Health Scrutiny Committee

Monday 16th February, 2015, at 6.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session

(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

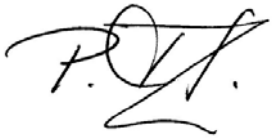
   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

5. NHS Quality Accounts - Provider Reports (Pages 1 - 12)

6. Delivery Against Committee Review Action Plans: Tobacco Control Review 2013/14 (Pages 13 - 16)

7. NHS England Co-Commissioning and Primary Care Intentions – Dudley Commissioning Group - Delegated responsibility for the Commissioning of General Medical Services (GP services) (Pages 17 - 37)

8. To consider any questions from Members to the Chair where two clear days notice has been given to the Strategic Director (Resources and Transformation) (Council Procedure Rule 11.8).



Strategic Director (Resources and Transformation)
Dated: 5th February, 2015

Distribution:

Members of the Health Scrutiny Committee:
Councillor C Hale (Chair)
Councillor N Barlow, (Vice-Chair)
Councillors C Elcock, M Hanif, D Hemingsley, S Henley, K Jordan, M Roberts, E Taylor, K Shakespeare and K Turner
Ms Pam Bradbury – Co-opted Member

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- Elected Members can submit apologies by contacting the officer named below. The appointment of any Substitute Member(s) should be notified to Democratic Services at least one hour before the meeting starts.

- The Democratic Services contact officer for this meeting is Manjit Johal, Telephone 01384 815267 or E-mail manjit.johal@dudley.gov.uk

The Dudley Group NHS
NHS Foundation Trust

Agenda Item No. 5

Health Scrutiny Committee – 16th February 2015

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY ACCOUNT/REPORT SUMMARY FOR 2014/15

1. Introduction

This paper confirms what quality priority topics and associated targets the Trust set at the beginning of the year in April 2014 and which were initially published in the Quality Account for 2013/14. It also gives an indication of where the Trust is presently at with the majority of these thirteen targets (not all of the targets as two of them are based on the results of an annual survey for which the results are not yet available) but it has to be appreciated that a final complete analysis and conclusion can only be undertaken after the end of the financial year which falls on 31st March 2015. The paper also indicates how the Trust is deciding on the quality priorities for 2015/16. At the time of writing, the full details of those priorities have yet to be agreed as these will be dependent on the final results against the 2014/15 targets and what goals are set both nationally and by our local commissioners, the Dudley Clinical Commissioning Group.

As has happened in previous years, a draft of the quality account/report will be circulated to the committee for formal comment when available. The final version will be provided too, which will include full end of year data, the statutory statements from the organisation on quality and a quality overview to include a selection of local and national quality indicators.

2. Quality Priorities/Targets for 2014/15 and present position at quarter 3 – December 2014)

1. PATIENT EXPERIENCE	
Hospital	**Community**
a) Maintain an average score of 8.5* or above throughout the year for patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 90 per cent of patients will report that their call bells are always answered in a reasonable time.	a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment. (2013/14 was 8.8 out of 10) b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished. (2013/14 was 8.3 out of 10)

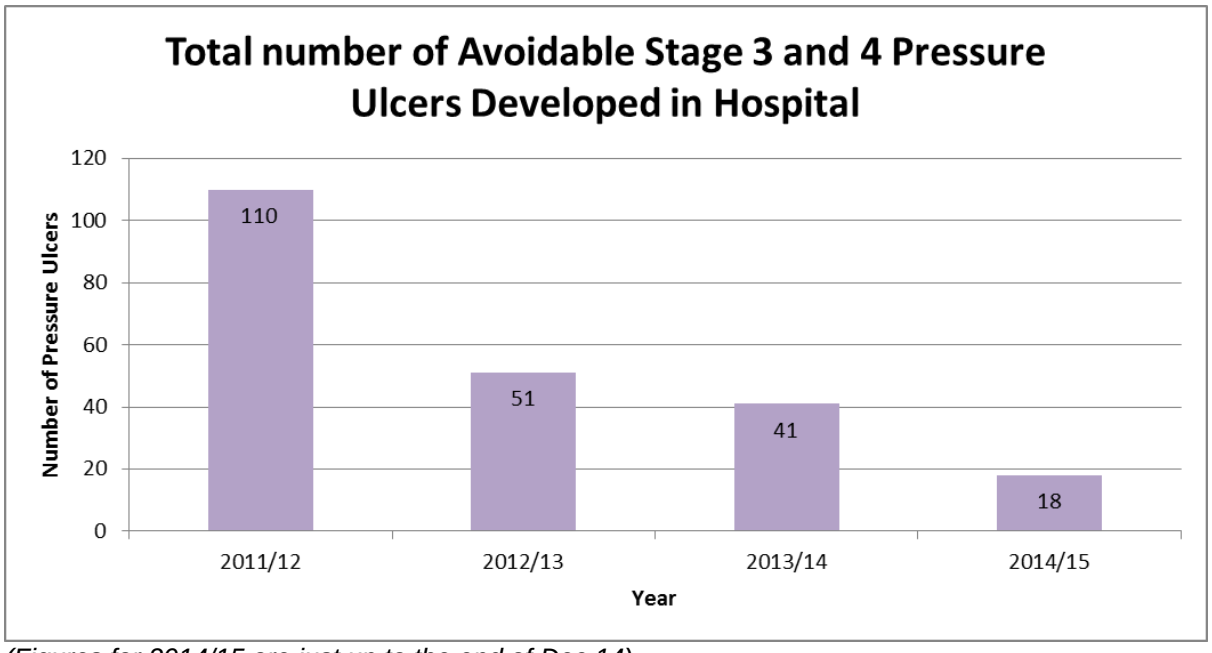
*Change of scoring system to be consistent with the national surveys. Now out of 10 rather than 100

Present position

With regards to patient's perceptions of receiving enough help to eat at meal times the survey results up to December 2014 indicate a score of 8.95 and so the target is presently being met. Of the 1140 patients surveyed, 10 reported they sometimes or never got the help they needed. Senior nurses are informed of these patients immediately so the problem can be resolved straightaway. Over 86% of patients are indicating that their call bells are always answered in a reasonable time so some work is still required to reach the end of year target. The community targets are based on an annual survey and this is not yet completed.

