCG's contracts with providers including Royal Wolverhampton Trust, Black Country Partnership Trust and third sector providers.
- **Private Session –** the committee met in private and agreed recommendations in relation to Complex Continuing Healthcare and Healthcare contract

3.2 The Committee was due to meet on 26 March 2020. This meeting has been cancelled due to the Government's Social Distancing Guidance and the Committee is taking Urgent Chair's Action decisions in relation to Community Anti-coagulation services and Ambulatory Wound Care.

4. FINANCE AND PERFORMANCE COMMITTEE

4.1. The committee met on 25 February 2020 and considered it's regular items of business, these include an update on Performance in Commissioned Services, Financial Performance and Contractual activity. The Committee also considered the risks under its purview.

4.2. The committee was due to meet on 31 February, this meeting has been cancelled and the reports giving the details of performance and financial performance will be shared with committee members for comment.

5. PRIMARY CARE COMMISSIONING COMMITTEE

5.1. The Committee met on 4 February 2020 and considered the following items of business:-

- **Regular Assurance Reports –** The committee received reports on Primary Care quality, which included details of flu planning and workforce development; Primary Care finance which highlighted the projected breakeven position of primary care budgets; The Primary Care Operational Management Group which included details of work to improve Primary Care Estate; GP Forward View highlighting progress with the STP action plan and Primary Care Contracting
- **Digital First Primary Care Specification –** The committee received an update on this specification, which had been approved urgently.
- **Private Session –** The Committee met in private session and received an update on the work of the Wolverhampton LMC and the Primary Care Network DES.

5.2. The Committee met on 3 March 2020 and, although it was not quorate, it considered the following items of business for assurance purposes:-

- **Primary Care Quality** – The committee received the regular assurance report which included details of work to address the impact of COVID-19 in Primary Care
- **Communications and Engagement –** The committee received a summary of engagement activity in Primary Care for information
- **Primary Care Milestone Review Board –** The committee received assurance on the delivery of the CCG's Primary Care Strategy.
- **Quality Assured Spirometry –** The Committee received an update on the implementation of this service in Primary Care
- **Private Session –** The committee met in private to consider an update from the Local Medical Council and the use of General Practice Resilience funding across the CCG. A further item relating to a practice contract was deferred.

6. QUALITY AND SAFETY COMMITTEE

6.1. The Committee met on 11 February 2020 and considered the following items of business:-

- **Quality Issues –** The committee received an overview report of quality issues in commissioned services. This provided updates on Cancer services, Referral to Treatment and Winter Pressures at Royal Wolverhampton Trust; Black Country Partnership's recent CQC rating of Good and issues with workforce and Bed Capacity and an update on the Transforming Care Programme
- **Emergency Planning, Preparation and Resilience –** The Committee received an update on the CCG's arrangements, including details of a submission of Core Standards to NHS England
- **Safeguarding –** The Committee received an update on safeguarding arrangements for Children and Vulnerable adults, including work on training and ongoing specific case reviews
- **Care Homes –** The committee received an assurance report setting out highlights of the CCG's work to assure and support quality in care homes.
- **Health and Safety –** The Committee received an assurance report on the CCG's Health and Safety arrangements for staff

- **COVID-19 –** The committee received an update on readiness to deal with the COVID-19 outbreak from colleagues in Public Health.

6.2. The committee was due to meet on 10 March 2020. This meeting was cancelled but the reports were circulated for comments. They included the Quality assurance report, highlighting issues relating to Cancer Services, Referral to Treatment and Sepsis at Royal Wolverhampton Trust, quality issues relating to Black Country Partnership and Transforming Care. The other reports on the agenda provide updates on Children with Special Educational Needs and Disabilities, Infection Prevention, Equality and Diversity, Breast Cancer screening and Information Governance.

7. REMUNERATION COMMITTEE

7.1. The Remuneration Committee met in common with its counterparts the other three Black Country and West Birmingham CCGs on 18 February 2020. It made a number of recommendations in relation to the remuneration arrangements for the new Single Executive Team that were considered by a meeting of the Governing Bodies in Common on 18 February 2020.

NHS Wolverhampton Clinical Commissioning Group | NHS Sandwell and West Birmingham Clinical Commissioning Group | NHS Walsall Clinical Commissioning Group | NHS Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 7.0

Title of Report:	**Draft Financial Plan 2020/21**
Purpose of Report:	To present the draft Financial Plan for 2020/21 for the Black Country and West Birmingham CCGs for approval.
Author of Report:	James Green, CFO Thomas Devonshire, STP Finance
Management Lead/Signed off by:	James Green, CFO
Public or Private:	Public
Key Points:	The purpose of this paper is to present the Governing Body with a view of the financial plan for the 2020/21 financial year for the four Black Country & West Birmingham CCGs and highlight the issues the CCGs are working through, which may have a financial impact, as part of the response to COVID-19.
Recommendation:	Members of the Governing Body are asked to:- 1. Discuss the content of the report; 2. Approve the a balanced financial plan to the end of month 4; 3. Note that work is ongoing to ensure the unidentified efficiencies balance within months 5-12 are fully identified and/or mitigated before the end of month 4; 4. Note that further the Governing Body and Finance & Performance Committee will be kept appraised of developments relating to the COVID-19 response, the actions being taken to close the unidentified efficiency gap and 2020/21 contracts.
Conflicts of Interest:	There are no conflict of interest issues identified in relation to this report.
Links to Corporate Objectives:	The Governing Body Committees support the Governing Body in delivering all of the CCG's Corporate Objectives
Action Required:	☒ Assurance ☒ Approval ☐ For Information
Implications:	
Financial	Yes
Assurance Framework	n/a
Risks and Legal Obligations	n/a
Equality & Diversity	n/a
Other	n/a

1. Introduction

The purpose of this paper is to present the Governing Body with the financial plan for the Black Country & West Birmingham CCGs for 2020/21.

This report will include an overview of the following key financial issues:-

- Business rules for CCGs;
- Planning assumptions;
- CCG allocations;
- Expenditure plans; and
- Efficiency targets.

The CCGs have been working to the national operation planning deadlines:

- Submission of draft financial plan 5th March 2020;
- Sign-off contracts by 27th March 2020; and
- Submission of the final financial plan on 29th April 2020.

However, with the need for the NHS to focus its efforts on the COVID-19 pandemic, NHSE/I issued a letter confirming that:

- The operational planning process is being stood down;
- The Payment by Results process is being suspended with Trusts being paid on a block basis until the end of July;
- Efforts nationally and at a Trust level to be made to free up capacity in inpatient and critical care and to ensure there is an adequate supply of oxygen, protective equipment;
- High-risk patients are identified in primary care and contacted; and
- Business continuity plans are in place.

This will have an impact on the financial, activity and workforce plans of all NHS organisations. The four CCGs will work through the impact on their financial plans in due course and a further update on the CCGs' financial plans will be provided to the Governing Body and Finance & Performance Committee in quarter 1 and/or quarter 2 depending on developments relating to the response to COVID-19.

The following sections of this document will provide detail in respect of the construction of the financial plan for each of the four CCGs.

2. Business Rules/Key Financial Metrics

The key business planning rules used for 2020/21 are expected to remain consistent with previous years and are summarised as follows:

Business Rules	DUD CCG RAG	SWB CCG RAG	WAL CCG RAG	WOL CCG RAG
Plan triangulation - Commissioner financial plans must triangulate with efficiency plans, activity plans and agreed contracts; finance, efficiency and activity assumptions must be consistent between commissioners and providers.	**Work is ongoing to ensure final plans triangulate with system partners, although there is currently a contract gap of £56.6m to resolve.**			
Minimum cumulative/ historic underspend of 1.0%				
Local contingency of 0.5%				
Admin costs - Remain within admin allocation				
Mental Health Investment Standard (MHIS) - comply with standard				
Better Care Fund (BCF) - minimum contribution must be complied with				

Due to the suspension of the 2020/21 operational planning process and movement to block payments on account to Trusts as confirmed in the letter referred to in the Introduction, contract negotiations have been suspended whilst the focus is on the response to the COVID-19 pandemic. Therefore, the CCGs are not in a position to confirm whether they will meet the plan triangulation business rule for 2020/21.

All four CCGs plan to meet the requirements of the other commissioner business rules.

3. National Tariff and Efficiency Factor

Where applicable the national tariff will be used. The 2020/21 expected national tariff uplift and efficiency factor is summarised below.

- Gross tariff Increase 2.5%
- Efficiency factor 1.1%
- Net tariff uplift 1.4%
- Plus Clinical Negligence Scheme Trusts (CNST) uplifts:
    - Acute 0.25%
    - Community 0.02%
    - Mental Health 0.03%
    - Ambulance 0.06%

The above national tariff planning assumptions have been applied to non-Payment by Results activity and locally priced contracts as appropriate.

Due to the NHSE/I letter regarding the COVID-19 response this assumption is void for the first four months of the financial year, but is assumed to be relevant to the period August onwards until further notice and dependent on the development of the COVID-19 response.

4. Planning Assumptions

The key planning assumptions used in the draft 2020/21 financial plan are summarised as follows, including the tariff uplift:

Key Planning Assumptions	DUD CCG	SWB CCG	WAL CCG	WOL CCG	BCWB CCGs
	£m /%/RAG	£m /%/RAG	£m /%/RAG	£m /%/RAG	£m /%/RAG
Notified Allocation Change (£'000)	17.1	34.8	16.1	17.0	85.1
Notified Allocation Change (%)	3.71%	4.64%	3.86%	4.38%	4.22%
Tariff Change - Acute (%)	1.65%	1.65%	1.65%	1.65%	1.65%
Tariff Change - Ambulance (%)	1.46%	1.46%	1.46%	1.46%	1.46%
Tariff Change - Community (%)	1.42%	1.42%	1.42%	1.42%	1.42%
Tariff Change - Mental Health(%)	1.43%	1.43%	1.43%	1.43%	1.43%
Demographic Growth (%)	0.41%	0.52%	0.49%	1.02%	0.58%
Total Growth - In-system Providers (%)	3.80%	3.80%	3.80%	3.80%	3.80%
Total Growth - Continuing Care inc. Efficiency (%)	8.68%	7.34%	3.02%	1.71%	5.58%
Total Growth - Prescribing inc. Efficiency (%)	1.09%	1.96%	2.96%	1.28%	1.83%
MHIS (exc. LD & Dementia) Growth (%)	6.65%	6.60%	5.79%	9.21%	6.89%

Each of the four CCGs has reflected the national tariff uplift and efficiency factor for Acute, Ambulance, Community and Mental Health NHS providers.

Notwithstanding the aforementioned letter, whilst contract offers have been calculated based on 2019/20 forecast outturn plus 2%, a standardised approach has been taken to the overall uplifts for in-system providers and plans reflect the Trusts' views of 2019/20 forecast outturn plus total growth of 3.8%. This has led to a deterioation in the previously planned £26.7m surplus for the four CCGs as noted in section 7 and 12 of this paper.

Challenging growth targets have been set for continuing care and prescribing net of efficiencies with some evidenced variation in expected growth between CCGs.

The Mental Health Investment Standard (MHIS) target of programme allocation growth plus an additional 1.7% growth has been factored in to all CCG plans.

5. Allocation/Revenue Resource Limit

NHSE/I published CCG allocations for the period 2019/20 to 2023/24 in January 2019. The 2020/21 allocation for each CCG has since been updated to reflect recurrent allocations received during 2019/20 totalling £3.2m and also an additional £1.5m recurrent allocation received for 2020/21 to reflect the net impact of the final national tariff and the transfer of commissioning responsibility for a number of services.

Recurrent allocations have increased by £95.2m compared to 2019/20, of which £88.6m is Programme, £8.7m is Delegated Commissioning, £1.5m is additional 2020/21 recurrent allocation as mentioned previously, and a £3.5m reduction in Running Costs due to the NHSE/I requirement for CCGs to make a 20% real terms reduction compared to 2017/18 allocations. When accounting for the removal of 2019/20 non-recurrent allocations the net increase in allocation is £62.3m.

The total in-year allocation across the four CCGs is £2.3bn for 2020/21, of which £26.3m is for Running Costs and £213.2m for Delegated Commissioning.

Revenue Resource Limit	DUD CCG		SWB CCG		WAL CCG		WOL CCG		BCWB CCGs	
	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m
Original Programme Baseline	451.8	469.6	738.8	775.0	411.5	428.3	382.4	400.0	1,984.4	2,072.9
Recurrent Changes In-Year	1.4	1.4	1.0	1.0	0.4	0.4	0.4	0.4	3.2	3.2
Additional Funding	-	0.3	-	0.6	-	0.3	-	0.3	-	1.5
Primary Care Co-Commissioning	43.0	44.6	82.0	85.4	41.4	43.2	38.1	40.0	204.5	213.2
Running Cost Allocation Recurrent	6.7	5.9	11.5	10.1	6.1	5.4	5.5	4.9	29.8	26.3
Total Notified Allocation	502.8	521.8	833.2	872.1	459.4	477.6	426.4	445.6	2,221.8	2,317.1
Other Non Recurrent allocations	4.0	-	5.6	(0.5)	6.1	-	16.8	-	32.4	(0.5)
In-Year drawdown/(drawup)	-	-	-	-	-	-	-	-	-	-
Total In-Year Allocation	506.8	521.8	838.8	871.6	465.4	477.6	443.2	445.6	2,254.3	2,316.6

6. Expenditure

In total, the planned expenditure across the four CCGs will rise by £66.2m from £2.25bn in 2019/20 to £2.31bn in 2020/21 to reflect the normalised 2019/20 position, commissioner business rules, planning requirements, growth assumptions and a planned surplus of £4.5m across the four CCGs.

Expenditure	DUD CCG		SWB CCG		WAL CCG		WOL CCG		BCWB CCGs	
	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m
Acute Services	267.0	279.6	408.9	420.6	227.8	238.7	212.3	221.5	1,116.0	1,160.3
Mental Health Services	46.0	48.3	107.5	112.3	48.3	50.0	45.9	44.2	247.8	254.7
Community Services	41.0	42.5	63.6	64.6	36.3	36.9	45.2	47.3	186.1	191.4
Continuing Care Services	21.5	23.4	34.2	36.7	24.5	25.5	16.4	16.7	96.6	102.2
Primary Care Services	7.5	7.7	14.8	12.1	13.4	12.6	8.2	4.9	43.9	37.2
Prescribing	55.9	56.5	81.4	84.4	50.2	52.0	49.5	50.9	237.0	243.7
Other Programme Services	17.6	12.4	32.2	35.1	16.9	13.4	19.2	10.7	85.9	71.6
Primary Care Co-Commissioning	43.0	44.3	82.1	85.3	41.4	43.0	38.1	40.0	204.6	212.6
Running Costs	6.1	5.9	11.0	10.1	5.7	5.4	5.2	4.9	28.0	26.3
Contingency		2.8		4.4		2.4		2.2	-	11.8
Total Expenditure	505.7	523.5	835.7	865.5	464.4	479.8	440.0	443.3	2,245.9	2,312.0

In-system NHS contracts have been included based on the providers' views of 2019/20 forecast outturns for each contract and uplifted by 3.8%. This is not a final position, but was STP-wide decision to reflect the contract risk in the bottom-line of organisations, rather than between contracts. Work is ongoing to reduce and/or mitigate the level of growth expectations for 2020/21 and positive progress was made to reduce the £84.4m gap disclosed in February down to around £56.6m by the 5th March submission through mitigations such as the repatriation of independent sector and out-of-STP NHS activity into the Black Country & West Birmingham (BCWB) STP. A list of the mitigations being explored is shown in the table below.

	STP SRO
Repatriation of private sector & NHS activity to BCWB NHS providers	CCG/Provider
Reduction/removal of investments to improve RTT performance	CCG/Provider
Reduction/removal of investments to improve other performance indicators	J Green
Reduction in CCG Contingency & Strategic Investment Reserve	P Maubach
Deferral of investments in LTP requirements, inc PCN DES	J Green
Review of estate and infrastructure investment	J Green
Prescribing	D Jenkins
Agency expenditure	All CEOs
Balance sheet review	All CEOs
Benefit in 2020/21 of 2/3 year agreement	All CEOs
Review of CCG merger benefits	P Maubach
Acceleration in the implementation of place/lead provider models	All CEOs
Review of system productivity– review of cost growth from 1718 compared to activity	J Green
Demand and capacity plan for whole system	R Beeken
'Grip and Control Review'	CCG/Provider
Out of Area Placements	M Axcell
PFI Subsidiaries	All CEOs
Review benefit of Radiology network	TBC
Review support functions	TBC
CIP / QIPP Review	CFO
Mental Health Investment Standard potential slippage	M Axcell

Clearly the letter issued by NHSE setting out the arrangements for NHS contract for the period Aril-Jul 2020 along with the pressures resulting from the COVID-19 situation now renders some of these opportunities not viable (i.e. repatriation of activity). However these opportunities will continue to be explored for implementation as and when appropriate.

Mental health investment will increase in 2020/21 and the CCGs' plans reflect achievement of the MHIS, which is to increase expenditure in mental health services by a minimum of programme allocation growth % plus an additional 1.7%. Submitted plans show an average growth of 6.9% against the planning target (exclusive of learning disabilities and dementia services).

During the Long Term Plan submission guidance and detail communicated to the STP by NHSE/I showed a clear expectation that the services requiring higher levels of growth than other mental health services included Improving Access to Psychological Therapies (IAPT), Adult Crisis, Children and Young People's (CYP) and Perinatal.

Continuing healthcare costs are expected to increase in 2020/21. This expected increase will be in the region of £5.6m, net of efficiencies totalling £7.0m currently allocated to this area, representing a significant challenge.

Planned prescribing expenditure is to increase by £6.7m from £237.0m in 2019/20 to £243.7m in 2020/21, net of efficiencies totalling £14.4m currently allocated to this area of spend. With the recently experienced pressures of No Cheaper Stock Obtainable (NCSO), Short Stock and Category M drugs expected to continue this is also a challenging target.

The CCG receives a delegated allocation in respect of GP primary care services. The entirety of this allocation must be invested in primary care services. Investment in GP primary care services is expected to increase by £8.1m from £204.6m in 2019/20 to £212.6m in 2020/21. There are potential cost pressures within these budgets that are being discussed and reviewed in detail to ensure expenditure is contained within the notified allocations. A separate, more detailed, financial plan in respect of primary care co-commissioning will be presented to the CCGs' Primary Care Co-commissioning Committees.

The CCGs are required to hold a contingency of 0.5% per business rules, which totals £11.8m across all four CCGs.

The CCGs' running costs will reduce to £26.3m in 2020/21, which is in-line with the allocation – a nationally mandated maximum spend on running costs. Work is underway to ensure structures are in place that live within the reduced allocation, including the expenditure with Commissioning Support Units, NHS Property Services and other non-pay.

A more detailed breakdown of the expenditure budgets for each CCG is provided in Appendix 1-4.

7. Surplus

The financial plan includes a surplus of £4.5m across all four CCGs. This is reduced from the £26.7m surplus included in the Long Term Plan submission made in January 2020, reflecting the majority of the contract gap between in-system CCGs and providers.

Surplus / (Deficit)	DUD CCG		SWB CCG		WAL CCG		WOL CCG		BCWB CCGs	
	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m	19/20 £m	20/21 £m
Total In-Year Allocation	506.8	521.8	838.8	871.6	465.4	477.6	443.2	445.6	2,254.3	2,316.6
Total Expenditure	505.7	523.5	835.7	865.5	464.4	479.8	440.0	443.3	2,245.9	2,312.0
In-year Surplus / (Deficit)	1.1	(1.6)	3.1	6.1	1.0	(2.2)	3.1	2.3	8.4	4.5
Surplus / (Deficit) B/fwd from 2019/20	11.7	12.8	20.7	23.9	5.7	6.7	10.0	13.2	48.2	56.6
Surplus / (Deficit) C/fwd to 2020/21	12.8	11.2	23.9	30.0	6.7	4.5	13.2	15.5	56.6	61.1

8. Underlying Surplus

The underlying position for each CCG and overall across all four CCGs has deteriorated by £20.2m when comparing the recurrent delivery of the 2019/20 position and the recurrent plan for 2020/21.

Underlying Position	DUD CCG £m / %	SWB CCG £m / %	WAL CCG £m / %	WOL CCG £m / %	BCWB CCGs £m / %
Recurrent Position 2019/20	2.3	10.5	9.8	3.8	26.5
Recurrent Position 2020/21	(3.0)	9.2	(2.2)	2.3	6.3
Favourable / (Adverse) Movement	(5.3)	(1.3)	(12.0)	(1.5)	(20.2)

The CCGs are currently forecasting a £8.1m surplus in 2019/20, which after removing the net impact of non-recurrent allocations, non-recurrent expenditure and including the full year effect of investments/run rate increase in 2019/20, improves to a £26.5m underlying surplus. However, the recurrent increase in allocations of £95.2m in 2020/21 is lower than the recurrent increase in expenditure due to the level of growth assumed against in-system providers as well as meeting the business rules and other key planning requirements. This deteriorates the underlying surplus to £6.3m. £1.8m net recurrent planned expenditure in 2020/21 reduces this to the £4.5m surplus.

9. Efficiency Programme

An efficiency target of £111.1m (4.8%) is incorporated into the 2020/21 financial plan, which is higher than in previous years. The need to achieve a £4.5m surplus and meet the planning and commissioner business rule requirements, as well as the currently assumed 3.8% growth on in-system contracts has necessitated this higher than usual efficiency target. £76.4m of schemes have currently been identified with £34.8m left to be identified (31.3%).

Efficiency Target	DUD CCG £m / %	SWB CCG £m / %	WAL CCG £m / %	WOL CCG £m / %	BCWB CCGs £m / %
Efficiency Target to Deliver Planned Surplus / (Deficit)	21.3	46.1	21.2	22.5	111.1
Efficiency Target as a % of Recurrent RRL	4.1%	5.3%	4.4%	5.1%	4.8%
Delivered through:					
Identified	9.0	33.4	16.4	17.7	76.4
Unidentified	12.3	12.7	4.9	4.9	34.8
Total Efficiency Target	21.3	46.1	21.2	22.5	111.1
% QIPP unidentified	57.8%	27.6%	22.9%	21.6%	31.3%

The efficiency programme will be reported at the Finance and Performance Committees.

10. Risks & Mitigations

There are a range of risks and mitigations included within the CCGs' draft financial plan submissions and due to the reflection of the majority of the in-system contract gap in the deteriorated bottom-line position, Sandwell & West Birmingham CCG, Walsall CCG and Wolverhampton CCG have submitted a plan with no additional net risk i.e. all risks have been covered by a range of mitigations including the 0.5% contingency. Dudley CCG have an additional net risk of £14.2m, which is mainly due to mitigations not being identified to cover the £12.3m unidentified QIPP.

This leads to a risk-adjusted in-year deficit of £9.7m across the four CCGs compared to the in-year surplus of £4.5m.

Net Risk	DUD CCG £m	SWB CCG £m	WAL CCG £m	WOL CCG £m	BCWB CCGs £m
Acute Services	-	-	1.4	-	1.4
Mental Health Services	-	-	-	-	-
Community Services	-	-	-	-	-
Continuing Care Services	(0.6)	-	-	-	(0.6)
Primary Care Services	(0.7)	-	1.0	-	0.3
Other Programme Services	(0.5)	-	(2.2)	-	(2.7)
Primary Care Co-Commissioning	-	-	(0.2)	-	(0.2)
Running Costs	-	-	-	-	-
Unidentified QIPP	(12.3)	-	-	-	(12.3)
Total Net Risk	(14.2)	-	(0.0)	-	(14.2)
Risk-adjusted In-year Surplus / (Deficit)	(15.8)	6.1	(2.2)	2.3	(9.7)

Each of the four CCGs' plans is balanced for the four months April to July 2020 inclusive with the unidentified efficiency phased into August 2020 to March 2021.

Firstly, this is to reflect the response to COVID-19 and secondly, this provides a window of time in which the CCGs will develop a range of actions in order to close the efficiency gap. The current level of unidentified efficiency is £34.8m across the four CCGs. See section 14 for next steps.

11. STP Financial Plans

On the 10th January 2020 the STP submitted the final version of its 5-year Long Term Plan, which agreed to the original Trajectory target set by and agreed with NHSE/I for 2020/21, including a £26.7m surplus across the four CCGs. Excluding the maximum Financial Recovery Fund (FRF) monies available for achievement of the trajectory the deficit across providers and CCGs was £28.5m and including FRF a surplus of £8.6m.

On the 5th March 2020 the STP submitted a planned deficit of £76.2m, which is £84.7m adverse to the revised financial improvement trajectory of £8.5m, inclusive of the £13.0m adjustment agreed with NHS Midlands in January 2020 and maximum FRF available. The adverse variance is due to the:

- Recognition of the contract risk between system providers, which was previously shown as a contract gap, rather than as an adverse impact on the bottom-line position;
- Loss of Marginal Rate Emergency Threshold (MRET) funds which would be available to acute providers on acceptance of their trajectory; and
- Loss of the potential maximum FRF as the STP plan no longer meets the set trajectory for 2020/21.

