NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING – PUBLIC SESSION

10 JANUARY 2017

Agenda item 6

Title of Report:	**The Future of Commissioning in the Black County – a discussion Paper for Wolverhampton, Dudley, Sandwell & West Birmingham and Walsall CCG Governing Bodies**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim Chief Officer
Governing Body Action Required:	**To discuss the proposals summarised in the attached and agree a way forward.**
Purpose of Report:	**This Paper:** **Is a single version of a paper which will be taken to each of the 4 Governing Bodies across the Black Country & West Birmingham during January 2017.** **1. Background:** Following meetings of Accountable Officers and Chairs of the 4 CCGs across the Black Country in October and November 2016 it was agreed that a version of a paper would be taken to each of the four CCG Governing Bodies to discuss potential future commissioning arrangements. The Governing Body received said paper at its November 2016 meeting and agreed that further discussions should be had. **2. The Black Country Sustainability and Transformation Plan:** The STP set out a clear plan which helped to define both the need and benefits for a two-tier; Black County and West Birmingham collaboration and

	local place-based care. However the STP cannot 'drive' any plan as it does not have any statutory authority. The current STP sponsorship group has done a very good job of creating a wave of action but is constituted without any delegated authority to make decisions on behalf of the system. Therefore, whilst the previous arrangements were useful in enabling the construction of the STP; it is not an effective basis for progressing delivery of the plan overall – some progress has been made in transforming care but not enough, and several workstreams have stalled for want of a clear consensus on commissioning / delivery plans. Without stating the obvious, all plans need to move to delivery at some point or there is little purpose in their construct. **3. January 2017:** As charged by their individual Governing Bodies, the Chairs and Accountable Officers of each of the 4 Black Country CCGs met again on 5 January 2017 to discuss options for further collaboration to move the STP to a 'delivery' model. A joint paper was agreed at this meeting, it is attached and has not been amended. **4. Attached January 2017 Paper:** The attached paper is a single version of words going to each Governing Body in January 2017 - all GB meetings are being held in public session. This paper is intended to facilitate discussion in each of the four CCG on the future of commissioning arrangements. The paper contains recommendations to be agreed by each Governing Body. The objective is to establish, if possible, a common consensus for collaboration between the four CCGs. **5. Joint Committee – delegated authorisation:** The attached paper sets out recommendations to be considered, one of which includes the setting up of a forum with delegated responsibility for commissioning – how much is in the 'delegated box'

	needs to be agreed. This 'Joint Committee' would consist of AOs and Chair of the 4 CCGs as a deminimus. **6. Governance of the 'Joint Committee':** Attached to the paper are a draft ''Terms of Reference' for a joint committee – these are at a very early stage and not agreed pending discussions at the 4 GB meetings and would need further detail and ratification. **7. Clinical Board** It is proposed that a 'clinical board' consisting of leaders across the commissioning and provider landscape is set to steer the work of any joint commissioning committee. There is much to do on operationalizing any such arrangement to ensure true engagement and representation. **8. CCG Statutory Responsibilities:** These remain unchanged until an Act of Parliament deceases and revision to current constitutional arrangements. This means that each CCG must maintain a Chair, AO and Governing Body. **9. Delegated Commissioning to a Joint Committee** Any delegation to a joint commissioning committee would require agreement of what this would include and financial considerations by the Governing Body – we are not at this point yet as there is much more detail to consider. **10. Next Steps:** a. It was agreed at the meeting between Chairs and AOs that this paper would be taken to each public board in January for approval. b. Chairs and AOs would meet again as a group in February to review comments from each Governing Body. c. A workshop with Executive / senior staff will be arranged in February 2017 to explore logistics. d. A further paper will be taken to each respective Governing Body in March 2017,

	which sets out the discussions from each Governing Body in January, and if agreed as a next step, the details developed from the senior workshop in February 2017. **11. Summary:** In considering the ambitions set out in the attached paper, the focus for discussion should be on whether this helps us as a commissioning body deliver on the outcomes for the population of Wolverhampton and our legacy as a Board.
Public or Private:	Public session
Relevance to CCG Priority:	This document is material to all of the CCG's priorities, although nothing contained within the draft plan thus far is contrary to those priorities.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation • **Domain2:** Performance – delivery of commitments and improved outcomes • **Domain 3:** Financial Management • **Domain 4:** Planning (Long Term and Short Term) • **Domain 5:** Delegated Functions	This report is material to all of the current domains within the CCG BAF.