2. PRESSURE ULCERS	
Hospital	**Community**
Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2014/15 does not increase from the number in 2013/14.	Ensure that there are no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload. Ensure that the number of avoidable stage 3 acquired pressure ulcers on the district nurse caseload in 2014/15 does not increase from the number in 2013/14.

Present Position



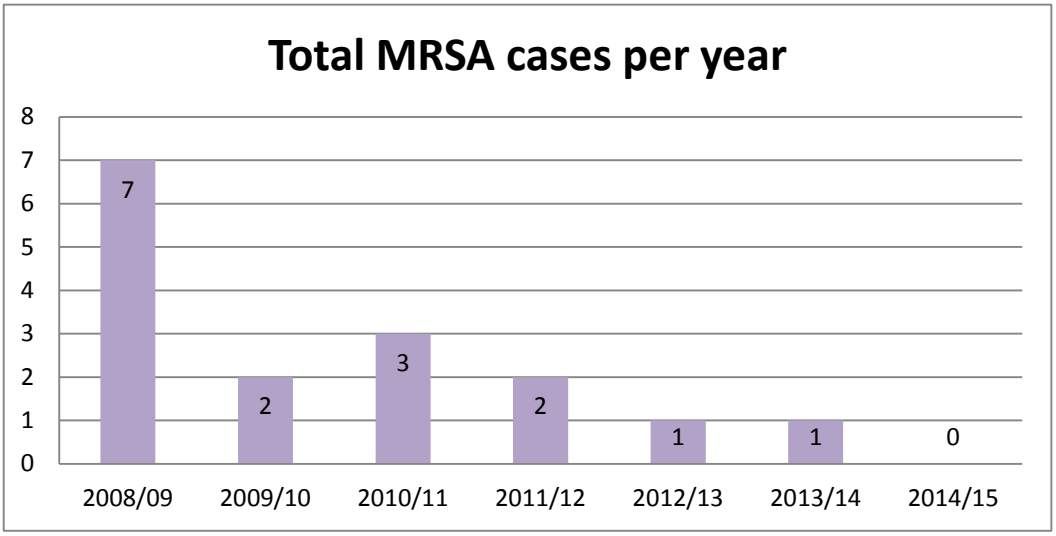
(Figures for 2014/15 are just up to the end of Dec 14)

With regards to avoidable pressure ulcers generally in the hospital, the above graph shows the steady decline in their incidence. With regards to the specific targets, the Trust has recorded 18 avoidable stage 3 pressure ulcers and a single stage 4 ulcer. This means we have missed one target and are on track to achieve the other. The picture in the Community indicates the achievement of one of the targets (no avoidable stage 4 avoidable ulcers) and with regards to avoidable stage 3 ulcers there have been four cases but two of these are under discussion due to their main cause being delayed equipment provided by an organisation unrelated to the Trust. The outcome of those discussions will likely affect the achievement or otherwise of the target.

3. INFECTION CONTROL	
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities.	
MRSA	**Clostridium difficile**
Have no post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 48 post 48 hour cases of Clostridium difficile.

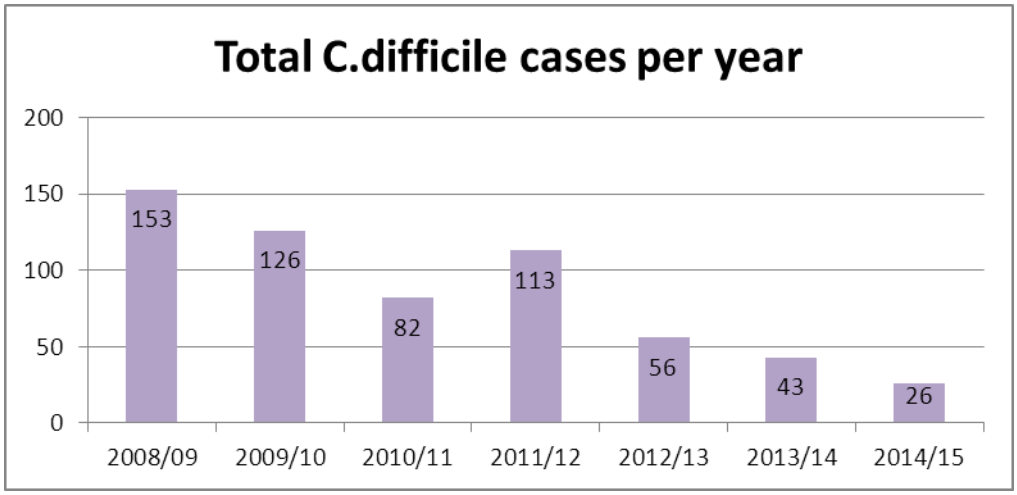
Present Position

Below are graphs that show the latest year on year figures and that this year's targets are being met:



(Figures for 2014/15 are just up to the end of Dec 14)

There have been no post 48 hour MRSA bacteraemia cases so far this year and so that target is being met.



(Figures for 2014/15 are just up to the end of Dec 14)

It can be seen above that for the third quarter the Trust is achieving its C. difficile target with 26 cases against a target of 36.

4. NUTRITION

Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2015).

5. HYDRATION

Ensure that on average throughout the year 93 per cent of patients' fluid balance charts are fully completed and accumulated at lunchtime.

These targets are measured by the Nursing Care Indicator process which consists of 10 records each month on every ward being audited. At the end of the third quarter both of these targets are presently being met with the weekly risk assessments for nutrition reaching 91% and 93% of the fluid balance charts being completed.

6. MORTALITY

Ensure that 85 per cent of in-hospital deaths undergo specialist multidisciplinary review within 12 weeks by March 2015.

Our Mortality Tracking Process includes clinical coding, validation, multidisciplinary specialist audit and where necessary senior medical and nursing review led by our Deputy Medical Director. This process takes up to 16 weeks in total to ensure that each and every death occurring in hospital is understood and that we are responsive to the information we gather from the process. At present, we are on schedule to achieve this target.