2020/21 Surplus / (Deficit) Against Trajectory	LTP 10-Jan £m	Notified Changes £m	Lost MRET/FRF £m	Contract Gap Reflected £m	5-Mar Plan £m
Commissioners	26.7	(0.1)	-	(22.0)	4.5
Total Commissioners	26.7	(0.1)	-	(22.0)	4.5
Acute Providers	(53.6)	0.2	(4.4)	(21.1)	(78.8)
Mental Health & Community Providers	(1.6)	0.1	-	0.0	(1.5)
Ambulance Provider	-	(0.5)	-	0.0	(0.5)
Total Providers	(55.2)	(0.2)	(4.4)	(21.0)	(80.7)
STP Surplus / (Deficit) inc. PSF, FRF (19/20 Only) and MRET	(28.5)	(0.3)	(4.4)	(43.0)	(76.2)
Maximum FRF Years 2 to 5	37.1	0.2	(37.3)	-	-
STP Surplus / (Deficit) inc. PSF, FRF (All Years) and MRET	8.6	(0.1)	(41.7)	(43.0)	(76.2)
FIT Target inc. Max. FRF	8.6	(0.1)	-	-	8.5
Favourable / (Adverse) Variance to FIT Target inc. Max. FRF	0.0	-	(41.7)	(43.0)	(84.7)

On the 12th March 2020 the STP had a remaining in-system contract gap of £13.3m, some of which is due to a difference in assumptions around MHIS increases to contract values with Dudley and

Walsall Mental Health Partnership NHS Trust and Black Country Partnership NHS FT. The main issue is the assumption in The Dudley Group Hospital NHS FT of an additional £8.3m from Dudley CCG, which is not reflected in the CCG's plans. If the Trust do not receive this income then their planned deficit will deteriorate further by this amount.

12. Response to the COVID-19 Letter

On the 17th March 2020 NHSE/I wrote to all ICSs, STPs, NHS organisations, GP practices, Primary Care Networks, Local Authorities, Local Resilience Forums, other community providers and NHS 111 providers to set out the actions required in response to the COVID-19 pandemic.

In summary the key actions required are:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.
- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

Contract Payments

As the NHS Trusts in particular will be focussing on creating inpatient and critical care capacity through, for example, the cancellation of non-urgent elective operations for a period of at least three months; ensuring the right level of respiratory support is in place for patients; and their staff have the equipment they need, NHSE/I have stated that one of the burdens to be removed will be the operational planning process and the Payment by Results national tariff payment architecture.

As a result of this NHSE/I have made clear that Trusts will be paid a block payment on account each month to the end of July. The amount will be based on the average monthly expenditure identified in the Trusts' month 9 2019/20 Agreement of Balances returns, with a top-up payment if costs in November 2019 to January 2020 are higher than this average. The average amount will be uplifted for inflation with no efficiency factor applied and no growth for activity. CCGs await confirmation of the block payment values, which are being calculated nationally for each CCG and Trust relationship. These values are due on 23rd March 2020.

The four CCGS will, in-line with guidance, agree a block contract based on the notified value for the period 1 April to 31 July 2020 with the Acute, Mental Health, Community and Ambulance NHS Trusts/FTs they currently hold a contract with. For Mental Health Trusts the block payment will also reflect an additional sum to reflect the delivery of the MHIS. All block contracts will be inclusive of CQUIN, which will be assumed to be achieved in full.

Trusts have also been instructed to cease invoicing for non-contracted activity for the period 1 April to 31 July and a sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner.

Both Trusts and Commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. The four CCGs have set up a tracking mechanism for COVID-19 related expenditure.

Due to the above the current contract negotiations have been suspended and will need to be re-implemented at a later date. However, all four CCGs and in-system Trusts recognise that when this is will be dependent on how the COVID-19 pandemic develops.

CCG Funding

NHSE/I confirmed the allocations communicated to CCGs will not be changed, however, individual CCG financial positions and affordability will be assessed and the following taken into account:

- The impact of the block payment approach and the net impact of the adverse impact to CCGs of there being no efficiency factor applied and favourable impact of activity growth not being included.
- The impact of including each Trust's non-contracted activity payment in the block contract held with lead CCGs.
- Costs of additional service commitments relating to the response to COVID-19:
    - Additional funding will be made available to CCGs for the additional costs incurred for additional enhanced discharge support services
    - Additional funding will be released from NHSE/I via lead commissioners to fund pressures on the NHS 111 service (this is additional to the nationally funded 111 response to COVID-19)
    - Income for GP practices will be protected if routine contracted work has to be substituted as an outcome of freeing up practices to prioritise workload according to prepare for and manage the response to COVID-19. Additional costs will be reimbursed by NHSE/I.
    - Procurement of additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred.
    - CCGs will be reimbursed for the following:
        - An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.
        - A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.
        - Payments to contractors who are required to close due to Covid-19 related reasons.
    - Additional services to be procured from the third sector or from independent sector organisations are expected to be reimbursed – details to follow from NHSE/I in due course.

The Governing Body will be kept appraised of developments over the coming months.

13. Next Steps

The financial plan and budget setting, in its current form, present some significant issues for the CCGs. These issues include but are not limited to the following:-

- Non-achievement of the NHSE mandated Financial Improvement Trajectory surplus.
- Financial planning gaps between commissioners and providers.
- Significant levels of unidentified QIPP.
- Increasing and unquantified future costs in respect of COVID 19.

In order to address these issues, the CCG will undertake a range of measures aimed at improving the financial position. These measures include:-

- Resolution of provider contracts.
- Delay of investments (where appropriate).
- Review of all CCG budgets.
- Confirm and challenge sessions with budget holders.
- Increased expenditure controls.
- Development of further QIPP and demand management initiatives.
- Quantification of COVID 19 related issues. Clearly this will be difficult to complete over the short to medium-term.

The Governing Body and local Finance and Performance Committees will be updated monthly in respect of progress in respect the above measures.

14. Conclusion

This paper proposes the initial financial plan for the four CCGs for the 2020/21 financial year.

Despite the additional funding allocated to the system and the reflection of the majority of the in-system contract gap within the bottom-line position of STP NHS partner organisations there are still some risks that need to be managed diligently in order that the planned surplus can be achieved across the four CCGs.

Mitigations have been identified for the majority of risks, but there are unmitigated risks as disclosed in this paper that need particular attention between now and the end of July 2020 as disclosed in the paper:

- The contract gap; and
- Unidentified efficiency.

The Governing Body and Committees will be kept appraised of developments and the impacts on the financial position due to the COVID-19 response and the actions being taken to ensure risks and unidentified efficiencies are mitigated.

15. Recommendations

Members of the Governing Body and Finance & Performance Committee are asked to:

- Discuss the content of the report;
- Approve the a balanced financial plan to the end of month 4;
- Note that work is ongoing to ensure the unidentified efficiencies balance within months 5-12 are fully identified and/or mitigated before the end of month4;
- Note that further the Governing Body and Finance & Performance Committee will be kept appraised of developments relating to the COVID-19 response, the actions being taken to close the unidentified efficiency gap and 2020/21 contracts.

James Green, Chief Finance Officer

19th March 2020

Appendix 1: NHS Dudley CCG Financial Plan 2020/21

Commissioning	*Total Budget (£000's)*
ACUTE SERVICES	
Acute Commissioning	259,022
Ambulance Services	11,718
NCAs	3,673
Planned Care	3,008
NHS 111	1,867
Urgent Care	3,004
Winter Resilience	1,225
ACUTE SERVICES TOTAL	**283,517**
MENTAL HEALTH SERVICES	
Mental Health Contracts	28,740
Dementia	95
Learning Difficulties	9,065
Other Mental Health	4,304
Child and Adolescent Mental Health	6,110
MENTAL HEALTH SERVICES TOTAL	**48,314**
PRIMARY CARE DEVELOPMENT	
Primary Care IT - Programme	1,614
GP Forward View	1,982
Primary Care Investments	1,125
PRIMARY CARE DEVELOPMENT TOTAL	**4,722**
DRUGS AND GP PRESCRIBING	
Central Drugs	2,087
Medicines Management - Clinical	919
Home Oxygen	510
Prescribing	53,868
DRUGS AND GP PRESCRIBING TOTAL	**57,384**
INTERMEDIATE & CONTINUING HEALTHCARE	
CHC Adult Fully Funded	15,215
CHC Adult Fully Funded Personal Health Budgets	1,672
Continuing Healthcare Assessment & Support	1,139
Funded Nursing Care	4,459
Intermediate Care	4,586
INTERMEDIATE & CONTINUING HEALTHCARE TOTAL	**27,071**
COMMUNITY SERVICES	
Community Services	28,399
Acute Childrens Services	396
CHC Children	710
CHC Children Personal Health Budgets	213
Children Services	6,246
COMMUNITY SERVICES TOTAL	**35,964**

Appendix 1: NHS Dudley CCG Financial Plan 2020/21

OTHER COMMISSIONING	
Better Care Fund	13,190
Local Enhanced Services	2,062
Statutory Reserves	(10,697)
Patient Transport	3,001
NHS PS & CHP Property Charges	2,760
Safeguarding	614
Integrated Clinical Leads	808
Non Recurrent Programmes	307
Collaborative Commissioning	20
High Cost Drugs	8
Hospices	933
Long Term Conditions	1,173
Commissioning - Non Acute	1,000
Palliative Care	826
Other	4,266
OTHER COMMISSIONING TOTAL	**16,004**
TOTAL COMMISSIONING	**472,976**
Running Costs	***Total Budget (£000's)***
CORPORATE SERVICES	
Clinical Management	266
Other Board	116
Organisational Development	138
CCG Management Team	693
Communications & Engagement	314
Finance & Performance	1,246
Administration & Business Support	462
Commissioning	634
Membership Development & Primary Care	323
IM&T Support	375
Quality	487
Contracting	374
Governance	242
Estates and Facilities	209
Other Corporate Support Services	65
RUNNING COST TOTAL	**5,946**
Primary Care Co-Commissioning	***Total Budget (£000's)***
GP COMMISSIONED SERVICES	
General Practice - GMS	27,973
General Practice - APMS	570
QOF	136
Local Enhanced Services	8,212
Premises Cost Reimbursement	4,456
Other Premises Costs	316
Dispensing/Prescribing Drs	281
Other GP Services	2,618
PRIMARY CARE CO-COMMISSIONING TOTAL	**44,563**
TOTAL	**523,485**

Appendix 2: NHS Sandwell & West Birmingham CCG Financial Plan 2020/21

APPLICATIONS - PROGRAMME	£000
Acute Services	
NHS Acute Services	
Sandwell & West Birmingham Hospitals NHS Trust	269,224
University Hospitals Birmingham NHS Foundation Trust	40,871
Dudley Group NHS Foundation Trust	41,374
Walsall Healthcare NHS Trust	9,943
Birmingham Women's & Children's Hospital NHS Foundation Trust	15,572
Royal Orthopaedic Hospital NHS Foundation Trust	5,980
The Royal Wolverhampton Hospital NHS Trust	3,067
West Midlands Ambulance Services NHS Foundation Trust	21,939
Worcestershire Acute Hospitals NHS Trust	483
University Hospitals of North Midlands NHS Foundation Trust	443
Shrewsbury & Telford Hospital NHS Trust	188
Total NHS Acute Services	**409,083**
Acute Services Other	
Non Contracted Activity & Out of Area	5,827
Individual Funding Requests	18
Extended Choice Contracts	4,662
Other Acute Services	2,403
Repatriation Opportunities	(5,242)
Total Acute Services Other	**7,668**
Total Acute Services	**416,751**
Commissioned Community Services	
NHS Community Services	
Sandwell & West Birmingham Hospitals NHS Trust	33,606
Birmingham Community Healthcare NHS Trust	19,874
Walsall Healthcare NHS Trust	352
The Royal Wolverhampton Hospital NHS Trust	194
Dudley Group NHS Foundation Trust	496
NHS Other	707
Total NHS Community Services	**55,229**
Community Assessment	
NHS 111	3,095
Clinical Assessment & Urgent Care Centres	2,408
Total Community Assessment	**5,502**
Continuing Healthcare	
Continuing Healthcare - Physical Disabilities	14,654
Continuing Healthcare - Children	645
Continuing Heathcare - Children's PHB	240
Continuing Healthcare - Staffing	2,441
Continuing Healthcare - Joint Funded	3,433
Personal Health Budgets	5,034
Joint Funded Personal Health Budget	2,252
Funded Nursing Care	7,956
Looked After Children	312
Total Continuing Healthcare	**36,966**
Other Community Services	
Interpreting Services	707
Safeguarding (Programme)	1,152
Carers	496
Hospices	222
Intermediate Care	1,599
Commissioning Schemes	88
Patient Transport	4,372
Non NHS Community Contracts	7,061
Total Other Community Services	**15,695**

Appendix 2: NHS Sandwell & West Birmingham CCG Financial Plan 2020/21

Property Costs	
NHS Property Costs	4,795
Total Property Costs	**4,795**
Total Community Services	**118,188**
Mental Health & Learning Disabilities	
NHS Trust Contracts	
Black Country Partnership NHS Foundation Trust	34,324
Dudley & Walsall Mental Health Partnership NHS Trust	2,643
Birmingham & Solihull Mental Health Trust	1,242
Forward Thinking Birmingham	7,289
Total NHS Trust Contracts	**45,496**
Mental Health	
Birmingham Joint Commissioning arrangements	24,350
Assessments	0
CAMHS	520
IAPT	3,163
Mental Health NCA	396
Mental Health Non NHS	1,196
Mental Health Placements	10,432
Mental Health Section 117	5,434
Total Mental Health	**45,490**
Learning Disabilities	
Learning Disability Placements	5,026
Learning Disability Joint Commissioning	10,104
Learning Disability Section 117	6,141
Total Learning Disabilities	**21,271**
Total Mental Health & Learning Disabilities	**112,257**
Winter Pressures	
Winter Pressure Schemes	1,067
Total Winter Pressures	**1,067**
Primary Care	
GP Commissioning (Delegated)	85,330
Local Incentive Schemes	656
Out of Hours	3,562
GP IT	2,077
Collaborative Commissioning	358
Primary Care Non Recurrent	3,746
Total Primary Care	**95,728**
Prescribing	
Prescribing Practice Budgets	82,374
Prescribing Other	1,996
Home Oxygen	763
Medicines Management Clinical	1,187
Total Prescribing	**86,320**
Better Care Fund	
Better Care Fund	21,707
IBCF	2,142
Total Better Care Fund	**23,849**
Reserves, Contingency & QIPP	
Reserves, Contingency & QIPP	1,187
Total Reserves	**1,187**
TOTAL PROGRAMME EXPENDITURE	**855,348**
APPLICATIONS - RUNNING COSTS	
CCG Running Costs	9,255
CCG Running Costs - CSU	779
CCG Running Costs - NHS 111	88
TOTAL RUNNING COSTS	**10,122**
TOTAL EXPENDITURE	**865,470**

Appendix 3: NHS Walsall CCG Financial Plan 2020/21

Expenditure	£000
Acute services	
Net Non-elective (zero length of stay)	8,520
Net Non-elective (non-zero length of stay)	70,284
Daycase Elective Spells	20,678
Ordinary Elective Spells	14,706
Total first outpatient attendances	10,997
Total follow-up outpatient attendances	11,678
Total outpatient procedures	8,897
A&E attendances - Type 1	14,399
A&E attendances - Other	119
Maternity	15,909
High cost drugs & devices	13,408
Ambulance	12,996
Other	32,096
Acute Services - Independent / Commercial Sector	2,208
Acute Services - Other Non - NHS	377
Acute Services - Other Net Expenditure	1,428
Sub-total - Acute services	**238,700**
Mental Health services	
Children & Young People's Mental Health (excluding LD)	4,263
Children & Young People's Eating Disorders	469
Perinatal Mental Health (Community)	718
Improved access to psychological therapies (adult and older adult)	3,175
A and E and Ward Liaison mental health services (adult and older adult)	668
Early intervention in psychosis 'EIP' team (14 - 65)	1,349
Adult Community Crisis (adult and older adult)	334
Ambulance response services	123
Community mental health, including new integrated models (adult and older adult, excluding dementia)	523
Other adult and older adult - inpatient mental health (excluding dementia)	28,077
Learning Disabilities	6,736
Dementia	3,538
Sub-total - MH services	**49,972**
Community Health Services	
CH Contracts - NHS	33,455
CH Contracts - Other providers (non-nhs, incl. VS)	3,490
Sub-total - Community services	**36,945**
Continuing Care Services	
Continuing Care Assessment & Support	405
Adult Joint Funded Continuing Care	464
Funded Nursing Care	3,126
NHS CHC Adult Fully Funded - Total	**16,855**
- CHC Standard	16,855
NHS CHC Adult Fully Funded PHB - Total	**2,921**
- CHC Standard - PHB	2,921
Children's Continuing Care	1,669
Children's Continuing Care: PHB	60
Sub-total - Continuing Care Services	**25,498**

Appendix 3: NHS Walsall CCG Financial Plan 2020/21

Primary Care services	
Prescribing	52,013
Community Base Services	7,177
Out of Hours	1,718
PC - Other	2,418
GP IT Costs	1,258
Sub-total - Primary Care services	**64,584**
Primary Care Co-Commissioning	
General Practice - GMS	23,367
Other List-Based Services (APMS incl.)	5,246
Premises cost reimbursements	7,336
Other premises costs	36
Enhanced services	2,142
QOF	4,225
Other - GP Services	604
Delegated Contingency	216
Sub-total - Primary Care Co-Commissioning	**43,172**
Other Programme services	
NHS Property Services re-charge (excluding running cost)	1,359
Social Care	11,021
Other CCG reserves	(1,770)
Other Programme Services	2,799
Sub-total - Other Programme services	**13,409**
Total - Commissioning services	**472,281**
Running Costs	
CCG Pay costs	3,526
CSU Re-charge	560
NHS Property Services re-charge / CHP Charges	452
Running Costs - Other Non-pay	823
Sub-total - Running costs	**5,361**
Contingency	2,172
Total Application of Funds	**479,814**

Appendix 4: NHS Wolverhampton CCG Financial Plan 2020/21

APPLICATIONS PROGRAMME	Proposed Budgets 2020-21 £000
Acute Services	
NHS Acute Services	
RWHT Acute	182,668
Walsall Hospital	2,389
Sandwell & West B'ham	1,313
Shrewsbury & Telford	430
UHNM	611
West Midlands Ambulance	12,838
UHB	2,890
RJ&AH	336
DGOH	5,396
B'ham Womens & Childrens	909
B'ham Womens & Childrens IVF	160
ROH	321
Total NHS Acute Services	**210,261**
Acute Services Other	
NCA	3,115
IFR	43
Nuffield	3,173
Other Acute Services	4,861
Total Acute Services Other	**11,191**
Total Acute Services	**221,452**
Commissioned Community Services	
NHS Community Services	
Midland Partnership FT	182
RWHT Community	38,036
Total NHS Community Services	**38,219**
Other Community Services	
MSK Services	3,128
Dermatology	508
Intermediate care	866
Community Other	1,355
Carers	248
Hospices	2,290
ILS	735
Total Other Community Services	**9,131**
Total Community Services	**47,349**

Appendix 4: NHS Wolverhampton CCG Financial Plan 2020/21

Mental Health & Learning Disabilities	
NHS Trust Contracts	
BCPFT	33,891
Midland Partnership FT	324
B'ham & Solihull MH Trust	158
Dudley & Walsall MH Trust	973
Total NHS Trust Contracts	**35,345**
Other Mental Health	
Individual Complex Cases	2,281
CAMHS	706
Peri Natal	450
Victoria Court	342
ACCI	248
Other Mental health(Programme costs)	141
MHIS Reserve	800
NCAs	2,596
Total Other Mental Health	**7,565**
Learning Disabilities	
LD Placements	1,277
Total Learning Disabilities	**1,277**
Total Mental Health & Learning Disabilities	**44,187**
Continuing Healthcare	
FNC	5,080
CHC	9,784
SEND	867
Continuing Care Staff Costs	932
Total Continuing Healthcare	**16,664**
Primary Care & Prescribing	
Primary Care Delegated	40,021
Enhanced services	758
Drugs Flu/Pneumo	691
Primary Care Network	0
MECS	397
GP IT	768
Other Primary Care	2,829
Home Oxygen	189
Prescribing	48,756
Prescribing Other	1,398
Total Prescribing	**95,807**
Better Care Fund	
BCF	8,024
Total Better Care Fund	**8,024**
Other Programme, Reserves, Contingency & QIPP	
Other Programme Services	8,809
Reserves, Contingency & QIPP	-3,880
Total Other Programme, Reserves, Contingency & QIPP	**4,929**
Running Costs	
Running Costs	4,865
Total Running Costs	**4,865**
Grand Total	**443,277**

NHS Wolverhampton Clinical Commissioning Group | NHS Sandwell and West Birmingham Clinical Commissioning Group | NHS Walsall Clinical Commissioning Group | NHS Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 8.0

Title of Report:	**Changes to 2019/20 Surplus – Wolverhampton CCG & Walsall CCG**
Purpose of Report:	The Governing Body to approve the recommendation in a reduction in the reported surpluses for Wolverhampton CCG and Walsall CCG as outline in the report.
Author of Report:	James Green, CFO
Management Lead/Signed off by:	James Green, CFO
Public or Private:	Public
Key Points:	To present the Governing Body with a recommendation to reduce the reported surpluses of NHS Wolverhampton CCG and NHS Walsall CCG to break-even for the 2019/20 financial year due to additional expenditure at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.
Recommendation:	Members of the Governing Body are asked to:- 1. Discuss the content of the report; 2. Approve the reduction in reported surpluses.
Conflicts of Interest:	There are no conflict of interest issues identified in relation to this report.
Links to Corporate Objectives:	The Governing Body Committees support the Governing Body in delivering all of the CCG's Corporate Objectives
Action Required:	☐ Assurance ☒ Approval ☐ For Information
Implications:	
Financial	Yes
Assurance Framework	n/a
Risks and Legal Obligations	n/a
Equality & Diversity	n/a
Other	n/a

1. Introduction

The purpose of this paper is to present the Governing Body with a recommendation to reduce the 2019/20 reported surpluses at NHS Wolverhampton CCG and NHS Walsall CCG due to additional expenditure at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

2. Proposed Additional Expenditure

It is proposed that NHS Walsall CCG make an additional payment of £4.0m to Walsall Healthcare NHS Trust and NHS Wolverhampton CCG make and additional payment of £5.0m to The Royal Wolverhampton NHS Trust.

Both payments are in respect of additional activity undertaken by the Trusts and the associated additional cost pressures they have incurred as a result. Both CCGs have undertaken detailed reviews of the contracts and activity incurred to ensure these additional payments are genuinely required.

The CCGs have undertaken a detailed review of the forecast positions as at month 11 and whilst it is possible some of this additional expenditure can be mitigated, it is not possible to do so in full and therefore both CCGs will miss their planned surpluses as a result.

It is worth noting that whilst there is an adverse impact on the CCGs, the additional income received by the Trusts, if this proposal is approved and actioned, will mean both will be able to achieve their control totals and therefore receive the full amount of Provider Sustainability Funding (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Fund (FRF) made available in 2019/20.

Table: PSF, FRF and MRET 2019/20

	RWH 2019/20 Plan £m	WHT 2019/20 Plan £m
PSF	7.45	5.50
FRF	-	11.50
MRET	2.25	1.38
Total	9.70	18.38

3. Proposed Reduction to 2019/20 Surpluses

As at month 11 NHS Wolverhampton CCG reported a forecast in-year surplus of £3.1m and cumulative surplus of £13.15m; and NHS Walsall CCG reported a forecast in-year surplus of £1.0m and cumulative surplus of £6.7m.

The proposal is to reduce NHS Wolverhampton CCG's surplus by £3.15m to an in-year break-even position and cumulative surplus of £10.0m; and NHS Walsall CCG's surplus by £1.0m to a forecast in-year break-even position and a cumulative surplus of £5.7m.

Table: Proposed Reduction to 2019/20 Surpluses

	Month 11 Forecast £m	Proposed Adjustment £m	Revised Forecast £m
NHS Wolverhampton CCG			
In-year Surplus / (Deficit)	3.15	(3.15)	-
Cumulative Surplus / (Deficit)	13.18	(3.15)	10.03
NHS Walsall CCG			
In-year Surplus / (Deficit)	1.00	(1.00)	-
Cumulative Surplus / (Deficit)	6.71	(1.00)	5.71

4. Conclusion

Due to the level of additional activity undertaken by the two Trusts and the associated additional costs incurred, the CCGs are being asked to make additional payments totalling £9.0m in 2019/20.

£4.85m of this can be covered by current flexibilities and forecasting assumptions, with the £4.15m balance leading to a deterioration in the currently reported forecast surpluses for the two CCGs.

5. Recommendations

Members of the Governing Body are asked to:

- Discuss the content of the report; and
- Approve the proposed change to the reported year-end position.