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Trisha Curran**	**08/01/17**

The Future of Commissioning in the Black County & West Birmingham
January 2017

Proposal for Joint Commissioning for Dudley, Sandwell & West Birmingham, Walsall and Wolverhampton CCG Governing Bodies

1. Introduction

Our four CCG governing bodies previously agreed to explore the potential future commissioning arrangements for how our four CCGs could and should collaborate across our STP footprint.

Each Governing Body considered the proposition:

- that after the current contract negotiations for 2017/18 contracts there would be substantial benefit in establishing more formalised collaborative commissioning arrangements across the four Black Country CCGs.
- because each CCG must retain its own statutory functions and because there is a considerable local placed-based agenda; it is preferable for each CCG to retain their own Accountable Officer for the foreseeable future.
- that our four CCGs should formalise the existing collaborations on the strategic clinical review of services; mental health and maternity.
- that our four CCGs should seek to establish a joint commissioning arrangement for acute and specialised services commissioning.
- That our four CCGs should seek to establish formal arrangements for sharing expertise in other relevant areas.

All four Governing bodies agreed that the CCG Accountable Officers and Chairs should meet as a group and be tasked to work together to produce a detailed proposal; including a staff engagement plan; on the detail of these arrangements for approval by each Governing Body.

This paper sets out the conclusions and recommendations from that group.

2. Identity with local place

The four CCGs in the Black Country and West Birmingham (BC&WB) are each associated with a clear local geography and placed-based identity, aligned to our local boroughs. And whilst our local authorities are collaborating on some agendas on the wider footprint of the West Midlands Combined Authority, it is clear that the main identity of place within the Black Country and West Birmingham is at the level of each local borough. So although in other STPs there may be a very clear shared identity and sense of community at an STP level, this is not the case to any degree of significance across the Black Country and West Birmingham.

Consequently the priority for public accountability; joint strategy development through forums like Health and Wellbeing Boards; and partnership working with local authorities – all rests at the level of place which is our local boroughs.

For the sake of stating the obvious, the NHS is a public service delivering care and treatment to the public. And more than that, the public are an integral part of the solution to the challenges that we face as they are fully involved in the provision of their own health and social care. We cannot expect the public to be more involved in their own care and shut them out from the development of that care. So local public engagement and accountability is key to the work of our CCGs – particularly in the design and delivery of those services that connect with people in their own communities. Therefore the priority for the sovereignty of CCG governance should continue to reside at this local level – ie: it should reside with the existing CCG footprints.

The development of new placed-based models of care affords the opportunity to achieve much of the local accountability and service delivery within these new models. New contract forms will shortly be available which will enable our CCGs to commission services through capitation, outcomes-based contracts through which relevant CCG activities can also be contracted.

Conclusion:

- Sovereignty of governance at the existing CCG level also does not hinder or limit the opportunities for formal collaboration at a wider scale and this paper goes on to explore the added value and opportunities for formal collaboration at the wider footprint of the Black Country and West Birmingham; as well as the opportunities that can be achieved through the development of the new local care models.

3. Local Place-based Commissioning

The local place-based models currently in development in each borough shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs); and requires engagement with the local public on the most appropriate models of care and mechanism for delivery in each local system. Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local population delivery and a priority on achieving improvements in outcomes. It also

reconfigures provider delivery priorities to align with the population priorities of the CCG – because the provider(s) are commissioned on a WPB capitation contract against a set of outcome measures.

Once the provider delivery priorities are aligned with the population priorities of the CCG, this enables the CCG to contract out to the provider system a range of relevant CCG activities. This, combined with appropriate partnership and risk share arrangements, can lead to the creation of a local accountable care system in each borough.

The significant benefits that can be gained from these new commissioning arrangements mean that it is in the interests of each local system to implement these new contracts as soon as possible. We will capitalise on our collective experience across the four CCGs to share our knowledge and learning in order to help expedite this work.

Conclusions:

- Each CCG will continue to develop their own local care model in partnership with their local council(s) and providers
- Each CCG will implement the new contractual framework to deliver their new care model, at least in shadow form, from April 2018 – with subsequent implementation based on local determination.

4. Collaboration across the Black Country & West Birmingham

Our current CCGs already collaborate as part of a wider group on the commissioning of WMAS and NHS111. We have also collaborated in the development of the STP and on the workstreams within that – noticeably on Mental Health, Maternity and local placed-based delivery. However none of these arrangements incorporate shared decision-making or shared commissioning resource.