Overall – With the data available for 11 of the 13 targets, it can be seen that the majority (nine) are on track to be met with two targets missed so far. However, as previously stated things may change by the end of the financial year.

4. Prioritisation of quality priorities for 2015/16 and involvement of patients and the public in our decisions

The Trust Board of Directors are of the view that the existing topics are still key care issues of importance to patients and the public and so should remain priorities next year. This view was endorsed at a recent meeting of the Council of Governors. It was agreed to keep the priority topics the same for 2015/16 to allow further progress to be made with these key issues.

The Trust has consulted in a number of ways with the public and various interested bodies on these proposals. A questionnaire was designed for this purpose. It was distributed at the Annual Members meetings and was available for completion on the Trust website.

5. Proposed Quality Priorities/Targets for 2015/16

PRIORITY 1: PATIENT EXPERIENCE
A Patient Experience priority to be retained. With the community results for 2014/15 still awaited, the details of both the hospital and community targets for 2015/16 have not yet been decided.

PRIORITY 2: PRESSURE ULCERS
This topic to be retained. Discussions will occur with the commissioners to agree the exact target; this is likely to involve a requirement to reduce further the incidence of Stage 3 avoidable pressure ulcers in the hospital and a zero tolerance to Stage 4 avoidable ulcers in both hospital and community.

PRIORITY 3: INFECTION CONTROL
This topic to be retained and the Trust will be set targets by the Department of Health. For MRSA Bacteraemia a zero tolerance is likely to continue.

PRIORITY 4: NUTRITION
This topic to be retained and the target set will depend on the outturn figures for 2014/15.

PRIORITY 5: HYDRATION
This topic to be retained and the target set will depend on the outturn figures for 2014/15.

PRIORITY 6: MORTALITY
This topic to be retained and the target set will depend on the outturn figures for 2014/15.

(*As stated, please note that the topics and detail of the associated targets still need final confirmation*).

6. Equality Impact

The Dudley Group NHS Foundation Trust is committed to ensuring that as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

7. Recommendation

7.1 That the committee receives this report for information and provides its view on the quality priorities for 2015/16.

Derek Eaves
Quality Manager
The Dudley Group NHS Foundation Trust

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Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Agenda Item No. 5

Health Scrutiny Committee – 16th February, 2015

DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST

QUALITY ACCOUNT SUMMARY FOR 2014/15

Report from the Head of Nursing, Quality and Innovation

1. Introduction

This paper describes the quality priorities and associated targets that the Trust set at the beginning of the year which were included in the published Quality Account for 2013/14. It gives an indication of current progress in respect of these. As this is not a 'year-end' position, it has to be appreciated that a final and complete analysis can only be done at the end of the year, which is 31st March 2015. It also indicates how the Trust has been developing its priorities for quality improvement for the coming year. At the time of writing, the priority topics have not yet been formally decided by the Trust.

The draft Quality Account will be circulated to the Committee when available. This will include full end of year data, the statutory statements from the organisation on quality and a quality overview to include a selection of local and national quality indicators.

2. Quality Priorities for 2014/15

Following a process of service review and consultation with staff, service users and carers and other partners, the Trust identified seven quality goals to be priority areas for 2014/15. These formed the basis of the Trust's Quality Account.

The Trust believes that these goals were especially pertinent as 'barometers' for service quality as they reflect the current priorities of the organisation, are distributed across the three domains of quality, represent both local and national agenda and will be applicable to new services being developed as part of the Trust's Service Transformation work.

The following sections show progress against the priorities stated in the Quality Account. The position at the end of the year will be available and reported within the Trust's 2014/15 Quality Account in June 2015.

Delivering high quality safe services

Quality Goal 1: Providing meaningful and effective inpatient activities

Rationale for Inclusion

The Trust identified this as a priority following feedback from a number of sources including, Experts by Experience Reports and Care Quality Commission feedback. Furthermore acute inpatient services and older adult services are undergoing service transformation and it is timely to revisit inpatient activities to ensure they are meaningful and effective.

Figure 1: Progress against Priority 1

Progress
The Trust is undertaking the development of a therapeutic hub; the hub will enable improved access to psychological therapies and ensure a range of diversion and therapeutic activities across inpatient services.
Education for inpatient nurses of the value of therapeutic activities will be provided through the nurse development programme.
A revised programme for therapeutic/diversion activities has been developed for inpatient services, alongside an activity recording tool in order to monitor interventions and activity.

Quality Goal 2: Embedding the 'Think Family' model across Child and Adolescent Services and Adult Mental Health services.

Rationale for Inclusion

Following the Trust's involvement in a thematic CQC / Ofsted inspection and the subsequent publication of a national report 'What about the Children,' the Trust has emphasised the importance of a 'think family' approach within services. The Trust has also received feedback from Serious Case Reviews and Domestic Homicide Reviews which have highlighted the need for further integration of think family processes between adult and child mental health services, including addressing domestic violence.

Figure 2: Progress against Priority 2

Progress
Roles and responsibilities training has been delivered to clinical managers/leads across all clinical services.
A joint working protocol between Adult Mental Health Services and Child and Adolescent Mental Health services has been developed, enabling more integrated service delivery.
A policy for dealing with Domestic Abuse has been developed with "think family" principles embedded throughout.

Quality Goal 3: Management of Disruptive and Aggressive Behaviour

Rationale for Inclusion

Disruptive and aggressive behaviour is one of the Trust's highest reported categories of incidents and therefore the Trust needs to ensure it is maintaining best practice guidelines and taking on board learning from national reports such as Winterbourne View 2012. This includes the Trust approach to restraint reduction planning.

Figure 3: Progress against Priority 3

Progress
Management of Violence and Aggression policy developed and ratified.
A new model to assist in developing behaviour support plans for patients is under development.
A revised model for debriefing both staff and patients following an incident is being developed.
Standards for reporting physical holding and clinical holding agreed and developed for Trusts incident reporting system.
An audit of 12 months incident data is currently underway to inform a restraint reduction plan.