James Green, Chief Finance Officer

24th March 2020

NHS Wolverhampton Clinical Commissioning Group | NHS Sandwell and West Birmingham Clinical Commissioning Group | NHS Walsall Clinical Commissioning Group | NHS Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 9.0

Title of Report:	**Aligned Governance Arrangements**
Purpose of Report:	To outline a proposed new aligned governance structure across the four CCGs for agreement by the Governing Bodies based on delegation of responsibilities to the Joint Commissioning Committee (which will be renamed the Joint Health Commissioning Board) supported by a shared Scheme of Reservation and Delegation.
Author of Report:	Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG Sara Saville – Head of Corporate Governance, Walsall CCG Emma Smith, Governance Support Manager, Dudley CCG Jodi Woodhouse, Acting Head of Corporate Governance, Sandwell and West Birmingham CCG
Management Lead/Signed off by:	Mike Hastings, Director of Technology and Operations
Public or Private:	Public
Key Points:	• In order to support the continuing alignment of the four Black Country and West Birmingham CCGs, an aligned and shared Governance Structure has been developed. • As highlighted at the meeting of the Governing Bodies on 21 January 2020 the Structure is based on delegation of commissioning functions to a Joint Health Commissioning Board supported by functional sub-committees • Terms of Reference for the Joint Health Commissioning Board and a draft Scheme of Reservation and Delegation are attached for approval.
Recommendation:	**That the Governing Bodies:-** • **Approve the Delegation of Commissioning Functions to the Joint Health Commissioning Board in line with the Draft Terms of Reference, the amendments to the Scheme of Reservation and Delegation and consequential amendments to the CCGs' Governance Handbooks and agree the proposed Corporate Calendar** • **Delegate authority to the Chief Finance Officer to make arrangements for the exercise of powers to sign off invoices** • **Note the proposed next steps in the development of Governance arrangements and the reappointment of External Auditors**
Conflicts of Interest:	Whilst there may be a perceived conflict of interest in adoption of the proposed Governance arrangements as it will impact on Governing Body members roles it will not have a direct financial impact and it is not possible for this decision to be referred elsewhere in order to manage the potential conflict.
Links to Corporate Objectives:	The new Governance structure is designed to support the four CCGs in developing and delivering shared Corporate Objectives.
Action Required:	☐ Assurance ☒ Approval ☐ For Information
Implications:	
Financial	The cost of implementing the new Governance structure will be met within existing resources.

Assurance Framework	The report highlights the need to develop a shared Assurance Framework to support the CCGs as they become a Single Commissioning Voice. This work is being picked up by the Governance workstream reporting into the Transition Board
Risks and Legal Obligations	There are risks associated with the CCGs not having robust arrangements for the delivery of statutory duties, the proposed governance arrangements have been designed to support assurance around the delivery of these duties and have been developed with the support of the CCGs' legal advisors.
Equality & Diversity	There are no specific equality and diversity implications arising from this report.
Other	The CCGs' Governance Handbooks will need to be amended to reflect the implementation of the new Governance Structure

1. BACKGROUND AND INTRODUCTION

1.1. At the meeting of the Governing Bodies of the four Black Country and West Birmingham CCGs in common on 21 January 2020 an outline proposal to move to a streamlined and aligned governance structure was agreed. This was based on the CCGs delegating a significant amount of their commissioning responsibilities to the Joint Commissioning Committee JCC they have established (supported by a number of functional sub-committees for key areas) and moving to hold other meetings in common wherever possible.

1.2. In order to develop this proposal, the Governing Bodies established a number of Task and Finish groups made up of Lay, Executive and GP members to examine specific issues, including the Scheme of Reservation and Delegation (SORD), membership of the new committee structure and approaches to delivering the CCG's statutory duties. These groups have been meeting and the outputs of their work have been used to develop the detailed proposals for the Governing Bodies consideration.

2. JOINT HEALTH COMMISSIONING BOARD

2.1. As highlighted at the meeting on 21 January 2020 the Health and Social Care Act 2012 allows CCGs to enter into Joint arrangements for the delivery of commissioning functions. The CCGs established a JCC in 2017 which was given delegated authority for decisions in relation to new mental health funding and oversight of the Transforming Care Programme for patients with Learning Disabilities.

2.2. In order to support the CCGs' transition to becoming a Single Commissioning Voice across the Black Country and West Birmingham it is proposed that the JCC is renamed the Joint Health Commissioning Board (JHCB) and that further functions are delegated to it as follows:-

- **Determination of arrangements for discharging the CCGs' statutory duties associated with their commissioning functions (including securing public involvement, promoting both awareness and use of the NHS Constitution, obtaining appropriate advice, promoting integration of services, enabling patients to make choices and promoting the involvement patients, carers and representatives in decisions about their healthcare).**
- **Determination of arrangements to promote a comprehensive health service.**
- **Determination of arrangements for working in partnership with the CCGs' local authorities to develop joint strategic needs assessments and joint health and well being strategies.**
- **Determining arrangements for promoting and promoting integration of both health services with other health services and/or health-related and social care services where this would improve the quality of services or reduce inequalities.**
- **Approve arrangements for risk sharing and/or risk pooling with other organisations (for example arrangements for pooled funds with other CCGs or pooled budget arrangements under Section 75 of the NHS Act 2006)**
- **Approval of commissioning decisions in line with the delegated financial limit for the Governing Bodies in the CCGs' Constitutions.**
- **Approval of business cases relating to new investments, new service developments or service increases within the overall operating plan or budgetary financial limit.**
- **Approval of the CCGs' contracts for any commissioning support (e.g. procurement)**

2.3. Delegating these functions will enable the JHCB to provide oversight of the four CCG's commissioning functions on behalf of the Governing Bodies as part of a streamlined approach to governance for the developing shared team across the CCGs led by the Single Executive team structure agreed by the Governing Bodies in January 2020. It will avoid the potential and delay involved in decision making across the system by the individual CCGs and avoid duplication for the management team in providing assurance on the delivery of functions as they continue to align across the CCGs. It will also allow the Governing Bodies, meeting collectively in common, to focus on setting the strategic direction and objectives for the CCGs, receiving assurance on the delivery of these objectives by the JHCB.

2.4. Detailed terms of reference for the JHCB are attached as **Appendix 1**. This sets out that the JHCB will meet in public (other than when it needs to consider confidential reports) and a proposed membership. This proposal has been developed by the Task and Finish Group of Governing Body members established in January, who have considered a number of issues including balancing clinical and non-clinical representation and ensuring representatives from each CCG are in place. They propose that

the membership is made up of the four CCG Chairs, a Lay member from each CCG, two further GP representatives (the Chairs of relevant sub-committees), a Secondary Care Consultant and the six Executive Directors (Accountable Officer, two Deputy Accountable Officers, Chief Finance Officer, Chief Nursing Officer and Chief Medical Officer). The terms of reference also set out that in order to be quorate, the JHCB will need Executive, lay and clinical representation which must include at least one GP or Lay representative from each CCG.

2.5. It is proposed that the JHCB will be supported in delivering its functions by the establishment of a number of function based sub-committees:-

- **Finance and Sustainability –** to provide an oversight of financial arrangements and performance across the four CCGs as they commission across the system.
- **Individual Commissioning Statutory Duties Assurance –** To provide an oversight of the CCGs' arrangements for commissioning services for individuals with specific and/or complex needs (including continuing healthcare, Children with Special Educational Needs and Disabilities, Patients with Learning Disabilities and complex mental health needs)
- **Quality and Performance –** to provide oversight of clinical quality, patient safety and performance in commissioned services across the system
- **System Commissioning –** To support the JHCB in developing commissioning arrangements including policies across the Black Country and West Birmingham system
- **Place Based Commissioning Committees –** Committees to provide oversight of commissioning arrangements (including the delivery of Integrated Care Provision) in each of the five places in the four CCGs (Dudley, Sandwell, Walsall, West Birmingham and Wolverhampton)

Terms of Reference setting out the specific functions of these sub-committees in more detail will be agreed at the first meeting of the JHCB under its new terms of reference

2.6. The Task and Finish Group reviewing membership have also outlined a proposed membership for each of the sub-committees. This is set out at **Appendix 2.** They propose that, of the sub-committees the Finance and Sustainability Committee should have a Lay Chair and the remaining sub-committees a clinical chair which, initially at least, should be a GP. Conversely, the group reviewing conflict of interest arrangements felt it was more appropriate for committees to be chaired by Lay Members in order to effectively manage the potential conflicts. Both groups recognised the need to ensure the CCGs' membership remained assured that governance arrangements reflected clinical leadership. The membership sub-group's view was that this meant the sub-committees should include GP and Lay representation from each CCG but that the quorum for each sub-committee should be representation from the Executive, Lay and GP membership. They also propose that each sub-committee should consider who else (including representatives of partner agencies) would add value to their work as participating attendees at their first meetings.

2.7. **RECOMMENDATION: The Governing Bodies approve:**

- **The delegation of functions to the Joint Health Commissioning Board outlined in the draft Terms of Reference.**
- **The draft Terms of Reference for the Joint Health Commissioning Board**
- **The proposed Membership for the Joint Health Commissioning Board and its sub-committees**

3. SCHEME OF RESERVATION AND DELEGATION

3.1. Each of the CCGs maintains a Scheme of Reservation and Delegation (SORD) which sets out the powers that are either reserved to the Membership or delegated to either the Governing, an Officer or another Committee. Historically, the SORD was a part of CCGs' constitutions however, since NHS England updated their model constitution for CCGs which clarified the core requirements for constitutions in line with legislation, it has been possible for CCGs to include it in a Governance Handbook not subject to the requirement to seek NHS England approval. This means that the Governing Bodies can agree to make amendments to the SORD (other than to powers reserved to the membership).

3.2. An initial draft SORD for the CCGs was considered at the meeting in common on 21 January, a Task and Finish Group established at that meeting has developed this into a detailed SORD for recommendation to the Governing Bodies. This draft is attached as **Appendix 3** and has been reviewed by the CCGs' legal advisors and sets out proposals for delegation of responsibilities to the JHCB and members of the Executive Team.

3.3. The SORD sets out the delegation of functions at a high level. As the CCG Transition programme progresses, work will be undertaken to develop a supporting operational scheme of delegation that sets out decision making responsibilities at different levels of the organisation. In addition, the financial details associated with these responsibilities will need to be reflected in the CCG's Standing Financial Instructions, (SFIs) along with the delegation to the JHCB make financial decisions on behalf of the Governing Bodies and the changes to the CCGs' Executive team. SFIs do form part of the CCGs' constitutions so any amendment to them will need NHS England approval.

3.4. In advance of an amendment to SFIs, in order to manage the continuation of business across the four CCGs under the newly established Executive Structure, in particular to allow prompt payment of invoices for previously authorised spend it is proposed that the Chief Finance Officer is given authority to authorise named officers to exercise the powers under the CCGs' delegated limits up to a value of £250,000 (such arrangements have already been put in place in Sandwell and West Birmingham CCG). Arrangements made under this authority will be reported to Audit and Governance and Finance and Sustainability Committees. It is also proposed that, where SFIs reference posts that are no longer in existence in the new Executive Structures, that the equivalent position (for example the relevant Managing Director) is given authority to exercise the powers provided

3.5. **RECOMMENDATION: The Governing Bodies:**

- **Approve the changes to the Scheme of Reservation and Delegation and the consequent amendment to the CCGs' Governance Handbooks.**
- **Authorise the Chief Finance Officer to make arrangements for named officers to exercise his delegated powers to sign off invoices up to a value of £250,000.**
- **Agree that, where posts referenced in Standing Financial Instructions no longer exist, that the equivalent officer in the new structure exercises the powers provided.**

4. OTHER COMMITTEES

4.1. As set out above, CCGs are able to enter into joint arrangements for commissioning functions. For committees dealing with other functions, including Audit and Remuneration (which CCGs are required to establish by legislation) and Primary Care Commissioning (which is delegated by NHS England) any streamlining of arrangements will be through meetings in common.

4.2. A number of Remuneration Committee meetings in common have already taken place to support the Management of Change process to establish a shared Executive team. It is proposed that this approach is used for future meetings of Audit, Remuneration and Primary Care Commissioning Committees as a common work programme develops for these committees.

4.3. It is likely that these shared work programmes will be introduced in a phased way as local work programmes are completed. This will include the completion of current Internal and External Audit programmes by Audit Committees in Quarter 1 before a common programme is developed for the remainder of the year. This will include the collective procurement of External Auditors following the plans for each CCG to extend their current arrangements for a further year.

4.4. It is also suggested that the Governing Bodies continue with meetings in common. These sessions will be balanced in focus between receiving assurance from Committees and the JHCB as well as allowing time in workshop format to develop shared CCG strategy and objectives.

4.5. All of these proposed meetings, including the planned meetings of the JHCB and its sub-committees have been programmed into a Corporate Calendar attached at **Appendix 4**. The Governing Bodies are asked to approve this draft Corporate Calendar.

4.6. **RECOMMENDATION: That the Governing Bodies**

- **Approve the proposed Corporate Calendar**
- **Note the work to reappoint External Auditors and the planned procurement of a single External Auditor from 2021/22.**

5. NEXT STEPS

5.1. A number of further steps, including the development of an Operational Scheme of Delegation and amendments to SFIs are set out above. In addition, a number of the Task and Finish groups established in January will continue to meet. This includes the group reviewing the approach to the delivery of CCG statutory duties, management of conflicts of interest and further detail on the committee reviewing assurance for statutory duties relating to commissioning for individuals. These groups will inform the development of further outputs including a common policy for managing conflicts of interest and further details in the shared Governance framework.

5.2. One key piece of work that will need to be undertaken will be amendments to the CCGs' constitutions to reflect the changes in SFIs based on the new SORD and team structures, the appointment of the new Executive team to Governing Bodies. This may also include a harmonisation of the CCG's Standing Orders which are being reviewed by the Governance Leads.

5.3. Other work that is being progressed by the Governance Workstream of the CCG Transition includes developing an approach to aligning risk management across the four CCGs. It is proposed that this supports the development and management of a shared set of Corporate Objectives by understanding and managing risks to the achievement of those objectives. Each committee will have responsibility for managing risks associated with its functional responsibilities which will inform an Assurance Framework which the Governing Bodies can manage with the support of the JHCB. Further details of the development of risk management arrangements will be shared with Audit Committees in due course.

5.4. The overall Transition Programme has, up until now, been managed on behalf of the Governing Bodies by a Transition Board which was initially made up of the CCG Accountable Officers, Chairs and Lay representatives. As the transition moves into its next phase the Transition Board is reviewing how it can most effectively support the transition process. Work is being undertaken to develop a structured programme for the next phase across specific work streams for Communications and Engagement, Governance and Human Resources with leads from these areas forming an Operational Group. This may mean that the Transition Board, with an amended membership made up of Lay and Clinical representatives is able to take a Sponsorship role to receive assurance on progress with the programme and resolve issues on behalf of the Governing Bodies. The current Board is planning to consider this with a view to making a recommendation to the Governing Bodies at their next meeting.

5.5. **RECOMMENDATION: That the Governing Bodies note the proposed next steps in relation to the development of Governance arrangements.**

6. SUMMARY OF RECOMMENDATIONS

6.1. The Recommendations to the Governing Bodies are as follows:-

- **To Approve the delegation of functions to the Joint Health Commissioning Board outlined in the draft Terms of Reference.**
- **To approve the draft Terms of Reference for the Joint Health Commissioning Board**
- **To approve the proposed Membership for the Joint Health Commissioning Board and its sub-committees**
- **To approve the changes to the Scheme of Reservation and Delegation and the consequent amendment to the CCGs' Governance Handbooks**
- **Authorise the Chief Finance Officer to make arrangements for named officers to exercise his delegated powers to sign off invoices up to a value of £250,000.**
- **Agree that, where posts referenced in Standing Financial Instructions no longer exist, that the equivalent officer in the new structure exercises the powers provided.**

- **Approve the proposed Corporate Calendar**

- **Note the work to reappoint External Auditors and the planned procurement of a single External Auditor from 2021/22.**
- **Note the proposed next steps in relation to the development of Governance arrangements.**

Agenda Item 9.0 (Appendix 1)

Draft terms of Reference for Joint Health Commissioning Board

BLACK COUNTRY AND WEST BIRMINGHAM HEALTH COMMISSIONING BOARD TERMS OF REFERENCE

1. ACCOUNTABILITY & RESPONSIBILITY

1.1. The Black Country and West Birmingham CCGs Health Commissioning Board ("the Board") is a joint committee of, NHS Dudley, NHS Sandwell and West Birmingham, NHS Walsall and NHS Wolverhampton Clinical Commissioning Groups (CCGs) and is set up to manage, to the extent permitted under s.14Z3 NHS Act 2006 (as amended), the activities of the four CCGs.

1.2. The Board's purpose is, on behalf of the CCG's Governing Bodies to have overarching responsibility for all matters relating to the commissioning of healthcare services across the Black Country and West Birmingham footprint.

1.3. In delivering this purpose it will be responsible for exercising the following functions that have been delegated it in line with the CCGs' Scheme of Reservation:

a) Determination of arrangements for discharging the CCGs' statutory duties associated with their commissioning functions (including securing public involvement, promoting both awareness and use of the NHS Constitution, obtaining appropriate advice, promoting integration of services, enabling patients to make choices and promoting the involvement patients, carers and representatives in decisions about their healthcare).

b) Determination of arrangements to promote a comprehensive health service.

c) Determination of arrangements for working in partnership with the CCGs' local authorities to develop joint strategic needs assessments and joint health and well being strategies.

d) Determining arrangements for promoting and promoting integration of both health services with other health services and/or health-related and social care services where this would improve the quality of services or reduce inequalities.

e) Approve arrangements for risk sharing and/or risk pooling with other organisations (for example arrangements for pooled funds with other CCGs or pooled budget arrangements under Section 75 of the NHS Act 2006)

f) Approval of business cases relating to new investments, new service developments or service increases within the overall operating plan or budgetary financial limit.

g) • Approval of commissioning decisions in line with the delegated financial limit for the Governing Bodies in the CCGs' Constitutions

h) Approval of the CCGs' contracts for any commissioning support (e.g. procurement)

1.4 In the exercise of its general purpose and the functions delegated to it, the Joint Health Commissioning Board will be responsible for the following:-

a) Developing common Black Country and West Birmingham wide strategic commissioning plans and monitoring the implementation of them within each CCG area.

b) Providing assurance to the CCGs' Governing Bodies on delivery against system-based objectives.

c) Receiving assurances via its established sub-committees regarding placed based delivery where this is specific to local places.

d) Ensuring the four CCGs are working collaboratively in exercising their functions for the improvement of the services they commission. This will include:

i. agreeing the annual programme of objectives; an operational plan; and performance milestones and measures;

ii. setting and monitoring the Black Country and West Birmingham CCGs Financial Plan including delivery of financial targets set by NHS England;

iii. to ensure the continuous improvement in the quality of services commissioned on behalf of the four CCGs through the development of a common quality assurance and reporting framework and quality improvement strategy;

iv. monitoring provider performance and taking remedial action where necessary;

v. reviewing and challenging plans/progress reports; making recommendations and agreeing remedial actions or mitigations, to the

extent it deems necessary, to support delivery of the CCG's targets, performance measures and financial plans;

vi. Establishment of a single risk management framework and thereby ensuring all principal risks are identified, managed and mitigated with appropriate plans, controls and assurance reported within the Group's assurance framework;

vii. Set up and oversee the effectiveness of sub committees deemed necessary, agreeing terms of reference and membership of any such sub-committees.

2. SUB-COMMITTEES

2.1 The Joint Health Commissioning Board has established the following sub-committees:-

- **Finance and Sustainability**
- **Individual Commissioning Assurance**
- **Integrated Assurance**
- **System Commissioning**

2.2 The Sub-Committees will have responsibility for the functions in line with the CCGs Schemes of Reservation and Delegation set out in the table below. The Joint Health Commissioning Board will have responsibility for confirming any recommendations made by the Sub-Committees outside of their agreed delegated powers.

Committee	Delegated Functions
Finance and Sustainability	• Approve arrangements for discharging the CCGs' statutory financial duties. • Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the CCGs' ability to achieve their agreed strategic aims. • Determination of the process for making grants and loans to voluntary organisations.
Individual Commissioning Assurance	• Approving the arrangements for managing exceptional funding requests
Integrated Assurance	• Approve arrangements, including supporting policies, to minimise clinical risk, maximise

	patient safety and to secure continuous improvement in quality and patient outcomes.
System Commissioning	No delegations currently

3. MEMBERSHIP

2.1 The membership of the Black Country and West Birmingham CCGs Health Commissioning Board shall be as follows:

- The Chairs of the CCGs
- The Accountable Officer
- The Deputy Accountable Officers
- The Chief Finance Officer
- The Chief Nursing Officer
- The Chief Medical Officer
- A Lay Representative from Each CCG Governing Body
- The GP Chairs of the System Commissioning Sub-Committee and Quality and Performance Sub-Committee
- A Secondary Care Consultant representative from the CCG's Governing Bodies

2.2 A standing invitation will be extended to other individuals in a non-voting capacity, where they are not already nominated or a member, to be in attendance at private meetings and meetings held in public, who the Board feel will contribute to their discussion. This will include other employees of the CCGs, representatives of local authorities and Healthwatch.

3.1 In the absence of a formal member, the formal member may nominate a deputy to represent them on their behalf. Nominated deputies shall be entitled to exercise voting functions at the Board meeting.

3.2 The Board shall be authorised to co-opt other members to the Board, to ensure it has sufficient expertise to enable it to deal with its agenda.

3.3 The Board may permit or require the attendance of officers of the CCGs to attend meetings of the Board, and may permit observers from the public.

4. CHAIR

4.1 The Chair is to be chosen from amongst the CCG Chairs, to serve for a term agreed by the Board.

4.2 In the absence of the Chair, meetings will be chaired by the Vice Chair who will be chosen from amongst the Lay Representatives.

4.3 In the absence of both Chair and Vice Chair, the meeting will be chaired by another non-conflicted voting member of the Board, who cannot be an executive member.

5 QUORUM

5.1 Meetings of the Board shall be quorate provided that one third of the total membership is present, which must include:-

- The Accountable Officer or a Deputy Accountable Officer;
- At least one GP member;
- At Least one lay member; and
- At least one lay or GP representative from each CCG.

5.2 A duly convened meeting of the Board at which quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.

6 VOTING

6.1 Members of the Board have a collective responsibility for its operation. Both members and attendees will participate in discussion, review evidence and provide or seek objective expert input to the best of their knowledge and ability, and endeavour to support the Board in reaching a collective view.

6.2 The Board will use best endeavours to make decisions by reaching a consensus, which should take into account the views shared by the non-voting attendees.

6.3 Exceptionally, where this is not possible, the Board Chair (or in their absence Vice Chair) may call a vote, using the following process:

a) The meeting must be confirmed as quorate, once conflicts of interest have been accounted for, by the Chair, or in their absence the Vice Chair;
b) Each member will have one vote;
c) A decision will be made by a majority of votes cast. In the event of a draw, the Chair (or in their absence the Vice Chair) will have a final and casting vote.

7 CONFLICTS OF INTEREST

7.1 The provisions of Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017[1] or any successor document will apply at all times.

7.2 The Board shall hold and publish a Register of Interests. This Register shall record all relevant and material, personal or business, interests as set out in the CCG's Managing Conflicts of Interest Policy or subsequent policy.

7.3 Each member and attendee of the Board shall be under a duty to declare any such interests. Any change to these interests should be notified to the Chair.

7.4 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the CCG's Standards for Business Conduct Policy and may result in suspension from the Board.

7.5 Any interest relating to an agenda item should be brought to the attention of the Chair in advance of the meeting, or notified as soon as the interest arises and recorded in the minutes.

7.6 All members of the Board and participants in its meetings shall comply with, and are bound by, the requirements in the CCGs' Constitutions, Standards for Business Conduct Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

7.7 The Black Country and West Birmingham Health Commissioning Board Chair (or Vice Chair in their absence or where the Chair is conflicted) will make a determination regarding the arrangements for management of conflicts of interest, in consultation, to the extent they feel appropriate, with the Governance Lead and/or CCG Conflicts of Interest Guardians.

8 MEETINGS AND PROCEEDINGS OF THE BLACK COUNTRY AND WEST BIRMINGHAM HEALTH COMMISSIONING BOARD

8.1 The Board shall hold at least 6 meetings each year. A special meeting may be called at any time by the Chair or by any two members of the Board upon not less than 7 working days' notice, or by exception in extremis, with 3 working days' notice being given to the other members of the Board of the matters to be discussed.

8.2 The Standing orders of Wolverhampton CCG insofar as they apply to the conduct of meetings will apply to Meetings of the Board, which shall be in Public and conducted as if the Public Bodies (Admission to Meetings) Act 1960 applied to the Board in the same way as it applies to the Governing Bodies of the CCG's. Reasonable provision

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[1] https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

will be made on public Board agendas to allow for public questions in accordance with the agreed protocol.

8.3 The Board shall keep minutes of its meetings and any committee or sub-committee that it sets up. Such minutes shall be approved as an accurate record of the meeting by the Board at its next meeting. Duplicate copies of the ratified minutes shall be submitted to each of the CCG Governing Bodies and published as part of their Board papers.

8.4 The Board may appoint working groups or sub committees for any agreed purpose which, in the opinion of the Board, would be more effectively undertaken by a working group or sub-committee. Any such working group or sub-committee may be comprised of members of the CCGs or other relevant external parties, who are not required to be members of the Board. Minutes/reports of working groups or sub-committees will be promptly submitted to the Board.