Our current arrangements involve little joint resources or decision-making and as a consequence we are not leveraging or steering sufficient collective change from our providers. So it is clear from the current financial challenges that we all face that we need to improve our impact.

There are some obvious benefits to adopting a more formalised joint arrangement for commissioning some of our services at scale across BC&WB:

- Ensuring consistent standards of delivery in key transformation areas that are identified in the STP, such as Maternity and Mental Health;
- Maximising the benefits of the 'devolution' of specialised services commissioning; and ensuring we can oversee and incentivise the collaboration that we require from our providers – particularly in acute care.
- Sharing our skills and capabilities to realise the maximum possible benefits from our providers;

A key foundation for driving improvement will be to ensure that there is a collective clinical leadership approach, aligned with appropriate patient and public involvement. Our patients and our clinicians are at the heart of everything we do. We will therefore reconstitute the STP clinical reference group as a BC&WB Clinical Board – which incorporates membership not just from the four CCGs but from all key stakeholders in the system - to steer the clinical reviews and improvement required. This Clinical Board will underpin these three work programmes:

4a. Transformation programme:

The STP identified a number of transformation areas which require a collaborative approach. These include but are not limited to:

- Mental Health and LD service configuration and wider public sector collaboration
- Maternity service delivery standards with a focus on reducing infant mortality
- Joint Workforce development
- Shared estate and wider economic planning
- Our IT digital roadmap
- Acute service configuration (covered in more detail as item 4b)
- Shared expertise on developing our local placed-based models of care

These programmes have made progress to varying degrees at this stage and the transformation programme will therefore need to ensure that appropriate resourcing and performance management is in place to ensure each of these priorities are taken forward.

Conclusion:

- These are important agendas which require a collective approach. The four CCGs will therefore need to ensure that there is a shared transformation programme to steer this work.

4b. Acute and Specialised Commissioning:

The STP identifies clear opportunities through establishing more integrated secondary care services – both acute care and specialist mental health. In fact, our system of care is not sustainable without significant restructuring and standardisation of acute care across the Black Country.

The STP also identifies a number of significant issues which need to be addressed including:

- potential 'over-capacity' of acute service estate across the system
- clinical services which require review and integration to optimise outcomes and/or sustainability
- variations in policy and variations in service delivery

In addition, the STP also identified that the NHS England framework for specialised services specifies 36 specialised services which could be devolved through the West Midlands Specialised commissioning board to a Black Country commissioning footprint. This offers the opportunity to align a Black Country CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider – to create an integrated Black Country approach to the commissioning of all major acute services.

Conclusion:

- We should create a joint capacity and capability to commission all of these services on the basis of a single acute network of provision across the Black Country working to the same standards of care.

4c. Shared skills and capabilities:

There are a number of areas where there could be substantial benefit derived from the four CCGs sharing skills and capabilities in order to deliver better results. There is also a need for the CCGs to reduce management costs overall in order to contribute to the wider system efficiency improvement.

Areas of potential collaboration include:

- Integrated assurance – standardising quality and safety reporting and developing specialist skills for RCAs; standardising routine performance reporting and contractual performance issues; creating shared capability for service review and problem solving
- Strategic Finance and Contracting – developing the technical expertise to implement new outcome-based contracts; specialist procurement expertise; evaluation of strategic issues such as estate capacity and capital financing
- Clinical strategy –acute and specialised services strategic reviews as already identified above; development of shared clinical policy (eg: POLCV and pharma); establishing clinical peer review processes to improve system performance
- Improved Effectiveness – ensuring we are achieving maximum value from CHC and individual placements; primary care contract management; understanding the impact of social care and public health changes on local systems; shared engagement with the wider public and private sector on the wider determinants of health

Our staff will be central to both shaping and ensuring that these collaborative arrangements are established in the right way to achieve the best results. We will therefore need to establish an shared organisational development programme, starting with a workshop with all senior staff from the four CCGs, to facilitate this work.

It is important to note that any collaboration in these areas will also need to be understood and coordinated alongside the activities which will be contracted down into each local-placed based care model. Therefore this work cannot be rushed and requires a considerable shared OD (and ultimately HR) process if it is to be developed properly.