Quality Goal 4: Focussing on dementia care

Rationale for Inclusion

The Trust identified dementia care as a quality improvement priority through internal clinical governance processes and feedback from the Care Quality Commission Review. It is also timely as older adult services are part of the Trust's current plans for service transformation programme. This will be informed by the national dementia care strategy.

Figure 4: Progress against Priority 4

Progress
Analysis of staff competency and training needs completed.
Basic skilled-based training has now been delivered to **All** inpatient nursing staff
Dementia Care Awareness E-Learning package rolled out 2014 - **All** relevant staff have now completed.
A review of the dementia ward environment has been undertaken by a specialist architect and a programme of refurbish work is to commence February 2015.
A dementia care workbook for staff has been developed by Learning and Development, Occupational Therapy and Psychology.

Quality Goal 5: Health Care Assistant development programme – Fundamentals of Care.

Rationale for Inclusion

One of the themes of the Francis Report was the importance of the role of untrained care staff in the delivery of high quality services. On this basis, the Trust has developed bespoke Heath Care Assistant (HCA) development programme. This was piloted in 2013/14 and was successful in terms of increasing knowledge, confidence, and engagement and in changing behaviours. This programme is currently being rolled out Trust wide.

Figure 5: Progress against Priority 5

Progress
A total of eight cohorts of HCAs and support staff have been agreed by the Trust and planned for a rolling programme. Cohort one completed with two and three underway and nominations for cohorts four, five and six on going.
Health Care Assistants mentorship books have been developed along with guidance for line managers.
A post course line manager and delegate evaluations form has been developed to measure the impact of training and will commence February 2015.

Quality Goal 6: My Care Plan

Rationale for Inclusion

During 2013/14, the Trust focussed on ensuring that service users were actively involved in the development of care plans and received copies. The Trust has decided to maintain care plans as a quality priority for 2014/215 with emphasis this year on ensuring that the quality of the care plan is recovery and outcome-focussed.

Figure 6: Progress against Priority 6

Progress
The Care Co- Ordination Association has published national best practice standards for care planning, which the Trust has now adopted and will provide clinicians with a Care Programme Approach best practice handbook to support practice and supervision.
My Care Plan now forms part of the nurse development programme in delivering recovery focused care planning.
Awareness training for clinicians is being developed to deliver Trust standards in line with best practice.

Quality Goal 7: Ensuring and enabling effective engagement with family and carer involvement

Rationale for Inclusion

Over the previous year, the Trust focussed on implementing the Triangle of Care model across inpatient and community services. To ensure this is fully embedded and monitored the Trust has maintained this as a priority for 2014/15 with emphasis on community services.

Figure 7: Progress against Priority 7

Progress
The Trust achieved accreditation from the Carers' Trust for its commitment and progress made in relation to the implementation of Triangle Of Care within the inpatient settings.
The focus is now on community services to include unannounced visits facilitated by the Experts By Experience and awareness sessions for community staff on Triangle of Care.
Pan-Trust carer awareness training has been developed and has commenced January 2015.

3. Quality Improvement Priorities for 2015/16

The Trust is currently in the process of developing its quality improvement priorities and is currently undergoing consultation with key stakeholders. Once agreed, they will be articulated in the Quality Account for the coming year which will be distributed for consultation and published in June 2015.

4. How do we review and monitor these priorities?

Each quality improvement priority identified for 2014/15 will be delivered through the framework identified in the Trust's Quality Improvement Strategy. Progress will be monitored through the quality governance framework and overseen by the Governance and Quality Committee. The Governance and Quality Committee and Trust Board will receive quarterly updates on progress and also any required exception reports.

Recommendation	Action	Lead/liaison with	Timescale	Progress/report Feb 2015
1.0 Stop Smoking Service				
1.1	Engage with key community groups to establish what will best help them to quit; best way to communicate dangers of smoking and benefits of quitting. Also engage with community and primary care to identify training needs to accelerate quit rates amongst key groups. Institute community Champions network from engagement with key groups to ensure the effective development of SSS services.	Public Health (PH) Dudley Stop Smoking Service (SSS) in collaboration with Dudley Clinical Commissioning Group (CCG) and DGHFT Community Services.	Sept 2015	PH SSS staff member has carried out semi structure interviews with male routine and manual workers (in workplace setting) as part of Masters research. Initial key findings suggest peer and family members smoking behaviour influences smoking initiation. Workplace policy is key to influencing and changing smoking behaviour. Final recommendation will be taken forward in the Tobacco Action plan for 2015-16 PH SSS have commissioned Dudley Healthwatch to engage with CCG, DGHFT and targeted communities. Work programme to commence Feb 2015
1.2, 1.3	Dudley SSS target provision for: MH groups; Routine/manual workers; key BME groups; and most disadvantaged communities evidenced through existing data monitoring	PH SSS working with DWMHPT, Key Voluntary Community Sector agencies, and Environmental Health - DUE.	March - Sept 2015	Dudley SSS have undertaken a scoping exercise with Mental Health service providers and patients to improve communication on promoting stop smoking services. Resources in development in conjunction with DWMHFT leads. Have seen an increase in uptake of workplace stop smoking services which targets routine and manual workplaces. Dudley SSS Health Equity Audit (HEA) for 2012-13 has shown the number of clients accessing the service is five times higher in the most deprived quintile compared to the least deprived quintile and Access from clients in routine and manual social economic classification is significantly higher than from other occupations 2 key localities identified from HEA that have high smoking prevalence and low stop smoking service access (Coseley East, Coseley West