8.5 In cases of emergency, the Chair may take urgent action to decide any matter within the remit of the Board, subject to consultation with at least three other members of the Board including a representative from each CCG unless conflicts of interest prevent this. Any such urgent action shall be reported to the next Board meeting and to the CCG Governing Bodies.

8.6 A schedule of meetings 12 months in advance will be published and notices of the meeting shall be given in line with the requirements of the Standing Orders. Notice shall be sent in writing or by email to the address notified by each Black Country and West Birmingham Joint Health Commissioning Board member to the Board Secretary.

9 ORGANISATIONAL SUPPORT

9.1 The Board shall agree with the CCGs support for the operations of the Board including the provision of administrative support for its activities.

10 RELATIONSHIP WITH CCG GOVERNING BODIES

10.1 The Board will provide reports for assurance to the CCGs' Governing Bodies that set out details of the proceedings and the decisions made in exercise of the functions delegated to the Board in the CCGs' Schemes of Reservation and Delegation.

10.2 The Board will review its Terms of reference and committee efficacy at least annually. This review will be used to support the CCGs' Governing Bodies review of the efficacy of the Joint Arrangements. The Terms of Reference may be amended by mutual agreement of between the CCG Governing Bodies as required to reflect changes in circumstances which may arise.

Proposed Membership

Executive Director Positions:-

AO - Accountable Officer
DAO - Deputy Accountable Officer
CFO - Chief Finance Officer
CNO - Chief Nursing Officer
DTO - Director of Technology and Operations
MD - Managing Directors
TTD - Transition and Transformation Director

Health Commissioning Board	Walsall	Dudley	SWB	Wolves	**TOTAL**	Notes
Executive Directors					6	(AO, DAO x2, CFO, CNO, CMO)
Secondary Care Clinicians					1	
Lay Members	1	1	1	1	4	To Include Chair of Finance, Lead Audit Chair, Lead PCCC Chair, Lead Rem Chair
CCG Chairs	1	1	1	1	4	
GPs					2	Chairs of System Commissioning and Quality and Performance Committee
TOTAL					**17**	

System Commissioning Committee

	Walsall	Dudley	SWB	Wolves	**TOTAL**	
Lay Members/ Secondary Care Consultant	1	1	1	1	5	To include a Secondary Care Consultant (either as the Lay Representative or in addition
GPs	1	1	1	1	4	One of the GPs to Chair (who will then be a member of the JHCB)
DAO					2	
CFO					1	
CNO					1	
CMO					1	
DTO					1	
TTD					1	
					16	

Finance & Sustainability Committee

	Walsall	Dudley	SWB	Wolves	**TOTAL**	
Lay Members	1	1	1	1	4	One of the Lays to Chair (Becomes a member of the JHCB)
GPs	1	1	1	1	4	
DAO					1	
CFO					1	
CNO/ CMO					1	Only one is required
DTO					1	
TTD					1	
					13	

Quality & Performance Committee						
	Walsall	Dudley	SWB	Wolves	**TOTAL**	
Lay Members	1	1	1	1	5	To include a Secondary Care Consultant (either as the Lay Representative or in addition
GPs	1	1	1	1	4	One of the GPs to Chair (who will then be a member of the JHCB)
DAO					1	
CFO					1	
CNO					1	
CMO					1	
DTO					1	
					14	

Further work is required to define the Membership of the

- Individual Statutory Duties Assurance Committee; and
- Place Based Commissioning Committee

The Joint Health Commissioning Board will agree the membership of these groups in advance of their first meetings.

SCHEME OF RESERVATION AND DELEGATION (SORD) – March 2020

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
Regulation And Controls	1. Delivery of the duty to act effectively, efficiently and economically		✓									
	2. Determine the arrangements by which the members of the Clinical Commissioning Group approve those decisions that are reserved for the membership.	✓										
	3. Consider and approve applications to NHS England on any matter concerning material changes to the Clinical Commissioning Group's constitution.	✓										
	4. The approval of any non-material changes to the CCG's constitution and other related documents.		✓									
	5. The approval of any changes to the Governance Handbook and related documents including terms of reference, overarching Scheme of reservation and delegation. (other than those decisions that are reserved to the membership)		✓									
	6. Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the CCG, delegated to the Governing Body, delegated to a committee or Sub- Committee of the CCG or to one of its members or employees.		✓									
	7. **Approve** the CCG's operational scheme of delegation that underpins the CCG's 'overarching scheme of reservation and delegation' as set out in its constitution.											✓ Accountable Officer

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	8. **Approve** detailed financial policies.		✓									
	9. Approve the arrangements for managing exceptional funding requests (i.e. IFR, PHB etc) .										✓	
	10. Determination of the process for making grants and loans to voluntary organisations								✓			
	11. Ensure the CCG's expenditure does not exceed the aggregate of the CCG's allotments for the financial year											✓ Chief Finance Officer
	1 2 . Ensure the CCG's use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year											✓ Chief Finance Officer
	13. Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the CCG does not exceed an amount specified by NHS England											✓ Chief Finance Officer
	14. Publish an explanation of how the CCG spent any payment in respect of quality made to it by NHS England											✓ Chief Finance Officer

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	15. Confirm the recommendations of the Joint Health Commissioning board's sub committee's where those sub-committees do not have executive powers						✓					
	16. Approve the terms of reference and reporting arrangements of all sub-committees that are established by the Joint Health Commissioning Board						✓					
	17. Approval of commissioning decisions in line with the delegated financial limit for the Governing Bodies in the CCGs' Constitutions						✓					
Practice Member Representatives And Members Of Governing Body	1. Approve arrangements for identifying practice members to represent practices in matters concerning the work of the CCG; and appointing clinical leaders to represent the membership on the CCG's Governing Body, for example through election (if desired).	✓										
Strate gy And Planni	1. Agree the vision, values and overall strategic direction of the CCG		✓									
	2. Approve the CCG's operating structure.											✓

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
												Accountable Officer
	3. Approve the CCG's commissioning plan.		✓									
	4. Approve the CCG's corporate budgets that meet the financial duties as set out in section the main body of the constitution.		✓									
	5. Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the CCG's ability to achieve its agreed strategic aims.								✓			
Annual Reports And Accounts	1. Approve the CCG's annual report and annual accounts.		✓									
	2. Approve arrangements for discharging the CCG's statutory financial duties.								✓			
Human Resources	1. Make recommendations to the Governing Body for decision on the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.				✓							
	2. Make recommendations to the Governing Body for decision on the terms and conditions of employment for all employees of the CCG including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the CCG.				✓							
	3. Make recommendations to the Governing Body for decision on any other terms and conditions of service for the CCG's employees and any other persons providing services to the CCG.				✓							

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	4. Approve disciplinary policies for employees, including the Accountable Officer (where he/she is an employee or member of the Clinical Commissioning Group) and for other persons working on behalf of the CCG.				✓							
	5. Review disciplinary arrangements where the Accountable Officer is an employee or member of another Clinical Commissioning Group.				✓							
	6. Approve arrangements for discharging the CCG's statutory duties as an employer.				✓							
	7. Approve human resources policies for employees and for other persons working on behalf of the CCG.				✓							
	8. To consider and make decisions on the recommendations made by the Remuneration Committee		✓									
Quality And Safety	1. Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.							✓				
	2. Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.					✓						
Operational and Risk	1. Approve the CCG's arrangements counter fraud and security management			✓								
	2. Approval of internal audit and counter fraud plans and other arrangement for/sources of assurance through an integrated governance framework			✓								

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	3. Review the findings of external audit and other significant assurance functions, both internal and external and consider the implications for the governance of the CCG			✓								
	4. Approve the CCG's risk management arrangements.			✓								
	5. Approval of action plans to address risks to the achievement of strategic objectives or acceptance of the risk as currently assessed		✓									
	6. To make a recommendation to the governing body on the arrangements for external audit services			✓								
	7. To approve the arrangements for external audit services		✓									
	8. Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006). (Where the risk share related to commissioning this would be delegated to JHCB. Non-commissioning related risks would be delegated to the governing Body)		✓ (non-commissioning related risk share)				✓ (commissioning related risk share)					
	9. Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the CCG.		✓									
	10. Approve proposals for action on litigation against or on behalf of the clinical commissioning CCG.											✓ AO & CFO

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	11. Approve the CCG's arrangements for business continuity		✓									
Information Governance	1. Approve the CCG's arrangements for handling complaints in relation to Data Protection.											✓
	2. Approve arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data.											✓
	3. Approve arrangements for handling Freedom of Information requests.											✓
Tendering And Contracting	1. Approve the CCG's contracts for any commissioning support (e.g. procurement)						✓					
	2. Approve the CCG's contracts for corporate support (e.g. Human Resources)											✓ Accountable Officer
Partnership Working	1. Approval of arrangements to exercise commissioning functions of the CCG jointly with other CCG's.		✓									
	2. Approve decisions delegated to joint committees established under section 75 of the 2006 Act.		✓									
	3. Determine arrangements for promoting integration of both health services with other health services and health services with health-related and social care services						✓					
	4. Determine arrangements for working in partnership with the CCG's local authorities to develop joint strategic needs assessments and joint health and wellbeing strategies						✓					
	5. Determination of arrangements for securing public involvement, promoting both awareness and use of the NHS Constitution, obtaining appropriate advice and promoting integration of services						✓					

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	6. Determination of arrangements for enabling patients to make choices						✓					
	7. Determination of arrangements for promoting the involvement of patients, their carers and representatives in decisions about their healthcare						✓					
Commissioning and Contracting for Clinical Services	1. Determination of arrangements for discharging the CCG's statutory duties associated with its commissioning functions.						✓					
	2. Determination of arrangements put in place to promote a comprehensive health service						✓					
	3. Determination of arrangements to meet the public sector equality duty						✓					
	4. Determination of arrangements for the review, planning and procurement of primary care medical services (under delegated authority from NHS England). To include • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract); • Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)"); • Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF); • The ability to establish new GP practices in an area; • Approving practice mergers; and • Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).					✓						
	5. Promoting integration of both health services with other health services and/or heath-related and social care services where the CCG considers that this would improve the quality of services or reduce inequalities						✓					

								Committees of the Joint Health Commissioning board				
Policy Area	**Decision**	**Reserved to the Membership**	**Governing Body**	**Audit and Governance Committee**	**Remuneration Committee**	**Primary Care Commissioning Committee**	**Joint Health Commissioning Board**	**Integrated Assurance / Quality and Safety Committee**	**Finance and Sustainability Committee**	**System Commissioning Committee**	**Statutory Duties for Individual Commissioning Committee**	**Officer responsibility**
	6. Approval of business cases relating to new investments, new service developments or service increases within the overall operating plan or budgetary financial limit						✓					
	7. Determine the arrangements for commissioning for individuals. For example SEND, PHB, etc.											✓

Wolverhampton Clinical Commissioning Group | Sandwell and West Birmingham Clinical Commissioning Group | Walsall Clinical Commissioning Group | Dudley Clinical Commissioning Group

GOVERNING BODIES IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 10.0

Title of Report:	**Continuity Governance Arrangements during COVID-19 Incident**
Purpose of Report:	To outline an approach to the operation of the CCGs' Governance arrangements during the response to the COVID-19 Incident
Author of Report:	Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG Sara Saville – Head of Corporate Governance, Walsall CCG Emma Smith, Governance Support Manager, Dudley CCG Jodi Woodhouse, Acting Head of Corporate Governance, Sandwell and West Birmingham CCG
Management Lead/Signed off by:	Mike Hastings, Director of Technology and Operations
Public or Private:	Public
Key Points:	• Subject to any further emergency legislation, the CCGs are still subject to the legislative provisions that apply to their operation, including their mechanisms for making decisions. • The decision making and assurance arrangements established in the CCGs' Governance Frameworks are based on the operation of committees which will not be able to meet physically during the current period of restriction on gatherings in public. • This paper sets out alternative approaches to continuing appropriate committee business whilst such restrictions are in place and CCG staff and resources are re-directed towards responding to the incident.
Recommendation:	That the Governing Bodies:- 1. Agree to the suspension of the calendar of meetings whilst a review of upcoming critical business is conducted. 2. Notes that following the review, committee business is likely to be scaled back to quarterly meetings initially. 3. Notes the mechanisms in place to support the continuity of business outside of formal committee meetings 4. Agree to the necessary suspension of Standing Orders in relation to the conduct of meetings (including the number of meetings required to be held and the requirement to hold in public)
Conflicts of Interest:	There are no identified Conflicts of Interest in relation to this paper
Links to Corporate Objectives:	The Governance arrangements will support the delivery of business critical Corporate Objectives
Action Required:	☐ Assurance ☒ Approval ☐ For Information
Implications:	
Financial	None
Assurance Framework	This report sets out initial proposals to manage assurance arrangements during the critical incident.

Risks and Legal Obligations	There are risks associated with the CCGs not having robust arrangements for making decisions. This paper sets out an approach to managing this based on a risk assessed view of business critical decisions and business required.
Equality & Diversity	There are no specific equality and diversity implications arising from this report.
Other	None

1. BACKGROUND AND INTRODUCTION

1.1. CCGs are established by legislation (primarily the NHS Act 2006 as amended by the Health and Social Care Act 2012). This legislation sets out the functions of CCGs, and how they will make decisions, including detailing that they will have constitutions and determine how to delegate functions within their Governance arrangements.

1.2. As outlined elsewhere on the agenda for the Governing Bodies in Common, much of the CCGs governance arrangements are articulated through the work of the Governing Bodies and Committee structure, which is conducted through formal meetings governed by CCG standing orders. Clearly, in the current unprecedented situation, face-to-face meetings of committees cannot take place whilst there are restrictions on gatherings and CCG staff and resources are focussed on supporting the response across the Health and Social Care system to the COVID-19 incident.

1.3. This paper sets out a recommended approach to the Governing Bodies to maintain good and effective governance arrangements during the response to the incident.

2. PROPOSED APPROACH TO GOVERNANCE ARRANGEMENTS

2.1. The CCG Governance Leads have already circulated a briefing note providing advice on governance arrangements during the incident, a copy of which is appended. The briefing note highlighted approaches to essential functions carried out through the conduct of Governing Body and committee meetings both in terms of making decisions and receiving and providing assurance.

2.2. As Governing Body members will be aware, a review is taking place of CCG functions to understand which are deemed to be ‘business critical’. This review is being informed by the unfolding situation, including the needs of the wider system and national guidance, which includes the issuing of Formal Directions to CCGs on the delivery of their functions. A number of national decisions, including the suspension of the usual deadlines for contract negotiations, delay to annual reporting timelines and suspension of some regulatory activity have already been made. As a result it is proposed that the current timetable of committee meetings is suspended whilst an assessment is made of the likely business requirements. If during the review period it is clear that a meeting does need to take place it will be re-instated with appropriate notice provided.

RECOMMENDATION – The Governing Bodies Agree to the suspension of the Corporate Calendar of Meetings.

2.3. Following the review, it is likely that a revised cycle of meetings, initially on a quarterly basis will be established and that alternative approaches to meetings (including further virtual meetings) and decision making will be adopted. As it is not yet known what activity will be taken place the Governing Bodies are asked to recognise that information received and discussed primarily for assurance purposes is likely to be managed via exception, with issues flagged in advance of any virtual meetings to support orderly discussion.

2.4. For matters that require a formal decision to be made by the governing bodies or committees (which are usually made by resolution at a quorate meeting), it will be possible to make such decisions through virtual meetings. As highlighted in the Briefing Note, any matters that require a more urgent decision can be made through the exercise of the Urgent Actions/ Emergency Powers in the CCGs’ constitutions.

RECOMMENDATIONS – That the Governing Bodies

- **Note that committee business is likely to move to an initially quarterly cycle of meetings**
- **Note the mechanisms in place to manage continuity of committee business outside of formal committee meetings.**

2.5 In order to progress these mechanisms, and to enable the CCGs' to put arrangements in place to not hold meetings in public in the usual way, it will be necessary to agree for the suspension of some of the standing orders. These may include the requirements in relation to the number of meetings to be held, the notice given for meetings and the requirement to hold them in public so the Governing Bodies are asked to consider suspending these standing orders (in the respective CCGs) until the COVID-19 incident is concluded. The taking of such a decision and a review of its reasonableness will be taken by the CCG Audit Committees in line with their responsibilities.

RECOMMENDATION – That the Governing Bodies agree to necessary suspension of Standing Orders in relation to the conduct of meetings (including the number of meetings required to be held and the requirement to hold them in public)

NHS Wolverhampton Clinical Commissioning Group | NHS Sandwell and West Birmingham Clinical Commissioning Group | NHS Walsall Clinical Commissioning Group | NHS Dudley Clinical Commissioning Group

GOVERNING BODY

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 11.0

Title of Report:	**Black Country and West Birmingham CCGs Corporate Objectives 2020/21**
Purpose of Report:	To propose a set of corporate objectives which are common to each of the four BC&WB CCGs
Author of Report:	Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG Sara Saville – Head of Corporate Governance, Walsall CCG Emma Smith, Governance Support Manager, Dudley CCG Jodi Woodhouse, Acting Head of Corporate Governance, Sandwell and West Birmingham CCG
Management Lead/Signed off by:	Mike Hastings Director of Technology and Operations
Public or Private:	Public
Key Points:	Following the approval for the single Accountable Officer and revised governance structure the Black Country and West Birmingham CCGs have agreed for the Governing Bodies to meet in common. In order for this to be effective it is important for the Governing Bodies to agree to a common set of corporate objectives which are broad enough to be relevant to all organisations. It is acknowledged that a set of priorities will be required by each CCG which describes the local detail for the delivery of the objectives.
Recommendation:	1. To approve the proposed corporate objectives for 2020/21 with the agreement that these can be revised in year if necessary
Conflicts of Interest:	None
Links to Corporate Objectives:	n/a
Action Required:	☐ Assurance ☒ Approval ☐ For Information
Implications:	
Financial	None
Assurance Framework	None
Risks and Legal Obligations	Failure to agree corporate objectives at the start of a financial year will put the effectiveness of the organisation at risk and may impact on the compliance of statutory duties
Equality & Diversity	None
Other	None

1.0 Introduction

1.1 The Black Country and West Birmingham CCGs have agreed to appoint a single Accountable Officer and to work collaboratively across the organisations. The governance review to facilitate this has resulted in an agreement for the Governing Bodies to meet in common. A common set of corporate objectives agreed by the Governing Bodies will support the single executive team to work effectively across the organisations and facilitate effective Governing Bodies in common with relevant agenda items and risk management.

1.2 The NHS is currently working to a national agenda through the long term plan and the corporate objectives have been proposed against this. They are broad enough to be relevant to each organisation and assist in a common discussion at Governing Body. The recommendation would be for each organisation to agree a set of operational priorities which will give local detail on the elements required in each CCG. This will be more evident in the place based commissioning models of care which are being developed in each CCG.

2.0 Corporate Objectives

2.1 Corporate objectives are the starting point in the new financial year to set expectations and outcomes and ensure clarity for the organisation from Governing Body level to all individuals as the objectives are translated into personal objectives through the PDR process.

2.2 The corporate objectives are also the backdrop for the risk management and assurance framework. The risks identified for the delivery of the objectives will drive the governing body agenda and discussion and enable effective decision making.

3.0 Accountability

3.1 The corporate objectives will be managed through the executive and committee structure for the delivery of the objectives. The table set out below details the relevant committees and directors.

	Objective	Committee	Director/s
1	Develop strong engagement and involvement arrangements with our public and partners	Q&P System CC Place CC PCCC	CMO
2	Maintain financial sustainability	F&S	**CFO**
3	Continue to improve quality, safety and performance of commissioned services	Q&P PCCC	**CNO/DPC**
4	Implement place based care models across the system	Place based CC PCCC	**DAO place MDs**
5	Develop a Black Country and West Birmingham integrated care system	System CC	**DAO system TTD**
6	Develop effective system leadership and governance	GB Rem A&G	**AO Chairs DHR TOD TTD**
7	Continue to invest in and develop infrastructure (eg estates, workforce and digital)	F&S Rem	**CFO TOD HRD**
8	Comply with our statutory duties	A&G	**AO TOD**

4.0 Recommendation

4.1 The Governing Body supports the adoption of the proposed corporate objectives noting the reporting arrangements with the management and committees.

NHS Wolverhampton Clinical Commissioning Group | NHS Sandwell and West Birmingham Clinical Commissioning Group | NHS Walsall Clinical Commissioning Group | NHS Dudley Clinical Commissioning Group

GOVERNING BODY'S IN COMMON

DATE OF MEETING: 31 March 2020
AGENDA ITEM: 12.0

Title of Report:	**Treatment Policies - Prioritisation Scorecard Framework**
Purpose of Report:	• To summarise background and current status • To share the prioritisation scorecard framework adopted by Sandwell and West Birmingham (SWB) CCG from Birmingham and Solihull (BSOL) CCG for the evidence-based Treatment Policies work programme • To clarify that the Black Country and West Birmingham (BCWB) CCGs need to harmonise retrospective policies as well as develop policies arising out of later phases of the national Evidence Based Interventions Programme, and agree how this is undertaken
Author of Report:	Angela Poulton, Deputy Chief Officer – Strategic Commissioning & Redesign
Management Lead/Signed off by:	Michelle Carolan, Chief Officer – Quality
Public or Private:	Public
Key Points:	• The 4 Black Country CCGs do not have an aligned position on evidence-based treatment policies • It has previously been agreed to set up a BCWB treatment policy working group with an agreed composition to harmonise policies by end July 2020 (extraordinary Governing Body January 2020) • As SWB CCG and Sol CCG has a shared treatment policy work programme, BSOL CCG's prioritisation scorecard framework has been formally adopted • Adopting this single prioritisation scorecard framework is consistent with the ambition to ensure full alignment of treatment policies during 2020/21 • The BCWB Joint Commissioning Committee agreed the adoption of the framework in principle and ways to do retrospective/future policy development
Recommendation:	1. The adoption of the prioritisation scorecard framework currently used by SWB and BSOL CCGs by all Black Country CCGs 2. To assign the retrospective policy work to the 'task and finish' BCWB policy development group, to deliver by January 2020/21 3. To approve Dudley, Walsall and Wolverhampton CCG's joining the BSOL CCG process, with a single Clinical Priorities Advisory Group and governance approval via the proposed System Commissioning meeting through to the BCWB Joint Health Board
Conflicts of Interest:	None
Links to Corporate Objectives:	• Treating and caring for people in a safe environment and protecting them from avoidable harm (NHS Outcome Framework – domain 5) • Improved outcomes for patients • Ensuring services commissioned are effective, efficient and economically justified • Achieving sustainable financial balance • Delivery of national guidance

Action Required:	☐ Assurance ☒ **Approval** ☐ For Information
Implications:	
Financial	• Policy harmonisation presents an opportunity to reduce expenditure by ensuring CCG funds are only invested in evidence-based interventions (Quality, Innovation, Productivity and Prevention - QIPP) • Potential impacts on finance and activity for each CCG area will need to be assessed • Deployment of clinical/managerial resources to undertake the policy development work
Assurance Framework	Achieving policy alignment will: • reduce variation across BCWB • enable consistency in the administration of Individual Funding Requests (IFRs) • stop unnecessary operations/interventions and release clinical time • demonstrate the best use of CCG funds
Risks and Legal Obligations	• Risk of patient/public challenge if the harmonisation process does not include proportionate engagement with local population
Equality & Diversity	• Aligned BCWB treatment policies to achieve equity and equality of service provision
Other	• Public health resources will be required to undertake evidence searches, attend the Clinical Priorities Advisory Group and support clinical/public engagement activities • Development of a standardised Equality Impact Assessment and Quality Impact Assessment process and proforma • Resources to disseminate joint policies developed and associated training

1.0 BACKGROUND AND CURRENT SITUATION

1.1 Clinical commissioners have a responsibility to make sure the operations we are offering on the NHS are the most appropriate treatments for each condition. This means ensuring they are safe for patients, deliver good outcomes for patients and, crucially, are clinically effective. Consistent with this the 4 Black Country and West Birmingham (BCWB) Clinical Commissioning Groups (CCGs) have been developing evidence-based treatment policies in recent years.

1.2 All Black Country and Birmingham and Solihull (BSOL) CCGs have been signed up to the Ethical Framework for priority setting and resource allocation policy for Collaborative Commissioning (Appendix 1) since 2014.

1.2 Scoring was not formally used by BSOL CCG as a process for selecting policies for review prior to 3 of Sandwell and West Birmingham (SWB) and BSOL CCG's Harmonised Policies programme. Following BSOL CCG's alignment of internal processes during 2018-19, SWB CCG was approached about adopt their methodology for scoring and prioritisation for the joint work on policy development. SWB CCG's Strategic Commissioning and Redesign (SCR) Committee formally approved the adoption of the Scorecard Framework methodology for the Treatment Policies work programme on 7th February 2019.

1.3 All policies developed and reviewed as part of the joint policy development work by the CCGs have still been subjected to ratification by both CCG's respective governance process.

1.4 In January 2020 the Executive Committee committed to the harmonisation of policies across the Black Country footprint to ensure there is no 'post-code lottery' and all patients have access to equitable, accessible and evidence-based health services.