However, given the extent of collaborative opportunity, once CCGs contract out activities into their local placed-based care model it is likely that the vast majority of remaining CCG functions – with the exception of local accountability and engagement - could best operate at a BC&WB level. Therefore the longer-term direction of travel ought to be to establish a single CCG management team across the BC&WB which works for the four CCGs collectively.

Conclusion

- We should establish a single OD programme to start to coordinate these activities and engage our staff accordingly (starting with a workshop with senior staff in February); determine over time the preferred model for working; with a view to fully establishing a single integrated arrangement at the same time as we contract out other activities into the placed-based care model.

5. Distribution of commissioning between Local place and the Black Country

The commissioning model that we are putting in place creates a two-tier arrangement:

- Black Country system-wide collaboration

- Local Placed-based care models in each borough

However, for this arrangement to be effective, there has to be consistency between the four CCGs in the scope of services that are commissioned at a Black Country level. Therefore it follows, that each local system must include the same scope of services in their local placed-based care model.

It will be necessary for there to be a single consistent policy on how services are configured within the Black Country collaboration. However for each local placed-based care model the only consistency that is required is that they apply the same scope of services - there can be local determination within each local system regarding how services are configured and how the care model is developed.

Conclusion:

- One of the first pieces of work which will need to be completed is to agree the scope of services at each of the two levels of the system (Black Country and local)

6. STP evolution to an Accountable Care System

The STP has set out a clear plan which clearly helps to define both the need and benefits for the two-tier arrangements – both Black County collaboration and Local place-based care.

However the STP does not address the statutory requirements of individual organisations; nor is the current STP sponsor group constituted with any delegated authority to make decisions on behalf of the system. Therefore, whilst the previous arrangements were useful in enabling the construction of the STP; they are not an effective basis for progressing the issues that the STP sets out.

Within current statute, CCGs cannot delegate their functions to a provider organisation. Therefore we cannot, in effect, merge CCGs with providers in order to create an integrated commissioning and provider organisation.

However, by moving to the two-tier system of commissioning as proposed, we create significant opportunities for creating accountable care systems. The new care models and capitation-based WPB contracts enables the CCGs to align provider configurations and priorities to the population-based priorities of the CCG. Similarly, by commissioning acute and specialist mental health services on a new collective basis – to create a single acute provider network through a single joint contract – we will substantially align acute service delivery priorities to the collective priorities of the four CCGs.

Once established, these new contractual forms therefore enable the creation of accountable care systems by facilitating a new partnership between each CCG and their local care model; and between the four CCGs and a single acute network and single specialist mental health network.

Conclusion:

- We should redefine the CCGs' collective ambition from the STP to the creation of an accountable care system across the Black Country, incorporating local place-based accountable care organisations working with an integrated Black County acute network.

7. Pace of Change

There are counter priorities which we need to consider in establishing the pace at which we implement these changes.

Firstly, the state of readiness both of each local system to implement a new care model; and of the acute trusts to create a single acute network; suggests that the pace of change will need to be measured.

Similarly, there is a considerable amount of work for the four CCGs to do to establish new contractual frameworks, even in shadow form; identify CCG activities which will be contracted from the new care models; and both quantify and implement the opportunities for collaborative working. It is also highly likely that each CCG will need capacity during 2017/18, not only to continue with existing plans already in place but also to update all of their contracts for 2018/19.

Contrary to this, the financial challenges facing the system demand that we take significant action as soon as possible in order to maintain financial and clinical sustainability – and that this needs to be a collaborative approach.

In addition, a long drawn-out process is likely to risk alienating our staff and will create a significant distraction away from carrying out the key tasks.

It is important to be clear that the four CCGs will continue as four statutory bodies throughout this whole change and into the new arrangements. What we are trying to achieve through this change is the best way to achieve maximum impact for our local populations.

Conclusions:

- A joint CCG arrangement needs to be put in place asap in order to take forward this work and in particular to start to work on the shared clinical strategy on Black Country acute and specialised commissioning
- Each CCG will need to continue to operate in their current form at least for the next financial year in order to progress the development of their local placed-based care model and to maintain oversight of existing contracts and services
- We should commit making the step-change into a single integrated CCG management structure from April 2018

8. Mechanism for Joint Commissioning

There are three ways in which the sovereignty of governance at the CCG level can be maintained whilst creating a collaborative arrangement between the CCGs.

8a. Option one: Committee in Common

The four CCGs establish a committee in common to enable collaboration but all decisions and recommendations by the committee have to be referred back to all four CCG Governing Bodies for approval. Therefore, in effect, no activities are delegated.