				and Pedmore & Stourbridge East.).Additional service provision has been set up in these areas from Nov 2014. Data on outcome/impact available May 2015. Plans to further target service provision in the 2015-16 Tobacco Action Plan in conjunction with CCG commissioners
1.4	Family Nursing Partnership (FNP) commissioned to recommended capacity with the particular aim of accelerating reduction of tobacco use across new families	CCG/NHS England-FNP commissioner (Public Health will be the commissioner of FNP from 2016)	Jan 2015	FNP have recruited 2 new Nurses who are due to commence in post the end of this month. That will take them to full capacity of 8 nurses/ 1 supervisor. They promote stopping smoking as key part of their role. The National FNP Unit are updating the programme to bring into line with UK policy . Tobacco update not completed yet but in process which hopefully will strengthen the current programme.
2.0 Young People-Tobacco Education				
2.1	Deliver a multifaceted local programme that supports smokefree communities, social norms , targets younger children and family/parents. Extend Kick-Ash creative advocacy approach across early years provision. Consult young people representative groups on development of programme including Youth Parliament.	PH SSS commission programme in conjunction with Children Services Education leads and Children Centres.	Sep 2014	PH SSS commissioned insight with health professional working with 0-5 years on the update of the Smokefree Children Programme (SFC). Engagement carried out Sep-Dec2014. Key actions and resource needs identified and are in progress. Workshops were developed using the straight talking DVD to discuss with primary school children where they encounter people smoking around them and what they think could be done about this. 19 school received creative workshop in Jun 2014 and a further 20 in Oct 2014 (total of 3,100 pupils) Follow up of the programme in Jan 2015 with a sample (100) of participants has shown 37 children have directly influenced someone to

				stop smoking around them or stop completely Kick Ash members held a 'red carpet' celebration event in Oct 2014 to showcase work to Youth Parliament, family & friends. 152 people attended and an advert produce by young people in Dudley was premiered this can viewed at www.dudleykickash...
2.2	Implementation of a voluntary smokefree code/policy specifically for outdoor play areas	Law and Governance - Corporate Resources	Sept 2014	96% of the primary school children that were followed up after the smokefree children workshops said they wanted action taken (by the Local Authority or Government) to protect them from second hand smoke. Plan for 2015-16 SFC programme to include developing smokefree school grounds (including school gates) and parks
3.0 Leadership, Partnership and Communication				
3.1, 3.2, 3.4, 3.5	Training for identified/appropriate front line staff to be provided by PH across Council Services to promote SSS and referral ensuring consistent message. Counterfeit/illicit tobacco surveillance embedded in routine home checks. Formalised reporting mechanism between Housing and Trading Standards (TS) to support targeted enforcement agenda particularly across high density social housing.	PH co-ordinate across Directorates through Corporate Board/ADs Group.	Mar 2015 onwards	Stop Smoking Services are being promoted widely as part of the council's Workplace Health & Wellbeing programme. PH and TS leads have met with DACHS T&EM Agreed three actions: **1.** TS to attend team meetings with Housing Managers/ASB Teams. Also discuss other issues TS get involved in **(in progress)** **2.** Look at placing advert into home affairs **(ad produced to go in Mar 2015 edition)** 3. Link with Housing Support **(in progress)** Already increased intelligence being received from housing manager to TS
3.3	Appoint an elected member, who would not be affected by any aspect of tobacco control to champion work for effective stewardship of strategy; and motivate leaders to support and	PH SSS in consultation with Corporate Resources	Sep 2014	On-going

	embed improvements in strategy for long-term success.			
3.6	Hardwire concession in HWWB/PNA strategy ahead of EU Directive restrict access of tobacco products and E-cigarettes to young people U 18. Implementation of pledge an action campaign encompassing local SME's with underpinning communications plan	PH SSS lead out in consultation with HWBB/Pharmacy Leads/Chamber of Commerce/Council Marcomms.	Mar 2015	This has been superseded with national consultation on Age of Sale for Nicotine Inhaling Products regulation under the children & Families Act. A brief was circulated to Health & Wellbeing & Corporate Board to support this via the Smoke Free Action Coalition. Endorsement sent on 26th Jan 2015 in support.
3.7	TS work with Marcomms to develop and promote a distinct whistle-blow process enabling members and the public to conveniently report cases for further investigation.	TS – DUE	Sept 2014	Using Tobacco Detection dogs has increased capacity, seizures and penalties. Has resulted in increased publicity and intelligence reporting from retailers and member of the public

Dudley Metropolitan Borough Council

Agenda Item No. 7

Health Scrutiny Committee – 16th February, 2015

Report of the Head of Membership Development

NHS England Co-Commissioning and Primary Care Intentions – Dudley Commissioning Group - Delegated responsibility for the Commissioning of General Medical Services (GP services)

Purpose of Report

1. To update the Committee regarding the CCGs submission to NHS England to take on delegated responsibility for the commissioning of GP services.

Background

2. In June 2014 the CCG expressed an interest to NHS England to take on delegated responsibility for the commissioning of GP services that was endorsed by the Dudley Health and Wellbeing Board

3. In November 2014 NHS England released further guidance "Next steps towards primary care co-commissioning" that set out the process for CCGs to apply to take on this additional responsibility

4. The CCG established a Task and Finish group to put together our submission to NHS England that was made in January 2015.

   The submission to NHS England required the CCG to undertake the following
   - Review and revise its conflicts of interest management policy in light of forthcoming new statutory guidance;
   - Describe the intended benefits of co-commissioning arrangements;
   - Detail the finance arrangements of the delegated budget; and
   - Complete and sign a declaration.

   The submission also required the Area Team of NHS England to confirm that
   - The CCG met the required assurance thresholds;
   - Confirm that the CCG met the required conflicts of interest management thresholds;
   - Confirm that the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements; and
   - Complete and sign a declaration.

   NHS England also required the following in support of the submission

   - A copy of the CCG Information Governance tool kit, Terms of Reference for new Primary Care Commissioning Committee, and updated CCG constitution with constitutional amendments submitted.

5. In January 2015 the CCG Board approved
    - The submission to NHS England to take on delegated commissioning of GP services with effect from 1st April 2015
    - The revisions to constitution as agreed by the Task and Finish Group
    - The Terms of Reference for the Primary Care Commissioning Committee as agreed by the Task and Finish Group
    - Devolved responsibility to the Chief Accountable Officer and Chief Finance Officer to negotiate with NHS England on managing the transfer safely

6. The Good Governance Institute (GGI) has reviewed our Constitution changes and Commissioning Committee terms of reference for taking delegated responsibility for GP services. GGI has confirmed that our governance arrangements provide a sound framework for managing the delegated responsibility and potential conflicts of interest effectively.