1.5 Currently, all four CCGs have slightly different approaches to policy development and the level of public health input and engagement also varies across the four areas.

1.6 Adopting a single Framework for policy harmonisation and future policy development will ensure the CCGs are able to demonstrate a transparent and consistent approach across the Black Country Sustainability and Transformation Partnership (STP).

1.7 The **NHS England (NHSE) Evidence Based Interventions (EBI) Programme** was launched in 2018. As medicine advances, some interventions can be found to be inappropriate in certain circumstances and safer, less invasive alternative becomes available. Surgical interventions can be painful and can result in unintended complications or harm. Therefore, they should only be offered to patients who really need it. The aim of the Evidence-Based Interventions programme is to prevent avoidable harm to patients, to avoid unnecessary operations, and to free up clinical time by only offering interventions on the NHS that are evidence-based and appropriate.

1.8 In November 2019, the national Programme issued implementation guidance for 17 procedures (often referred to as Phase 1 EBI) where the evidence suggests that they only work in certain circumstances and that exposure to an unnecessary operation can have harmful side effects, and as such the National Institute of Health and Care Excellence (NICE) recommended they should be used as a last resort. Phase 1 guidance identified 4 interventions that should not be routinely offered to patients unless there are exceptional circumstances and 13 interventions that should only be offered to patients when certain clinical criteria are met.

1.9 SWB and BSOL CCGs were invited to become a Demonstrator Community (DC) as part of the NHSE EBI national policy development programme in 2019. NHSE recognises the robust process followed by both CCGs and applauds our approach to patient and clinical engagement. As a result, NHSE invited both CCGs to present at a webinar hosted for the DC during 2019.

1.10 By adopting this Framework, the Black Country CCGs will be utilising a tool that is being recognised nationally and already being used by other local CCGs for the purpose of policy development e.g. BSOL CCG and North Staffordshire CCG.

2. PRIORITISATION FRAMEWORK

2.1 This section describes the policy developed by BSOL CCG for the Prioritisation of Healthcare Resources (Appendix 2) that is based on best practice and has been adopted by SWB CCG. The policy is adhered to by the BSOL CCG's Clinical Priorities Advisory Group (CPAG). CPAG undertakes technical assessments of proposals and provides clinical advice and recommendations to the Clinical Investment and Disinvestment Committee, Treatment Policy Clinical Development Group and BSOL CCG's Health Commissioning Board.

2.2 CPAG is not a decision-making body of BSOL CCG. Any recommendations made by this group are still expected to follow the due governance process for approval of proposals and policies.

2.3 The Prioritisation Scorecard Framework of this policy, also known as Portsmouth Scorecard (Appendix 2, Section 8) outlines the process undertaken in detail. Every policy or procedure under review is scrutinised and scored based on a defined 'PICO' which stands for:

- Population under study
- Intervention
- Comparator/control
- Outcomes measured as appropriate to the condition.

2.4 The Prioritisation Framework Scorecard is detailed on pages 26-32 of the Prioritisation Policy (Appendix 2). This includes breakdown of the seven factors taken into consideration during the prioritisation process, namely:

- Strength and quality of evidence
- Magnitude of health improvement benefit
- Prevention of future illness
- Supports people with existing health problems
- Cost effectiveness ratio
- Addresses health inequality or health inequity
- Delivers national and/or local requirements/targets

2.5 CPAG uses a modified version of the Portsmouth scorecard (Appendix 2: page 26) and supplementary guidance is also made available to enable the Treatment Policy Clinical Development Group to apply the criteria consistently.

2.6 The above seven factors are scored on a scale ranging from very low to very high and awarded points based on criteria outlined in the policy. The maximum score possible is 240 and the service or policy must receive a minimum of 90 points to be considered as a commissioning priority. Any procedure/policy achieving a score of less than 90 is recommended to be not routinely commissioned.

2.7 There is a separate Scorecard developed for Diagnostic procedures detailed on pages 33-34. The Diagnostics Scorecard scores the procedure under review on the parameters below:

- Strength and quality of evidence
- Effectiveness of the test in placing the patient on a subsequent pathway
- Is it valuable in determining the patient's condition and ensuring patient is placed on the appropriate pathway?
- Potential for harm
- Potential for acceptability
- Cost effectiveness ratio
- Addresses health inequality or health inequity
- Delivers national and/or local requirements/targets.

2.8 The above factors for a diagnostic procedure are scored on a scale ranging from very low to very high and awarded points based on criteria outlined in the policy.

2.9 Based on the outcome of the above Scorecards, the Clinical Priorities Advisory Group makes one of the following recommendations:

- Continue to commission the current service if score above threshold
- Investment if currently not commissioned but score above threshold
- Disinvestment if currently commissioned service is below threshold.

2.10 If the score is below threshold, whilst it may be advised the service is not routinely commissioned a policy may still need to be developed.

2.11 Given the agreement to harmonise all BCWB policies in January 2020 using a consistent approach makes sense. This was discussed by the Joint Commissioning Committee (JCC) in March 2020. Given the integrity and successful application of the Framework by SWB and BSOL CCG, and noting the Demonstrator Site status, **the JCC recommends the adoption of the prioritisation scorecard framework currently used by SWB and BSOL CCG's by all Black Country CCGs.**

3. APPROACH TO ACHIEVING HARMONISED POLICIES

3.1 The JCC acknowledged that there are two strands to the work to be undertaken to ensure consistent treatment policies across the BCWB, and the approach to delivery recommended takes each element separately:

- Review of retrospective policies
- Implementation of later phases of the national EBI programme (Phase 2 expected during 2020/21).

3.2 At the direction of the JCC, the approach to delivering the 2 strands has been considered.

3.3 The retrospective policy harmonisation work does not involve BSOL CCG**. It is recommended that the BCWB STP treatment policy development group is assigned the retrospective policy harmonisation task for completion by January 2021**. The original timescale for this work was for completion by July 2020 but given the COVID-19 virus outbreak this delivery timeframe is no longer deliverable, hence the suggested timeframe October-January 2020/21, subject to review as the national escalation progresses.

3.4 There are 2 options for the implementation of the later phases of the national EBI programme:

- Option 1 – Establish a BCWB CPAG
- Option 2 - Join BSOL CCG's CPAG

3.4.1 **Option1 – Establish BCWB CPAG**

Pros:

- Natural evolution of the BCWB Policy Development Group
- BCWB STP independent direction and influence on the work programme
- Reduced complexity in delivering the work e.g. convening key joint meetings/events
- Supports the BCWB collaborative commissioning agenda
- Retains a stronger focus on the BCWB local populations for which the CCGs are responsible

Cons:

- Complexity of undertaking retrospective and future treatment policy development work simultaneously, and impact on pace if EBI phase 2 is launched before retrospective policy alignment work is completed
- Breaks the long-standing, successful joint SWB and BSOL CCG's joint approach, nationally recognised and ensures consistent treatment for patients for the whole of Birmingham
- Loss of the synergy and benefits of an established process and experience/expertise of Solihull Public Health input to share with Black Country Public Health teams e.g. evidence reviews, supporting clinical and public engagement
- Additional costs potentially created by having a duplicate work organisation to deliver e.g. administration, engagement, venues

3.4.2 **Option 2 – Join BSOL CCG's CPAG (recommended option)**

This option enables BCWB to realise the benefits of the cons outlined in 3.4.1 whilst supporting the collaborative commissioning agenda. A key consideration is the need to ensure joint agreement of the work programme and equal observance of each STP's governance.

It should be noted that BSOL CCG CPAG has already discussed the other CCGs joining the process. BSOL CCG have agreed in principle to this process provided the workload is shared across public health teams in terms of evidence searches and Black Country clinicians attend CPAG (requiring changes to the current terms of reference).

4.0 KEY RISKS AND MITIGATIONS

4.1 There is a risk that policy decisions could be challenged if the policy development process does not comply with CCG's legal duties i.e. Patient and Public Involvement. This risk is mitigated by having a co-ordinated approach across the Black Country and a robust public and clinical engagement exercise being undertaken with each phase of policy development. Furthermore, the local clinicians across the Black Country are already aware of the Scorecard methodology as all the CCGs collaborated on the Phase 3a (development of three clinical policies) during 2019-20, which were developed based on the same framework.

4.2. As part of the planned policy harmonisation exercise across the Black Country, several key factors will need to be considered to mitigate any associated risks:

- Resources including commissioners' capacity and associated cost
- Timelines
- SWBCCG alignment with BSOLCCG
- Potential impact on finance and activity of making any changes to the current policy positions in each CCG.

4.3 However, adopting a single methodology across the four CCGs will help ensure consistency in approach as well as a transparent and fair process for policy development and harmonisation across the Black Country.

5. OTHER IMPLICATIONS

5.1 **Public Health support** – This framework requires significant Public Health input to undertake the evidence-base review and produce the scorecards. CPAG works very closely with Public Health team at Birmingham Local Authority for the purpose of Clinical Prioritisation and Evidence review for the same. In order to facilitate successful roll-out of the Framework across the Black Country CCGs, Public Health support should be identified and agreed for this work programme to ensure ongoing support is secured prior to commencing the formal Harmonisation of Policies programme.

5.2 **Governance**- CPAG in BSOLCCG facilitates the Prioritisation Scorecard Framework and SWBCCG has inadvertently benefitted from the support provided by CPAG during Phase 3 policy development. However, the Executive Team will need to agree whether a similar committee should be set up on behalf of Black Country CCGs or in the absence of such a committee, how this framework may fit in the new governance structure.

5.3 **Equality and Inclusion** – a comprehensive Quality Impact Assessment (QIA) has been undertaken by BSOL CCG on their Policy for Prioritisation of Healthcare Resources. A local Quality Impact Assessment can be undertaken to ensure any additional issues identified across the Black Country CCGs are incorporated into the QIA and given due consideration. Both SWB and Wolverhampton CCGs have QIAs implemented as part of the local governance process. Therefore, the Executive Directors will need to agree a standardized QIA template to be used across all four CCGs.

5.4 **Legal –** There is a risk of patient and public challenge to any policy changes if it is perceived that local patient population have not had an opportunity to engage and be involved in the development or revision of treatment policies. The Prioritisation Scorecard Framework is very robust and using this methodology ensures the policy position is derived from the evidence-base review and patients are not unnecessarily exposed to any surgery and the associated risks of underdoing a surgical procedure.

6. RECOMMENDATIONS

6.1 The Governing Body in Common are requested to:

1. Approve the adoption of the Prioritisation Scorecard Framework currently used by SWB and BSOL CCGs by all Black Country CCGs
2. Approve assigning the retrospective policy work to the ‘task and finish’ BCWB policy development group, to deliver by January 2020/21
3. Approve Dudley, Walsall and Wolverhampton CCG’s joining the BSOL CCG process, with a single Clinical Priorities Advisory Group and governance approval via the proposed System Commissioning meeting through to the BCWB Joint Health Board.

Midlands and Lancashire
Commissioning Support Unit

Agenda Item 12 (Appendix 1)

NHS Birmingham Cross City Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

Collaborative Commissioning Policy

Ethical framework for priority setting and resource allocation

Version 1.2 – October 2014

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1. Introduction

The Secretary of State has a duty to continue to promote a comprehensive health service.

The Clinical Commissioning Group receives a fixed budget from Central Government and must arrange for the provision of healthcare to the extent it consider necessary to meet the reasonable requirements of its patients, subject to the duty to stay within its allocated resources.

Directly commissioned services include those provided through primary, secondary and tertiary care NHS providers, the independent sector, voluntary agencies and independent NHS contractors.

The mechanism through which investment and disinvestment decisions are taken is through a range of Clinical Commissioning Group processes. The Clinical Commissioning Group undertakes strategic planning, which leads to decisions made in its annual commissioning round. All decision making within the Clinical Commissioning Group is underpinned by this ethical framework. The Clinical Commissioning Group seeks to take decisions about which services to commission through a systematic approach which is centred on the needs of patients but which fairly distributes services across different patients groups. It can only do so if all decision making is based on clearly defined evaluation criteria and follows clear ethical principles.

Given resource constraints, the Clinical Commissioning Group cannot meet every healthcare need of all patients within its areas of responsibility. The fact that the Clinical Commissioning Group takes a decision not to commission a service to meet a specific healthcare need due to resource constraints is an inevitable fact of life in the NHS and does not indicate that the Clinical Commissioning Group is breaching its statutory obligations.

This ethical framework underpins priority setting processes and informs decision making by the Clinical Commissioning Group and its associated committees. In particular, it supports decision making in:

- the development of strategic plans for individual services
- making investment and disinvestment decisions during the annual commissioning cycle
- making in-year decisions about service developments or disinvestments
- the management of individual funding requests

The purpose of setting out the principles and considerations to guide priority setting is to:

- provide a coherent framework for decision making;
- promote fairness and consistency in decision making; and to
- provide a means of expressing the reasons behind decisions that have been taken.

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The ethical framework has two parts:

1. Core principles

These are the principles which guide all decision making by the Clinical Commissioning Group both at the service and individual level. As with all Clinical Commissioning Group policies, this policy should be reviewed at regular intervals. However, core principles will guide all decision making unless and until the Clinical Commissioning Group decides to amend this policy.

The core principles will be applied when dealing with individual funding requests, in conjunction with other general or treatment specific commissioning policies which might be relevant to the case.

Five important themes can be found within these principles:

1. The first is that, as budget holder for a defined population and the responsible commissioner for a defined range of clinical services, the Clinical Commissioning Group and its committees should ensure that all decisions are framed and considered in such a way that all options for investment are considered.

   This means that there should not be a parallel system operating which allows individual treatments or patients to bypass prioritisation. The commissioning and operating policies that have been adopted by the Clinical Commissioning Group already allow for high priority service developments to be considered as a matter of urgency and for individuals who have unusual and high priority clinical needs to be funded.

   The principles that require the Clinical Commissioning Group to consider competing demands when committing resources avoid the situation in which patients, patient groups and services who lobby, being given undue priority.

2. The second theme is that a commissioner should not give preferential treatment to a patient who is but one of a number of patients with the same clinical needs. Either a treatment or service is made available to all patients with equal clinical need or, if this cannot be afforded, it should not be commissioned for any patient. A decision to treat only some of the patients may be unfair because the decision about whom to treat would potentially be arbitrary and risks being discriminatory.

   The Clinical Commissioning Group considers that if funding for a treatment cannot be justified as an investment for all patients in a particular cohort, the treatment should not be offered to only some of the patients *unless it is possible to discriminate on a rational basis between different sub-groups of patients on clinical grounds*.

   A treatment policy approved by the Clinical Commissioning Group should therefore not be approved unless the Clinical Commissioning Group has made funds available to allow all patients within the clinical group identified in the policy to access treatment.

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3. The need to demonstrate that a treatment is clinical effective or that a service development represents value for money is only the first stage in assessing priority.

   It is important to appreciate that being effective (or providing value for money) is *a minimum requirement* in order to be subject to prioritisation for funding and not **the** sole criteria that have to be met for funding to be agreed.

4. Commissioners are frequently asked to take on funding commitments made by another statutory body or other type of organisation (including pharmaceutical companies, research bodies or acute trusts) or indeed an individual who has funded the treatment themselves. While there might be instances where a commissioning body may choose to take on that responsibility for a number of reasons, another important principle is that the Clinical Commissioning Group cannot assume responsibility for a funding decision in which it played no part unless there is a legal requirement to do so.

5. Related to point 4 is the issue of financial support provided to research and development. Commissioner support for R&D is highly desirable but it needs to be placed within appropriate constraints. These constraints should protect high priority treatments and services of established value.

2. Factors to be taken into account when prioritising competing needs for healthcare

The NHS cannot possibly provide a service that meets the "best interests" of every patient and, indeed, does not have a legal obligation to do so. The Clinical Commissioning Group recognises that commissioners do not have a duty of care to the patients they serve but have an obligation to provide a fair system for deciding which treatments to commission, recognising that the Clinical Commissioning Group does not have the budget to fulfil every single need of the patients for whom it is responsible.

This means that the key task of priority setting is to choose between competing claims on the Clinical Commissioning Group's budget. This requires the Clinical Commissioning Group to adopt policies that allow potential and existing demands on funds to be ranked, preferentially, in the context of a strategic plan for the service. However the Clinical Commissioning Group recognises that its internal resources will not allow every service to be assessed and ranked within every annual commissioning round.

When prioritising both within and across healthcare programmes, a commissioner has to make complex assessments and trade-offs. Section 2 sets outs the common factors which are taken into account when making these decisions. This list is not exhaustive.

The Clinical Commissioning Group will seek, within the resources available to it, to take rational decisions about which services to commission. As part of that process the Clinical Commissioning Group is committed to examining existing services and reserves the right to withdraw funding from existing services which are not determined to justify their funding since this will release resources to fund other services which have a higher ranking.

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2. The policy

2.1 Core principles

Principle 1
The values and principles driving priority setting at all levels of decision making should be consistent.

Principle 2
The Clinical Commissioning Group has a legal responsibility to commission healthcare, within the areas for which it has commissioning responsibility, in a manner which is consistent with its legal duty not to overspend its allocated budget.

Principle 3
The Clinical Commissioning Group has a responsibility to make rational decisions in determining the way it allocates resources to the services it directly commissions and to act fairly in balancing competing claims on resources between different patient groups and individuals.

Principle 4
Competing needs of patients and services within the areas of responsibility of the Clinical Commissioning Group should have a fair chance of being considered, subject to the capacity of the Clinical Commissioning Group to conduct the necessary healthcare needs and services assessments. As far as is practicable, all potential calls on new and existing funds should be considered as part of a priority setting process. Services and individual patients should not be allowed to bypass normal priority setting processes.

Principle 5
Access to services should be governed, as far as practicable, by the principle of equal access for equal clinical need. Individual patients or groups should not be disadvantaged or unjustifiably advantaged or on the basis of age, gender, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual / cognitive function or physical functions.

There are proven links between social inequalities and inequalities in health, health needs and access to healthcare. In making commissioning decisions, priority may be given to health services targeting health needs in sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to services.

Principle 6
The Clinical Commissioning Group should only invest in treatments which are of proven cost-effectiveness unless it does so in the context of well designed and properly conducted clinical trials that will enable the NHS to assess the effectiveness and clinical effectiveness of a healthcare intervention. Other forms of service developments must represent value for money.

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Principle 7
New treatments should be assessed for funding on a similar basis to decisions to continue to fund existing treatments, namely according to the principles of clinical effectiveness, safety, cost-effectiveness / value for money, and then prioritised in a way which supports consistent and affordable decision making.

Principle 8
The Clinical Commissioning Group must ensure that the decisions it takes demonstrate value for money and an appropriate use of NHS funding based on the needs of the population it serves.

Principle 9
No other body or individual, other than those authorised to take decisions under the policies of the Clinical Commissioning Group, has a mandate to commit the Clinical Commissioning Group to fund any healthcare intervention unless directed to do so by the Secretary of State for Health.

Principle 10
The Clinical Commissioning Group should strive, as far as practicable, to provide equal treatment to individuals in the same clinical circumstance. The Clinical Commissioning Group should therefore not agree to fund treatment for one patient which cannot be afforded for, and openly offered to, all patients with similar clinical circumstances and needs.

Principle 11
Interventions of proven effectiveness and cost-effectiveness should be prioritised above funding research and evaluation unless there are sound reasons for not doing so.

Principle 12
Because the capacity of the NHS to fund research is limited, requests for funding to support research have to be subject to normal prioritisation processes.

Principle 13
Patients participating in clinical trials are entitled to be informed about the outcome of the trial and to share any benefits resulting from having been in the trial. The responsibility for this lies with the party initiating and funding the trial and not the Clinical Commissioning Group unless the Clinical Commissioning Group has either itself funded the trial or agreed in advance to fund aftercare for patients entering the trial.

Principle 14
Unless the requested treatment is approved under existing policies of the Clinical Commissioning Group, the Clinical Commissioning Group will not, save in exceptional circumstances, commission a continuation of privately funded treatment even if that treatment has been shown to have clinical benefit for the individual patient.

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2. Key factors that will be taken into account when assessing the relative priorities of competing needs for healthcare

1. Whether there is a Direction or other legal requirement which mandates the Clinical Commissioning Group to fund a particular proposed service development or an element of any proposed service development.

2. Whether or not the proposed service development and/or the benefits anticipated to be derived from the proposed service development have been identified as a priority within the strategic plan for that service. This includes the extent to which the proposed service development supports the delivery of the Clinical Commissioning Group's Quality, Innovation, Productivity and Prevention Plan.

3. The anticipated effectiveness of the proposed service development particularly in reference to patient oriented outcomes.

4. The specific nature of the health outcome or benefit expected from the proposed service development.

5. The anticipated impact of the proposed service development on the population affected by the proposed service development.

6. Potential impacts of the proposed service development on one or more other services funded as part of NHS treatment (positive or negative).

7. The level of confidence the Clinical Commissioning Group has in the evidence underpinning the case for the proposed service development or the individual funding request (i.e. the quality of the evidence).

8. The level of confidence the Clinical Commissioning Group has in the robustness of the business case for the proposed service development.

9. Value for money anticipated to be delivered by the proposed service development (this includes cost-effectiveness where available).

10. The anticipated budgetary impact of the proposed service development including:

    a. An assessment of the total budgetary impact of funding the proposed service development; and

    b. Whether the proposed service development is cost saving in the short, medium or long term or cash releasing.

11. Any anticipated risks related to the proposed service development.

12. Whether the proposed service development will improve access to healthcare and for whom.

13. The effect of the proposed service development on patient choice.

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14. The level of uncommitted funds that the Clinical Commissioning Group has at the time that it makes the decision and the affordability of the proposed service development.

15. Whether or not extraordinary circumstances are operating which justify variance from any original funding plan (e.g. the management of a major outbreak)

3. Documents which have informed this policy

- Department of Health, The NHS Health Service Act 2006, The NHS Health Service (Wales) Act 2006 and The NHS Health Service (Consequential Provisions) Act 2006. NHS Act - **http://www.legislation.gov.uk/ukpga/2006/41/contents** consequential provisions - **http://www.publications.parliament.uk/pa/ld200506/ldbills/138/2006138.pdf**

- Department of Health, The NHS Constitution for England, 2012 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

- The National Prescribing Centre, Supporting rational local decision-making about medicines (and treatments), February 2009, http://www.npc.nhs.uk/local_decision_making/resources/handbook_complete.pdf

- NHS Confederation Priority Setting Series, 2008

  Priority setting: an overview
  Priority setting: legal consideration
  Priority setting: strategic planning
  Priority setting: managing new treatments
  Priority setting: managing individual funding requests

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Glossary

TERM	DEFINITION
Clinical effectiveness	C*linical effectiveness* is a measure of how well a healthcare intervention achieves the pre-defined clinical outcomes of interest in a real life population under real life conditions.
Clinical trial	*A clinical trial* is a research study in human volunteers to answer specific health questions. Clinical trials are conducted according to a plan called a protocol. The protocol describes what types of patients may enter the study, schedules of tests and procedures, drugs, dosages, and length of study, as well as the outcomes that will be measured. Each person participating in the study must agree to the rules set out by the protocol. The ethical framework for conducting trials is set out in the Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended). It includes, but does not refer exclusively to, randomised control trials.
Cost effectiveness	*Cost effectiveness* is an assessment as to whether a healthcare intervention provides value for money. In this document it does not necessarily imply that this is measured using a specific methodology.
Effectiveness - general	*Effectiveness* means the degree to which pre-defined objectives are achieved and the extent to which targeted problems are resolved.
Effectiveness - clinical	C*linical effectiveness* is a measure of the extent to which a treatment achieves pre-defined clinical outcomes in a target patient population.
Experimental and unproven treatments	*Experimental and unproven treatments* are medical treatments or proposed treatments where there is no established body of evidence to show that the treatments are clinically effective. The reasons may include the following: • The treatment is still undergoing clinical trials for the indication in question. • The evidence is not available for public scrutiny. • The treatment does not have approval from the relevant government body. • The treatment does not conform to an established clinical practice in the view of the majority of medical practitioners in the relevant field. • The treatment is being used in a way other than that previously studied or for which it has been granted approval by the relevant government body. • The treatment is rarely used, novel, or unknown and there is a lack of evidence of safety and efficacy. • There is some evidence to support a case for clinical effectiveness but the overall quantity and quality of that evidence is such that the commissioner does not have confidence in the evidence base and/or there is too great a measure of uncertainty over whether the claims made for a treatment can be justified.
Healthcare intervention	A *healthcare intervention* means any form of healthcare treatment which is applied to meet a healthcare need.
Healthcare need	*Healthcare need* is a health problem which can be addressed by a known clinically effective intervention. Not all health problems can be addressed.