Whilst this retains sovereignty with all four CCGs, this creates an extremely cumbersome and bureaucratic process, and creates the potential for areas of disagreement to be repeatedly referred back to Governing Bodies.

8b. Option two: Joint Committee

The four CCGs establish a joint committee and jointly determine the delegated authority to that committee for any activities on behalf of all four CCGs.

With this mechanism, the four CCGs retain sovereignty by virtue of determining what activities the joint committee can undertake – and those activities can be varied over time through joint agreement by all four CCGs Governing Bodies. However this enables the committee to take decisions within the scheme of delegation it has been given and therefore creates a more efficient and effective process.

8c. Option three: Simultaneous Governing Bodies

The four CCGs bring their four Governing Bodies together so that all four CCG governing bodies meet simultaneously in one shared meeting.

With this mechanism this enables the four CCGs to make simultaneous decisions on collective commissioning arrangements. It also enables each individual CCG business to be conducted, where needed, as there can be CCG-specific papers as required. This mechanism will work well where there is a single integrated management structure in place for the four CCGs – however it would be unwieldy and almost impossible to manage whilst the CCGs independently maintain their existing Governing Body structures given the number of people that would therefore be involved. This arrangement could therefore only be implemented once the Governing Bodies have been significantly streamlined and reduced in size.

Conclusion:

- It is therefore recommended that for 2017/18 the CCGs establish a joint committee to take forward this work. The point at which a significant stepped change occurs and a single integrated CCG management team is put in place, would be the point at which the CCGs could then move to a simultaneous meeting of governing bodies.

Recommendations

1. Our four CCGs will reshape the STP – which is a plan – as the outline for creating accountable care across the Black Country & West Birmingham

2. The accountable care system will operate at two levels:
    a. A BC&WB accountable care system, incorporating the four CCGs (integrated together with a single shared management structure, chair and accountable officer) working together in partnership with a single integrated acute provider network and specialist mental health network
    b. Encompassing local placed-based accountable care systems where the local CCG works in partnership with their respective local authority and has contracted out most of its activities to the new local placed-based care model

3. We will establish a joint committee across the four CCGs (as a first step towards this model) to be operational from April 2017. The proposed terms of reference for the committee are attached as Appendix One

4. We will establish a BC&WB Clinical Board to drive the process of clinical review and change required. This will report into the joint committee.

5. The joint committee will undertake the following key activities:
    a. First recommend the scope of services between the Black Country system and the local place-based system
    b. Establish three main work programmes:
        i. a transformation programme to continue with the key initiatives identified in the BC&WB STP
        ii. oversight of acute services and the development of specialised services commissioning
        iii. an OD and HR programme for developing immediate benefits from shared working and for migrating to the future arrangements
    c. Recommend the resource requirements for running each of the three work programmes (taking the outcomes from the CCG staff workshop in February)

6. Commit to establishing the new contractual frameworks, at least in shadow form, for the new placed-based care models from April 2018

7. Commit to moving from a joint committee arrangement to a simultaneous CCG governing body arrangement from April 2018, to enable both:
    a. the transfer of activities from CCGs to the new care models from April 2018
    b. the establishment of a single integrated CCG team from April 2018 to be able to fully implement the new accountable care arrangements from April 2019

APPENDIX ONE

Black Country and West Birmingham Commissioning Board

TERMS OF REFERENCE

1. PURPOSE

1.1 To establish a single commissioning view for key services across the Black Country and West Birmingham through the creation of a Joint Committee of the 4 Black Country and West Birmingham CCGs.

2. BACKGROUND

2.1 The Black Country STP identified a number of key transformations that needed to take place in order to create a potentially sustainable health and care system with the area,

These are:

- Place based integration through the development of ACO arrangements on a locality footprint
- consistent delivery of secondary and tertiary care across the area to remove unwarranted variation
- the transformation of a number of priority services including mental health and learning disabilities services, maternity services and a focus on reducing infant mortality
- the development of revised commissioning arrangements to support the delivery of the plan and to move beyond the STP process

2.2 Placed based integration clearly has to be locally focussed and delivered through partnerships with local authorities and others local partners. The other programmes however, all require co-ordination at a Black Country and West Birmingham scale. Even the local integration work stream would benefit from a co-ordinated approach in some regards, especially relating to the more technical aspects of the specification, procurement and mobilisation of the revised arrangements.