7. A submission was made to NHS England on the 7th January 2015. We are awaiting a formal response in February 2015. We have been advised by NHS England that approval should now be a formality.

8. The addition of delegated commissioning to the CCGs portfolio will require additional investment in support functions to deliver the services required to support this additional activity. The CCG structure is being reviewed with a view to identifying the additional capacity required.

9. NHS England has established Task and Finish groups for all Birmingham, Solihull and Black Country CCGs to ensure a safe handover and transition of functions to CCGs taking on the responsibility for full delegation.

Finance

10. The CCG will be assuming a budget of £37.5M as set out in the submission made to NHS England.

    The financial information has been provided by NHS England and is being reviewed to ensure that there are no cost pressures being passed to the CCG once we assume delegated responsibility for the from 1st April 2015.

Recommendation

11. It is recommended that that the Committee:-
    - Note the content of this report for the CCG to assume delegated responsibility for the commissioning of GP services
    - Note that the submission to NHS England provides full assurance that the CCG has taken action to ensure that any potential conflicts of interest have been addressed
    - Note that a process in now in place to ensure a managed transition of functions from NHS England into the CCG

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Daniel King
Head of Membership Development

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List of Background Papers
Submission to NHS England as approved by the CCG Board

DUDLEY CLINICAL COMMISSIONING GROUP

Proposed changes to the group's Constitution December 2014 – IMPACT ASSESSMENT

INTRODUCTION

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

IMPACT ASSESSMENT AGAINST REVIEW CRITERIA

Criteria	Impact of changes
The constitution meets the requirements of legislation and is otherwise appropriate.	The constitution continues to meet legislative requirements and remains otherwise appropriate after the proposed changes to the Constitution are made. Changes are required to reflect co-commissioning arrangements soon to be put in place
Each of the members is a provider of primary medical services.	This is the case
The area is appropriate (ie that there are no overlapping CCGs and no gaps),	This remains the case
The proposed Accountable Officer is appropriate	No changes have been made
T the CCG has made appropriate arrangements to ensure it is able to discharge its functions	Proposed changes have a positive impact upon our ability to discharge our functions, particularly in relation to commissioning of primary medical services
Arrangements are in place to ensure that its governing body is correctly constituted and otherwise appropriate	The proposed addition of a further Clinical Executive (for Systems Redesign) is intended to strengthen the governing body membership
The likely impact of the requested variation on the persons for whom the CCG has responsibility – so the registered and resident population of the CCG	The changes sought regarding primary medical service commissioning going forward are reflected in the Constitution, and these will benefit our registered and resident population.
The likely impact on financial allocations of the CCG and any other CCG affected for the financial year in which the variation would take effect	No variation in CCG membership that would require ant financial variation to be enacted
The likely impact on NHS England's functions	The proposed changes reflect the delegation of primary care medical services for Dudley, from NHS England to the CCG.
The extent to which the CCG has sought the views of the following, what those views are, and how the CCG has taken them into account: • any unitary local authority whose area covers the whole or any part of the CCG's area; • any other CCG which would be affected; and • any other person or body which in the CCG's view might be affected by the variation requested • patients and the public; what those views are; and how the CCG has taken them into account	The group has sought the views of appropriate stakeholders in relation to changes to primary care medical service commissioning and agreement at our Primary Care Commissioning Task & Finish Group of proposed changes to the Constitution. The Governing Body will adopt the changes to the Constitution at its 8 January 2015 meeting.

CONCLUSION

The proposed changes are required to ensure that our governance arrangements are fit for purpose and properly described within our Constitution. This impact assessment confirms that the proposed changes satisfy the requirements of NHS England to support constitutional changes.

IG Toolkit Assessment Summary Report
NHS Dudley CCG
(Clinical Commissioning Group)
Prepared on 18/12/2014

Information Governance Management

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Exempt	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 11 (2013-2014)	Published	0	0	3	2	0	0	5	80%	Satisfactory	Satisfactory	n/a
	Target	0	0	3	2	0	0	5	80%	Satisfactory	Satisfactory	n/a

Confidentiality and Data Protection Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Exempt	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 11 (2013-2014)	Published	0	0	7	0	1	0	8	66%	Satisfactory	Satisfactory	n/a
	Target	0	0	7	0	1	0	8	66%	Satisfactory	Satisfactory	n/a

Information Security Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Exempt	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 11 (2013-2014)	Published	0	0	13	0	0	0	13	66%	Satisfactory	Satisfactory	n/a
	Target	0	0	13	0	0	0	13	66%	Satisfactory	Satisfactory	n/a

Clinical Information Assurance

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Exempt	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 11 (2013-2014)	Published	0	0	1	0	0	1	2	66%	Satisfactory	Satisfactory	n/a
	Target	0	0	2	0	0	0	2	66%	Satisfactory	Satisfactory	n/a

Overall

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Exempt	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 11 (2013-2014)	Published	0	0	24	2	1	1	28	69%	Satisfactory	Satisfactory	n/a
	Target	0	0	25	2	1	0	28	69%	Satisfactory	Satisfactory	n/a

Grade Key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

Version 11 (2013-2014) History

Status	Date
Reviewed (Satisfactory)	31/03/2014 10:22
Published	29/03/2014 12:46
Confirmed	29/03/2014 12:45
Started	28/03/2014 12:54
Confirmed	28/03/2014 12:54
Published	27/03/2014 15:17
Confirmed	27/03/2014 15:16
Started	04/07/2013 15:17

NHS England

Next steps towards primary care co-commissioning: Annex B

Submission proforma for delegated commissioning arrangements

November 2014

Introduction

The following proforma should be completed by CCGs and area teams where a CCG wishes to implement a delegated commissioning arrangement.

Part one is for completion by the CCG. It requires CCGs to:

- review and revise its conflicts of interest management policy in light of forthcoming new statutory guidance;
- describe the intended benefits of co-commissioning arrangements;
- detail the finance arrangements of the delegated budget; and
- complete and sign a declaration.