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In-year service development	An *in-year service development* is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Clinical Commissioning Group agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.
Normally commissioned care	*Normally commissioned care* is healthcare which is routinely funded by the patient's responsible commissioner. The Clinical Commissioning Group has policies which define the elements of healthcare it is and is not prepared to commission for defined groups of patients.
Priority setting	*Priority setting* is the task of determining the priority to be assigned to a service, a service development, a policy variation or an individual patient at a given point in time. Prioritisation is needed because the need and demands for healthcare are greater than the resources available.
Prioritisation	*Prioritisation* is decision making which requires the decision maker to choose between competing options.
Service Development	A *Service Development* is a proposal to amend what is normally commissioned by the Clinical Commissioning Group. The term refers to all new developments including new services, new treatments (including medicines), changes to treatment thresholds, and quality improvements. It also encompasses other types of investment that existing services might need, such as pump-priming to establish new models of care, training to meet anticipated manpower shortages and implementing legal reforms. Equitable priority setting dictates that potential service developments should be assessed and prioritised against each other within the annual commissioning round. However, where investment is made outside of the annual commissioning round, such investment is referred to as an *in-year service development*.
Similar patient(s)	*A Similar Patient* refers to a patient within the CCGs population who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of one or more similar patients indicates that a policy is required of the Clinical Commissioning Group.
Strategic planning	*Strategic planning* is the process by which an organisation determines its vision, mission, and goals and then maps out measurable objectives to accomplish the identified goals. The outcome is a *strategic plan* which sets out what needs to be done and in what time scale. Strategic planning focuses on what should be achieved in the long term (3, 5, 7, or 10 year time span) while operational planning focuses on results to be achieved within one year or less. Strategic plans should be updated through an annual process, with major re-assessments occurring at the end of the planning cycle. Strategic planning directs how resources are allocated.
Value for money	*Value for money* in general terms is the utility derived from every purchase or every sum spent.

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Birmingham and Solihull
Clinical Commissioning Group

Policy for the Prioritisation of Healthcare Resources

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Ratified by	
Date ratified	
Name of originator/author	Elizabeth Nalwadda
Review date	November 2019
Target audience	CCG staff

Version Control
Review/Consultation

Version	Name/Title	Amendments/Review	Date
V1	Rebecca Hutchin	Initial draft	30.01.17
V1.1	Rachel O'Connor	Updates	31.01.17
V1.2	Rebecca Hutchin	Updates	01.02.17
V1.3	Rachel O'Connor	Insertion of CPAG membership	02.02.17
V1.4	Rachel O'Connor	Amendments post planning meeting consideration Recommendations from Equality assessment made in policy	07.02.17
V1.5	Angela Szabo	Minor amendments to wording following legal advice. Added Quality Impact Assessment section Following legal advice updated the consultation and engagement sections. Following legal advice included the need to publish the following on the CCGs websites: Equality Impact Assessment template Quality Impact Analysis template Case for Change templates CPAG prioritisation scores Updated CID TOR following HCB amendments Added Equality Impact Assessment on Prioritisation Policy detail into Appendix H EQIA: Revised 5.1 to replace several paragraphs referencing equality impacts as per Appendix H	26.05.17
V1.6	Elizabeth Nalwadda	Amendments and updates have been made to the Terms of Reference, Threshold, The Prioritisation Framework Scorecard. There has also been the introduction of a diagnostic score card. An explanation around the identification of candidate services as well as exclusions to CPAG has been added.	09.11.18
V1.7	Elizabeth Nalwadda	Search strategy and Prioritisation Flow chart added	13.11.18
V1.8	Elizabeth Nalwadda	Changes to Fundamentals for Case for change/Service Redesign. Prioritisation flowchart embedded into policy text. Governance Process Flow chart amended. Further changes to CPAG TOR to reflect the accountability of CPAG.	16.11.18
V1.9	Elizabeth Nalwadda	Inclusion of Case for change to Appendix E	30.11.18

Ratification & Approval

Committee	Amendments/Review/Approval	Date
Operational and Financial Plan Mtg	Review and Amendments	03/02/17
HCB	Review	14/02/17
Governing Bodies	Final Policy Approved by BSC CCG on 1st March 2017	01/03/17
HCB	Final Policy Approved by HCB on 14th June 2017	14/06/17
PRG	Review of amendments	19/10/18, 16/11/18
EMT	Review	03/12/18
CID	Review	11/12/18
Q&S		18/12/18
F&P		18/12/18
Governing Body		05/02/19

NHS
Birmingham and Solihull
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1. Introduction

1.1 NHS Birmingham Solihull CCG has adopted this Prioritisation of Healthcare Resources Policy, having reviewed good practice from across the country1.

1.2 Prioritisation, or priority setting, is the process of ranking competing items, such as tasks or potential purchases, in order of importance. Priority setting is a key component of the process of evaluating health interventions in order to decide what investments and/or disinvestments should be made with limited resources. It is part of the commissioning business cycle.

1.3 This policy sets out the approach which the CCG has adopted, ensuring the CCG has a robust policy and processes to evaluate and prioritise options for investment, and disinvestment to cover all healthcare expenditure of the CCG.

1.4 This policy takes into account the CCG's Ethical Decision Making Framework Document (Appendix A).

2. Purpose

2.1 The policy aims to bring consistency in the CCG's approach to prioritisation across the Birmingham & Solihull (BSOL) area. Clinical Commissioning Groups have limited budgets which they cannot exceed. These finite monies are used to commission the healthcare that each CCG considers necessary to meet the reasonable requirements of its patients.

2.2 The purpose of this policy is to provide clarity to the CCG's Programme Leads when ranking competing options for investment and/or disinvestment in order of importance. Clinical effectiveness will be considered when determining which investments or disinvestments should be made within the limited resources.

2.3 The policy will also act as a mechanism to provide healthcare providers, CCG Staff, the public as well as patients, with clarity and transparency around how the CCG manages it's commissioning priorities and responsibilities.

2.4 This policy will be of relevance to the following:

a) The Governing Body
b) The commissioning staff including Commissioning Support Units where there is delegated responsibility on behalf of the CCG
c) GPs and CCG clinical members/leads
d) members of the public who consider they have a need to understand how the CCG commissions
e) service providers
f) those who scrutinise the commissioning and provision of healthcare.

[1] Credit to NHS North Staffordshire Clinical Commissioning Group

3. Equality Statement

3.1 The CCG has a statutory duty under the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between those with a protected characteristic and those without. Protected characteristics include age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

3.2 The CCG endeavours to challenge discrimination, promote equality and respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our population and workforce within the finite resources available.

3.3 Managers, staff and providers are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs.

4. Equality Impact Assessment

4.1 In order to ensure that the CCG remains alive to the potential impact of its strategic commissioning output on different groups, an equality impact assessment will be undertaken. This will use the agreed CCG tool in line with the CCG's policies, procedures and guidelines. This will be part of the Case for Change submission where a change in commissioning is proposed.

5. Quality Impact Assessment

5.1 In order to ensure to ensure that the CCG fulfils is statutory duties in relation to patient experience, patient safety, effectiveness of service/interventions and an assessment of other impacts to the CCG financial or reputational, a quality impact assessment will be undertaken. This will use the agreed CCG tool in line with the CCG's policies, procedures and guidelines. This will be part of the Case for Change submission where a change in commissioning is proposed.

6. BSOL CCG Core Values

6.1 The CCG is responsible for making decisions aimed at delivering the objectives set out in its Operating Plan 2017/19. The Plan sets out the CCG's determination to commission high quality, safe and effective healthcare services for its population.

6.2 As a system, the CCG has worked together with local leaders to develop the Sustainability and Transformation Plan (STP) to deliver better health and care

for local people. It is no secret that both the NHS and the social care sector are addressing significant financial challenges and increased demand. In light of this, health and social care organisations need to work together to make resources go further, whilst ensuring that the quality of care people need can still be delivered.

6.3 The system partners have developed a number of priority STP programmes for each of the CCG's strategic objectives which form the basis of the delivery plan for the system. This will lead to the development and transformation of care and support received by all patients and the public.

7. Responsibilities

Clinical Priorities Advisory Group (CPAG) – undertakes technical assessments of proposals to inform investment and disinvestment decisions during the annual commissioning cycle, providing clinical advice and recommendations to the Clinical Investment & Disinvestment Committee and/or Governing Body.

Programme leads – comply with the policy and its relevant procedures and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track, and monitor outcomes.

Healthcare providers – refer to the policy when requesting the CCG to invest in healthcare services in order to understand CCG rationale and processes to be followed.

Patients (and their families/carers)– may find it helpful to refer to the policy in order to understand how the CCG decides how best to invest finite resources for its patient population.

Clinical Investment & Disinvestment Group (CID) – Subject to agreed delegated financial limits, take account of prioritisation in the approval of investment decisions and make recommendations to the Governing Body regarding disinvestment.

Quality &Safety Committee (Q&S) and Finance & Performance Committee (F&P) - reviews the output of CPAG through the Case for Change submissions. Both committees provide quality and safety advice in relation to significant quality and equality impact issues arising from impact assessments and changes to service specifications and makes recommendations to CID and the Governing Body

Governing Body (GB) – reviews CID recommendations to inform a decision taking account of prioritisation in the approval of investment decisions subject to agreed delegated limits and all disinvestment decisions, excluding primary care investment/disinvestment decisions. Will receive and agree CPAG work plan and the prioritization policy.

8. The Prioritisation process

8.1 The process of prioritisation involves horizon scanning by either engaging with health care programme leads during their annual commissioning rounds or identifying services and interventions that may require review, redesign, commissioning, investment, decommissioning or disinvestment.

8.2 The CCG's Prioritisation of the use of healthcare resources including decommissioning and disinvestment is managed through the prioritisation process using a dedicated management group. The management group consists of the Chief Medical Officer, Assistant Director of Finance & Contracting, Clinical Prioritisation Officer and Public Health support. The outputs of the management group are submitted through to the Clinical Priorities Advisory Group (CPAG). The prioritisation work plan is also reporting through to the CCG's Programme Review Group in relation to the review of expenditure areas to deliver potential QIPP.

8.3 The CCG has also given delegated authority to the Clinical Priorities Advisory Group (CPAG) to make recommendations on the CCG's approach to the prioritisation of healthcare services, and interventions.

8.3.1 Clinical Prioritisation Advisory Group (CPAG)

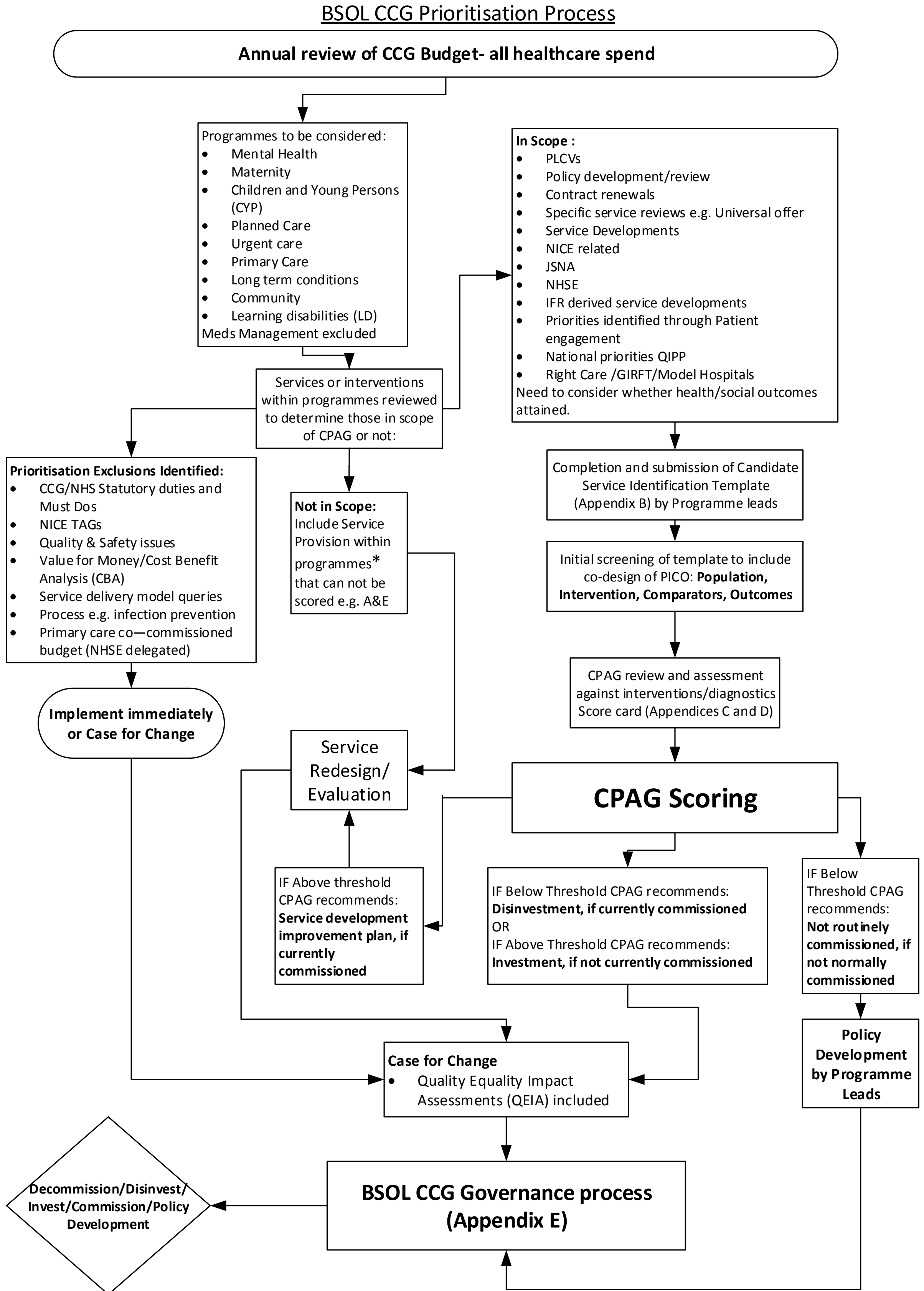
8.3.1.1 CPAG assesses services and interventions according to their clinical effectiveness, overall benefit to patients in supporting with existing and future illness, value for money, whether they contribute to health equality and equity as well as how they support the meeting of national or local targets.

8.3.1.2 CPAG is not a decision-making body, rather it undertakes technical assessments of services and interventions, providing clinical advice and recommendations to BSOL CCG through its governance process.

8.3.1.3 It is possible that these recommendations may affect the commissioning of services and in those circumstances where there could be a substantial change in service provision, a case for change will be required.

8.3.1.4 CPAG comprises of clinicians, members of the public, Public Health representatives, legal advisors and may consult with a number of local health experts when assessing services and interventions. A full list of the members of CPAG can be found in the Terms of Reference (Appendix F).

8.4 Prioritisation flowchart



8.4.1 The flow chart above illustrates that an initial review of the entire CCG budget is vital in the assessment of all health care spend within the different programmes.

8.4.2 The Programme areas to be considered include: Mental Health, Learning Disabilities, Maternity, Children and Young People (CYP), Planned Care, Urgent Care, Integration, Primary Care and Community.

8.4.3 Programme areas with their own mechanism of prioritisation or clinically- led needs assessment such as the Pharmaceutical Needs Assessment (PNA) for Medicines Management and Optimisation will not be considered within this prioritisation process.

8.4.4 The following steps explain the process of prioritisation and the specific role of CPAG.

8.4.4.1: Step 1 - Review of services and interventions within the programmes

The different health care provisions within each area of spend will be looked at to determine whether they can be scored via CPAG or considered for prioritisation.

All services and interventions for consideration will be categorised as:

a) ***Prioritisation Exclusions*** - The CCG prioritisation process has identified the following exclusions to the prioritisation process:

i) Investments required to address Quality & Safety issues;
ii) National NHS Must-Dos E.g. Transforming Care, Looked after children, NICE Technical Appraisal Guidance (TAG);
iii) CCG Statutory duties;
iv) Where a Value for Money assessment or Cost Benefit Analysis shows that ending an arrangement would cost more to deliver the same quality health outcomes;
v) Processes that are not services or interventions e.g. infection prevention, care planning;
vi) Where there is a query around where and how a service or intervention should be commissioned.

Once a Service/intervention is deemed an exclusion, the Programme leads will be advised.

b) ***Not in Scope*** - Not all services and interventions can be scored within the prioritisation process to determine how they can be ranked against competing health care provision within Birmingham and Solihull.

Many of these are services that the CCG has an obligation to deliver such as Accident and Emergency (A&E) will not be scored unless there is need for a

service re-design or improvement. In this case, the responsible Programme leads will follow the process for a case for change.

The Programme leads will be advised to follow steps below:

(i) Use prioritisation flow chart and guidance to determine whether the service is in scope or not. If the service is **in scope**, then refer to the in scope steps below.

(ii) The following **Seven (7) Fundamentals** will need to be considered when preparing a Case for Change or undertaking a Service Review/Evaluation (if determined as necessary):

Fundamental 1 - Where a service or intervention is not in scope the question to be considered is: *Is the commissioning proposal investment optimally designed, delivered, procured and delivering the quality outcomes required?*

Fundamental 2 - The following tests should also be considered as part of populating the full case for change template:

What is the clinical evidence base?

What standard of service is the minimum requirement, gold standard and where do we need to be clinically within affordability?

Fundamental 3 - Value for Money/Cost Benefit analysis – For larger investments the profiling of the investment will need to fit financial affordability:

Fundamental 4 - Is the current model as effective and efficient as it could be before additional investment is considered? Consider procurement options – *could another provider deliver the service offer at a reduced cost?*

Fundamental 5 - Service/pathway review

What is the best practice model?

What other models are available?

What are our comparators?

How does the investment fit within the whole service pathway?

Are there options to integrate health and social care services to generate some efficiencies to offset investment?

Fundamental 6 - Outcome based delivery models – *Consider redefining required outcomes which has led to different models of service delivery to release costs.*

Fundamental 7 - Use of technology to improve access and reducing the overall cost of the model.

c) ***In Scope*** **-** There are a number of processes within the commissioning framework from which services and interventions for consideration for prioritisation scoring via CPAG can be found:

i) Procedures of Lower Clinical Value (PLCV)

The CCG is working together with other commissioners within the NHS to curb ineffective or risky medical treatments given to its population. The Planned Care programme is responsible for reviewing and considering all commissioning policies to ensure up to date clinical evidence is reviewed to ensure that these interventions are clinically effective and provide efficient use of the NHS funds. A review of these interventions, some of which may be diagnostic in nature enables the CCG to effectively assess the health need of these interventions and enables appropriate commissioning decisions.

ii) Policy development and review

As part of the work with PLCVs, CPAG supports the Planned Care programme when policies are being reviewed and updated to ensure that appropriate commissioning decisions are made based on current evidence. Where CPAG recommends that a policy is developed, the programme leads would be responsible for following this through the appropriate Governance process.

iii) Contract renewals

The Contracting Team support a number of programme areas by providing an oversight on the contracts with a variety of providers across the NHS and the Third Sector. By identifying the contracts that are up for renewal, the contracting team will be able to initiate discussions around these with the providers and the programme leads.

Where it is identified that contracts are no longer required, these services and interventions will need to be assessed by CPAG.

iv) Specific Service reviews

When considering a review to specific pathways for the provision of health care where a subset of a population may be affected, it may be useful to determine whether there is duplication of health care provision. In cases where one group of patients have co-morbidities whose clinical characteristics result in them receiving care parallel to or within another pathway, it is important to review the pathways to ensure efficiency in health care provision. For example, a review of the Universal Offer Framework within Primary Care. Programme Leads will be able to submit these candidate services for assessment via CPAG.

v) Service developments/ Individual Funding Requests (IFRs)

The IFR process is a means by which the CCG manages funding requests and identifies gaps within its commissioning that may result in the request for a service development. Service Development requests will usually be identified via the IFR process and business cases submitted by providers. These requests will be submitted for assessment to determine whether there is sufficient clinical evidence to recommend commissioning or investment.

vi) NICE related guidance or other professional body recommendations

From time to time the current guidelines (excluding NICE Technology Appraisal Guidance) are reviewed in light of new evidence or changes to practice that may require a change to the commissioning of services and interventions. Programme leads will be able to identify these and consider how these may affect their relevant areas. Should there be a need to change the commissioning of these services and interventions, then an assessment will be required via CPAG.

vii) Joint Strategic Needs Assessment (JSNA)

A Joint Strategic Needs Assessment (JSNA) looks at the current needs of local communities and helps health and care organisations to plan support and services for the future. It is an ongoing process that identifies the future health and wellbeing needs of the people of Birmingham and /or Solihull bringing together a range of strategic overviews and detailed needs assessments. These feed into the different Programme Areas and where a need has been identified, then an assessment via CPAG will be able to make recommendations for BSOL CCG.

viii) NHS England initiatives

NHS England is responsible for the commissioning of healthcare for armed forces, veterans, prisons, dental, ophthalmology as well as specialised services. NHS England will often review its policies and therefore make national recommendations based on clinical evidence that in turn affect the commissioning of healthcare locally.

For example, the recent proposals to stop or reduce routine commissioning of 17 interventions, including breast reductions and snoring surgery, where less invasive, safer treatments are available and just as effective.

Similar recommendations have direct impact on the CCG's priorities and therefore would need to be assessed via CPAG following a review of the needs of the local population.

ix) Priorities identified through patient engagement

Involving the public and patients in the planning of their healthcare to ensure than it meets their needs involves providing a route for feedback so patients can share their experiences and concerns. This is a useful tool in identifying where there may be a need to change or improve the delivery of a service.

By engaging with its population, the CCG will be able to understand the impact of the health care provided and involve the people in decisions that affect their healthcare. It is these discussions that help identify services or interventions that may be assessed via CPAG.

x) National priorities leading to QIPP savings

Overtime, programme leads carry out a review of their commissioned services to ensure they are able to make savings to ensure the sustainability of the resources within their NHS funding provision. These may be identified through different processes throughout the annual commissioning round and referred to CPAG.

8.4.4.2 Step 2: Completion of the Candidate Service Identification template

Services or interventions identified within the Programme areas that are in scope for CPAG review will need to be forwarded for an initial screening.

8.4.4.3 Step 3: Initial Screening of Candidate Service Identification template

All information submitted will be scrutinised and Programme leads will be invited to support the co-design and development of the PICO parameters, where PICO stands for:

P = Population under study including any exclusions; it may be necessary to complete a number of different scorecards for an intervention if the evidence found varies by population
I = Intervention
C = Comparator / Control
O = Outcomes measured as appropriate to the condition.

Before an intervention can be scored the PICO must be completed to inform the evidence base review for the completion of the scorecard criteria for the Intervention under review.

Where services or pathway developments are under review these must be broken down into individual interventions so CPAG is able to score each intervention against their expected comparator. Where there are multiple interventions the programme lead may choose to select the intervention within the service that drives most of the activity within the service to inform commissioning priorities. The programme lead could also select interventions within a service specification that are not thought to be adding value to the service.

8.4.4.4 Step4: CPAG review and assessment against interventions/ diagnostics Score card.

CPAG uses a modified version of the Portsmouth scorecard. The criteria in the scorecard have been subject to clarification through discussion with the Birmingham Local Council Public Health Team and supplementary guidance is available to enable the group to apply criteria consistently.

The assessment of the candidate services/interventions is carried out by the Birmingham Public Health Team who follow a moderation process to score the interventions on the Prioritisation scorecard (Appendix C) using the available evidence base.

CPAG, in conjunction with the Public Health Team has developed a separate Diagnostic Score card (Appendix D) to support the assessment of diagnostic/screening interventions or services.

8.4.4.4.1 Criteria used for the prioritisation process

The process involves assessing each service/intervention against the following criteria in order to generate a score out of a maximum of 240:

a) Strength and quality of evidence
b) Magnitude of health gain / improvement
c) Ability to prevent future ill-health
d) Extent to which the intervention supports existing health issues
e) Cost-effectiveness
f) Whether the intervention addresses health inequalities
g) Whether the intervention supports delivery of a national or local target (completed by the CCG).

The diagnostic score card criteria has been amended to enable scoring (Appendix D).

8.4.4.4.2 Threshold for establishing clinical priority

The current agreed Threshold is 90 though may be reviewed at any time. All services/interventions that are scored above the agreed threshold score of (= 90) may, potentially, be commissioned. Any that are scored below the threshold

score may, potentially, be de-commissioned, to release funds for reinvestment elsewhere.

This threshold will be kept under regular review, in light of financial affordability and changing strength of evidence as well as experience of using the scorecard criteria.

8.4.4.5 Step 5: CPAG Scoring

CPAG will meet and discuss and further moderate the scoring.

Voting members within CPAG will take a vote and agree a recommendation upon considering whether the score is above or below the threshold (above or below 37% of points available).

8.4.4.6 Step 6: Outcomes/recommendations by CPAG

Below are the recommendations that CPAG may make:

a) If Score is **above the threshold, CPAG may recommend a Service development plan if the candidate is currently commissioned.** This will result in a Service review or re-design which the Programme lead will need to follow through the appropriate Governance process.

b) If Score is **below Threshold, CPAG may recommend Disinvestment, if currently commissioned**

OR

c) If Score if **above Threshold, CPAG may recommend Investment, if not currently commissioned.** A business case will be developed and submitted to the Programme Review Board for review prior to submission through the CCG Governance processes, in accordance with the agreed delegated financial limits.

The outcomes (a) – (c) will require the completion of a **Case for Change which will include an Equality and Quality Impact Assessment.**

d) If Score is **below Threshold, CPAG may recommend service is Not routinely commissioned, if not normally commissioned. This will require policy development** and the Programme leads will be advised to follow this through the BSOL CCG Governance process.