2.3 In order to facilitate this, Dudley, Sandwell and West Birmingham, Walsall and Wolverhampton CCGs have agreed in principle to establish a joint committee to provide a basis for co-ordinated collective action to commission these arrangements.

3. GOVERNANCE

3.1 The joint committee will be constituted in a way that reflects the governance of the CCGs and will therefore be;

- clinically led
- managerial supported
- independently moderated

3.2 The committee will therefore comprise the chairs, AOs and one non-executive or lay member from each CCG. It will be chaired by one of the clinical chairs elected for this purpose by the other members of the committee through an annual review and election process.

3.2 The committee will elect a vice chair also from amongst the clinical chairs who will deputise for the chair as required

3.3 The committee shall have delegated authority to act on behalf of the four CCGs for the purposes of commissioning a range of services to be determined by the CCGs. It will act a the basis for a partnership with NHS E to explore the delegation of commissioning for a range of specialised services to be determined through agreement with NHS E.

3.4 The Joint Committee will be known as the Black Country and West Birmingham Commissioning Board. (BCWBCB)

3.5 Each CCG will continue to operate as an sperate statutory body with its own board, AO and governance. The BCWBCB will be accountable to each CCG for those areas delegated to it.

4. INFRASTRUCTURE

4.1 The Black Country & West Birmingham Commissioning Board will be supported by a programme director and a small programme team (including a secretariat) that will co-ordinate the work of the committee.

4.2 The programmes of commissioning will be undertaken through the development of joint teams comprising relevant staff drawn from all four CCGs.

4.3 The programme director will co-ordinate this process. The programme team will provide a PMO function and the secretariat for the committee.

5. ORGANISATIONAL DEVELOPMENT

5.1 There will be a strong organisational development component to the work of the Black Country & West Birmingham Commissioning Board to both create the cross CCG teams for the various commissioning programmes and to begin the process of

transitioning to the new organisational arrangements that will be required following the mobilisation of ACOs on a locality basis.

5.2 To that end the programme team will have a senior HR/OD lead to ensure that this aspect of the work of the team is properly integrated into the verbal work of the Black Country & West Birmingham Commissioning Board.

6. FREQUENCY OF MEETINGS AND QUORACEY

6.1 The BCWBCB will usually meet monthly and not less than 10 times a year.

6.2 Meetings will be deemed to be quorate provided there is at least one representative from each CCG present and the meeting is chaired by the chair or deputy and attended by at least one of the AOs and one non-executive or lay member.

7. SCOPE OF RESPONSIBILITIES

7.1 The Black Country & West Birmingham Commissioning Committee will have delegated authority for commissioning a range of services to be determined by the four CCGs. This may include any of the areas of commissioning for which they are responsible.

7.2 The committee may also (through agreement with NHS E) act as the basis for a partnership with NHS E for the commissioning of specialised services.

8. RELATIONSHIP WITH THE STP

8.1 The four Back Country and West Birmingham CCGs believe it is important t move beyond the STP arrangements and see the creation of the BCWBCB a a basis for this. The current STP arrangements have no formal authority or governance, they do not provide a satisfactory basis for true partnership working with Local Government (including the West Midlands Combined Authority) and could not act as the basis for a partnership with NHS E for the delegated commissioning of specialised services.

8.2 The BCWBCB provides a way of addressing these issues. Its creation would allow the creation of new governance arrangements that go beyond the STP and better support the implantation of the plan developed through the STP process.

8.3 To that end, the current STP arrangements would evolve and a revised basis for partnership working with Local Authorities, providers and other stakeholders would be developed through joint planning with those partners.

9. RELATIONSHIPS WITH OTHER STPs

9.1 There are crucial links between the work in the Black Country and West Birmingham and work in neighbouring areas including Staffordshire and Birmingham and Solihull and Hereford and Worcestershire.

9.2 Collaborative commissioning arrangements are being developed in these areas and the Black Country & West Birmingham Commissioning Board will work with these new arrangements as needed to ensure co-ordination with neighbouring areas.

10. NEXT STEPS

The priorities for the next three months are:

-To seek approval to proceed for the GBs of the four CCGs in January. 2017

- to bring together the executive teams of the CCGs for a workshop to refine these proposals in February.

- to seek final approval for the detailed arrangements from CCG GBs in March

- to establish the committee with effect from the beginning of April 2017.

Parallel discussions will take place with NHS E regarding the commissioning of specialised services.

Dated Ratified: January 2017

Date of Review: June 2017