Part two is for completion by the area team. It requires the area team to:

- confirm that the CCG meets the required assurance thresholds;
- confirm that the CCG meets the required conflicts of interest management thresholds;
- confirm that the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements; and
- complete and sign a declaration.

CCGs and area teams are encouraged to take note of the supporting annexes in the *Next steps towards primary care co-commissioning* document, specifically the model wording for constitutional changes (Annex C) and model terms of reference (incorporating the scheme of delegation) for delegated commissioning (Annex F) when completing this proforma.

Please note: this annex is provided in draft form and will be finalised following publication of forthcoming NHS England statutory guidance on managing conflicts of interest in December.

CCGs and area teams should submit the following to

england.co-commissioning@nhs.net by **noon on Friday 9 January 2015**

1. This form, with parts I and II completed
2. Conflicts of interest policy (draft or ratified version)
3. CCG governance structure, including any terms of reference and scheme of delegation
4. Copy of the CCG(s) IG Toolkit
5. CCG constitution or proposed constitutional amendment submitted

Please note that any necessary constitutional amendments should also be sent to the **relevant regional office**.

PART I: TO BE COMPLETED BY THE CCG

A	Conflicts of interest
	CCGs have a statutory requirement to: • Maintain one or more registers of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees. • Publish, or make arrangements to ensure that members of the public have access to these registers on request. • Make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group, and record them in the registers as soon as they become aware of it, and within 28 days. • Make arrangements, set out in their constitution, for managing conflicts of interest, and potential conflicts of interest in such a way as to ensure that they do not and do not appear to, affect the integrity of the group's decision-making processes. Conflicts of interest, actual and perceived, need to be carefully managed within co-commissioning. New statutory guidance for conflicts of interest management in primary care co-commissioning is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor, HealthWatch and the National Audit Office, and will be published in December 2014. The guidance will include a strengthened approach to: • the make-up of the decision-making committee; • national training for CCG lay members; • external involvement of local stakeholders; • register of interest; and • register of decisions. Further detail is set out in of the conflicts of interest section in the *Next steps towards primary care co-commissioning* document. The CCG declaration (below) confirms that the CCG has reviewed and revised its conflicts of interest management processes and procedures in light of the forthcoming NHS England statutory guidance on managing conflicts of interest to ensure that it meets the requirements.

	CCGs must attach a copy of its revised conflicts of interest policy. Draft versions will be accepted, although confirmation that the CCG governing body has ratified the updated policy is required by 30 January 2015.
B	**CCG supporting statement to describe the intended benefits to patients through delegated co-commissioning arrangements** *<maximum 400 words>*
	We are ideally placed to take full advantage of the opportunities such a partnership would offer for our patients – including better quality of care, improved outcomes, reduced inequalities, more integrated services and greater patient and public involvement. Our Primary Care development strategy was approved at the Sept 2013 Dudley Health and Wellbeing Board (H&WBB); and subsequently, following further consultation resulted in approval at the January 2014 H&WBB for Dudley CCG to approach NHS England to jointly commission GP Services as the best means to delivering the benefits set out in the strategy. This was subsequently incorporated into both the CCG five-year strategy (approved at the March 2014 H&WBB) and the local Area Team strategy. Our proposal for full delegated authority is predicated on three areas • To effectively review and pilot new ways of commissioning outside of the core requirements of GMS – setting one set of outcome measures that will apply to all those services commissioned and working as part of an integrated population based health and wellbeing service with primary care at the heart of the model. • To commission for shared outcomes across the whole system of integrated care to ensure that all the organisations working in Dudley are working to the same outcome objectives for our population. • To lead and manage the process for review and revising all GP contracted activity outside of GMS (so including QOF, enhanced services and PMS resource allocations), and retain any surplus within Dudley to reinvest within Dudley to improve the quality of primary care services and support the delivery of our service integration model. We have well developed plans to redefine and improve the quality standards for primary care, including a 3rd option for re investing PMS premium into a local quality improvement scheme, and we have the engagement infrastructure with our GP membership to support performance improvement in a way that NHS England just does not have the capacity for. We have well established patient and public involvement in the commissioning of our services with 42 out of 47 practices with active PPGs and already engage with patients elected from our constituent PPGs in reviewing commissioning priorities. We have developed robust governance arrangements that have been independently assessed by the Good Governance Institute: these include a revised and conflict of interest policy, standards of business conduct policy and amended constitution that have been agreed by the Governing Body on the 8th January 2015.

C	Finance template for delegated budgets: to be completed by CCGs on or before noon on 9 January 2015
	Notes for completing the finance template: 1. Double click into the table to complete the excel template. 2. Please enter the notified numbers for your CCG. 3. Please enter how you intend to spend the delegated budget in 2015/16. If your proposal is approved you will need to submit the detail of your planned spend as set out in the planning guidance. 4. Please include any additional investment the CCG is planning to make in primary care services from other areas of spend.

Dudley CCG's Co-comissioning finanical submission

	Notified delegated Budget (1)	Movement out of GP Services (2)	Movement Into GP Services (3)	Total
	£'000	£'000	£'000	£'000
GP Services	+	-	+	+/-
General Practice - GMS	10,483			10,483
General Practice - PMS	13,780			13,780
Other list based services (APMS)	285			285
Premises cost reimbursements	3,121			3,121
Other premises costs	-			-
Enhanced services	2,358		2,246	4,604
QOF	4,145			4,145
Other GP services	1,014			1,014
Primary care NHS property services - GP	2,384			2,384
Sub Total GP services	37,571	-	2,246	39,817

	N/A	+	-	+/-
Acute services				-
Mental health services				-
Community health services				-
Primary care services			- 2,246	- 2,246
Continuing care services				-
Other care services				-
Sub total CCG programme costs		-	- 2,246	- 2,246

Total	37,571	-	-	37,571

Please provide a description in the change in spend detailed above:

The financial information has been provided by NHS England's central team and is being reviewed to ensure no cost pressures are being passed onto the CCG if we are successful in our bid for full delegation of Primary Care Commissioning budgets from 1st April 2015. Therefore the submission is made on a number of conditions and will be open to change to reflect ongoing discussions with NHS England to agree the final delegated budgets.