Once a decision has been made, the Programme Lead will be advised and the topic will be recorded in the CPAG log on the CCG's website.

8.4.4.7 Step 7: CCG Governance Process

The governance structure sees CPAG's recommendations considered through a case for change document which is reviewed by Programme Review Group and approved through CCG Governance according to financial value.

The CCG Governance process can be found at Appendix E.

All decisions on Decommissioning and Disinvestment are made by the Governing Body (GB).

9. Patient and Public Engagement and Consultation

9.1 The Prioritisation of Services programme will be managed through the CPAG of which it is anticipated there will be at least two members of the public (see Terms of Reference, Appendix F).

9.2 The Prioritisation of Services page on the CCG's websites will set out the process and indicative timetable for prioritisation consideration. It will also include the Final scores of the services and interventions scored by CPAG.

9.3 A list of topics to be considered by CPAG will be posted on the website regularly, with the proviso that topics may be added at any time – but this would be signposted on the website.

9.4 The scorecard is moderated at CPAG with a minimum of one patient representative and one lay advisor present.

9.5 The CCG will publish the outcome of the CPAG prioritisation scoring process following approval of the full case for change through CCG governance processes.

9.6 Any investment/disinvestment decisions made by the CCG following the prioritisation process via CPAG will use the CCG's case for change template. The case for change will indicate the level of engagement and/or consultation required specific to each case. Decisions will be made in line with the CCGs scheme of reservation and delegation.

9.7 The CPAG scores are final. Therefore, there is no appeal process.

10 Accountability

10.1 CPAG is accountable to the Governing Body.

11. Audit and Quality Assurance

11.1 The Governing Body will seek assurances from the Q&S and F&P Committees with regards to its compliance with this policy.

11.2 In order to ensure compliance with the policy, an annual audit will be undertaken. This is to consist of a review of all of the priorities assessed as not for investment/or for disinvestment and 10% of those that were approved for investment.

11.3 The audit must assess consistency of the use of the prioritisation format; assessment and decision making to timescale, documentation management and the monitoring of implementation of priorities. The audit must be presented to the Governing Body.

12. Resource Implications

12.1 The aim of assessing priorities in healthcare is to identify what healthcare services or interventions are to be commissioned to the greatest effect within a finite commissioning budget.

12.2 Services or interventions that are deemed not to be a clinical priority for the population will be disinvested, or not invested in the future, in order to focus on those services and interventions which should provide a greater return for the investment, to maximise the outputs from the finite monies available.

12.3 The CCG aims to invest in effective healthcare for its population with the aim of meeting its strategic objectives for improving health and quality within a finite commissioning budget.

13. Training

13.1 Training will be provided for those who are required to implement and maintain the use of the policy and relevant procedures. The staff and agencies using the policy must ensure that any new personnel who are expected to use the policy and procedures clearly understand the requirements and are able to work with them. Appropriate training must form part of their local induction.

14. Policy Approval and Review

14.1 This policy is reviewed by the Executive Management Team (EMT) who will recommend the policy approval to the Governing Body in line with current BSOL Governance processes.

14.2 Prioritisation of healthcare is an evolving area. Therefore, CPAG and PRG will retain operational oversight through regular updates. The policy will ordinarily be updated on an annual basis.

15. Related Policies

15.1 The following CCG strategies/policies are relevant: -

- BSOL Operating Plan and Financial Plan 2017/19
- Joint Strategic Needs Assessments (JSNAs) of Birmingham and Solihull
- Individual Funding Request Policy
- Risk Management Strategy
- Equality & Diversity Strategy
- Information Sharing Policies
- Communications & Engagement Strategy
- CCG Ethical framework for priority setting and resource allocation
- CCG In-Year Service Development Policy

All relevant CCG policies are published online.

16. Relevant Legislation/Guidance

- Human Rights Act 1998
- National Health Service Act 2006
- Equality Act 2010
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended). (Replacing Directions to Primary Care Trusts and NHS trusts concerning decisions about drugs and other treatments. DH 2009)

17. Appendices

Appendix A: Ethical framework for priority setting and resource allocation principles

Appendix B: Candidate Service/Intervention identification template

Appendix C: Prioritisation Framework Scorecard

Appendix D: Diagnostics Prioritisation Scorecard

Appendix E: Governance Gateway process

Appendix F: Terms of Reference of the Clinical Priorities Advisory Group (CPAG)

Appendix G: Definitions

Appendix H: Equality Impact Assessment

Appendix A: Ethical framework for priority setting and resource allocation principles

Core principles

Principle 1
The values and principles driving priority setting at all levels of decision making should be consistent.

Principle 2
The Clinical Commissioning Group has a legal responsibility to commission healthcare, within the areas for which it has commissioning responsibility, in a manner which is consistent with its legal duty not to overspend its allocated budget.

Principle 3 The Clinical Commissioning Group has a responsibility to make rational decisions in determining the way it allocates resources to the services it directly commissions and to act fairly in balancing competing claims on resources between different patient groups and individuals.

Principle 4
Competing needs of patients and services within the areas of responsibility of the Clinical Commissioning Group should have a fair chance of being considered, subject to the capacity of the Clinical Commissioning Group to conduct the necessary healthcare needs and services assessments. As far as is practicable, all potential calls on new and existing funds should be considered as part of a priority setting process. Services and individual patients should not be allowed to bypass normal priority setting processes.

Principle 5
Access to services should be governed, as far as practicable, by the principle of equal access for equal clinical need. Individual patients or groups should not be disadvantaged or unjustifiably advantaged or on the basis of age, gender, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual / cognitive function or physical functions.

There are proven links between social inequalities and inequalities in health, health needs and access to healthcare. In making commissioning decisions, priority may be given to health services targeting health needs in sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to services.

Principle 6
The Clinical Commissioning Group should only invest in treatments which are of proven cost effectiveness unless it does so in the context of well-designed and properly conducted clinical trials that will enable the NHS to assess the effectiveness and clinical effectiveness of a healthcare intervention. Other forms of service developments must represent value for money.

Principle 7
New treatments should be assessed for funding on a similar basis to decisions to continue to fund existing treatments, namely according to the principles of clinical effectiveness, safety,

cost-effectiveness / value for money, and then prioritised in a way which supports consistent and affordable decision making.

Principle 8
The Clinical Commissioning Group must ensure that the decisions it takes demonstrate value for money and an appropriate use of NHS funding based on the needs of the population it serves.

Principle 9
No other body or individual, other than those authorised to take decisions under the policies of the Clinical Commissioning Group, has a mandate to commit the Clinical Commissioning Group to fund any healthcare intervention unless directed to do so by the Secretary of State for Health.

Principle 10
The Clinical Commissioning Group should strive, as far as practicable, to provide equal treatment to individuals in the same clinical circumstance. The Clinical Commissioning Group should therefore not agree to fund treatment for one patient which cannot be afforded for, and openly offered to, all patients with similar clinical circumstances and needs.

Principle 11
Interventions of proven effectiveness and cost-effectiveness should be prioritised above funding research and evaluation unless there are sound reasons for not doing so.

Principle 12
Because the capacity of the NHS to fund research is limited, requests for funding to support research have to be subject to normal prioritisation processes.

Principle 13
Patients participating in clinical trials are entitled to be informed about the outcome of the trial and to share any benefits resulting from having been in the trial. The responsibility for this lies with the party initiating and funding the trial and not the Clinical Commissioning Group unless the Clinical Commissioning Group has either itself funded the trial or agreed in advance to fund aftercare for patients entering the trial.

Principle 14
Unless the requested treatment is approved under existing policies of the Clinical Commissioning Group, the Clinical Commissioning Group will not, save in exceptional circumstances, commission a continuation of privately funded treatment even if that treatment has been shown to have clinical benefit for the individual patient.

Appendix B: Candidate Service/Intervention identification template

Please refer to the Clinical Prioritisation policy to ensure no CPAG exclusions are submitted.	
Project Details	
Candidate Intervention/Service	
Programme/Project Lead	
Clinical Lead	
Programme Area	
CPAG Scope for consideration: Does the Service/Intervention fall within any of the following?	☐PLCVs ☐Policy development/review ☐Contract renewals ☐Specific service reviews e.g. Universal offer ☐Service Developments ☐NICE related ☐JNSA ☐NHSE ☐IFRs ☐Priorities identified through Patient engagement ☐National prioritises or QIPP ☐Other, please specify___________________________
Can you specify the health/social outcomes to be realised?	
Is this submission part of a Service re-design or review? ***Please provide details***	
What is the current pathway? Please give a brief description to include service delivery model.	
Provider Organisation	
Contract type and duration	

Notice period required	
Service Metrics **(including activity/outcomes/cost)**	
Is the candidate service provided across all BSOL CCG patch? ***If not, specify the area covered.***	
Is this service currently commissioned by BSOL CCG? ***Please provide details of policy/guidelines in place or for review.***	
Is the service/intervention CCG responsibility to commission?	
Key Questions	*Please provide details:*
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	
Does the service deliver value for money? ***Please provide evidence.***	
Does the service meet the needs of the population? (As per the JSNA)[2]	
Can you identify similar services/interventions likely to achieve the same health outcomes? How does this service benchmark against similar services?	
Is there any NICE Guidance or other guidelines to support this intervention/service?	
Are there any interdependencies identified? ***Please specify***	
Additional comments	

[2] https://www.birmingham.gov.uk/info/50120/public_health/1337/jsna_themes
http://www.solihull.gov.uk/About-the-Council/Statistics-data/JSNA

P.I.C.O (to be co-designed with Programme Lead)	
Define the Population the Service/intervention caters for (including any exclusions)	
Intervention (if different from above): Where a service is being considered, define a specific intervention with highest volume/low priority to be scored.	
Comparator(s): What is the main alternative to compare with the intervention/service?	
Outcomes: What is expected health gain for the population identified?	

APPENDIX C: Prioritisation Framework Scorecard

Prioritisation Framework Scorecard – Advice for completing scorecards

Factor	Scale					Score
	Very Low	Low	Medium	High	Very High	
1 Strength and quality of evidence **Is the evidence base robust (as appropriate for the condition)?**	3 points Evidence is either unavailable or does not permit a conclusion.	10 points Low confidence that the evidence reflects the true effect	20 points Moderate confidence that the evidence reflects the true effect	30 point High confidence the evidence reflects the true effect	40 points There is very strong, high quality peer reviewed evidence available	
2 Magnitude of Health Improvement benefit **To what extent does this intervention improve the health gain for the patient over the comparator?**	3 points Negligible or no improvement in health benefit	10 points	20 points Moderate benefit	30 points	40 points Large health improvement benefits	
3 Prevention of future illness **Does this intervention support 1º or 2º prevention of future health conditions?**	3 points Negligible or no prevention benefit	10 points	20 points Moderate prevention benefit	30 points	40 points Very high prevention benefit	
4 Supports people with existing health problems **Does this intervention improve the quality of life for the patient with the condition in question? Taking into account the baseline health utility and the capacity of the intervention to improve the health state**	3 points High health utility and low or moderate capacity of intervention to improve the health state	10 points Moderate health utility and low capacity of intervention to improve the health state Or High health utility and high capacity of intervention to improve the health state	20 points Very low health utility and low capacity of intervention to improve the health state Or Moderate health utility and moderate capacity of intervention to improve the health state	30 points Very low health utility and moderate capacity of intervention to improve the health state	40 points Very low health utility and high capacity of intervention to improve the health state	
5 Cost effectiveness ratio **What is the cost per QALY of this intervention? If no information, default score =10**	>£30\k 3 points	£>20K - £30K 5 points	£>10K - £20K Or default score: 10 points	£5K - £10K 15 points	<£5K 20 points	
6 Addresses health inequality or health inequity **Does this service reduce or narrow identified inequalities or inequities in the local population?**	3 points if it does not address any inequality or inequity	5 points If there is an indirect association between the health state in question and a specific demographic / socioeconomic group	10 points If there is a direct association between the health state in question and a specific demographic / socioeconomic group	15 points If there are multiple direct associations between the health state in question and a specific demographic / socioeconomic group	20 points if it completely addresses an identified inequality or inequity	

7 Delivers national and/or local requirements/targets **Does this intervention support the CCG in delivering identified national or local requirements or targets?**	3 points if not a requirement	10 points if it addresses one target or requirement	20 points if it addresses two targets or requirements	30 points if it addresses three targets or requirements	40 points if it addresses four or more targets or requirements	
TOTAL SCORE						

Maximum score = 240

Notes on the criteria and interpretation

General notes:

- Default scores (where not otherwise stated) are 3.
- Default scores to be used where insufficient evidence exists.
- "In between" scores must not be used – ONLY the suggested full score such as 3, 10, 15, 20, 30, 40 must be used.
- As some questions are weighted, different scoring thresholds may apply – refer to guidance notes for individual questions.
- **For all scorecards a PICO question should be completed, where PICO stands for:**

P = Population under study including any exclusions; it may be necessary to complete a number of different scorecards for an intervention if the evidence found varies by population
I = Intervention
C = Comparator / Control
O = Outcomes measured as appropriate to the condition.

1. Strength & quality of evidence
Question to be answered*: Is the evidence base robust (as appropriate for the condition)?*
Score framework:

Very Low	Low	Medium	High	Very High
3 points Evidence is either unavailable or does not permit a conclusion.	10 points Low confidence that the evidence reflects the true effect	20 points Moderate confidence that the evidence reflects the true effect	30 point High confidence the evidence reflects the true effect	40 points There is very strong, high quality peer reviewed evidence available

To ensure that an assessment of the validity and quality of the evidence can be made, the following scoring applies:

Strength of evidence	Definition	Score
Very High	**High confidence that the evidence reflects the true effect and that evidence available is based upon high quality peer reviewed evidence (such as Cochrane reviews)** Further research is very unlikely to change our confidence in the estimate of effect.	40
High	**High confidence that the evidence reflects the true effect.** Further research is very unlikely to change our confidence in the estimate of effect.	30
Moderate	**Moderate confidence that the evidence reflects the true effect.** Further research may change our confidence in the estimate of effect and may change the estimate.	20
Low	**Low confidence that the evidence reflects the true effect.** Further research is likely to change the confidence in the estimate of effect and is likely to change the estimate.	10
Very low	Evidence either is unavailable or does not permit a conclusion.	3

Having taken account, the quality and validity of evidence as above, the maximum scores available for each study type should not exceed the following:

Hierarchy of Evidence	Grading of Recommendations	Score
Ia Evidence from systematic reviews or meta-analysis of randomised controlled trials	A Based on hierarchy I evidence	Up to 40
Ib Evidence from at least one randomised controlled trial		Up to 30
IIa Evidence from at least one controlled study without randomisation	B Based on hierarchy II evidence or extrapolated from hierarchy I evidence	Up to 30
IIb Evidence from at least one other type of quasi experimental study		Up to 20
III Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies	C Based on hierarchy III evidence or extrapolated from hierarchy I or II evidence	Up to 20
IV Evidence from expert committee reports or opinions and/or clinical experience of respected authorities	D Directly based on hierarchy IV evidence or extrapolated from hierarchy I, II or III evidence.	Up to 10

2. Magnitude of health improvement for the patient group/population

Question to be answered: *To what extent does this intervention improve the health gain for the patient over the comparator?*

Scoring framework:

Very Low	Low	Medium	High	Very High
3 points Negligible or no improvement in health benefit	10 points	20 points Moderate benefit	30 points	40 points Large health improvement benefits

This question is only concerned with the health related improvement of the intervention in relation to its comparator.

Health gain can be conceptualised in terms of the NHS Outcome Framework domains:

Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing quality of life for people with long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring that people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

To be consistent with commissioning policy (for example in the IFR policy) social factors will not be considered.

Physical health and mental health are presumed to be included.

N.B. It may be necessary to reference both the health gain against the gold standard and against usual care or treatment.

Negative impacts must be taken into account in the scoring if there is evidence to show that this intervention reduces health benefit in any way.

3. Prevention of future illness

Question to be answered: *Does this intervention support 1º or 2º prevention of future health conditions?*

Scoring framework:

Very Low	Low	Medium	High	Very High
3 points Negligible or no prevention benefit	10 points	20 points Moderate prevention benefit	30 points	40 points Very high prevention benefit

This question relates to the extent the intervention prevents future illnesses. This relates to other illnesses rather than recurrence in the illness that was addressed by the intervention in question. i.e. this is about preve not progression, therefore only primary and secondary prevention are considered (see below for definitions).

Where possible interventions should be scored in relation to the comparator.

Primary prevention	Any health & wellbeing intervention that may prevent the onset of illness in the future e.g. diet, exercise, not smoking, education, immunisation.
Secondary prevention	Measures taken to manage risk factors for a medical condition that already exist or to identify a condition that is not yet symptomatic, and may still be improved/reversed e.g. cholesterol lowering medication, cancer screening.

4. Existing Health Problems

Question to be answered*: Does this intervention improve the quality of life for the patient with the condition in question?*

This relates to the improved quality of life that would not have been possible without the intervention. This question covers tertiary prevention i.e. Measures taken to manage a diagnosed condition with the aim of reducing the potential to lead to further life-threatening events or limitations to activities of daily living.

This scoring takes into account the **baseline health state ("health utility")** prior to the intervention and considers this against the improvement in quality of life/ tertiary prevention that can be achieved following the intervention. Health utility is measured on a scale of 0 to 1 where 0 is death and 1 is perfect health.

Please Note: This parameter is NOT measured against the comparator.

Scoring framework:

Very Low	Low	Medium	High	Very High
3 points High health utility and low or moderate capacity of intervention to improve the health state	10 points Moderate health utility and low capacity of intervention to improve the health state Or High health utility and high capacity of intervention to improve the health state	20 points Very low health utility and low capacity of intervention to improve the health state Or Moderate health utility and moderate capacity of intervention to improve the health state	30 points Very low health utility and moderate capacity of intervention to improve the health state	40 points Very low health utility and high capacity of intervention to improve the health state

This can be conceptualised using a three by three table as follows:

Capacity of intervention to improve health utility		Health utility		
		High	**Medium**	**Low**
	Low	3 points	10 points	20 points
	Medium	3 points	20 points	30 points
	High	10 points	30 points	40 points

5. Cost Effectiveness Ratio

Question to be answered*: What is the cost per QALY of this intervention?* If no information, **default score =10**

This refers to the cost effectiveness that could be achieved if the intervention/service is done the best. This is the published QALY or SORI. CPAG agrees that it is not appropriate to use non UK based evidence for cost effectiveness due to the differences in pricing systems.

5.1 How does this service compare with alternatives? **ICER** = Incremental Cost-Effectiveness Ratio. The ratio of change in costs: change in effects	**3 points** if many other options with best ICER	**5 points** if other options with better ICER	**10 points** if other options but equivalent ICER	**15 points** if limited options with poorer ICER	**20 points** if there are no alternative options (cannot be expressed using ICER, default to cost per QALY if known)
5.2 What is the cost per QALY of this intervention? **QALY** = Quality-Adjusted Life Year. NICE uses range £20K - £30K	**3 points** >£30000	**5 points** £>20000 - £30000	**10 points** £>10000 - £20000	**15 points** £5000 - £10000	**20 points** <£5000
5.3 What is the cost per QALY SORI of this intervention? **SORI** = Social Return on Investment. Use if known, and ICER and QALY unknown	**3 points** Worse than 1:1	**5 points** 1.1 – 2:1	**10 points** 2.1 – 5:1	**15 points** >5:1	**20 points** Not allocated

6. Addresses health inequality or health inequity

Question to be answered*: Does this service reduce or narrow identified inequalities or inequities in the local population?*

Scoring framework:

Very Low	**Low**	**Medium**	**High**	**Very High**
3 points if it does not address any inequality or inequity	5 points If there is an indirect association between the health state in question and a specific demographic / socioeconomic group	10 points If there is a direct association between the health state in question and a specific demographic / socioeconomic group	15 points If there are multiple direct associations between the health state in question and a specific demographic / socioeconomic group	20 points if it completely addresses an identified inequality or inequity

Health inequalities are the differences in health and wellbeing which we can be measured between different population groups and geographical populations. They can be caused by, but not limited to socio-economic, age, ethnicity, educational achievement and employment factors.

Where health inequalities are attributable to the external environment and conditions mainly outside the control of the individuals concerned, such as difficulty in accessing services, the uneven distribution may be unnecessary and avoidable. For example, this would be relevant to provision or lack of a service that discriminates against a population group with high prevalence of a condition.

Consider: is the baseline health state in question associated with a specific demographic / socioeconomic group? Is this a direct or indirect association?

In addition, the question could be asked as to whether the intervention is likely to work as well in areas of deprivation. The answer to this may be inferred from extrapolation from studies of other interventions, so in which case the scoring should reflect that.

Is the intervention likely to be as successful in a deprived community as any other?

If there is no information relevant to this criterion the **default score is 5.**

7. Delivers national and/or local requirements/targets

Question to be answered*: Does this intervention support the CCG in delivering identified national or local requirements or targets?*

The aim of assessing priorities against the CCG's local and national strategies is to provide a higher clinical weighting to the delivery of the CCG's local and national operational plan requirements to inform commissioning decisions.

BSOL CCG Prioritisation Score cards - Search Strategy:

Below are the detailed pre-appraised and primary sources of evidence reviewed by the Birmingham Public Health Team. This is based upon the hierarchy of evidence so it is suggested that searches should start with the resources at the top of the list, working down until a sufficient evidence base is obtained. Source: https://www.england.nhs.uk/wp-content/uploads/2017/02/tis-guide-finding-the-evidence-07nov.pdf

Research Type	Resource	URL
Guidelines, systematic reviews and meta-analyses	NICE Guidelines	https://www.nice.org.uk/guidance
	Nice Evidence search	https://www.evidence.nhs.uk/
	TRiP Database	https://www.tripdatabase.com/
	Cochrane Library	http://www.cochranelibrary.com/
	DARE	https://www.crd.york.ac.uk/CRDWeb/
	PubMed Clinical Queries	https://www.ncbi.nlm.nih.gov/pubmed/clinical
Systematic reviews, meta-analyses, critically appraised topics and articles, point of care decision making tools; randomised controlled trials; cohort studies; case controlled studies, case series and reports	Medline	Via Open Athens: https://openathens.nice.org.uk/Auth/Login
	Embase	
	CINAHL	
Expert opinion and patient experience	Royal Colleges	Numerous
	Professional societies	Numerous
	Health professionals	Numerous
	Health talk online	http://www.healthtalk.org/
	Health talk (Youth)	http://www.healthtalk.org/young-peoples-experiences

APPENDIX D: Diagnostics Prioritisation Scorecard

Factor	Scale					Max Score
	Very Low	Low	Medium	High	Very High	
1 Strength and quality of evidence **Is the evidence base robust?** **Is there a NICE diagnostic assessment?**	< 3 points if there is low confidence that the evidence reflects the true effect	10 points	20 points if there is modest confidence that the evidence reflects the true effect	30 points	40 points If there is very high confidence that the evidence reflects the true effect	40
2A Effectiveness of the test in placing the patient on a subsequent pathway **What are the results of the evidence/NICE assessment?**	<3 points if negligible	10 points	20 points if there is moderate confidence in the effectiveness of the test	30 points	40 points if there is strong evidence in the effectiveness of the test	40
2B Is it valuable in determining the patient's condition and ensuring patient is placed on the appropriate pathway?	<3 points no impact on placing patient on subsequent pathway	10 points	20 points if there is moderate evidence of the test placing the patient on a subsequent pathway	30 points	40 points if there is strong evidence of the test placing the patient on a subsequent pathway	40
3A Potential for Harm **Significant side effects and test preparation effects** **Is the test acceptable?** **3B Potential for Acceptability** **Significant side effects and test preparation effects** **Is the test acceptable?**	< 3 points if it does significant side effects and/ OR has a low uptake	10 points	20 points if there is a mild side effect and /OR a medium uptake ***Scores shared out equally between 3A and 3B (each max of 20)**	30 points	40 points if it does not have any significant side effects and /OR a high uptake	40
4 Cost effectiveness ratio **What is the cost per QALY of this intervention?**	>£30\k < 3 points	£>20K - £30K 5 points	£>10K - £20K 10 points **If no information, default score =10**	£5K - £10K 15 points	<£5K 20 points	20
5 Addresses health inequality or health inequity **Does this test contribute to reducing or narrowing identified inequalities or inequities in the local population?**	< 3 points if it is not associated with any inequality or inequity	5 points	10 points if it is partially associated with an identified inequality or inequity	15 points	20 points if it is completely associated with an identified inequality or inequity	20
6 Delivers national and/or local requirements/targets **Does this intervention support the CCG in delivering identified national or local requirements or targets?**	< 3 points if not a requirement	10 points if it addresses one target or requirement	20 points if it addresses two targets or requirements	30 points if it addresses three targets or requirements	40 points if it addresses four or more targets or requirements	40
TOTAL Maximum SCORE						240

Diagnostic Prioritisation Scorecard factor definitions

1. **Strength and Quality and Evidence for diagnostics definitions to be used:**

Strength of evidence	Definition	Score
Very High	**Very High confidence that the evidence reflects the true effect.** Further research is very unlikely to change our confidence in the estimate of effect.	40
High	**High confidence that the evidence reflects the true effect.** Further research is very unlikely to change our confidence in the estimate of effect.	30
Moderate	**Moderate confidence that the evidence reflects the true effect.** Further research may change our confidence in the estimate of effect and may change the estimate.	20
Low	**Low confidence that the evidence reflects the true effect.** Further research is likely to change the confidence in the estimate of effect and is likely to change the estimate.	10
Insufficient	Evidence either is unavailable or does not permit a conclusion.	3

2. **A - Effectiveness of the test**
   B – How effective is the test in determining the patient's condition and ensuring patient is placed on the appropriate pathway?
   This is defined as the accuracy of the test
   - To be scored based on Positive/Negative Predicted Value or if not available
   - Sensitivity/specificity

2A and 2B are each scored out of a maximum of 40 separately.

3. **Potential for Harm OR acceptability - these are considered separately as 3A and 3B where each should be scored with a maximum of 20**
   This is defined as significant side effects and test preparation effects.
   This also incorporates acceptability:
   - Is the test acceptable?
   - What is the uptake?
   - Is there informed dissent?

4. **Cost effectiveness ratio** – See main prioritisation policy definitions

5. **Addresses health inequality or health inequity** - See main prioritisation policy definitions

6. **Delivers national and/or local requirements/targets** - See main prioritisation policy definitions

PICO

PICO = Population, Intervention, Comparator and Outcomes

Each Scorecard must have a completed PICO to enable the evidence searches to be carried out in the correct context in the case of Diagnostics the PICO questions are defined below.

Population – Define patient cohort – use of diagnostic text X for prognosis/ diagnosis/ screening or monitoring of Y

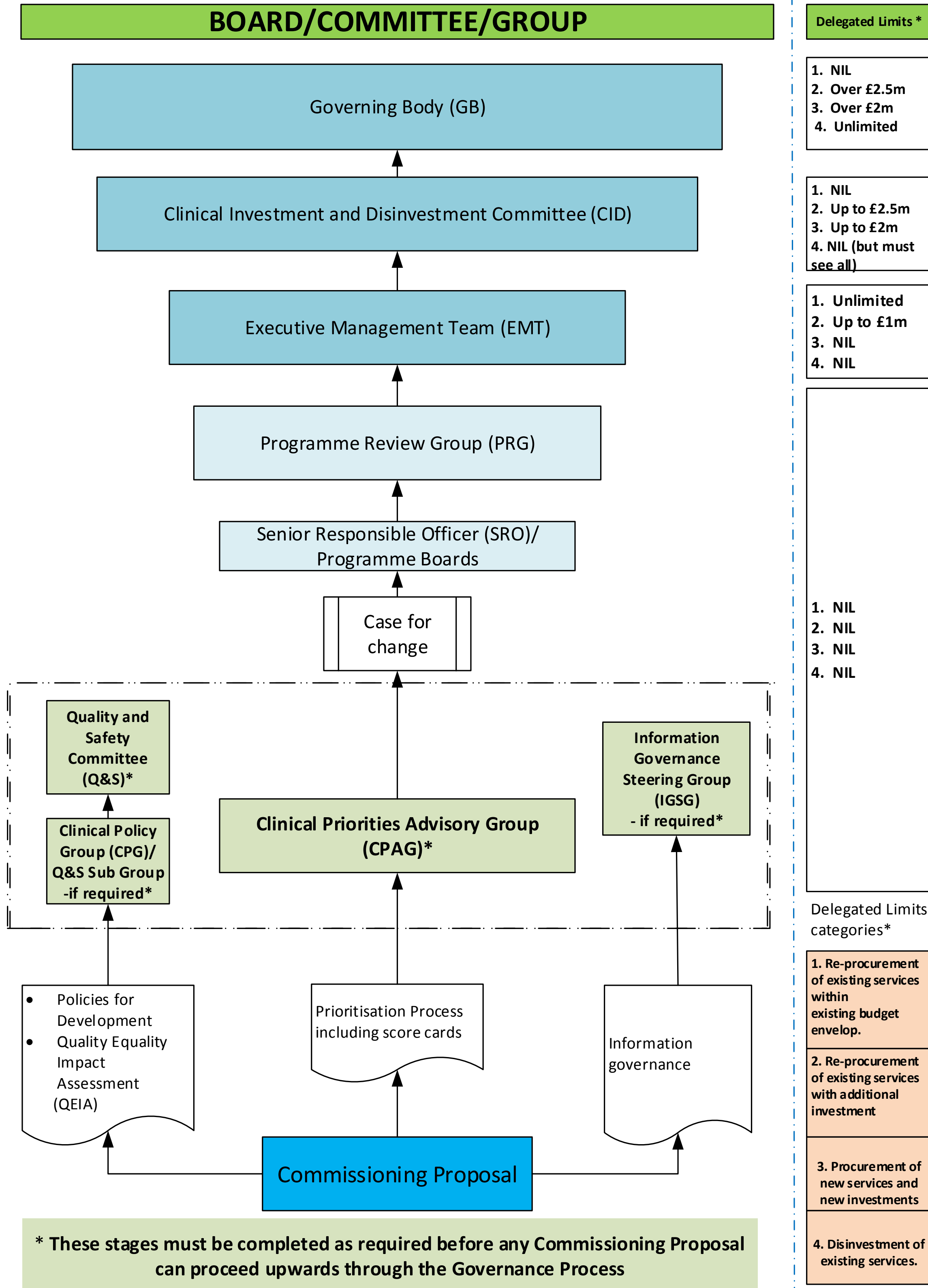
Intervention – Diagnostic Test

Comparator – Nothing, complimentary testing, front-line testing, test sequencing, a number of tests. Define what the GOLD STANDARD is.

Outcomes – Effectiveness of the diagnostic in placing a patient on a subsequent pathway

NHS Birmingham and Solihull Clinical Commissioning Group

Appendix E: Governance Gateway Process



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Birmingham and Solihull
Clinical Commissioning Group

Appendix F: Terms of Reference of the Clinical Priorities Advisory Group (CPAG)

TERMS OF REFERENCE

1. PURPOSE

1.1 The Clinical Priorities Advisory Group ("CPAG") is established by the Birmingham & Solihull CCG Governing Body in accordance with its Prioritisation Policy.

1.2 The purpose of the CPAG is to
a) Inform strategic planning
b) Inform annual commissioning cycle by recommending priorities for investment and disinvestment.
c) Advise on funding of in-year service developments
d) Make recommendations in respect of the above to the Clinical Investment & Disinvestment Committee and/or Governing Body

2. ROLES AND RESPONSIBILITIES

2.1 To manage the prioritisation framework of the CCG to inform investment and disinvestment decisions during the annual commissioning cycle.

2.2 To undertake an ongoing programme of work throughout the year providing explicit advice and recommendations to the Clinical Investment & Disinvestment (CID) Committee and/or the Governing Body regarding which healthcare interventions (including therapeutics, interventional procedures, technology, healthcare and public health programmes) should be the subject of investment or disinvestment.

2.3 To review existing and new commissioning policies.

2.4 To consider and make recommendations to the CID and/or Governing Body regarding innovations or service developments. These may be identified via a variety of mechanisms including, but not limited to:
a) the priorities set out in the BSOL Operating Plan 2017/19 and STP plan.
b) gap analysis by commissioning managers of currently commissioned services;
c) opportunities for improvement in productivity/efficiency or review of NICE guidance where a policy change (e.g. restricting/extending patient selection criteria for an intervention) would be required;
d) review of intervention(s) identified through the Individual Funding Request Panel;
e) outcomes of the STP proposals
f) review of interventions or new treatments identified through horizon scanning;
g) provider proposals to commission new interventions/innovations;

h) review of requests to consider interventions not covered by a) – f)

2.5 To ensure appropriate clinical input is in place, which has taken account of any potential conflicts of interest by such means as is appropriate to the scale of case for change, and ensuring that the principles and values set out in the CCG Constitution and the NHS Constitution are adhered to.

3. MEMBERSHIP

3.1 Members of the CPAG may be appointed from the BSOL CCG Governing Body or CCG clinical leads or members, or other external bodies as required to enable to the CPAG to fulfil its purpose.

3.2 The CPAG will include the following voting members. Members marked with * are clinical:

- A Clinical Lead or Governing Body GP*
- A Medicines Management representative*
- A nursing representative*
- Finance Senior Manager
- Chief Medical Officer Chair or nominated deputy* from BSOL CCG
- 1 patient representative from the Patient Participation Group (PPG)
- 1 lay representative – Governing Body Independent member

3.3 The following attendees will be invited in a non-voting capacity:

- Health watch (from both Birmingham & Solihull)
- Legal representative
- Consultant in public health (or their nominee)

3.3 Members can nominate a deputy to attend on their behalf when required.

3.4 The CPAG will nominate and agree its Chair and Vice Chair from the voting membership.

4 DECLARATION OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

4.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs [3] or any successor document will apply at all times.

4.2 Where a member of the CPAG is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring

[3] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/revsd-coi-guidance-june16.pdf

this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

4.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice-Chair will act as Chair for the relevant part of the meeting.

4.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the CPAG, will be recorded in the minutes.

4.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Standards for Business Conduct Policy and may result in suspension from the CPAG.

5 QUORACY

5.1 The quorum necessary for the transaction of business shall be **five of the core members with a minimum of 3 clinical members**.

5.2 A duly convened meeting of the Group at which quorum is present, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.

5.3 In respect of a primary care member conflict of interest, clinical representation will require a non-conflicted clinician to take the place of a conflicted member and count towards quorum, for example secondary care doctor, a clinical member of the executive team, or independent GP input/opinion. Their contribution may be via electronic/virtual means.

6 DECISION MAKING

6.1 The CPAG will use its best endeavours to make its advice and recommendations by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote in order to reach a final recommendation. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.

6.2 Only voting members of the CPAG set out at 3.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the CPAG will hold the casting vote.

6.3 Meetings of the CPAG may utilise tele-conferencing or other electronic methods to support the contribution of its members.

7 ACCOUNTABILITY

7.1 The CPAG is accountable to the Clinical Investment & Disinvestment Committee (CID) and through it, to the Governing Body. It has a direct relationship in terms of providing advice and recommendations to the Clinical Investment & Disinvestment Committee and/or CCG Governing Body (subject to delegated financial limits).

8 FREQUENCY OF MEETINGS

8.1 Meetings will usually be held monthly, but may be called at any other such time as the CPAG Chair may require.

9 REPORTING ARRANGEMENTS

9.1 The CPAG will report operationally to the Programme Review Group (PRG) and to the Clinical Investment & Disinvestment Committee or Governing Body, confirming all advice and recommendations made in respect of decisions being taken forwards via the CCG governance processes.

10 REVIEW DATE

10.1 These terms of reference and the effectiveness of the CPAG will be reviewed after three months and at least annually thereafter.

Appendix G: Definitions

Term	Definition/Meaning
BSOL	The term used to describe the Birmingham and Solihull CCG area
BSOL CCG	Means NHS Birmingham and Solihull CCG Where CCG means Clinical Commissioning Group
BSOL CCG GB	The NHS Birmingham & Solihull CCG Governing Body
CID	Clinical Investment & Disinvestment Committee
CPAG	Clinical Priorities Advisory Group
IFR	Individual Funding Requests
JSNA	Joint Strategic Needs Assessment
NICE	National Institute for Clinical Excellence
QIPP	Quality, Innovation, Productivity & Prevention

Appendix H: Equality Impact Assessment

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for the Prioritisation of Healthcare Resources

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Policy for the Prioritisation of Healthcare Resources		
EA Author	Michelle Dunne	Team	Quality & Safety
Date Started	07/02/17	Date Completed	08/02/17
EA Version	V0.2	Reviewed by E&D	

What are the intended outcomes of this work? Include outline of objectives and function aims

The policy aims to bring consistency in the approach of Birmingham and Solihull CCG. CCGs have limited budgets; these are used to commission healthcare that meets the reasonable requirements of its patients, subject to the CCG staying within the budget it has been allocated.

Prioritisation is the process of ranking competing items, such as tasks or potential purchases, in order of importance. Priority setting is a key component of the process of evaluating health interventions in order to decide what investments should be made with limited resources. It is part of the commissioning business cycle.

The policy sets out the approach which the CCG has adopted, ensuring the CCG has a robust policy and processes to evaluate and prioritise all options for investment, and disinvestment. The purpose of the policy is to provide clarity to commissioners when ranking competing options for investment and/or disinvestment in order of importance and determining which investments should be made within limited resources.

The policy will also act as a mechanism to provide healthcare providers and the public, as potential customers, with clarity around how the CCG manages its commissioning priorities and requirements and acts as a transparent way of informing patients of the same.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

The policy applies to the following:

a) CCG Governing Bodies and BSOL Programme Review Group
b) CCG commissioning staff including Commissioning Support Units
c) GP's and CCG clinical members/leads
d) Members of the public who consider they have a need to understand how the CCG commissions
e) Service providers
f) Those who scrutinise the commissioning and provision of healthcare

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
NHS Commissioning Board and CCGs (Responsibilities and Standing Rules) Regulations 2012		Primary Care Trust Network
Human Rights Act 1998		The NHS Confederation
Equality Act 2010		National Primary Care Action Team
Underpinning principles are from case law and national best practice guidance where there was clinical and public engagement and research into the underpinning methodologies.		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

All protected characteristics are covered in the CCG Ethical Framework Principles which is reflected within the policy.

The policy describes the process for decision making – no specific negative impacts have been identified for any of the protected characteristics or vulnerable groups. The policy aims to bring about benefits of transparency, equity and consistency in its decision making on prioritisation and resource allocation.

The policy does not address any specific health inequalities or inequities but does require users of the policy to consider and record findings on these elements in their decisions (i.e. in the use of the scorecard).

Where a decision is to be taken, the policy requires an Equality Analysis to be undertaken to ensure that the impact on protected characteristics, human rights and other vulnerable groups are taken into consideration.

Demographic Information:

- There is a relatively higher proportion of older people in Solihull with 18.8% of the population aged 65 and over compared with 16.5% in England and 17.2% in the West Midlands. This is estimated to be 22% by 2021 representing a significant challenge to health and social care services.
- Birmingham's population in 2011 was 1,073,045 million. It is a young population with 66% being under 44 years old. The 20-29 age group represents around 19% of the total population. People aged over 65 represents about 13% of the population. Conversely, Solihull has a more ageing population with 21% of the population above 65 years.

3. Impact and Evidence:

No adverse impact identified.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

Demographic Information:

- Population with a disability: According to census data across Birmingham as a whole 9.1% of the population either have a disability that limits their day to day activities a lot, compared to 8.2% for Solihull and 8.3% for England. When you look at activities limited a little, the figure for Birmingham is the same as England at 9.3%, though the figures for Solihull are higher at 9.7%.
- 4,100 people in Solihull have a learning disability, while severe learning disabilities are less common affecting around 0.4% of the population (approximately 800 people in Solihull). In an approximate learning disability population of at least 23,560 individuals, of which 23,150 would have mild learning disability. If we were to consider only the adult population[4], then we would have at least 17,829 Adults with learning disability, of which 17,517 would have mild learning disability. (LD JSNA Birmingham).

Almost 1 in 5 people (19%) in the UK have a disability. Only 17% of disabled people were born with their disabilities. The majority of disabled people acquire their disability later in life. *(Disability in the United Kingdom 2013 Facts and Figures – Papworth Trust report)*

No Adverse Impact Identified. See response to Age (above)

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree". NHS England have completed a national review into gender identity services, and a government inquiry was completed in 2016.

No Adverse Impact identified. See response to Age (above)

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

No Impact identified. See response to Age (above)

[4] ONS 2007 Mid-Year Estimate adjusted for 2009: 782,011.

3. Impact and Evidence:

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

No Impact identified. See response to Age (above)

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

Demographic Information:

- Ethnicity and the associated cultural and religious differences is a big factor in Birmingham, the most ethnically diverse city in the United Kingdom. 62.2% of Birmingham's population is White British, but the White British share varies widely with age. 42% are BAME.

- Ethnic minority groups are very unevenly distributed within Birmingham. The heart of the city has the majority of the 'non-white' ethnic groups. Over half of the 'non-white' population (51%) live in these areas with only 18% in south Birmingham. 15 % have a first language other than English. South Asian languages are predominant.

- Solihull is less ethnically diverse than Birmingham with over 90% of the population being white. 1.3% have a first language other than English.

Race	Birmingham	Solihull	England
White English	53.1%	85.8%	79.8%
White Irish	2.1%	1.9%	1.0%
White Gypsy or Irish Traveller	0.0%	0.0%	0.1%
White Other	2.7%	1.4%	4.6%
White & Black Caribbean	2.3%	1.2%	0.8%
White & Black African	0.3%	0.1%	0.3%
White & Asian	1.0%	0.6%	0.6%
Other Mixed	0.8%	0.3%	0.5%
Asian Indian	6.0%	3.4%	2.6%
Asian Pakistani	13.5%	1.7%	2.1%
Asian Bangladeshi	3.0%	0.3%	0.8%
Asian Chinese	1.2%	0.4%	0.7%
Asian Other	2.9%	0.7%	1.5%
Black African	2.8%	0.4%	1.8%
Black Caribbean	4.4%	0.9%	1.1%
Black Other	1.7%	0.2%	0.5%
Other Arab	1.0%	0.2%	0.4%

3. Impact and Evidence:

Other	1.0%	0.4%	0.6%

No impact identified. See response to Age (above)

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

Demographic Information:

- Christianity is the largest religion in Birmingham however at 46.1% this is lower than that of England as a whole which is 59.4%. Birmingham has more Muslims (21.8%), Sikhs (3%) and Hindus (2.1%) than England (5%, 0.8% and 1.5% respectively).
- In terms of religion, the majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%). The numbers of Christians has fallen by -13% (-20,421) since 2001, with no religion increasing by +84% (+20,154). This is consistent with the pattern nationally. In terms of other religions there are significantly more Muslims (+3,610, 221%), Sikhs (+1,938, 124%) and Hindus (+1,834, 99%) than in 2001.

No adverse impact identified. See response to Age (above)

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

Demographic Information:

- Birmingham has a slightly higher number of women 545,239 (50.8%) than men 527,806 (49.2%) this reflects the picture for England as a whole.
- In Solihull it is slightly different, where again women are in the majority but by a higher figure than for that of Birmingham and England (51.4%).

No adverse impact identified. See response to Age (above)

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

Demographic Information:

- According to ONS, in 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB).
- More males (2.0%) than females (1.5%) identified themselves as LGB in 2015.
- Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015.
- The population who identified as LGB in 2015 were most likely to be single, never married or civil partnered, at 68.2%.

No adverse impact identified. See response to Age (above)

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

3. Impact and Evidence:

Demographic Information:

- A carer is defined in the Carers (Recognition and Services) Act 1995 as a person who provides a "substantial amount of care on a regular basis". The 2001 Census indicates that there were nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%.
- In Birmingham the 10% of the population are defined as carers, of which 4% provide over 20 hours care a week.

No adverse impact identified. See response to Age (above)

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

- Demographic Information: Birmingham as a whole is the 10th most deprived Local Authority in England.
- Birmingham is a growing city linked in part to migration (9.9% increase since 2004)
- Solihull and Birmingham have a prosperity gap reflected in the 10-year life expectancy gap between the least and most affluent wards.
- Birmingham has a homelessness level more than three times the England average – 7.6 per 1000 households against the England average of 2.3 per 1000 household
- As a whole Solihull is a relatively affluent borough, however wards in the north of Solihull are amongst the most deprived 10% in the country.
- The biggest health challenge in Solihull is closing the inequalities gap between deprived and more affluent communities

No adverse impact identified. See response to Age (above)

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	Policy includes requirement to consider the impact on health inequalities.
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

The prioritisation framework is based on a scorecard, which features a section on addressing "health inequality or health inequity" with increasing points/score awarded for how much the proposal addresses an identified inequality or inequity.

The policy reflects the principles of from the CCG Ethical framework for priority setting and resource allocation (which are detailed in appendix A of the policy); principle 5. Within this principle the link between social inequalities and inequalities in health, health needs and access to healthcare are stated. This principle also supports the opportunity to prioritise decision making with targeted health services to sub-groups of the population who experience poorer health outcomes or poorer access to services

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	No infringement on any human rights identified. Each business case will be supported by an equality analysis which will review the impact on human rights.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	
	How will this affect a person's right to freedom of thought, conscience and religion?	
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	
Right to **Life**	Will or could it affect someone's right to life? How?	
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	

6. Social Value
Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	Not applicable to this policy which describes the authorisation processes for commissioning decisions.
Create fair employment and good work for all	
Create and develop health and sustainable places and communities	
Strengthen the role and impact of ill-health prevention	

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date
Internal engagement with senior officers across BSOL planning, contracting and finance teams.		

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

Engagement to date has been limited to internal management across a range of teams.

Future proposals on policy revision and related procedures will be subject to following: Ongoing development and revision of the policy and related procedures will be managed through the Programme Review Group (PRG) and approved at BSOL CCG Governing Body of which it is anticipated there will be at least two members of the public.

Consultees will include:

a) Clinical Priorities Advisory Group (CPAG)
b) CCG Senior Managers
c) BSOL Governing Body
d) Health watch
e) The public through the patient and public involvement members of CPAG
f) Legal advisors

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The policy describes the process for prioritising healthcare resources through its governance structures, ethical principles for decision making, and use of a scorecard. The policy includes:

- ✓ An equality statement
- ✓ Embedded consideration of the impact on health inequalities and health inequity into the scorecard
- ✓ A requirement that where the scorecard has been used and results in an investment, disinvestment or service delivery plan that a business case will be developed and taken to the Programme Review Group (PRG).
- ✓ A commitment to "engage with …and patient health panels as a minimum annually on the prioritisation pipeline and the Commissioning Intentions Events"

The prioritisation framework is based on a scorecard, which features a section on addressing "health inequality or health inequity" with increasing points/score awarded for how much the proposal addresses an identified inequality or inequity.
The policy reflects the principles of from the CCG Ethical framework for priority setting and resource allocation (which are detailed in appendix A of the policy); principle 5 concerned with access of service which should be governed as far as practicable, by the principle of equal access for equal clinical needs is of particular relevance. Within this principle the link between social inequalities and inequalities in health, health needs and access to healthcare are stated. This principle also supports the opportunity to prioritise decision making with targeted health services to sub-groups of the population who experience poorer health outcomes or poorer access to services.
Gaps identified:

- Policies equality statement requires updating;
- Policies equality analysis statement requires updating;
- Inclusion of equality in audit processes
- Emphasis of the need to demonstrate due regard (to the General Equality Duty – Equality Act 2010) in decision making/recording
- Training of staff on involved in decision making to understand their responsibilities around the Equality Act 2010 with focus on demonstrating due regard in decision making.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

The following recommendations are made to address the gaps identified in Section 8 of this equality analysis.

Recommendations:

The policy includes an Equality Statement and information on the Equality Analysis – the wording of both would benefit from updating. The following is suggested:

Equality Statement (to replace section 4.1 of draft policy)

"4.1 The CCG's have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. The CCG's are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, the CCG's will have due regard to the different needs of protected equality characteristics, in line with the Equality Act 2010."

Equality Analysis (to replace sections 5.1 and 5.2 of draft policy)

"5.1 The CCGs aim to design and implement services, policies and measures that are fair and equitable. As part of its development, this policy and its impact on staff, patients and the public have been reviewed in line with the CCGs Legal Equality Duties. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of their protected characteristics.

5.2 An Equality Analysis of this policy has been undertaken on (insert date); no disproportionate adverse impacts have been identified."

Audit and Compliance (section 11)
It is recommended that when undertaking the annual audit of compliance with the policy that the template includes seeking assurance that an equality analysis was undertaken and presented to assist decision making.

Consultation (section 8.6, paragraph 8.6.8)
It is recommended that in addition to the 'good record keeping' of decisions that reference is made to the equality duty requirement 'to demonstrate due regard to the aims of the general equality duty' in decision making i.e. through the use of equality analysis.

Training (section 13)
It is recommended that staff involved in decision making have up to date training on the requirements of the Equality Act 2010 and associated duties around demonstrating due regard in decision making.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy will not result in the awarding of a contract in it-self; however, it will inform future service activity. All service investments/disinvestments paperwork will include an equality analysis detailing the potential impacts to inform decision making.

Individual service contracts will contain equality and diversity requirements (part of the standard NHS contract); the completed equality analysis(EA) undertaken for each business case may also include equality aspects for inclusion as appropriate to the findings of the EA, this can be in the form of key performance indicators and/or reporting requirements.

This policy will be constantly under review through PRG and all relevant committees and ordinarily updated on an annual basis.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

This policy will not of itself result in procurement activity; however, it does inform the processes which could result in procurement. Equality and Diversity requirements are embedded into the procurement process, containing questions which are derived from the outcomes of the equality analysis completed as part of the business case.

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.

The equality analysis will accompany the policy when presented for sign-off by the Programme Review Board (PRG).

The finalised policy and competed equality analysis will be available on the CCG's website.

Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:	M K Dunne	08/02/2017

Which Committee will be considering the findings and signing off the EA?		
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net