Please provide a description in the change in spend detailed above: (Continued)

Dudley CCG's share of the planning framework assumptions is still to be agreed and therefore it is assumed that a share of the Contingency reserve, 15/16 Growth funding and other reserves relevant to primary care such as premises and investments will be in addition to the budget figures being reported in the appendix above.

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

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

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

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

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

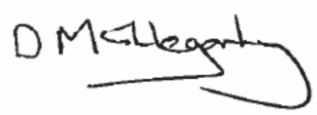
D	CCG declaration

I hereby confirm that NHS Dudley CCG membership and governing body have seen and agreed to all proposed arrangements in support of taking on delegated commissioning arrangements for primary medical services on behalf of NHS England for 2015/16.

Signed on behalf of NHS Dudley CCG governing body

Name: **Dr David Hegarty**

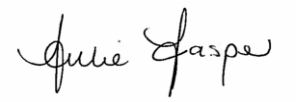
Position: **Chair**



Date: **9 January 2015**

I hereby confirm that the CCG has in place robust conflicts of interest processes which and have been reviewed in light of the CCG's statutory duties set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), and the NHS England statutory guidance on managing conflicts of interest, prior to submission.

Signed by Dudley CCG Audit Committee Chair



Name: **Mrs Julie Jasper**

Position: **Chair of the Audit Committee**

Date: **9 January 2015**

Signed by Dudley CCG Accountable Officer

Name: **Mr Paul Maubach**

Position: **Chief Accountable Officer**

Date: **9 January 2015**

PART II: TO BE COMPLETED BY AREA TEAM

Assurance domains ***To be pre-populated by Area Team from 2014/15 Q2 data***	**Current Level**
Domain 1: Are patients receiving clinically commissioned, high quality services?	
Domain 2: Are patients and the public actively engaged and involved?	
Domain 3: Are CCG plans delivering better outcomes for patients?	
Domain 4: Does the CCG have robust governance arrangements?	
Domain 5: Are CCGs working in partnership with others?	
Domain 6: Does the CCG have strong and robust leadership?	
Additional assurance	
Area team confirms the CCG is capable of taking on delegated functions.	*[please tick]*
Area team confirms the CCG meets the required conflicts of interest management thresholds in line with the forthcoming statutory guidance.	*[please tick]*
Area team confirms the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements.	*[please tick]*
Any additional comments	

Area team declaration
I hereby confirm, on behalf of NHS England, that NHS **[insert name]** CCG meets the required conflicts of interest management, finance and assurance thresholds to proceed with delegated commissioning arrangements. **Signed on behalf of the NHS England [insert name] Area Team** Name: Position: Date:

PART III: FOR NHS ENGLAND OFFICE USE ONLY

NHS England Commissioning Committee
This serves as confirmation that, following a meeting of the NHS England Commissioning Committee on **[insert date],** NHS **[insert name]** CCG has been approved to proceed with delegated commissioning arrangements for 2015/16, having met the required conflicts of interest management, finance and assurance thresholds. Name: Position: Date:
Confirmation of financial arrangements
Signed on behalf of the NHS England Name: Position: Date:

NHS England

Next steps towards primary care co-commissioning: Annex B

Submission proforma for delegated commissioning Arrangements.

DUDLEY CCG

DUDLEY CCG

PART II: TO BE COMPLETED BY AREA TEAM

Assurance domains ***To be pre-populated by Area Team from 2014/15 Q2 data***	**Current Level**
Domain 1: Are patients receiving clinically commissioned, high quality services?	Assured
Domain 2: Are patients and the public actively engaged and involved?	Assured
Domain 3: Are CCG plans delivering better outcomes for patients?	Assured with support
Domain 4: Does the CCG have robust governance arrangements?	Assured
Domain 5: Are CCGs working in partnership with others?	Assured
Domain 6: Does the CCG have strong and robust leadership?	Assured
Additional assurance	
Area team confirms the CCG is capable of taking on delegated functions.	✓
Area team confirms the CCG meets the required conflicts of interest management thresholds in line with the new NHS England statutory guidance.	✓
Area team confirms the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements.	✓

Any additional comments

Dudley CCG have actively planned for the delegation of GP primary care over a number months with a well organised approach managed through a task group which has involved the Area team at all stages .

The CCG has involved its membership and wider stakeholders in the decision to put forward their proposal and are clear on the benefits it will bring to providing integrated local care for patient's across Dudley.

The CCG has carefully reviewed the governance arrangements seeking external advice to support their proposal.

All CCGs have identified financial caveats to support their bids. Whilst the Area Team recognise that some of these reflect uncertainty at a point in time the Area Team is working to the following joint principles.

The allocation will be based on the finalised national figures.

The Area Team has been working with CFOs to understand the intrinsic notes within the allocation.

The Area Team cannot commit to any further funding over and above the total allocation for services to be transferred; it will continue to work closely with CCGs during the financial planning rounds.

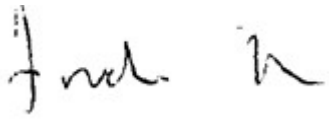
Access to any contingency will be mutually agreed through a designated process.

The Area Team strongly supports the CCG submission for undertaking full delegation form April 2015.

Area team declaration

I hereby confirm, on behalf of NHS England, that NHS Birmingham, Solihull & Black Country CCG meets the required conflicts of interest management, finance and assurance thresholds to proceed with delegated commissioning arrangements.

Signed on behalf of the NHS England Birmingham ,Solihull & Black Country Area Team



Name: Andrew Reed

Position: **Director of Commissioning Operations (West Midlands)**

Date:7th January 2015

PART III: FOR NHS ENGLAND OFFICE USE ONLY

NHS England Commissioning Committee
This serves as confirmation that, following a meeting of the NHS England Commissioning Committee on **[insert date],** NHS **[insert name]** CCG has been approved to proceed with delegated commissioning arrangements for 2015/16, having met the required conflicts of interest management, finance and assurance thresholds. Name: Position: Date:
Confirmation of financial arrangements
Signed on behalf of the NHS England Name: Position: Date: